

Monday, 3 November 2025

1
2 (10.04 am)
3
4 **KATHERINE ASHWORTH (sworn)**
5 **Questioned by MR MOSS**
6 **SIR ADRIAN FULFORD:** Thank you very much. Please have
7 a seat.
8 Yes, Mr Moss.
9 **MR MOSS:** Thank you, sir.
10 Just start by giving us your full name, if you
11 would.
12 **A.** Katherine Marie Ashworth.
13 **Q.** If we could have on the screen, please, LCC0001998. Can
14 you just confirm that this is the main statement that
15 you provided to this Inquiry, it is dated 5 September
16 but the signature block shows that you signed it on
17 16 September; is that right?
18 **A.** That's correct.
19 **Q.** Are the contents of that statement true to the best of
20 your knowledge and belief?
21 **A.** They are.
22 **Q.** Thank you. You have helpfully provided a second witness
23 statement. Could we have on the screen, please,
24 LCC002309.
25 That statement is dated, on its face, 26 October but
I think you signed it on 27 October. Can you just

1

1 Wellbeing Service in 2017?
2 **A.** I did.
3 **Q.** Thank you. I think at that time, 2017, you had been
4 promoted through the ranks, such that you were one of
5 three senior managers in the team, at that stage; is
6 that right?
7 **A.** Yes, that's right.
8 **Q.** Then, come Covid, if I've understood the chronology
9 correctly, the Head of Service left early in the
10 pandemic and you took over, initially as Acting Head of
11 Service?
12 **A.** I did, yes.
13 **Q.** Then, I think, you gained the role substantively?
14 **A.** That's correct.
15 **Q.** Do you still hold that role today?
16 **A.** I do.
17 **Q.** Thank you. You tell us, and we should recognise it from
18 the outset, in paragraph 4 that, in the post that you
19 held, you didn't have any direct involvement at the time
20 in decision-making on AR's case?
21 **A.** That's correct, I've had no involvement in that at all.
22 **Q.** Thank you. Ms Ashworth, you have been put on notice of
23 this, so it won't come as surprise to you, but I'm going
24 to in my questioning deal with the first period when AR
25 was opened to CFW in a little bit more detail, drawing

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1 confirm that that second statement is true to the best
2 of your knowledge and belief as well?
3 **A.** It is.
4 **Q.** Thank you. If we go back to the first statement,
5 LCC001998, at page 1, please. You set out, Ms Ashworth,
6 some details relating to your experience and your role
7 and, importantly for us, you are the Head of Service for
8 Children and Family Wellbeing of the local authority; is
9 that right?
10 **A.** That's correct.
11 **Q.** You are responsible, I think, for the provision of
12 Lancashire County Council's Early Help service, which
13 included both Targeted Youth Support and the Family
14 Intensive Support teams that we have been hearing about?
15 **A.** It does, yes. It comprises both.
16 **Q.** Thank you.
17 In terms of your own background, paragraph 3 on this
18 first page, I think you qualified as a youth worker
19 yourself back in 1988?
20 **A.** That's correct.
21 **Q.** Did you remain in that role, in the youth service area
22 of work, at Lancashire County Council until that service
23 was cut in 2017?
24 **A.** That's correct, yes.
25 **Q.** Did you then move across to the Children and Family

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1 on your management experience, in part because the CFW
2 worker who was assigned to the case, for good reasons,
3 has not been able to give evidence. So I want to look
4 at that first period, 8 October to 13 December 2019. Do
5 you follow?
6 **A.** That's correct. Yes, that's fine.
7 **Q.** Thank you. So if we can start, please, with
8 paragraph 44 of your statement on page 10, you explain
9 there that AR was first received as a case following
10 a referral from the MASH that had been promoted,
11 I think, by PC McNamee's high risk referral; is that
12 correct?
13 **A.** That is correct, yes.
14 **Q.** If we can look at it together -- just note that on your
15 statement it says 16 October -- if we look at LCC000003,
16 please, can we see that the date of this was actually
17 8 October rather than the 16th?
18 **A.** Yes, that is correct.
19 **Q.** Thank you. If we go to page 2 and just look at the main
20 box on page 2, we will see what was being raised at this
21 stage. So if we could just have maybe the top half of
22 that text. So we see:
23 "High risk VA, PVP -- a referral came from Childline
24 regarding [AR] ..."
25 I'm looking at the first paragraph under

4

1 "Circumstances"?

2 **A.** Okay.

3 **Q.** "... who had made concerning comments to them. [AR] has

4 been bullied by a male called [the name has been

5 redacted] and [AR] has become highly agitated and

6 frustrated regarding this. As a result [AR] has taken

7 a knife from his kitchen to school on several occasions.

8 "[AR] was spoken to by police and admitted to taking

9 the knife to school previously. He seemed honest

10 throughout and told us that if things escalated with

11 [the boy concerned] then he believes he may use the

12 knife."

13 **A.** That's what it says and I believe that's what he

14 discussed with the police.

15 **Q.** So that was coming in, certainly so far as the police

16 were concerned, into the MASH as a high risk case; would

17 you agree?

18 **A.** That is their definition of it under their protecting

19 vulnerable persons arrangements and the referral to the

20 MASH.

21 **Q.** Then, if we look in the same document, please, if we can

22 just go on to page 5. If we could just look at the

23 "Reason for action taken", the manager's comments, in

24 fact they seem to say the same things:

25 "Concerns around bullying in school and [AR] taking

5

1 to be a mismatch between the concept of something that

2 one agency is referring to as a high-risk PVP, and

3 then -- which the MASH is considering should be

4 responded to at an Early Help level.

5 So I can understand the differences that that might

6 make but, if we drill down to what we were being asked

7 to do, effectively, from that referral, the emotional

8 support and the work around consequences of behaviour,

9 that kind of work is very much within the wheelhouse of

10 Early Help to do with a young person. And so, in terms

11 of I suppose the anticipated forward kind of view of

12 what would happen, that does seem in accordance with

13 Early Help.

14 What I cannot see is that, from reviewing records,

15 we didn't in any way push back against that referral at

16 that time. So, effectively, that's what we would refer

17 to as a step down from the MASH.

18 **Q.** Yes, and do you think, in terms of the information on

19 risk to others that's evident here, in terms of how

20 frequently he had been carrying the knife and an intent

21 to use it, do you think that there was a case for

22 pushing back to say, well, look, this sort of support is

23 work that Early Help can do but aren't the risks here

24 quite high?

25 **A.** There might have been a case for pushing back and

7

1 a knife into school. The police have dealt with this,

2 [AR] may benefit from emotional support and work around

3 the consequences of behaviours, such as taking a knife

4 into school.

5 "The concerns meet level 2 -- case to step down to

6 CFW to follow up with mother and offer appropriate

7 support ..."

8 Do you see that there?

9 **A.** I do see that.

10 **Q.** Even at this stage, we know from Mr Cregeen, the

11 safeguarding lead at the Range school, that he contacted

12 the MASH to express concern about this being stepped

13 down to as low as level 2. Reflecting on matters now,

14 given the information about AR stating that he had

15 an intention to use the knife, do you share that

16 concern, that this was stepped down, too far too

17 quickly?

18 **A.** I think what it's reasonable to say is that the

19 information that you are showing me now is the basis of

20 the information that we would have received through from

21 the MASH, as part of that referral. It gives some clear

22 steer in that to Early Help about the sort of work that

23 the MASH will be indicating we might go on to do in

24 response to that family. And I can see that, you know,

25 if you take a high level view of this, there might seem

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1 I think that's what I'm acknowledging and we didn't

2 appear to do that, at that time. We did take this

3 request for support on the face value of how it's

4 outlined in this MASH referral and the work that we

5 would go on to do or attempt to go on to do. So, yeah,

6 I can acknowledge that that might be the case.

7 **Q.** Thank you. If we can go then, please, to LCC002302.

8 Ms Ashworth, you will be familiar with this type of

9 record but I'm afraid the documents are a little bit

10 clunky to deal with because of the fine print. But we

11 can see, starting at page 1 -- and I'm not going to go

12 through them all -- that if we just have the top of the

13 page highlighted, that there were various attempts,

14 starting with the first one that's documented there at

15 the top of the page on 14 October, to contact the

16 family. A number of which, I think you'll be familiar

17 with, were not successful, although there was some

18 successful contact, for example, on the 14th, as we can

19 see in the next entry.

20 Do you agree that that's a fair summary?

21 **A.** I absolutely agree that's a fair summary. You know,

22 this case, this family situation, this young man were --

23 requested support from us, in a context where we had no

24 background, we'd not been familiar with them previously.

25 So, we are at a standing point of building up

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1 information to help us to then work out what we would
2 need to do and in that early stage, after this request
3 for support came through, actually, right through until
4 about, I think, 5 December, we actually didn't have any
5 significant meaningful direct engagement with the
6 family --

7 **Q.** Thank you.

8 **A.** -- or with AR himself. That 5 December was the first
9 time we saw him. We were gathering information from
10 other agencies that were in contact with the family but
11 not direct contact.

12 **Q.** In relation to that gathering information, if we look at
13 the bottom of the same page and just highlight the final
14 entry, we can see part of that, I think, was further
15 contact from Mr Cregeen. Can you see that he's raising
16 concern. So I think it's four lines up from the bottom:

17 "[AR's] reactions seem to be out of proportion, he
18 was tapped on the head so punched another pupil. When
19 asked why he brought in the knife, very calm saying he
20 would stab him, no remorse, was not to scare him off,
21 and said it was to stab him. He was fed up of [the
22 other boy] pushing him around. School feel this is out
23 of proportion, no threats to life were made to [AR] or
24 family and [AR] stated he was ready to stab [the boy]."

25 So the clearest possible indications, would you

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1 would it be fair to say that, in practice, it was
2 perhaps under recognised?

3 **A.** At that stage, yes, possibly. That would be fair to
4 say.

5 **Q.** And later too, on reflection?

6 **A.** I think in subsequent encounters that we had with the
7 family, where other factors around those risks were
8 pertinent, I think there was more of an engagement
9 around that from CFW, alongside our colleagues in the
10 Youth Offending Team.

11 **Q.** We'll come to some of that. So in the chronology, if we
12 can go back to LCC002302, page 2, please. Not perhaps
13 necessary to go through the detail but Ms Cookson
14 contacts the family on 16 October, but it wasn't until
15 29 October, the third entry on this page, that
16 Ms Parkinson attempted to get into contact as the
17 caseworker herself, so almost two weeks later. Was that
18 sufficiently timely or should that have happened sooner?

19 **A.** It doesn't appear timely on review of the records that
20 I've been able to do and it certainly wouldn't meet with
21 our standards today where we do have set standards
22 around the timeliness of following up from the point of
23 a request for support, to the point where you first see
24 the children -- the subject of the request for support.
25 That is now very clearly defined and this would have not

11

1 agree, of the Range School's concerns, maintaining their
2 concern about this being a high-risk case?

3 **A.** Yes.

4 **Q.** In general terms, would you agree that, if a child or
5 a young person seriously harms somebody else, that is
6 also likely to cause harm to themselves because of the
7 implications on them in terms of possible custody and
8 the effect on their life chances?

9 **A.** Yes, that's correct.

10 **Q.** Was that something that you think at the time was
11 adequately understood in CFW, that serious risk of harm
12 to others could equate to a risk to the child
13 themselves?

14 **A.** I think it was known but, at this stage and this point
15 in the journey, with this first request for support, we
16 were still learning and hearing information for the
17 first time, trying to assimilate that and think about
18 how we would move forward to be able to respond to that
19 through the processes that we have at our disposal.
20 I think the primary driver around safeguarding, from
21 an Early Help perspective and certainly at this point in
22 2019, would have deferred more to the risk of harm to
23 him as an individual, rather than the risks that were
24 posed to others.

25 **Q.** So, although you think that that proposition was known,

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1 met those standards at that time.

2 However, it does reflect the process that was in
3 place at the time, where requests for the support that
4 came to us from the MASH, which was where this came from
5 to us, were initially kind of received into CFW by
6 a senior family support worker and kind of reviewed with
7 a sense to, you know, what the request for support was
8 containing, what it was pointing to in terms of the work
9 that we would go on to do and how that would then be
10 best allocated to a support worker.

11 **Q.** Taking it a little bit more shortly, the process
12 involved a bit of delay because a senior would look at
13 it and review and then hand it on and it took some time?

14 **A.** Yes.

15 **Q.** All right. We know from the records that Ms Cookson and
16 Ms Parkinson then carried out a visit on 6 November --
17 bottom entry on page 3, sir, for your note.

18 Ms Parkinson then obtains information from Parenting
19 2000. I'm just mentioning this so that the context is
20 fairly set out. Parenting 2000 had been working with
21 the family. Information was obtained from Acorns, the
22 new school, and from CAMHS. So all of that is at page 3
23 to 5 and we don't need to go through it but I set it out
24 in overview.

25 **SIR ADRIAN FULFORD:** Thank you.

12

1 **MR MOSS:** By 29 November, if we can have page 6 of this
2 document, please, it is about halfway down -- so it's
3 the entry in the middle of the page. It's the
4 supervision note. I'm looking in particular,
5 Ms Ashworth, at the last line here. This is information
6 obtained from various sources but looking at what's come
7 from the school:

8 "Acorns School have discussed concerns re [AR].
9 School are [just] getting to know him and need to
10 understand his behaviours. [AR] has shown some interest
11 in inappropriate news headlines and imagery that
12 possibly links to the knife incident [that's] being
13 monitored."

14 Do you see that there?

15 **A.** I do see it.

16 **Q.** In addition to the high risk concerns from The Range,
17 the new school is giving information about new
18 developments with AR showing risky behaviour, in the
19 sense of an interest in inappropriate material and
20 imagery that might link to the knife incident; would you
21 agree?

22 **A.** That's correct.

23 **Q.** Thank you. Go over to page 7. That theme rather
24 continues -- if we could look at the 3 December entry at
25 the top of the page, please -- because Acorns are then

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1 we do that in partnership with all those other agencies
2 that are also working with the family, and it's not
3 singularly incumbent on CFW to be the agency that raises
4 concerns or makes a request for support back to the MASH
5 to suggest something like a step up.

6 That can be done by any partner and, at that stage,
7 the information that was being received and sort of
8 processed was by the school itself. We had not heard
9 any of this information first hand.

10 **Q.** But is that quite fair on the other agencies because
11 Mr Cregeen had flagged up very clearly his concern about
12 the high level of risk. It had come in, initially, as
13 a high-risk referral and had been stepped down and
14 twice, within the space of ten days, the school are
15 raising concerns, and the response of CFW seems to be,
16 "Put that in through the MASH", rather than taking any
17 proactive steps themselves; would you agree?

18 **A.** Well, partially. In the interests of how we would
19 respond to those issues that had been identified by the
20 school as concern, that's part of our multi-agency team
21 around the family which we go on to work on further over
22 the next few days. But it is worth knowing that --
23 I can see clear evidence in the notes that conversations
24 were taking place with school about, you know, these are
25 the sorts of concerns that might be useful to pursue

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1 in contact, sharing further information on further
2 developments concerning conversations in art around
3 guns, decapitation, discussions about his understanding
4 of what's appropriate and not.

5 We can see that what's being said there by
6 Ms Parkinson was that that information be shared with
7 the MASH. Do you see that there?

8 **A.** I do.

9 **Q.** In the evidence from The Acorns School, they have
10 suggested that they had difficulties at this time in
11 sort of getting the message through, my summary, but
12 they were attempting to get support from PC McNamee,
13 from the Early Action Team and from the MASH. Rather
14 than Ms Parkinson say "Share this information with the
15 MASH", wasn't there a case for CFW to approach the MASH
16 themselves or direct this towards Children's Social Care
17 at this stage, given the mounting concerns?

18 **A.** You could say that. I think it's worth noting that, by
19 this date, we haven't yet met the family directly. That
20 happens only for the first time a couple of days after
21 this and, in that meeting, there is further discussion
22 about these concerns that school have about some of the
23 presentations that AR is making but, you know, I think
24 what I would like to contextualise is that, when we
25 approach working with a family at an Early Help level,

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1 through the Prevent methods that we have at our
2 disposal, and it was Anne Cookson from CFW that
3 suggested to school that we maybe needed to pursue that
4 first Prevent referral. That was pursued by school and
5 rightly so --

6 **Q.** I'm going to come onto that. You're jumping ahead in
7 the chronology.

8 **A.** Sorry.

9 **Q.** Just deal with the point that I'm raising and we'll come
10 to the chronology in due course. There's then a school
11 meeting on 5 December and we have that at the bottom of
12 the same page. Can we just have that text highlighted?

13 Would you agree here that there were very
14 significant signs of concern once CFW did get to hold
15 this in-person meeting along with the school?

16 **A.** Yes, the same concerns that had been intimated earlier
17 and had been the subject of conversation were outlined
18 in this meeting and were discussed directly with the
19 family.

20 **Q.** But they went further, did they not, in terms of the
21 approach of Alphonse R, AR's father?

22 **A.** In what context, sir?

23 **Q.** Well, so, if you see about eight or nine lines down:

24 "Dad said he had spoken to [AR] about some of the
25 incidents and that [AR] had said he had not done this or

16

1 that, it was taken out of context.

2 "School and myself shared the significance of what
3 had happened and how there were possible warning signs
4 of some underlying interests or thought process that
5 could be potential harmful to [AR] or others and there
6 was a duty ... to look into this and challenge the
7 situation."

8 Then Dad comes back:

9 "Dad did not feel that [AR] was a danger to himself
10 or others and that he did not lie. He said that he knew
11 his son better than anyone and that he was not a danger
12 and had never lied.

13 "I asked that if this was the case, why, when [AR]
14 had took the knife into school and stated he would use
15 it, was this too the truth. Dad said that [AR] had been
16 misunderstood and when he said 'use it' he had not
17 stated how he would use it."

18 That was before AR was brought into the meeting --
19 wait for the question.

20 Putting it very bluntly, Alphonse R seemed to be
21 somewhat in denial, didn't he?

22 **A.** Yes, that is true. There is evidence there to suggest
23 that the father, and subsequently AR, were -- their
24 position was to play down the significance of those
25 factors and not to have that full understanding of the

17

1 comes to light that there were very grave reasons to
2 doubt, first of all, that AR himself was really seeing
3 the seriousness of the situation, yes?

4 **A.** Yes.

5 **Q.** His father appears to be somewhat in denial, both about
6 his son's behaviour and about the seriousness of it?

7 **A.** Yes, I would agree with that.

8 **Q.** If we go over the page, please, still in the same
9 note -- and I'm afraid our warning about sharing the
10 document has obliterated part of the text but if we
11 could just have the top page, I'm sorry it's hard to
12 read, it's our fault -- but what that reads is that:

13 "Alphonse denied receiving any contact from CFW. So
14 discussed the need for a TAF meeting. Lucy Parkinson
15 had been trying to contact him to continue with the
16 agreed support. Dad said he had not received any calls
17 or messages. I explained that we had sent a letter he
18 did not think he had received any or may not have opened
19 it."

20 Would you agree that, on the face of the CFW
21 records, that doesn't seem to ring true, given how many
22 attempts to contact the family there had been?

23 **A.** That's correct. We had made multiple attempts to engage
24 and contact and make arrangements to go and see the
25 family and start processes rolling and, very clearly,

19

1 potential consequence.

2 **Q.** Then when AR was brought in he doesn't see the
3 significance of that, hadn't done the things that he's
4 recorded as doing, accused the teacher of lying, but the
5 school were keen at this meeting, appropriately keen,
6 I'm going to suggest, to demonstrate to CFW and others
7 that this was wrong because they were making the point,
8 it's not just one teacher but different teachers.

9 Father then is in support, agreeing with AR that it
10 was a misunderstanding and didn't have the significance.
11 The classroom teacher was actually brought in to go over
12 what was said and AR continued to deny it in the face of
13 the teacher. Father then said that the school was like
14 a prison -- so he's undermining their referral unit,
15 yes --

16 **A.** Yes.

17 **Q.** -- and they were magnifying and exaggerating the
18 situation that AR could not speak without it being
19 logged and challenged:

20 "[AR] felt he was being singled out and that other
21 children behaved inappropriately but that was not
22 challenged. He said school were lying or accusing him
23 of being a liar."

24 So, it wasn't just the case, was it, of this meeting
25 repeating the information. The concerning information

18

1 AR's father disputes that at that stage.

2 **Q.** As you rightly touched on earlier on, this leads to
3 a Prevent referral and I don't challenge for a moment
4 the general evidence that you have given about that,
5 that CFW had a part in discursive discussions about that
6 but if we can pull away from this record and look at
7 your statement, please, at paragraph 49 -- it's on
8 page 11 -- what you say there is:

9 "It would not have been possible for statutory
10 services to get involved at that time as the risk
11 factors identified would not have made threshold for
12 a referral to children's safeguarding."

13 Then you get onto how events were overtaken with the
14 second incident. Put the second incident out of your
15 mind for the moment. That might be thought,
16 Ms Ashworth, given that this was a statement on which
17 you were reflecting on events as a manager, to be
18 a somewhat surprising assertion.

19 This was a situation where there is a risk to others
20 from him carrying a knife on multiple occasions; he's
21 said that he had an intent to use it, to stab the boy
22 with it; he's shown no remorse; there's risky internet
23 usage at his new school, showing an interest in
24 shootings, beheadings, guns; there's limited engagement
25 from the family; and when there is engagement with the

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1 family, the father is undermining the new school and
2 appears to be in denial about the seriousness of events
3 and is underplaying his son's behaviour and defending
4 his son.

5 Why, against that panoply of reasons, would there
6 not have been a case there and then for seeking to step
7 it up?

8 **A.** I think that's a reasonable question to ask and there
9 wasn't a pursuance of any sort of step-up or any sort of
10 discussion about that with Children's Social Care at
11 that time. I do think that what I've said in my
12 statement is correct, that the thresholds operating at
13 that time would not have identified that situation as
14 starkly as you've put it and, you know --

15 **Q.** Why not?

16 **A.** -- as risk of significant harm to AR himself, which was
17 the threshold for Section 47.

18 **Q.** But why wouldn't it have recognised -- you seem to say,
19 "That's a reasonable question, when you put it like that
20 but, at the time, it wouldn't have recognised it". What
21 was wrong with the system at the time, given that that
22 list of factors was objectively available at the time:
23 what was it in the system at that time that meant that
24 it wouldn't have been perceived as crossing the
25 threshold, even though, if I've understood your answer

21

1 Stephanie Hallaron of the Liaison and Diversion Service,
2 contacted Ms Parkinson on 12 December -- we don't
3 perhaps need to look it up -- seeking to gain consent
4 for the step up to level 3, yes? Do you remember that
5 from the records?

6 **A.** Yes.

7 **Q.** Ms Hallaron also tried to refer to the MASH but they
8 wouldn't accept it at level 4, as it was open to CFW.

9 Sir, the reference for that is page 12 on LCC002302.

10 **SIR ADRIAN FULFORD:** Thank you.

11 **MR MOSS:** Isn't that a concern that others seeing this,
12 trying to get it stepped up, were facing resistance from
13 the MASH, saying, "no"?

14 **A.** Yes.

15 **Q.** Thank you. After that, with the further incident, of
16 course it does then get stepped up to Children's Social
17 Care, yes?

18 **A.** Yes.

19 **Q.** We should recognise that, although it was stepped up,
20 I think CFW did continue a level of involvement because
21 they attended the strategy meeting on the 17th?

22 **A.** That's correct.

23 **Q.** Others have dealt with that. Thank you.

24 Having dealt with that -- thank you for your
25 assistance in that. As I say, Ms Parkinson is not

23

1 correctly, perhaps it should have done?

2 **A.** I think perhaps, at that time, back in 2019, and the
3 guidance that -- kind of the national guidance that we
4 were working together -- the national guidance working
5 together, would have placed more of an emphasis, in
6 terms of children's services' response to that
7 situation, to be about the potential for the risk of
8 significant harm to the individual, AR himself, and, in
9 that context, whilst those things are stark in the way
10 they are presented and how they've unfolded and we've
11 come to understand them in those meetings that we have
12 had and reflect on those subsequently, I still believe
13 that they would not have met the threshold for
14 significant harm to AR at that time.

15 **Q.** But should we then understand, forgive me interrupting,
16 paragraph 49 of your statement in a slightly different
17 way, to say, "In the way that we were working at the
18 time, this wouldn't have been viewed as meeting the
19 threshold for statutory services" --

20 **A.** Yes.

21 **Q.** -- "but, on reflection, better practice would have meant
22 that it should have met those thresholds"?

23 **A.** That's a very good way to put it, thank you, yes.

24 **Q.** Thank you. We see, do we not, some difficulty for other
25 agencies in attempting to get the position changed. So,

22

1 available to give evidence.

2 Can we take a step back then and look at some
3 aspects about the structure and remit of the Children
4 and Family Wellbeing Service. It sat within the
5 Education and Children's Services and I think still
6 does?

7 **A.** It does, yes.

8 **Q.** As you explain in your statement, it's not a statutory
9 service but intended to resolve issues prior to the
10 statutory threshold being met?

11 **A.** That's correct.

12 **Q.** We've heard about two of the four teams in particular,
13 the Family Intensive Support and the Targeted Youth
14 Support teams. Can I ask you about the Targeted Youth
15 Support schemes. You explain in your statement --
16 I don't think we need to look the references up -- that
17 that was reintroduced in 2021 after having been cut in
18 2016/2017; is that right?

19 **A.** That's correct.

20 **Q.** That, I think, was effectively -- the name may have
21 changed -- the team you were in for many years before
22 you have a change of role in 2017?

23 **A.** It was entirely disestablished, yes.

24 **Q.** Was the Targeted Youth Support team reintroduced at the
25 same time as the changes to Early Help, in around 2021?

24

1 **A.** Yes, at a similar time. They were part of the same
 2 service restructure process that put the new model and
 3 processes for Early Help in place, earlier in 2021,
 4 because we were beginning Targeted Youth Support
 5 essentially from scratch within that restructure. That
 6 took a little bit longer than the rest of the structure
 7 to get up and running. So Targeted Youth Support was
 8 a couple of months behind the main restructure of
 9 services.

10 **Q.** All right. So not exactly at the same time but within
 11 the same period?

12 **A.** Yes, there or thereabouts.

13 **Q.** If we look at page 3 of your statement, LCC001998 at
 14 page 3. I'm interested in paragraphs 16 and 17 towards
 15 the bottom of the page, please.

16 I've understood from these paragraphs, please
 17 correct me if I'm wrong, that under the former way of
 18 things being organised, under the "Risk Sensible" model,
 19 cases would be held by a social worker but work with the
 20 family that did not meet the statutory threshold was
 21 conducted by a family support worker who would be
 22 associated in a team with the social worker; is that
 23 right?

24 **A.** Yeah, in the former model, there were family support
 25 workers, a substantial number of those, that sat within

25

1 **Q.** What does "upstream in Early Help" -- you've got to use
 2 plain English, I'm afraid.

3 **A.** Apologies. So the bulk of the family support work
 4 resource that had previously sat in Children's Social
 5 Care, as part of the restructure arrangements, was
 6 transferred into the Early Help service and those
 7 workers were then conducting their business alongside
 8 the Early Help model, in the delivery of an intensive
 9 support resource that we could offer to individual
 10 families, in line with our way of working around family
 11 safeguarding. So it was a way of creating a robust
 12 resource at the Early Help level that hadn't previously
 13 been there to any significant extent, that was able to
 14 respond at the newly defined level in the Continuum of
 15 Need of level 3, where a family needs an intensive
 16 support response at an Early Help level.

17 **Q.** I understand. So that was the thinking but the old
 18 approach presumably had the advantage that, at that
 19 level, level 3, there would have been input from social
 20 workers into the kind of preventative work that was
 21 going on?

22 **A.** There would but level 3 in the previous iteration was
 23 defined as Child in Need, Section 17 Children Act, not
 24 Early Help.

25 **Q.** I understand that but, putting it another way, were

27

1 the Children's Social Care system and, yeah, the work
 2 around particularly Section 17 Child in Need work was
 3 held by a social worker. So the family would have
 4 an appointed social worker who held the case and the
 5 plan but, actually, aspects of the direct work that went
 6 on day to day, with the family and the children, might
 7 have been delivered by the family support workers that
 8 were in that structure.

9 **Q.** So at that level, level 3, the case would be held by
 10 a social worker, who would have some oversight of it,
 11 who could be consulted, but the day-to-day work might be
 12 done by referred to subsequently as an Early Help
 13 workers?

14 **A.** Yeah, much of the day-to-day work, not necessarily
 15 exclusively the family support workers, the social
 16 worker would have involvement, but a lot of the direct
 17 work would be done by family support workers.

18 **Q.** With the changes that were introduced in 2021, did that
 19 change the nature of the cases that CFW dealt with or at
 20 least that the way in which those cases were supervised
 21 and sat within the teams?

22 **A.** It did. In the sense that we made a decision as a local
 23 authority to sort of -- essentially, to move some of
 24 those family support work resources upstream into Early
 25 Help.

26

1 there not two -- looking back at it now -- downsides of
 2 the change in 2021: the first being that you lost that
 3 immediate supervision and consultancy role by social
 4 workers, in those category of cases?

5 **A.** We didn't lose it, it was just provided in a different
 6 way --

7 **Q.** Less direct?

8 **A.** Less direct, yes. Potentially --

9 **Q.** And less effective?

10 **A.** Not necessarily less effective because the work has
 11 changed. What we are now dealing with is a new
 12 Continuum of Need, in which there is a defined level 3,
 13 which is intensive Early Help, targeted Early Help, and
 14 that's the support that we are offering at that stage.

15 **Q.** Is that really accurate because, in AR's case, we don't
 16 seem to see on the records, looking at it as a whole,
 17 a marked tendency from CFW to consult social workers on
 18 what might happen in the periods when it's not at level
 19 4. They seem to be taking their own decisions not
 20 consulting --

21 **A.** That's correct and that's how the system was designed to
 22 be. Initially those consultative mechanisms were not as
 23 firmly or directly identified.

24 **Q.** So they were less effective? So when I asked earlier
 25 on, "and less effective", is the answer to my question

28

1 "yes"?

2 **A.** Yes.

3 **Q.** The second downside, would this be right, that those

4 working in the requisite team at level 2 but

5 particularly at what would have been level 3 Child in

6 Need, now were having to deal with more complex cases,

7 without the immediate supervision of a social worker?

8 **A.** That is correct.

9 **Q.** We see in your second statement that -- if I can just

10 have that back on the screen, please, LCC002309,

11 starting at page 6, please. I'm not going to go through

12 this, Ms Ashworth, in detail because you set it out in

13 helpful detail within your statement but on this page

14 and the second page, you explain how the authority is in

15 the process of implementing models that go back to

16 a system where there's a social worker giving direct

17 supervision and oversight of this type of case?

18 **A.** Correct.

19 **Q.** Is that right?

20 **A.** Yes, and that's in line with the new sort of legislative

21 model of children's safeguarding response that is

22 encapsulated within the family's first programme that

23 we're currently working on the implementation of, as are

24 all local authorities across the country.

25 **Q.** So the overall picture, is this right, that two

29

1 sort of signalled for us, that was a move to adopting

2 a new method of social work in our local authority that

3 was based on a model that had been trialled in other

4 local authority areas, alongside a number of different

5 models.

6 **Q.** So this wasn't something that you alone were doing; this

7 was something that was being looked at by others and

8 being tried by others?

9 **A.** Yes, and overseen by the Department for Education and

10 looked at the family safeguarding model as a way of --

11 you know, the principles behind which are very, very

12 positive around adopting an approach that is based on

13 strengths and looks to support keeping children with

14 their families, wherever that is entirely possible to do

15 so and where the safety considerations can be managed

16 around that. You know, that is a laudable, positive

17 developmental step and choice that we made as a local

18 authority and, in adopting that way of working, that had

19 to align itself right across the Continuum of Need. It

20 couldn't just be about how we changed how social work

21 was done. It wouldn't work that way. It had to be

22 across the whole system from, you know, the end point,

23 where sometimes we do have to make the decision to take

24 children into local authority care, right through where

25 we have to employ Child Protection measures, through the

31

1 significant changes have both been effectively reversed

2 or are in the course of being reversed. So the cutting

3 of the youth service, Targeted Youth Support, which was

4 cut but then reintroduced, that's one, yes?

5 **A.** Yes.

6 **Q.** The process whereby there had previously been a direct

7 oversight and supervision by social workers, that was

8 removed but is now being reintroduced?

9 **A.** Yes, reintroduced in a slightly different way but

10 reintroduced, yes.

11 **Q.** All right. Perhaps the fine detail doesn't matter for

12 the purposes of my questions. Can you help with this,

13 being candid, were those two decisions that have been

14 reversed, were they driven by resource constraints or

15 were they genuine principled decisions to try to run it

16 a different way, which have now been recognised didn't

17 lead to the necessary improvements?

18 **A.** I think partly both. A little bit of both. It wouldn't

19 be right of me not to acknowledge that the first point

20 that you make, about the removal of a youth service as

21 previously existing in the local authority, wasn't in

22 some way driven by what was happening to local

23 authorities around austerity and the need to make

24 savings at that time but, also, it wouldn't be fair to

25 not acknowledge that the move -- that the 2021 changes

30

1 arena that is defined for us in law and Child in Need,

2 back through Early Help from a more intensive, to a less

3 intensive point, right back to universal services. The

4 whole system had to change in accordance to make that

5 happen and do it effectively.

6 **Q.** Isn't it somewhat of a fallacy to see the direct

7 involvement and supervision and oversight of social

8 workers as equating with not keeping children with their

9 own parents? You seem to suggest in your answer, "Well,

10 we had to do this to recognise the new ways of working

11 of the added importance given to supporting parents and

12 keeping children with their parents, where it is

13 appropriate to do so". But having social workers

14 involved doesn't immediately equate to the removal of

15 children from their parents, does it?

16 **A.** No, perhaps I've not explained myself well enough there.

17 I think what I'm trying to say is that family

18 safeguarding, for us, has been a way of trying to work

19 with families at the stage they are at and in the way

20 they need a service provider to them and, sometimes,

21 that's not always required -- that doesn't require

22 social work inputs and sometimes, actually, social work

23 input could be counterproductive to that, particularly

24 in the arena of consent around Section 17.

25 Sometimes a family is more likely to engage at an

32

1 Early Help level with us, my services and others, and,
2 you know, working as a team around the family across
3 multi-agency partners, we can put a good enough plan in
4 place to be able to respond to their needs at that time.

5 **Q.** The Chair has your answer. Paragraph 33 of your
6 statement please, LCC001998, back in the first
7 statement. Page 6, paragraph 33. Thank you.

8 The practical effect:

9 "In 2019, I will say there was a steep learning
10 curve, it was a new provision, people were coming in
11 from other roles, a formal youth worker, learning
12 everything about children and the expectations placed
13 upon us for the [formation] of a new service, there was
14 a mishmash of professional backgrounds. It was
15 challenging for a few years. It took a couple of years
16 to manage this change."

17 Is that right?

18 **A.** That is true. That is true to say. That is about the
19 culture of how we developed the response over time and
20 put those arrangements in place.

21 **Q.** Would you sometimes be having fairly newly qualified
22 workers having to do complex cases that were on the
23 margins of level 4?

24 **A.** Yes, that is potentially one of the consequences of
25 that, yeah.

33

1 **Q.** -- and pushing for escalation?

2 **A.** In this case, no, I would have to say I don't see that
3 in this case.

4 **Q.** Is that overall a significant shortcoming, would you
5 accept?

6 **A.** I think it's -- I think it's -- with the benefit of
7 hindsight, we -- there were -- there are points along
8 the way where you might say that was a point where you
9 could have considered step up, you could have at least
10 asked for that or put that forward through a process and
11 we didn't. And I think that can only relate -- I can't
12 speak for the workers who were there at the time doing
13 that work and I wasn't directly consulted on any of
14 these threshold points, as it were, but I think that was
15 about those workers believing at that time that, with
16 the team around the family that they were working with,
17 the needs of that family at that time could be met at
18 an Early Help level.

19 **Q.** Why is that only with the benefit of hindsight? In
20 light of the clear risk information that other agencies
21 were raising time and again, shouldn't that have been
22 visible at the time with the information that was known?
23 You don't need hindsight for that, do you?

24 **A.** No, no, I'm saying that with hindsight from myself,
25 reviewing the situation, but, no, those facts were clear

35

1 **Q.** Who had the authority and the responsibility: if a case
2 from the MASH was put at level 2, but should have been
3 higher, who had the responsibility and the authority to
4 challenge that and how should that have been challenged?

5 **A.** So, I think you're referring to sort of like the concept
6 of escalation. It starts with the worker themselves,
7 obviously, and works through layers of management,
8 I suppose, if issues can't be resolved and agreed
9 between those individuals. So, you know there's been
10 an escalation process in place, essentially, throughout
11 that period, in which, if a worker at a local level was
12 concerned about the complexities or the risks associated
13 with a case, they can raise that through a process to
14 consider step up and, if they disagree with that
15 interaction --

16 **Q.** One understands.

17 **A.** -- can escalate that to a higher-level manager to take
18 up that case on their behalf with higher-level managers
19 within MASH or Children's Social Care.

20 **Q.** If you are being honest and candid when you reflect, as
21 you will have done, as the senior manager, on the
22 various periods involving AR, do you see much sign of
23 CFW workers reflecting on, in particular, the risk to
24 others --

25 **A.** No.

34

1 and present at the time and, yeah, it is true to say
2 that there were points where, you know, you might have
3 considered a step up or a discussion with Children's
4 Social Care. We have a process in place now that is
5 really quite robust that we refer to as "family
6 discussions": it could have been enacted at that time.

7 **Q.** Can you keep to how things were at the time and we'll
8 come to improvements later.

9 **A.** Sorry.

10 **Q.** Not at all. No need to apologise. If we look at
11 LCC001926. This is the Continuum of Need, as amended.
12 If we go to page 10, please. You'll be expert in this
13 in a way that I'm not but just refamiliarise yourself
14 with it, at page 10, please.

15 So you will recognise that, I think, as the
16 post-2021 changed way of looking at the Continuum of
17 Need, yes?

18 **A.** Yes.

19 **Q.** Then if we go in the same document to page 15, bearing
20 in mind that level 3 "Family struggling to cope, complex
21 support needs". If we go to page 15, please. I'm not
22 going to go through this but, just so that you have the
23 context, you can see examples being given of the type of
24 case that would be appropriate for level 3, yes? Then
25 over the page to 16, it goes on to looking at the next

36

1 level up, 4a. If we look at that passage at the bottom
 2 of the page, please, and have the level 4a part
 3 highlighted, it did, in terms of the threshold, set out
 4 that, for level 4a "Intensive needs":
 5 "If you suspect a child is suffering or at risk of
 6 suffering significant harm, self harm and/or at high or
 7 very high risk of harm to others, follow Child
 8 Protection procedures."
 9 So, at the time, without the benefit of hindsight,
 10 would you agree that the CFW caseworkers and their
 11 supervisors should have been having a very careful eye
 12 to whether there was a high risk of harm to others
 13 because that could put the case into level 4?
 14 **A.** Yes.
 15 **Q.** If we go over the page, please, under "Safe from harm",
 16 do we see about halfway down that "parental refusal to
 17 engage over concerns" is given as an example of one
 18 factor that would also fit within level 4, yes?
 19 **A.** Yes, and this is what goes to me saying I think there
 20 are points at which we could have raised those factors
 21 and there are examples where we didn't.
 22 **Q.** Thank you. Consistent with the answer you've just
 23 given, would you accept that parents who superficially
 24 engage, but who are in denial about the seriousness of
 25 their child's conduct, would fall full square within

37

1 So, Children's Social Care made the decision to
 2 engage Mr Penswick to come in and do some work with us,
 3 as a bit of a reflective exercise, about where we were
 4 at, at that point in time -- so this is earlier in this
 5 calendar year -- around those matters to do with
 6 threshold decision-making; what processes are operating;
 7 what do they constitute; how does that compare with
 8 maybe some benefit of his expertise around the way
 9 things work in other local authority areas that we might
 10 consider as good practice; you know, a look at some of
 11 the individual cases of children and how they relate to
 12 those threshold decisions; and come back with some
 13 thoughts about our operations, particularly, with a view
 14 to whether there was learning that we needed to take on
 15 board, could take on board, that would help us develop
 16 positively as we move forward.

17 So it was a piece of consultative work that was
 18 done.
 19 **Q.** I follow. Thank you. Just looking at page 4, just to
 20 pull out some of the perhaps most pertinent points to
 21 this Inquiry. Page 4, if we look at paragraph 8,
 22 I think that one of the points that Mr Penswick was
 23 pointing out is that:

24 "From the current guidance, Early Help staff (who
 25 support children and families at identified level 3)

39

1 that parental refusal to engage over concerns?
 2 **A.** Yes, could potentially.
 3 **Q.** Thank you. If we could go next, please, to LCC002194,
 4 at the first page, please. Ms Ashworth, I'm showing you
 5 the title page so that you've got the context. Could
 6 you just help us with the background to this. The title
 7 to this is:
 8 "An evaluation of threshold decision-making by
 9 Lancashire County Council Education and Children's
 10 Service on the provision of support at level 3 and 4."
 11 If we just go full page again, please, and see that
 12 the author is Neil Penswick, and it's 7 March this year.
 13 Just tell us about the background to this report, who he
 14 is and how this report came to be commissioned, just in
 15 brief terms?
 16 **A.** My understanding is that Neil Penswick is a very
 17 experienced former Ofsted inspector -- maybe even
 18 current Ofsted inspector, apologies, I don't quite know
 19 that -- but certainly has an experience as an Ofsted
 20 inspector and, therefore, has a level of insight into
 21 the processes, the decision-making arrangements,
 22 threshold type considerations really, that operate in
 23 and around the boundaries between the different points
 24 on a Continuum of Need and across the spectrum of
 25 services that might be provided.

38

1 will, at times, be working with those that, at least in
 2 the national guidance, would be identified as children
 3 in need. This raises the question of the professional
 4 social work support they receive."

5 Yes?

6 **A.** Correct.
 7 **Q.** So raising something of a concern in that regard, would
 8 you agree: certainly a question for consideration?
 9 **A.** A question for consideration, yes.
 10 **Q.** That also arises as a question for consideration about
 11 how AR's case was handled; would you agree?
 12 **A.** You could draw the link, yes.
 13 **Q.** Well, you say "you could draw the link" but it wouldn't
 14 be unreasonable to do it, would it?
 15 **A.** Well, we have been discussing the points of threshold
 16 interaction around AR's case, certainly.
 17 **Q.** Paragraph 11, further down the same page, please, even
 18 in March this year:
 19 "For some, decision-making related to thresholds for
 20 support is not as consistent as it needs to be. In
 21 part, this relates to the guidance which lacks clarity,
 22 and the application of thresholds in the real world
 23 faced with complex family circumstances and histories,
 24 and limited information."

25 Would you agree?

40

1 **A.** I would agree that working with threshold decisions in
2 the real world, faced with complex family circumstances
3 and histories and limited information, is a very, very
4 tricky area and, you know, requires constant
5 consideration and careful monitoring by all concerned
6 really, whether from frontline workers, right the way
7 through all the agencies through MASH to managers who
8 are helping with those threshold decisions. That is
9 definitely the case.

10 And I think that the point that he's making
11 previously there about, you know, Early Help, CFW, my
12 service being a service that the definition of which is
13 to work in that arena of level 3 on the current
14 Continuum of Need, which is this intensive Early Help,
15 targeted Early Help level, it is highly probable that,
16 in any circumstances, if you were to take a review and,
17 whilst Mr Penswick won't have looked at -- probably
18 we've got something in the order of 5,000 children that
19 are potentially open to services from targeted Early
20 Help through Child in Need to Child Protection, he
21 weren't have looked at them all, but he did look at
22 a substantial number of children's cases.

23 And I think in any cohort of that size, you are
24 going to find some children where two professionals
25 might take a different view as to whether the very fine

41

1 "However, for a significant percentage (19 per cent)
2 there were repeat referrals due to the issues not yet
3 having been resolved. This is often when there are on
4 going domestic abuse and parental substance misuse.
5 Some of these are stepped down to Early Help Support.
6 At times, consideration of the cumulative impact of
7 events on the children is not robustly considered."

8 Again, AR's was definitely a case of repeated
9 referrals, some of them stepped down, some of them
10 referrals in -- would you agree --

11 **A.** Yes.

12 **Q.** -- where this factor, a lack of a proper consideration
13 of the cumulative impact of the number of referrals,
14 might be thought to be a fair criticism of the way in
15 which the case was handled?

16 **A.** I could understand why that would be the case. Our
17 experience in Early Help is that we often receive
18 referrals from a family that then repeat themselves over
19 time. Sometimes where the matters of concern for that
20 family, the unmet needs, are the same unmet needs as
21 we've seen previously and sometimes they are different
22 needs. In the evolution of any family over a period of
23 time, they're gonna face different needs and challenges,
24 and I don't think that's unusual or not
25 understandable --

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1 threshold between targeted Early Help and Child in
2 Need --

3 **Q.** One understands that --

4 **A.** -- is correct.

5 **Q.** -- but if he's been engaged because of his wide
6 experience in making these decisions, presumably his
7 conclusion that, "The decision-making related to
8 thresholds is not as consistent as it needs", he's not
9 there suggesting, on the face of it, "Well, there's
10 always going to be some difficult cases and I haven't
11 seen here anything of concern that I wouldn't see across
12 the country"; he's flagging up a problem, is he not?

13 **A.** He's flagging up something for us to think about, that
14 there may be some inconsistencies that we need to
15 consider and I think that is right and proper.

16 **Q.** Well, his words were, "the support is not as consistent
17 as it needs to be"?

18 **A.** Yes, inconsistencies, yes.

19 **Q.** Page 5, please. Paragraph 21 and 22, at the bottom of
20 the page:

21 "Child and Family Assessments conducted by the
22 specialist teams across the country are in the main
23 thorough and timely, with good consideration of the
24 presenting issues and history."

25 So a positive identified:

42

1 **Q.** But you are saying it is understandable that there would
2 be repeat referrals. Take that as read but my question
3 was whether it might be a fair criticism that the
4 significance of the cumulative impact of the number of
5 referrals may not have been sufficiently taken into
6 account in AR's case. Would you agree with that or not?

7 **A.** That may have been the case and, in this instance, with
8 AR, the issues across the sort of four episodes of
9 contact, that CFW certainly had with him over that
10 five-year period, did contain needs and issues that were
11 similar across time.

12 **Q.** Yes. Paragraph 22, "Across the CSSH/MASH". Just help
13 us with CSSH?

14 **A.** I think it refers to Children's Services Support Hub and
15 it's part of the Multi-Agency Safeguarding Hub, the
16 MASH. It is the part of it that is kind of concerned
17 with processing where a response is likely to be made at
18 an Early Help level.

19 **Q.** Thank you:

20 "Across the CSSH/MASH, duty, and assessment, on some
21 of the more complex cases not following a Child
22 Protection pathway, work is not progressed due to
23 repeated lack of consent. Whilst it is important to
24 work in partnership with parents, there is not
25 sufficient consideration of the day-to-day life of the

44

1 children. The process for dispensing with consent needs
2 to be tightened."

3 Again, that's a bit more than raising something for
4 consideration: that's raising a concern that, at the
5 level below level 4, lack of consent is sometimes
6 getting in the way of making sufficient progress on
7 cases; would you agree?

8 **A.** Not just at below level 4. It includes level 4 because
9 Section 17 Child in Need, which is part of our level 4
10 response, our Children's Social Care's response, does
11 require consent to work with a family.

12 **Q.** But short of a Child Protection pathway, it's being
13 flagged as a concern?

14 **A.** Short of a Child Protection pathway. I think that is
15 a reference to -- it points us to consider whether we
16 need more robust mechanisms about the criteria against
17 which we would be willing to override those matters of
18 consent, which are sort of detailed in law, aren't they,
19 in certain circumstances within the work that the MASH
20 and the CSSH do.

21 **Q.** Thank you. Over the page, please, paragraph 25:

22 "There are families stepped across from the
23 CSSH/MASH and following Child and Family Assessments
24 which turn out to be above their threshold for support
25 and are clearly children in need. FIS workers continue

45

1 That's what he is saying in paragraph 25?

2 **A.** I think he's raising that he will have come across -- to
3 substantiate that paragraph, he will have come across
4 some cases where he's viewed the situation and it may be
5 that he's found cases where, though they have been taken
6 for that kind of discussion, and have not been accepted
7 as moving across into the threshold area of Children's
8 Social Care, yes.

9 **Q.** Taking it shortly, would you accept that that too echos
10 with a shortcoming in how AR's case was handled overall
11 by CFW?

12 **A.** Not directly, no, because I think what I have
13 acknowledged already in the conversations that we've had
14 is that there wasn't -- apart from where circumstances
15 kind of overtook the situation and the case got stepped
16 across, there wasn't a lot of active push from the CFW
17 point of view around AR's case for that case to step
18 across at different points, across the episodes we
19 worked with the family.

20 **Q.** But isn't that the problem: that there should have been
21 that push to put it further up to level 4 and a lack of
22 recognition that that's what should have happened?

23 **A.** I think I answered that before, in the sense that you
24 could say that but I do think that that was because
25 workers were looking at the situation at the time and

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1 to work tenaciously to try and address the needs. When
2 this occurs, there is not always the needed additional
3 social work support and difficulties stepping cases back
4 to a more appropriate service."

5 That seems to be referring to cases being addressed
6 perhaps at level 2 or particularly level 3 where the FIS
7 workers do their very best to try to address the needs
8 but there are difficulties with recognising that it's
9 a case that needs to go up to level 4 and getting it
10 back up to level 4; would you agree?

11 **A.** That's what that paragraph implies, absolutely. We do
12 have a process in place to address that. It's what we
13 call family discussions. They happen every week in
14 every area in Lancashire and they are a conversation
15 between team managers in my service and team managers in
16 Duty and Assessment, Children's Social Care about those
17 threshold decisions, where cases have been identified
18 that we believe are very complex and could be considered
19 as needing to step up, could be considered as actually
20 meeting the threshold for Child in Need on the cusp of
21 that.

22 **Q.** Forgive me for interrupting but we do need to make
23 progress. That's the mechanism by which that is meant
24 to happen but do you recognise that, even in March 2025,
25 Mr Penswick had concerns about how effective that was?

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1 believed that the situation could be responded to at an
2 Early Help level.

3 **Q.** All right. I'm going to move on now, thank you, to just
4 briefly deal with some issues related to note taking and
5 record keeping. We don't need to turn it up. You
6 explain in your statement that Liquidlogic was the
7 system introduced to the CFW before the time we are
8 involved in, so October 2018?

9 **A.** That's right.

10 **Q.** We don't need to deal with the situation prior. CFW
11 have an aspect of Liquidlogic called the Early Help
12 module and that's what we have been looking at on
13 screen, is it not?

14 **A.** It is, yes.

15 **Q.** Children's Social Care have their own part of
16 Liquidlogic and I think, for workers, they would have
17 read only access to the other teams?

18 **A.** That's correct.

19 **Q.** Thank you. The expectation would be for key
20 interactions to be noted more or less contemporaneously.
21 I think there is service standard saying within five
22 working days?

23 **A.** Sorry? Just repeat that.

24 **Q.** You would expect key interactions to be noted more or
25 less contemporaneously. I think there is a service

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1 standard that it should be recorded within five working
 2 days at most?
 3 **A.** Yes and child seen within seven.
 4 **Q.** Thank you. One aspect that we have been looking at is
 5 LCC000973, please. The context of this was Ms Barrett
 6 passing on information to Andrea Fontaine, which, in
 7 fairness to Ms Barrett, may be summarising information
 8 that was contained on the notes, in any event. But
 9 rather than just indicate "You don't need to make
 10 a separate copy of this because this will be on the
 11 notes already", what Ms Barrett actually said was:
 12 "Once you have digested this email, please delete
 13 it."
 14 What do you make of that? Was that appropriate?
 15 **A.** I don't know what to make of that, really. I don't
 16 understand why that would have been a requirement to
 17 delete it. I'm sorry.
 18 **Q.** You can't shed any light on that?
 19 **A.** I can't.
 20 **Q.** Is it somewhat concerning on its face?
 21 **A.** Not necessarily because we place a high emphasis on
 22 handling personally sensitive information very carefully
 23 as is right and proper to do.
 24 **Q.** Thank you. When a Children and Family Wellbeing Service
 25 worker comes fresh to a case, what is the expectation of

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1 **Q.** But would you accept that there are indications that
 2 this is a problem area in AR's case. So, for example,
 3 there was the occasion in January 2021, in which AR
 4 assaulted his father, which was well known to
 5 Ms Fontaine at the time, but didn't seem to appear at
 6 all in subsequent records when there were subsequent
 7 referrals?
 8 **A.** If that was something that was historic, it wouldn't
 9 necessarily appear but it would remain on the system and
 10 available to view and consider.
 11 **Q.** A clear pattern, I suggest, of a dilution of the
 12 information about the significance of the risk, so, by
 13 the end of 2019, it was known that AR, in particular,
 14 had said that he intended to use the knife in October
 15 2019 to stab the person he perceived to be a bully and,
 16 in relation to the December incident, likewise: he said,
 17 effectively, he had the knife in order to kill the
 18 individual if the hockey stick didn't work.
 19 **A.** Yes.
 20 **Q.** But that was gradually diluted in terms of summaries
 21 when later referrals came in. Would you agree that
 22 that's both a pattern and a concern?
 23 **A.** I don't think I recognise that it was gradually diluted.
 24 **Q.** We could go to many examples of it but when, in
 25 subsequent referrals, the CFW caseworkers gave a summary

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1 them reading into the back notes?
 2 **A.** Yes, I would have an expectation that, when you take on
 3 a case, part of your preparation for that would be to
 4 make yourself familiar with at least the overview, if
 5 not all the detail of what's available to you as
 6 intelligence that might come from the systems that we
 7 have, if we've had prior contact with that family, but
 8 also obviously to begin that process of connecting with
 9 other key partners that were also working with the
 10 family and building up information and sharing
 11 information that way.
 12 **Q.** Was the clarity at the time in terms of instructions to
 13 staff about what the expectations were -- I've asked you
 14 if they were meant to read back through the notes and
 15 you've said, effectively, yes, at least the overview.
 16 Already in that answer, perhaps we are getting into
 17 areas where it's a bit unclear exactly what they are
 18 expected to do. Do you think there might have been
 19 a lack of clarity around expectations on that?
 20 **A.** I don't, to be honest. I think that would be clear and,
 21 if you sort of reflect on how we train our Family
 22 Support Workers, for example, you know, we place some
 23 emphasis on them considering the benefits of
 24 understanding the history of children, if that's
 25 available to them. So I think that's fairly clear.

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1 of the background, they would sometimes refer to the
 2 previous knife incidents but the information about the
 3 intent to kill was dropped off?
 4 **A.** Okay.
 5 **Q.** Have you not seen that in your own work on the papers?
 6 **A.** I haven't fully absorbed that but ...
 7 **Q.** A third example would be Mr Coughlan, who told this
 8 Inquiry that his own practice was only to review the
 9 referral. He preferred to rely on the young person to
 10 provide him with the information, rather than reading
 11 back through the notes. Is that a concern?
 12 **A.** That wouldn't be our expectation.
 13 **Q.** Bad practice?
 14 **A.** It wouldn't be our expectation but I can understand
 15 where his comment is coming from as a youth work
 16 professional and I think it goes more to the importance
 17 that we do place on balancing the voice of the child
 18 within what we do, alongside the other voices that might
 19 cast light on circumstances, including the parents and
 20 other agencies.
 21 **Q.** Yes, of course, and it may be that, in conversations,
 22 especially early on with the child, you'd want to show
 23 that you are listening to them and not judging them by
 24 the previous records.
 25 **A.** Yes.

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1 Q. But please would you answer the question: that is bad
 2 practice not to inform yourself of what's in the
 3 previous notes?
 4 A. Yes.
 5 Q. I think, at the time, there was no system in the notes
 6 for having ready reminders of headline risk issues but
 7 such a system has subsequently been introduced; is that
 8 a fair summary?
 9 A. Yes.
 10 Q. We have had an example put in which is perhaps
 11 a different type of case. Can I ask you this: do the
 12 current ready reminders that appear on a front page, so
 13 a list of warning signs, do they include risk of harm to
 14 others?
 15 A. I don't think that they do but I may be incorrect on
 16 that one.
 17 Q. All right. If they don't, that might be a serious
 18 matter of concern, so could you please check that and
 19 get back to the Inquiry about it?
 20 A. I can. I think, whether I'm misinterpreting your
 21 question, what I do know that there is are hazard
 22 indicators.
 23 Q. That's what I'm asking about, so the hazard indicators?
 24 A. There are hazard indicators, yes.
 25 Q. Did they include where there is a serious harm to

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1 seeing more records when you checked the records than
 2 had been disclosed to the Inquiry?
 3 A. No.
 4 Q. Thank you. Now, for the remainder of the periods, so
 5 periods 2 through to 5, I'm not going to go through them
 6 chronologically. We've taken them up with some of the
 7 workers concerned but I just want to look at some
 8 examples of themes and we'll deal with the first one
 9 before taking a short break.
 10 So, the first theme I want to pick up with you is
 11 multi-agency coordination. We have heard, obviously,
 12 about the important role of convening the TAF meetings,
 13 yes?
 14 A. That's a standard part of our process, yes.
 15 Q. Ms Williams, in terms of the concept of the FSW workers
 16 being described as a lead professional, has suggested
 17 that it's not really having much authority and it's much
 18 more administrative than managerial. Would you agree
 19 with that description?
 20 A. I can see some clarity in what she's saying there, in
 21 the sense that the primary role of the lead professional
 22 is to kind of coordinate the response that's happening,
 23 in recognition of the fact that, if a Team Around the
 24 Family is in place, there's an immediate implication
 25 that there's more than one agency involved in working

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1 others?
 2 A. If that is known, that would form part of the hazard.
 3 Q. Thank you. Ms Ashworth, I've put you directly on notice
 4 of this issue: because of your seniority, the Inquiry
 5 understands that when you produced your statement, you
 6 had access to the totality of the CFW records because of
 7 the high levels at which your permissions are set; is
 8 that a fair summary?
 9 A. It is. Just to clarify, I retained -- I, as an
 10 individual, retained the levels of access to the case
 11 files on EHM and LCS that I would ordinarily have --
 12 Q. I'm not suggesting there's anything --
 13 A. -- and I was one of the smaller number of people who
 14 retain that level of access.
 15 Q. I'm not suggesting there was anything wrong with it but
 16 because of your seniority, you had a greater level of
 17 access and permissions than some others: it's a simple
 18 point?
 19 A. Yes.
 20 Q. I don't want you to disclose anything that was passed
 21 between you and your legal representatives in the form
 22 of legal advice during the time that your witness
 23 statement was taken, all right? I do need to ask you
 24 this: as you were preparing your witness statement, were
 25 you as an individual at any time aware that you were

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1 with the family, otherwise it would be a single-agency
 2 response. And it is correct to say that Early Help
 3 provision and the Team Around the Family, those
 4 processes that underpin the methods by which we work in
 5 Early Help rely entirely on collaboration.
 6 Q. Yes, but doesn't it suggest that, for some, they might
 7 lack the confidence or the authority to really act as
 8 a lead professional and that they see it more as
 9 administrating the meeting and the record of the
 10 meeting; isn't that a risk?
 11 A. It may do but I think it goes more to the point that an
 12 Early Help worker has no specific authorities or
 13 compulsions to make other agencies participate, to make
 14 them accountable for anything that's agreed. It is
 15 a collaborative process.
 16 Q. Yet you say in your statement that part of the role is
 17 to hold other agencies to account?
 18 A. That is technically the viewpoint, that's the attempt
 19 that is made by the lead professional, to bring people
 20 together into a room with regular review points where
 21 that reflection is -- and to ask that to be exposed and
 22 share that information -- that information shared but it
 23 goes no further than the willingness for agencies to
 24 participate and collaborate. The lead professional
 25 holds no particular compulsion capability, really, over

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1 other agencies' work.

2 **Q.** At other times, is there a risk -- and I'm going to
3 suggest evident from AR's case -- that the lead
4 professional role sometimes translated into not taking
5 sufficient account of other agencies' views? Do you
6 recognise that as having been a problem in AR's case?

7 **A.** I recognise a couple of points that I can see, you know,
8 the way in which they've been recorded, that go to the
9 potential that an agency had a particular view, and one
10 might say that the Early Help worker didn't follow
11 through on that view, entirely.

12 **Q.** So if we look at LCC000998, please. Could we take it at
13 page 9, please, this is May 2020, six months after the
14 hockey stick incident. AR and his family have been very
15 difficult to engage with in the early stage of the
16 pandemic and Mrs Hodson is now writing to Andrea
17 Fontaine, with others copied in.

18 The Inquiry has seen this a number of times and
19 I hope that you are familiar with it. Do you see the
20 long list of points that were being raised as a concern
21 by Mrs Hodson --

22 **A.** I do.

23 **Q.** -- focusing in particular on the fact that Alphonse R
24 was underplaying AR's responsibility, and undermining
25 the school, and not recognising the seriousness of what

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1 That may be thought to be giving something of
2 a brush off?

3 **A.** I can see why that could be construed as the case.

4 **Q.** Well, it's a reasonable interpretation, is it not? It's
5 not just a question of "I can see why that could be
6 construed as the case". The school were saying not only
7 has he done all of these things, which they'd previously
8 given in a very detailed -- because you say in your
9 statement, they weren't raising anything specific --
10 they'd given previously a very detailed list of their
11 concerns, the beheading point, the videos that he had
12 attempted to watch, the news stories, all of those
13 matters that you will be familiar with, and she's now
14 saying, on top of this, that the family are not dealing
15 with this appropriately -- my words not theirs. They
16 don't seem to recognise the risk, there isn't a good
17 role model, in fact quite the opposite, father is
18 diminishing that. Yet, it is said in response, that the
19 parent's view isn't relevant to risk, effectively. Now,
20 (1) that can't be right and (2) it's not an appropriate
21 response; would you agree?

22 **A.** Yes.

23 **Q.** Would you accept that this is a case of an appearance of
24 multi-agency working but perhaps not seeing it through,
25 in terms of the substance of genuinely listening to the

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1 had happened, and seeing his own son as the victim.

2 Yes?

3 **A.** Yes.

4 **Q.** Would you agree that that's an agency in good faith
5 raising really quite serious concerns?

6 **A.** It is.

7 **Q.** The response to that, at page 8, from Ms Fontaine, while
8 civilised and courteous in its tone, in substance didn't
9 agree to do anything. It said:

10 "In any case, Alphonse's view of his son's
11 temperament and behaviour and [the] expression of his
12 preferred educational placement, does not, in my
13 opinion, influence the risk level ... the risk
14 assessment is not the basis of AR's return to education.
15 Therefore I think it would be beneficial to have a copy
16 of your risk assessment to see where the risk lies."

17 Also giving information about the importance of
18 giving Alphonse an opportunity to respond to the
19 challenge and provide AR with an opportunity to
20 contribute his thoughts, feelings and wishes:

21 "I can appreciate that all necessary strategies need
22 to be put in place to ensure everyone's safety, however,
23 there does not appear to be any new or additional
24 information shared that would suggest an increased
25 risk."

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1 concerns of other agencies?

2 **A.** I don't think that was the intention behind it but I can
3 understand why that might be viewed in that way.
4 I think what Andrea was sort of referring to at this
5 point was about the baseline of the risk of AR being in
6 school at that time and I think -- this is at the height
7 of the Covid pandemic when the national lockdown
8 circumstances were in play, I understand, and the family
9 were also expressing concerns about AR being in school
10 during that period anyway.

11 So, I think, Andrea is possibly coming from a place
12 there -- I'm reading somebody else's decisions, they are
13 not my own, I wasn't there to be part of that -- but
14 I think she was referring to -- because I think there's
15 a reference to risk of proximity, at some point, that
16 the school raise and he wasn't in school at that time,
17 so that risk wouldn't be realised and, in actual fact,
18 he didn't go back to school until the September when we
19 were --

20 **Q.** No, he went back to school in July. He went back to
21 school in July.

22 **A.** Okay.

23 **MR MOSS:** Sir, would that be an appropriate moment?

24 **A.** Apologies.

25 **SIR ADRIAN FULFORD:** How long: 15 minutes?

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1 **MR MOSS:** Yes, thank you.

2 **SIR ADRIAN FULFORD:** I will sit again at 11.50 am.

3 (11.35 am)

4 (A short break)

5 (11.50 am)

6 **SIR ADRIAN FULFORD:** Yes, Mr Moss.

7 **MR MOSS:** Thank you, sir.

8 Ms Ashworth, we were looking at examples of
9 multi-agency working and what that meant in practice.

10 A couple of weeks after the exchange that I took you
11 to, but in the same email exchange, LCC000998 at page 5,
12 please. While that's coming up on screen, effectively
13 what happened was that there was discussion about
14 support in getting AR to school. In the context of
15 that, it became apparent that the CFW was contemplating
16 closing the case effectively over the summer and I think
17 you'll be aware that, in general terms, Acorns
18 responded -- we can pick it up at page 2 -- indicating
19 concern about that. So it's the bottom email on this
20 page. The difficulties of engaging but noting that CFW
21 had had somewhat better luck, even though they had found
22 it difficult as well, and not really understanding why
23 CFW, if they weren't involved at all over the summer,
24 what support there would be, and asking for that
25 support, though it was all very difficult, to continue.

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1 **Q.** -- but what the school were saying is, "You're actually
2 having a bit more luck in engaging than we are and, if
3 you withdraw, there will be nothing at all over the
4 summer, therefore, please keep him open", but the stamp
5 comes down saying "no"?

6 **A.** I think it's reasonable to say we could have kept it
7 open over that summer, that wouldn't have been
8 an unreasonable thing to do.

9 **Q.** One of the later referrals, the tail-end of 2021, into
10 early 2022, in that period we know that there were the
11 incidents of violence in November, four during the
12 course of the month, there'd been a concern that I'm
13 going to come onto about a potential extremism risk and,
14 at that stage, after all of that has happened at the
15 tail-end of the year, when you get into January, if we
16 just look at LCC000137 -- these are the TAF notes for
17 January. I will just let you get your bearings on the
18 front of the document. So you can see 12 January 2022;
19 can you see that there?

20 **A.** Yes.

21 **Q.** Then if we go to page 4 and if the top text could be
22 expanded, please, understanding that planned work may
23 have been coming towards an end, what's actually said
24 is:

25 "TAF members have been informed that, once the work

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1 Then the response that comes to that, at pages 1 to
2 2 -- if we can just go to page 1 -- is, effectively,
3 bottom of page 1, that because the work that they wanted
4 to do was face to face and that couldn't be done, that
5 there was still no role and that they were going to
6 withdraw that in any event. At the top of the page, at
7 the supervisory level, Ms Barrett added that this was
8 very professional and well put.

9 Again, do you think that there is a risk in this
10 that it looked very much like the school wasn't being
11 listened to?

12 **A.** I think it goes to the same point as just before we
13 broke really, in that I think it's reasonable that you
14 could consider that that looks like the school's not
15 being listened to and, you know, in circumstances where
16 what's been discussed is like a temporary step down,
17 a temporary closure of the case, due to the prevailing
18 conditions around Covid, I can see some absolute
19 understanding around why that will be the case.
20 Effectively, we weren't in a position to do any of the
21 things that we were wanting to do, needing to do, with
22 the family because of the impact of the Covid
23 conditions.

24 **Q.** But that was your agency's view --

25 **A.** That was our agency's view.

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1 has been completed by Targeted Youth Support, the case
2 no longer sits at level 3 on the Continuum of Need as it
3 will be around [AR's] educational and health needs."

4 Now, that reads on the record as somewhat of
5 a declaration, rather than a multi-agency decision;
6 would you agree?

7 **A.** It's a statement, yes.

8 **Q.** Well, "have been informed", it's not indicating "The
9 pros and cons were discussed in session and, on balance,
10 the general view was", is it?

11 **A.** No, that's fair.

12 **Q.** I think you'll be aware that that then perpetuated in
13 February and March, at the TAF meetings -- without
14 turning them each up -- that there were a number of
15 issues come March, not least of which was the fact that
16 AR was going to be very shortly moving to Presfield, the
17 new school --

18 **A.** That's right.

19 **Q.** -- a time of transition --

20 **A.** Yes.

21 **Q.** -- that was likely to be difficult and, yet, the same
22 course was sailed regardless; would you agree?

23 **A.** It was and I think I address that in my first statement,
24 that, you know, reviewing that with the benefit of
25 hindsight, whilst on balance I can see why, in terms of

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1 the things that were in the plan that CFW were tasked
2 with working on around the family, those were being
3 done, there was progress being seen and they were coming
4 towards an end, there was that significant transition
5 for AR to make to a new school and we do understand that
6 those are sometimes challenging times when young people
7 make any transition and, with the benefit of hindsight,
8 I think we could have kept it up and tried to see
9 through that transition.

10 **Q.** Forgive me for making this observation but it's very
11 easy to say "with the benefit of hindsight".

12 **A.** I appreciate that.

13 **Q.** It is not with the benefit of hindsight in this case, is
14 it, with the information that was known at the time
15 because this was being directly flagged up: LCC001003,
16 please.

17 The bottom email, you will note the date, 4 March.
18 This is Ms Allred, who, on some of the evidence, may
19 have been one of the teachers who knew AR better than
20 others:

21 "I hope you have been given the very good news that
22 [AR] will be starting at Presfield after Easter ... he
23 is disengaging more from Acorns ... hoping this is
24 short-term ... it is premature to invite the teacher
25 from Presfield to the next TAF but the TAF thereafter

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1 going missing? Do you see that: Sam Steed to
2 Ms Barrett, the bottom email?

3 **A.** Yes.

4 **Q.** Then the response from that, LCC000966. Ms Lewis -- and
5 this is before the service had learned that AR had been
6 found, and again we've seen this a number of times:

7 "I am aware that [he's] gone missing as Alphonse has
8 contacted the office this morning. Alphonse has acted
9 appropriately by contacting the police and that is only
10 advice we could give. There was a high chance [of this]
11 following the meeting last week that this may happen as
12 Alphonse made it clear that he didn't want the support
13 to [end]. As agreed in the meeting by all
14 professionals, there was no outstanding work from CFW
15 level 3 and for the family to be supported via health
16 and school (EHCP). The case was closed after the
17 meeting. Moving forward I'm unsure of what other
18 support can be offered to them, other than what's
19 already in place and his parents need to be positively
20 encouraging [AR] to attend and to follow any advice from
21 school and strategies learnt through the parenting
22 programme."

23 Then these words:

24 "If you feel that the needs of the family meet
25 level 3, however, this one incident currently would not

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1 would be a [good time, my paraphrase] to involve
2 Presfield as the new school."

3 So it's not a hindsight point; this was being raised
4 at the time, wasn't it?

5 **A.** No, that's correct.

6 **Q.** What was the response?

7 **A.** I think the response was that that wasn't fully taken
8 into consideration in terms of whether or not remaining
9 open to the family to be part of that transition period
10 would have been a good idea.

11 **Q.** It was a bit more determinative than that. If we go to
12 the top of the page:

13 "After this meeting on Friday, the case will be
14 closing ..."

15 **A.** Yes, that's correct.

16 **Q.** A manifest failure to listen to a good email raising
17 an appropriate and genuine concern that AR was going to
18 be going through a transition and it would be good to
19 have continuity?

20 **A.** We didn't take that continuity into account, no.

21 **Q.** A third example, please, just on this aspect of
22 multidisciplinary working, the bus incident in March --
23 if we could have LCC000989. So just three days after
24 that closure, in the face of AR's transition --

25 LCC000989 -- we see CAMHS making CFW aware, yes, of AR

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1 meet threshold as parents acted appropriately calling
2 the police."

3 Again, may I suggest that that is giving the brush
4 off. It's indicating, before anything is known really
5 about the circumstances of what had happened, "We're not
6 going to take this back as a level 3 referral because
7 the circumstances of him going missing don't meet it in
8 circumstances where the parents had called the police"?

9 **A.** I can see why you would view it that way.

10 **Q.** Well, how do you view it?

11 **A.** It does seem to be a singular response to the situation.

12 **Q.** What do you mean by that?

13 **A.** It seems to be that -- it seems to be that the worker
14 shares a view about whether something meets threshold on
15 fairly limited information that she has at that time.

16 **Q.** Do you see any evidence of professional curiosity in
17 this response?

18 **A.** No.

19 **Q.** Do you see any evidence of a motivation to work closely
20 with other agencies to find out what had actually
21 happened?

22 **A.** Not in this singular email, no.

23 **Q.** Thank you. I want to turn to look at some issues in
24 relation to consent and how that may have been
25 problematic in the working with AR. Obviously, consent

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1 important because it is a consensual service, it's not
 2 at the statutory level where services could be provided
 3 and interventions made regardless of consent; would you
 4 agree, in simple terms?
 5 **A.** That's, yes, correct.
 6 **Q.** At the same time, would you agree that, if the family,
 7 both the child and child's parents, in this case
 8 particularly Alphonse R, are being difficult around
 9 consent and either being manipulative or withholding
 10 consent at times, that can itself be an indication that
 11 the risks are higher.
 12 **A.** It could be.
 13 **Q.** If one takes an example of this, if we could look at
 14 LCC002302, at page 36. It's the bottom of the page.
 15 I'm not going to read it out because the learned Chair
 16 has seen this a number of times and I think you'll be
 17 familiar with it but you will recall that this is the
 18 passage in which Alphonse R was, in terms, refusing
 19 consent for information to be passed from CFW to the YOT
 20 and -- if we just go over the page -- at the same time,
 21 indicating that he viewed the YOT as the service that
 22 was there to punish AR and saying that he was being
 23 candid in his view with CFW but didn't want that
 24 information that they were opening up to be passed to
 25 the YOT; do you follow?

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1 with you and I think that's what she will have attempted
 2 to do in those circumstances. I'm sorry, I'm not sure
 3 if I'm answering your question.
 4 **Q.** That's for others to judge.
 5 If we look at page 36, the response that comes in in
 6 relation to this is effectively to say that not to
 7 worry, that the information won't be shared with
 8 consent. Now, it's fair to say, in relation to that,
 9 that that was an initial response by text and the
 10 evidence that was given, in relation to this, is that
 11 there may have been a subsequent conversation with the
 12 family where something was agreed whereby information,
 13 or at least some information, could be shared with the
 14 YOT. That's what was said in evidence.
 15 But the Inquiry has seen no evidence that there was
 16 any feeding back to the YOT of this concerning
 17 information, and wouldn't you have expected that?
 18 Either if the refusal of consent was retained to say,
 19 "We can't tell you what information we have been
 20 provided with, but you need to know that this family is
 21 refusing consent to share information with you" because
 22 that itself is something the YOT was need to know, isn't
 23 it?
 24 **A.** Yes, I would expect that to be part of a conversation
 25 with the YOT at some point, whether that was directly

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1 **A.** Yes.
 2 **Q.** Now, that, would you agree is concerning on a number of
 3 levels: one is what it might say about the risk of
 4 what's going on in the family; and, secondly, is that
 5 the family are viewing the work of the YOT as being to
 6 punish AR, yes?
 7 **A.** Yes.
 8 **Q.** What would you have expected to have been done about
 9 that.
 10 **A.** I think this goes to a whole -- the basis of
 11 a conversation that we always have to have with families
 12 about privacy and consent and what the constraints and
 13 boundaries around that are, and I think the worker, in
 14 the circumstances, will often experience questions and
 15 concerns and sort of articulations from a family that
 16 will talk about what the boundaries of consent are. So
 17 they may be willing to consent for information to be
 18 shared with one agency but not another.
 19 Their ability to do that sits within the laws around
 20 consent essentially. Workers will be asked to kind of
 21 routinely try to reassure families about what consent is
 22 about and its place, particularly with a view to the
 23 reassurance that we're working in this way with you and
 24 we need this consent to work with you on the basis that
 25 we can do good for you, that we're working positively

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1 off within the context of the Team Around the Family
 2 meeting.
 3 **Q.** And if consent had been forthcoming, on the other hand,
 4 to share subsequently, you would have expected to see
 5 evidence of the CFW team specifically saying to the YOT
 6 that, "We have now got consent to share this exchange,
 7 and there's a problem here because father sees you as
 8 the punishing service and therefore you may not be
 9 getting the full picture because he may not be opening
 10 up to you". Again, that would have been an appropriate
 11 way to tackle Alphonse R's approach to consent on this
 12 occasion, would it not?
 13 **A.** It would, yes.
 14 **Q.** If we look at LCC000972, it's a more limited example but
 15 in November 2020, in relation to a CAF report, if we
 16 just have the bottom email, bottom half of the page,
 17 please.
 18 "Thank you for email of the CAF report. Below are
 19 my suggested corrections.
 20 "On the first page under 'reason for CAF assessment'
 21 please replace knives with a knife. (He carried one
 22 knife during that period)."
 23 What do you make of that as an intervention by AR's
 24 father knowing what we do about October and December
 25 2019?

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1 A. I see it as an attempt on his part to, I suppose,
2 control what was written down as being what he perceived
3 to be the truth.

4 Q. And whether it's technically correct in that AR was
5 carrying the same knife, can you see that that matters
6 not one jot because the risk and the point about
7 carrying knives was that he carried a knife on ten
8 occasions to school in October 2019 and then repeated it
9 in the course of the hockey stick incident in December?

10 A. Yes.

11 Q. Yes?

12 A. Yes, yes.

13 Q. So isn't there a risk here of Alphonse R manipulating
14 the use of consent?

15 A. Yes, that is a potential risk. I think this goes to
16 what certainly I have seen threaded in various notes on
17 the system in various encounters with the family where
18 there is a propensity for this man to want to try to
19 control the narrative.

20 Q. Do you think that at times the desirability to keep the
21 family on board, which no doubt is a genuine concept,
22 perhaps had too much focus and that there was a failure
23 by CFW to stand up to Alphonse R on some of these
24 matters and to say, "Very sorry, but actually there's
25 clear evidence, including admissions made by your son,

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1 I alluded to earlier where I can see a couple of points
2 where one might say that an accumulation of
3 circumstances leads to a position where we could have at
4 least taken that for a conversation, a family
5 discussion, around step up. Whether or not it would
6 have gone on to meet the thresholds determined by level
7 4 would be another matter, but I can't identify that
8 that was the case at that point in time.

9 Q. There might be grounds for a little bit of concern about
10 the vagueness of some of the language. When you say
11 "one might say", I can see a couple of points where one
12 might say that an accumulation of circumstances leads to
13 a position where "we could have at least taken that".
14 Putting it more bluntly, shouldn't that have
15 happened?

16 A. On the situation that was happening at that time, where
17 after something in the order of 20 plus weeks of
18 attempts had been being made to engage the family,
19 particularly AR, you know, in a course of action and
20 support, and us failing to maintain that -- get that
21 engagement, I think there was little else we could do
22 but to close that case on the basis of that
23 non-engagement. We weren't going to be able to change
24 that circumstance. I think you could say --

25 Q. Forgive me. At that stage -- I was going to come to

75

1 that he carried the knife or knives on multiple
2 occasions and that's the point. Therefore we're not
3 going to take this out of the assessment". Shouldn't
4 there have been some push-back to that effect?

5 A. There should and I can't say that there wasn't. All
6 I can say is that we don't see that in what's been noted
7 down on general note records.

8 Q. And just finally in terms of consent, for the final
9 period, when you know that ultimately closed in
10 September 2023 and it reaches a stage where AR was
11 deemed to be just refusing consent to engage with the
12 service, what was said, if we look at LCC000203, and
13 have the main box highlighted, please, and so what we
14 can see, towards the bottom of the page, as has been put
15 it up for us very helpfully, is:

16 "[AR] is very clearly now voicing to professionals
17 both directly and indirectly by refusing contact that he
18 is not ready for the support ... There are no
19 safeguarding concerns."

20 Yes? Now, that's perhaps accurate so far as it goes
21 but would you agree that there doesn't seem to be
22 sufficient scrutiny of whether this was a case in which
23 there might need to be an overriding of that consent,
24 potentially by stepping it up to level 4?

25 A. Yes, I think this is one of the circumstances that

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1 this later but let's deal with it now -- this is a boy
2 of 16 or 17 years old, who is not going outside really,
3 who has withdrawn from CAMHS services, who is not being
4 seen by CAMHS, who is refusing to be seen by CFW
5 workers, who effectively is hidden away online the whole
6 time against a background of very significant concerns
7 about his former behaviour, his risk to others,
8 a criminal conviction and you say in relation to that,
9 there's nothing else we could have done.

10 Now, perpetuating it at a level 3 case with CFW
11 obviously wasn't working and you say 20 weeks and so on.

12 A. Yes.

13 Q. But surely there the point is to say, well, he's not
14 consenting but we need to look at more intensive
15 intervention; therefore, this should be stepped up to
16 level 4. That's the obvious other choice, isn't it?

17 A. We could have done that. What I'm saying is, whether it
18 would have met threshold for that, I can't say. And, in
19 relation to getting the consent of a 17 year old young
20 person to work with you, because you can't do anything
21 if you don't have that consent and engagement, there's
22 no sort of magic bullet that social care have over Early
23 Help that would have made them be in a position to be
24 able to do the same thing.

25 Q. We'll pick up with our later witnesses today whether it

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1 may have met the threshold but, again, when you say "we
2 could have done that", can I suggest that that should
3 have been done?

4 **A.** Yes, you can suggest that. I think, on balance.
5 Possibly yes.

6 **Q.** Turning to how the needs of the child were assessed.
7 Culturally of course -- and this is extremely
8 important -- would you agree, that your whole service is
9 rightly focused on the needs of the child and the risk
10 to the child, yes?

11 **A.** Yes.

12 **Q.** And that is something which would have been reinforced
13 in training?

14 **A.** Yes.

15 **Q.** Both initial training and refresher training, yes?

16 **A.** Yes, yes.

17 **Q.** But we've already looked at that feature which you can
18 see at the level 4 cases, the guidance of what would be
19 a level 4, and you've accepted that a risk of harm to
20 others could be a risk of harm to self.

21 If we look at the 20 January 2021 episode, you will
22 remember that that's when there was an allegation by AR
23 that his father had hit him, yes?

24 **A.** Yes.

25 **Q.** And it emerged -- we perhaps don't need to turn up the

77

1 relatively trivial when he didn't get his way and then
2 showing no remorse afterwards?

3 **A.** Yes, that doesn't feature highly. Yes.

4 **Q.** Thank you.

5 Another example of perhaps the needs of the child --
6 which, again, I can't stress enough are very important
7 and mustn't of course be overlooked but perhaps
8 eclipsing the risk to others -- in the tail half of 2021
9 there were those four incidences, yes, of violence in
10 the home, two with the police being called, two others
11 involving pouring items (so a form of assault) over AR's
12 father.

13 In the course of those, Ms Steed of CAMHS had asked
14 for consideration to be given to raising it to level
15 4 -- so a Section 47. She had asked for that by email.
16 And yet those matters don't seem to have been
17 discussed at the TAF that followed in December 2021.

18 Can you explain from your assessment of the records
19 why episodes of significant violence in the home were
20 not discussed at all in the next TAF meeting,
21 notwithstanding that CAMHS had asked for a Section 47
22 assessment?

23 **A.** No, I can't explain that. I don't know why that is the
24 case. CAMHS asking for consideration of the situation
25 at Section 47, wasn't progressed but neither was it

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1 documents for this -- that what had happened was that AR
2 had actually threatened to break his father's laptop,
3 Alphonse R had tried to stop him and stood in the way of
4 him getting towards the laptop, and AR had then kicked
5 his father in the testicles and Alphonse, on any view,
6 inappropriately but had retaliated with a slap to the
7 face. So that was the incident.

8 When that was addressed by CFW, it was established,
9 do you recall this from the records, that AR showed no
10 remorse about that at all, commenting that he hadn't
11 hurt his father that much, yes?

12 **A.** Yes.

13 **Q.** And that would be a concern?

14 **A.** Yes, it would.

15 **Q.** Direct assault, not a trivial assault, and then showing
16 no remorse for it.

17 Would you agree that in the way that that was
18 handled though at the time, without turning up all the
19 records, that the entire focus was on whether that was
20 serious enough to warrant intervention in relation to
21 the risks to AR from his father?

22 **A.** I would agree, yes.

23 **Q.** And there was a failure there to take into account that
24 this was an escalation of violence within the home of AR
25 being prepared to kick his father over something

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1 progressed by them either. I just kind of really wanted
2 to say I'd like it to be remembered that CFW isn't the
3 only -- the only agency operating in and around the
4 family that has got the opportunity to escalate
5 something.

6 **Q.** We have called CAMHS. We've asked them similar
7 questions that I'm asking to you but you'll understand
8 why, for you, I have to focus on what your side did and
9 didn't do.

10 **A.** Yes.

11 **Q.** All right. Let's move from the focus on the needs of
12 the child to a risk assessment. If we look in your
13 statement at the risk assessment topic, it is LCC001998
14 at page 7, please, Ms Ashworth -- very bottom of the
15 page.

16 You were asked about a whole range of policies and
17 processes and procedures and a risk assessment. What
18 you answered in relation to this was:

19 "Use of standard [Lancashire County Council] systems
20 and procedures for health and safety -- including use of
21 Evolve system for management of educational visits ...
22 Procedures for premises related assessment of work
23 settings and out reach including PPE where necessary,
24 including soft play and sensory rooms. Procedures in
25 lays for lockdown due to extreme threat. Lone working

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1 arrangements in place -- extensive use of SOS Fob system
2 for alert and response. Standby duty system ..." and so
3 on.

4 You go on to home visiting; hazard flags for known
5 risk at property; anticipated violence and aggression.

6 This all seems to relate either to PPE and health
7 and safety or to the risk of CFW workers; would you
8 agree? That's how you chose to answer this.

9 **A.** I guess so, although there are a number of factors
10 listed in there that go to the one-to-one working with
11 individual families.

12 **Q.** What seems to be absent is any clear policy in relation
13 to the risk that someone like AR posed to other people,
14 the risk of them attacking and the assessment of that.
15 Is that because that was overlooked or is that because
16 it was largely left to other agencies?

17 **A.** I don't think that it's overlooked per se. I think that
18 it is more a reflection and recognition that the role --
19 of the role that Early Help plays and that, in those
20 circumstances, where the factors are about the risk that
21 an individual poses to others, there are other agencies
22 that are better placed, more skilled, trained, have
23 statutory measures at their disposal to respond and deal
24 with those circumstances than Early Help would be and
25 I guess that sort of more detailed policy would sit

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1 counsel", the observation is made that some of the views
2 that he was expressing, if said in the wrong
3 environment, may put him in a compromising position.

4 Then you get on to the issues about a political
5 discussion and went on to say that MI5 and MI6 can
6 access information on his social work and CFW records.
7 It then got vocal on politics, American Government and
8 the Taliban. Do you see that there?

9 **A.** I do.

10 **Q.** Now, at least on the face of the records, if we look at
11 LCC000977, Ms Barrett says, well, this was not
12 an immediate risk. It is on the background of what was
13 known. But eight days later, Ms Barrett was sending to
14 Ms Lewis the list of proscribed terrorist organisations
15 and saying that that needed to be discussed with AR's
16 parents.

17 We've seen LCC000321. Ms Lewis' assessment towards
18 the bottom of this page. I think it is the penultimate
19 paragraph but if we have the text:

20 "There have been concerns in relation to [AR's]
21 extreme thoughts around what is going on in the world
22 and politics which could put [AR] at risk of being
23 involved in left-wing extremist behaviours and it's
24 thought being said in the wrong environment may make him
25 vulnerable."

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1 there. I'm thinking about agencies like the police and
2 the Youth Offending Team, for example.

3 **Q.** And in relation to information that might be relevant to
4 terrorism risk, or extreme violence risk, Prevent?

5 **A.** Prevent, yes.

6 **Q.** But if you're not going to have internal policies that
7 gradate those sort of risks, it's very important that
8 the information is at least shared with those others
9 agencies, yes?

10 **A.** Yes, that's fair comment.

11 **Q.** If we look in that context at LCC002302 back in the case
12 notes, and page 48 please this time.

13 If we could have the large box towards the top of
14 the screen. This is the joint visit that was done by
15 Ms Lewis and Ms Barrett on 4 October and you will be
16 familiar with this. The Chair has seen it now a number
17 of times.

18 It starts with an outright refusal from AR to let
19 his parents or his father say what the issue is that he
20 had demanded be done and mum at this stage seemingly
21 supporting that in saying to Alphonse R that he
22 shouldn't speak to them.

23 It then develops into further discussion and in the
24 course of that further discussion about news and
25 an offer made about, "Would you be interested in youth

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1 And LCC000402 at page -- LCC000401. Forgive me,
2 I think I said 402. LCC000401 at page 2. In the
3 supervision form, we can see Ms Barrett and Ms Lewis
4 reflecting that AR has a referral to Prevent:

5 "... going from school due to his extreme views.
6 This needs to be followed up as the outcome is yet
7 unknown and [AR] remains at risk of becoming groomed by
8 extremist groups."

9 Those are all indications after that conversation.
10 The outcome of asking about that seems to be that,
11 although they thought at that time that the Prevent
12 referral was open, they then learnt that it had been
13 closed. But, against that background, they don't seem
14 to have understood that, in fact, it had been closed
15 months earlier in May 2021; that there doesn't seem to
16 have been any advice taken from LCC's Prevent lead and
17 ultimately this information was never passed to Prevent
18 or even to the local police.

19 Would you agree that that's concerning?

20 **A.** If that's correct, that's concerning but we're talking
21 about several Prevent referrals, aren't we, over
22 a period of time.

23 **Q.** Well, three had been made --

24 **A.** Three.

25 **Q.** -- but the third had long since been closed by this

84

1 time.

2 **A.** Yes.

3 **Q.** This is October 2021 and the third had been closed in

4 May. So this is after that.

5 **A.** Yes.

6 **Q.** A discussion in which AR had raised the Taliban and

7 effectively said that it was unfair because the Taliban

8 were criticised in a way that the American Government

9 weren't. Now, that's not pro-Western view, it may not

10 be directly supporting the Taliban, but it is a matter

11 of concern for somebody who has AR's background; would

12 you agree?

13 **A.** Yes.

14 **Q.** That plainly should have been passed to Prevent?

15 **A.** Okay. Yes, I agree with that.

16 **Q.** Do you know why that wasn't done?

17 **A.** I don't. I don't know. I had an understanding that the

18 third Prevent referral was around this time --

19 **Q.** No, it had been closed.

20 **A.** -- in November.

21 **Q.** No.

22 **A.** Okay.

23 **Q.** And in terms of not having an internal risk assessment

24 process perhaps for risk to others and perhaps relying

25 on other specialist agencies, other specialist agencies

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1 **A.** I don't think that specific fact was, no.

2 **Q.** CFWS is a time-limited service. Could we look at

3 paragraph 31 of your statement, please. I just want to

4 get some help from you on this. It's page 5.

5 So bottom of the page, you explain that:

6 "Back in 2019 our service was time limited to an

7 extent."

8 That changed in the reconstruction in 2021. Time

9 limit was "only ever notional":

10 "When working in level 2, not through MASH but

11 direct referrals, we were probably dealing with around

12 3,700 [cases] before a £5 million investment ... You had

13 to have as many cases closing as you had opening. 12

14 weeks was the threshold point of referrers to say

15 anything up to 12 weeks was acceptable and beyond 12

16 weeks there needs to be a closer eye kept on the case."

17 Is that right?

18 **A.** That's true.

19 **Q.** You help us, but that's what we would have expected to

20 see up until 2021 but not thereafter?

21 **A.** Yes. Just the volumes that are pointed to in that

22 statement really were the presiding factor and, you

23 know, just to stress that there was no cut off on the

24 basis of time. That would never have been applied in

25 that way. It was a kind of a management overlay that

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1 can only act if the CFW pass on the relevant

2 information.

3 **A.** That's fair comment, yes.

4 **Q.** This was a discussion in October at which only the

5 family and CFW workers were present.

6 **A.** Okay.

7 **Q.** That was a significant failure; would you agree?

8 **A.** Yes.

9 **Q.** Thank you.

10 Could I just turn to repeat referrals. We touched

11 on that a little bit earlier and, in a way, I got ahead

12 of my questioning. But just to go back to that, that in

13 the five periods do we see that to some extent, whether

14 because there was a step-down from Children's Social

15 Care or a fresh referral in, there was over the course

16 of over two years something of a sense of the case

17 coming back time and again and it always being difficult

18 to get full engagement and make much headway?

19 **A.** Yes.

20 **Q.** Do you think that sufficient consideration was given to

21 that very fact and the fact that we've tried, we've

22 tried before, this family keep coming back, the concerns

23 keep being raised, it is time to put this family to the

24 level 4 team. Do you think that that thinking was

25 sufficiently evident?

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1 sort of said once something's progressed beyond about 12

2 weeks we just need to make sure we're keeping an eye on

3 it, that the case is progressing, that it is continuing

4 positively, that there isn't any unnecessary drift that

5 we need to address.

6 **Q.** I follow. And although there wouldn't be a nominal

7 cut-off at 12 weeks, would it follow that if the case

8 was difficult and thought not to be going anywhere,

9 whether because consent wasn't forthcoming or the

10 support wasn't really getting anywhere, that there would

11 be pressure to close?

12 **A.** I don't think so, no. I don't any pressure to close.

13 And if you use the third time that we worked with the

14 family as an example of that, we were working with them

15 for 20 weeks in that instance.

16 **Q.** After the 2021 rearrangement, what was the position

17 there? You go on to say:

18 "This was to prevent drift as there was pressure to

19 close as many cases as were coming in. Now that we are

20 working at the complicated area of the spectrum ... the

21 average time an episode is open to us is 21.3 weeks ..."

22 So you seem to slightly jump from the pre-'21

23 position to the position now.

24 **A.** That would have been the case.

25 **Q.** What would have been the position from 2021 to 2023 in

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1 terms of time limits for time-limited service and
 2 periods of weeks?
 3 **A.** Yes, not that we are operating any time limits, that
 4 that position about the length of time that you work
 5 with a family is open to the consideration as to
 6 whenever you reach the point where the needs that you've
 7 identified, that you're working on have been
 8 sufficiently met. So it's not governed by a time limit
 9 in that same sense.
 10 **Q.** We'll look at some examples where that language was used
 11 in a moment. But paragraph 32:
 12 "There is not a culture to try to close cases as
 13 such, but circumstances are relevant as to trying to
 14 manage demand."
 15 Then you said this:
 16 "This is not targeted, risky or complicated work."
 17 What did you mean by that?
 18 **A.** Because that is what Early Help is meant to be. Not
 19 risky or difficult work in that sense. That is the
 20 definition of Early Help.
 21 **Q.** But don't we see in relation to AR, certainly when he
 22 was being dealt with not as the statutory service in
 23 Section 47 terms but at level 3, as he sometimes was,
 24 that it was certainly complicated work dealing with,
 25 amongst other risks, a risk of harm to others?

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1 my reading of what will have been being driven at there
 2 is the propensity for particularly the father to
 3 continually want CFW to be working with the family. So
 4 there are circumstances where, you know, we're having
 5 a final TAF meeting and all agencies and the family are
 6 agreeing that things should close at that point but,
 7 even so, the father is asking for that to remain -- CFW
 8 to remain open to the family.
 9 **Q.** Yes, but that wasn't the case here, was it?
 10 Ms Ashworth, we've looked at this. It wasn't the case
 11 that all agencies were agreeing to close because --
 12 **A.** It was at that stage.
 13 **Q.** Forgive me, this is the --
 14 **A.** Dad specifically did ask for us to remain open to help
 15 with the transition to Presfield.
 16 **Q.** Forgive me, but this is 11 March 2022 and you have seen
 17 the 4 March email from Ms Allred at Acorns suggesting
 18 that there should be a further TAF to involve Presfield,
 19 and you said "Oh, if the family" -- the family are
 20 agreeing, but Alphonse R wasn't agreeing at this stage.
 21 **A.** No, he wasn't. That's what I've just said. He --
 22 **Q.** But nor was the school?
 23 **A.** No, and that's why I've said I make that concession
 24 that, you know, on the basis of that we could have held
 25 that case open a little longer to support and ease that

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1 **A.** Yes, that is more the case now post the 2021 changes.
 2 **Q.** So post-2021 you could be dealing with, and you were
 3 dealing with in AR's case, a risky and complicated case?
 4 **A.** Yes.
 5 **Q.** If we look please at LCC002302 back in the notes at
 6 page 98 this time. This is March 2022. It is the
 7 second entry, please: the whole of the middle of the
 8 page. You see in March 2022:
 9 "All actions in the plan have been met and the TAF
 10 members have reported that there has been significant
 11 improvements for [AR]. He's been offered a place at
 12 Presfield ..."
 13 You will remember that this is the point of time
 14 I raised with you where you accepted it could have been
 15 left open. But in part of the rationale for why it
 16 wasn't kept open, we see in the bottom line of that
 17 first sub-box:
 18 "Alphonse was reminded that CFW are a time-limited
 19 service that works at level 3 on the Continuum of Need
 20 and that currently there are no unmet needs in the
 21 family."
 22 So, in terms, that concept of being a time-limited
 23 service was still being used as an explanation in March
 24 2022.

25 **A.** Yes, and that does surprise me in that sense. I think

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1 transition.
 2 **Q.** I mean, just on its face, it's very concerning that
 3 a supervision report -- so it's not even at the
 4 caseworker level -- is still referring to it as
 5 a time-limited service to justify closing down.
 6 **A.** Yes, I agree that's surprising to see there at that
 7 date.
 8 **Q.** And although the language of time-limited service isn't
 9 used, if we wind forward to September 2023, if we just
 10 look at LCC000971, this is coming from Della Heaton to
 11 the team, I think, and understandably giving motivation
 12 to the team, 80 per cent of new families have visits
 13 within a very short period of time. But then she comes
 14 to the bad news, towards the bottom of the page:
 15 "With the good comes the not so good -- lots of
 16 children not seen in the month ... Putting it down to
 17 holidays, et cetera ... the hard bit is maintaining it
 18 ... not seen in the month (Sharon can we get [AR] closed
 19 please)."
 20 That does seem again to resonate with the sense of
 21 wanting to get the cases closed after a period of time;
 22 would you agree?
 23 **A.** I can see why that would be seen to be the case reading
 24 that, but I don't believe that to be the case generally
 25 in terms of the culture at that time.

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- 1 Q. Just moving on to look more generally at the decision to
2 close AR's case and the absence of any decisions to step
3 up, we've dealt with this to some extent but can we just
4 draw the strands together.
- 5 We looked at the first period. For the second
6 period, impacted as we must recognise by Covid, as we've
7 explored the case was closed in the face of opposition
8 from the school who wanted support to continue over the
9 summer period, yes?
- 10 A. Yes.
- 11 Q. In the third period, the closure occurred just as the
12 YOT involvement was ended, when there had been an
13 episode of violence in January 2021 and when a Prevent
14 referral had just been received?
- 15 A. Say those three things again, sorry, sir.
- 16 Q. The third period, the closure occurred just as the YOT
17 had finished their work, so there was one service
18 withdrawing. There had been the episode of violence in
19 January 2021 and Acorns School had just sent a new
20 Prevent referral.
- 21 A. Okay.
- 22 Q. Yet in the face of all of those developments, again, the
23 case was closed by CFW?
- 24 A. Yes, I wasn't aware of the YOT coming to an end at that
25 time.

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- 1 However, I do accept there are some circumstances,
2 and you've just pointed them out and we've talked about
3 them already, where we might have considered having
4 family discussions or considered step-up as an outcome
5 rather than a closure.
- 6 Q. Thank you.
- 7 You've set out in your statement very helpfully and
8 in detail, both in your first statement and your second
9 statement, a number of improvements. That stands as
10 part of your evidence. I'm not going to go through it
11 now.
- 12 Could you just help us with this. Reviewing this as
13 a senior manager, what areas, in conclusion, have you
14 identified that should have been done better by the
15 service?
- 16 A. I think there are some matters of record keeping that we
17 have discussed, specific incidents that could have been
18 represented better, more fully, and I think there are
19 those circumstances again that we've already discussed
20 where, at the outcome of a period, an episode of working
21 with the family where we've closed a case, we might have
22 considered a conversation about step-up and the risks at
23 that time. I think they are the principal ones.
- 24 I think further to those, threaded through a period
25 of what is essentially five years, from the very

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- 1 Q. In the fourth episode, as we've been exploring -- that's
2 September 2021 to March 2022 -- we've looked at that.
3 You've got the 4 October 2021 visit with reference to
4 the Taliban, episodes of violence in November 2021 and
5 that January TAF meeting, what I suggested looked like
6 a declaration that it was going to close and then not
7 changing despite the Presfield. We've just looked at
8 that. Again, closed in the face of disagreement from
9 others, school, father, yes?
- 10 A. Yes.
- 11 Q. And in the fifth episode, closed as we've also explored
12 in the face really of not making any headway at level 3
13 because AR was simply not engaging, but in circumstances
14 where there are real grounds to be concerned that this
15 was a boy who had just totally withdrawn against
16 a background of earlier risk to others?
- 17 A. Yes, we've discussed that, yes.
- 18 Q. That whole pattern surely suggests that there was
19 an inappropriate approach being taken to the closure of
20 cases by the CFW; would you agree?
- 21 A. No, I wouldn't agree. I would say that where closures
22 were being made, they were being made on the basis of
23 whether or not we'd arrived at the position where either
24 we could do no more or we'd done what we could do and
25 I can see that threaded throughout.

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- 1 beginnings of a service being implemented from scratch
2 back in 2017/2018 and beginning to become more evolved
3 in terms of both its practice model, what we can offer
4 and the expectations on it, I think we have made
5 significant improvements and I have outlined those what
6 I think in my witness statements and I would stand by
7 those in saying that I do believe that Early Help does
8 make a significant difference to a large number of
9 children and their families.
- 10 Q. But should we add to those reflections a lack of focus
11 on the risk to others?
- 12 A. That's been acknowledged already.
- 13 Q. And not listening enough to the concerns of other
14 agencies in a fully multidisciplinary way?
- 15 A. And, again, in those specific instances I have
16 acknowledged that.
- 17 Q. And one significant event of failing to pass relevant
18 information on to Prevent?
- 19 A. Okay, yes. Yes.
- 20 Q. Thank you. Is there anything else that you would like
21 to add?
- 22 A. I don't think so.
- 23 MR MOSS: I'm just going to look to my left.
- 24 **Questioned by MR CHAPMAN**
- 25 MR CHAPMAN: Mr Moss asked you about Mr Coughlan's evidence,

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1 that his practice was not to look at the records to
 2 build a rapport. I think your initial response was,
 3 words to the effect that you could see where he was
 4 coming from and you were expressing some sympathy for
 5 that approach; is that right?
 6 **A.** Yes, from a particular perspective. Yes.
 7 **Q.** But you accepted that was bad practice.
 8 **A.** I did.
 9 **Q.** Liquidlogic, you were also asked about that. That has
 10 a feature, doesn't it, for highlighting important
 11 information?
 12 **A.** In terms of flags?
 13 **Q.** Yes?
 14 **A.** Yes.
 15 **Q.** But that's no good to a youth worker if they don't look
 16 at it; is that right?
 17 **A.** That would be correct, yes.
 18 **Q.** Can I suggest to you that bad practice is perhaps not
 19 strong enough and that the practice of not looking at
 20 the records is plain daft, because it might contain
 21 really important information?
 22 **A.** Yes, it might very well, yes.
 23 **Q.** "Plain daft" is fair?
 24 **A.** Yes.
 25 **MR CHAPMAN:** Thank you.

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1 in the real world that could happen?
 2 **A.** It is.
 3 **SIR ADRIAN FULFORD:** Both now and back in 2019?
 4 **A.** Yes, both now and back in 2019, although I do think that
 5 agencies' appreciation of those circumstances has become
 6 better as the years have progressed and particularly
 7 with Working Together 2023 being a bit more explicit
 8 about the context of contextual harm and harm to others
 9 of young people posing a risk to other people that we
 10 have needed to take that on board in terms of how we
 11 evolve our practice, and I think agencies are still
 12 working on that.
 13 **SIR ADRIAN FULFORD:** That's very helpful.
 14 So, I would like just for a moment to pause and for
 15 a moment to use the benefit of hindsight. So we have
 16 been doing all we can during this Inquiry not to use the
 17 benefit of hindsight because we look at the decisions
 18 that were taken before the events on 29 July.
 19 But we know that on 11 December 2019, AR, who had
 20 been carrying a knife or knives into school on ten
 21 occasions, we know certainly from some sources that his
 22 intention was to use the knife on another pupil, that he
 23 had put that plan into effect by travelling not to The
 24 Acorns School by taxi but to The Range School by taxi,
 25 armed with a hockey stick and a knife and was only

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Questioned by THE CHAIR

1 **SIR ADRIAN FULFORD:** Thank you, Mr Chapman.
 2 You are very nearly there, Ms Ashworth. Just one
 3 thing from me.
 4 You will understand that one of the things I've to
 5 consider is whether the overall system provides
 6 presently sufficient protection against those or to
 7 control those who present a real threat to others of
 8 either death or very serious harm.
 9 And it is in that context I want to ask you not
 10 necessarily focusing on this case at all, but really
 11 more as an abstract possibility whether, if somebody
 12 really does present that level of risk, interventions
 13 have been tried and they've failed, essentially not
 14 being controlled by the parents at home, and there is
 15 a real fear that somebody may die or be caused grievous
 16 bodily harm, can you envisage a situation where, having
 17 stepped up to level 4, that they would be removed from
 18 the home and taken into care?
 19 **A.** I can envisage that situation and certainly at level 4
 20 those statutory services do have a range of mechanisms
 21 at their disposal to consider how they might approach
 22 that.
 23 **SIR ADRIAN FULFORD:** So this isn't just a sort of abstract
 24 sort of theoretically possible result; this is something

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1 unable to get to his victim because there was a school
 2 assembly taking place -- so a long-term determination to
 3 do this.
 4 Now, applying the benefit of hindsight and imagining
 5 that one had all of that information at one's
 6 fingertips, can you imagine -- obviously not what the
 7 final result would be -- but that would be one of the
 8 situations in which there would be a level 4 discussion
 9 which could lead for a period to that individual being
 10 removed from the home and being placed into care?
 11 **A.** I could imagine that.
 12 **SIR ADRIAN FULFORD:** Thank you very much for coming. I'm
 13 sorry we didn't reach your evidence last week and I hope
 14 that hasn't caused inconvenience. You are now free to
 15 go.
 16 **MR MOSS:** Sir, forgive me, just before the witness is
 17 discharged, my learned friend Mr Weatherby raises one
 18 matter and I wonder if, through you, I may just ask.
 19 Ms Ashworth, would it be possible for you or
 20 somebody else just to check the position in relation to
 21 those markers that come up of key risk indicators to
 22 check whether risk to others is indeed one of them.
 23 I think you indicated you think it was but could you
 24 take that away and just make sure that somebody provides
 25 the Inquiry with --

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1 A. We absolutely can and I think I understand during our
2 short break that actually some information might have
3 been provided to verify --

4 MR MOSS: Then it has come in already. I'm very grateful.

5 A. Thank you.

6 SIR ADRIAN FULFORD: Thank you very much indeed.

7 MR MOSS: Might we say 1.40 pm.

8 SIR ADRIAN FULFORD: We certainly might. 1.40 pm.

9 (12.57 pm)

(The short adjournment)

11 (1.40 pm)

12 MR GOSS: Sir, before we swear the next witness, could
13 I just take this opportunity to put something on the
14 record, which is that there is a correction to CTI's
15 opening statement that is going to be going on to the
16 website overnight to address two issues. First, the
17 position as regards the passage of information as
18 between Acorns, Alphonse R and Lancashire Constabulary
19 on the morning of 11 December 2019.

20 Sir, you may recall that relates in particular to
21 the "hell bent" comment, which is only fair is addressed
22 prior to Alphonse R's evidence later this week.

23 Secondly, it also corrects the position as regards
24 Amazon's evidence in relation to providers or potential
25 providers of weapons, which resulted from inaccuracies

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1 an annex to that statement, which was a chronology of
2 Children's Social Care contact with AR, that has
3 helpfully been produced. If we could just have the
4 first page of that up, please.

5 Again, can you confirm that the contents of that
6 chronology are true to the best of your knowledge and
7 belief?

8 A. I can, yes.

9 Q. Thank you.

10 If we could start with your experience and your
11 role, please, Ms Anderson. You have been the Director
12 of Children's Social Care at Lancashire County Council
13 since November 2022?

14 A. That's right.

15 Q. At paragraph 4 of your witness statement, you set out
16 various graduate and postgraduate qualifications you
17 hold, including an MA in social work, and, in terms of
18 career history, I think you've been a social worker
19 since 2007 for various local authorities, including as
20 Principal Social Worker for City of Wolverhampton
21 Council between 2016 and 2020 and then, after that,
22 a senior leadership role in Wolverhampton before moving
23 to Lancashire, as you've said in November 2022?

24 A. Yes.

25 Q. Thank you. The first topic I want to explore with you

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1 in their initial disclosure.

2 I'm not going to read out that correction now given
3 the time but it will be available on the website
4 overnight.

5 SIR ADRIAN FULFORD: Thank you very much. It is important
6 that people should know that those corrections are going
7 to be made.

8 MR GOSS: Thank you, sir.

9 SIR ADRIAN FULFORD: Would you mind standing.

LOUISE ANDERSON (sworn)

Questioned by MR GOSS

12 SIR ADRIAN FULFORD: Thank you very much. Please have
13 a seat.

14 Yes, Mr Goss.

15 MR GOSS: May it please you, sir. Could you start by giving
16 us your full name please.

17 A. Louise Anderson.

18 Q. If we could have LCC001855, please. Is that your
19 witness statement for the Inquiry?

20 A. It is, yes.

21 Q. It's signed on 19 September 2025, are the contents of
22 that statement true to the best of your knowledge and
23 belief?

24 A. They are.

25 Q. At paragraph 43, on page 14, you introduce LCC001854 as

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1 is about Children's Social Care, its structure, its role
2 and, in particular, its role in managing risk to others.

3 You set out that there were various different
4 services within Children's Social Care. One of those is
5 the MASH; is that right?

6 A. Yes.

7 Q. As a thumbnail sketch then, what is the MASH?

8 A. So the MASH is the Multi-Agency Safeguarding Hub. It is
9 where all contacts come into the local authority from
10 other partners, from other organisations, from members
11 of the public, with regards to children who might be at
12 risk of harm. It's a multi-agency hub: it has within it
13 police, probation, education and health. It has Early
14 Help and social work staff there and they essentially
15 triage those contacts that come in and make decisions as
16 to where in our system they should go, if they should go
17 anywhere at all.

18 Q. Thank you. We'll come back to various specific
19 interactions with the MASH.

20 There is the Duty and Assessment team, in which Anna
21 Jameson -- sir, from whom you heard last week -- and
22 also Stacey Haydock, from whom we will hear a little
23 more today, they both worked in that team. What does
24 the Duty and Assessment team do?

25 A. The Duty and Assessment team have the role of

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1 undertaking as an assessment to understand what is the
2 level of need that a child has. So, they will do an
3 assessment that will identify whether a child should be
4 open to Children's Social Care, should become a Child in
5 Need. They might find that a child meets the threshold
6 for Section 47 and they may initiate that Section 47
7 process. They might decide, at the end of their
8 assessment, that a child needs Early Help or universal
9 or no further action at all. So they conduct the
10 initial assessment which is around understanding the
11 level of need. They also do a separate task in
12 Lancashire in which they undertake eligibility
13 assessments with regards to children with disabilities
14 or with SEND and, within that part of their work, they
15 would be assessing whether a child meets the eligible
16 criteria for services as a child with SEND or whether we
17 should provide services to help a carer deliver their
18 caring responsibilities.

19 **Q.** I follow. There are then Child in Need, Child
20 Protection and Court teams. That is for cases which,
21 after the initial assessment, are kept open at what
22 I think is now level 4 on the Continuum of Need?
23 **A.** That's correct.
24 **Q.** So those are teams that can hold a case for longer than
25 merely an initial assessment period, to work with

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1 a contextual safeguarding service. I couldn't tell you
2 exactly when it was -- when it began. We remodelled
3 2022/2023.
4 **Q.** Thank you. The Youth Justice Service, I think, falls
5 under your directorate as well. We've heard about that
6 from Ms Callon. One team that I don't think you mention
7 in the overview you give in paragraph 5 of your
8 statement is the Missing from Home team. In particular,
9 in 2022, how did that operate?
10 **A.** So the reason it's not mentioned is now it is just
11 a part of our EmPower Service. In 2022, it was
12 a separate service. It's a group of people that
13 undertake Missing from Home interviews and we are
14 required by law to have people who are independent of
15 children to undertake Missing from Home interviews.
16 **Q.** We'll come back to them. In terms of the kind of cases
17 that Children's Social Care are dealing with, if we can
18 have LCC001900 and page 16, please. This is some of the
19 explanatory notes that sit behind the Continuum of Need,
20 Ms Anderson, with which you will be familiar.

21 The orange flagged text at the top is in relation to
22 level 3 and we can see that it then goes over to level 4
23 at the bottom of the page. In terms of level 3
24 indicators, they include, "Difficulty coping with anger,
25 frustration and upset", and a child who has entered the

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1 a child, with a family, up to and including bringing
2 court proceedings as regards how that child should be
3 looked after?

4 **A.** Yes. So they are multidisciplinary teams that have
5 social workers, domestic abuse workers, probation
6 workers, health workers, substance misuse workers and
7 they're called adult workers, and their role is to work
8 with parents to reduce risk and enable children to
9 remain safely within their families.

10 **Q.** There is a contextual safeguarding team, we have heard
11 a little bit about contextual safeguarding. What does
12 that team do?

13 **A.** That team has evolved, it's now called the EmPower
14 Service and it is a little bit more than a contextual
15 safeguarding service now. That service we say that it
16 works with extra-familial harm. This is where children
17 are at risk of harm but the primary reason for that
18 isn't a parental factor. So it could be contextual
19 safeguarding, risks in the community, but it could be
20 mental health.

21 **Q.** Whose mental health?

22 **A.** The child's mental health.

23 **Q.** You say that team has evolved. When did that team get
24 introduced?

25 **A.** So that team existed before I arrived in Lancashire as

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1 Criminal Justice System at the pre-conviction stage.
2 Those sorts of indicators you would still expect to be
3 dealt with by Early Help, rather than necessarily
4 meaning that this was a Child in Need or higher; is that
5 right?

6 **A.** That's correct.

7 **Q.** Then if we look at the level 4 indicators. Bear in mind
8 that level 4a is the lowest of the levels within
9 level 4. As a general point, at the top:

10 "If you suspect a child is suffering or at risk of
11 suffering significant harm, self harm and/or at high or
12 very high risk of harm to others, follow Child
13 Protection procedures."

14 So the risk of harm to others is clearly a relevant
15 factor in terms of whether a child is a Child in Need or
16 a child in need of protection, if I can put it that way?

17 **A.** So I think this needs some context, if that's okay?

18 **SIR ADRIAN FULFORD:** Of course.

19 **A.** So risk of -- I really have wanted and have been looking
20 forward to the opportunity to really talk this through
21 and where social work sits with this. So social work
22 legislation, the Children Act 1989, was originally
23 created to safeguard children against interfamilial
24 abuse and severe neglect. As time has gone on, those
25 lines have become a little bit more blurred but, as you

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1 work through our legislation, there is a strong line
2 around abuse to the child that social workers are
3 focused on. So as a social worker in training, most of
4 my training was absolutely about protecting the children
5 from risk of harm by their parents.

6 We've moved on and we now think about risk of harm
7 from adults but abuse and neglect is at the centre of
8 what we do in children's social work. It's been
9 interesting as we've talked about this comment around
10 "risk to other", which for me is really a public
11 protection matter and it is something that social work
12 is involved in but I think it is -- it's really
13 important that the Inquiry understands that it is not
14 our primary focus up until this point.

15 So at the moment, our primary focus is always on: is
16 this individual child at risk of harm? That comes
17 through as you work through our legislation in a bit
18 more detail. So, for example, children who are
19 subjected to Child Protection plans become subject to
20 the Child Protection plan under a category of abuse and
21 those categories of abuse may be physical, they might be
22 sexual, they might be emotional but we have to name
23 a category of abuse and so most of our legislation
24 pushes us to be thinking, "Is the child you are working
25 with suffering harm?"

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1 we saw at the lower level but then also:

2 "Child assessed at high risk of harm to others as
3 a result of offending behaviour."

4 About a third of the way down:

5 "CYP assessed as high risk either to themselves or
6 others ..."

7 Also in there we have poor/abusive parental
8 relationships, chronically socially excluded or extreme
9 isolation. I just bring those out now because they're
10 ones we may want to have them in mind as we go through.
11 Even in 2021, and bearing in mind the helpful context
12 that you've given about the history of some of the
13 legislation and the culture of social work, the risk of
14 harm to others was clearly a factor that Children's
15 Social Care needed to have in mind when thinking about
16 how to assess a child and the level of risk around
17 a child; is that right?

18 **A.** It is, yes, and would be taken alongside various other
19 factors within the family and the home environment.

20 **Q.** Yes. You've touched on some elements of the statutory
21 framework. You've set it out very helpfully in your
22 witness statement, if we could have that back on screen,
23 please, starting at page 2, LCC001855.

24 You've set it out over almost ten pages of your
25 witness statement, Ms Anderson. I'm not going to go

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1 And so I agree with you that this is written here
2 but I think the context of understanding our profession
3 and what it was built on and what is our primary role is
4 really important as we move through today, and we'll
5 probably talk more about that.

6 **Q.** We will, because these are the indicators for the
7 Lancashire Continuum of Need, as I understand it, as it
8 was in place from 2021?

9 **A.** Yes.

10 **Q.** If we can go to the next page, please. If we could
11 expand the "Safe from harm" box, the indicators here,
12 the first indicator under this category is
13 "challenging/disruptive behaviour putting others in
14 danger", isn't it?

15 **A.** It does say that, yes.

16 **Q.** There is likewise, "Regular involvement in criminal or
17 anti-social behaviour and parental refusal to engage
18 over concerns". If we then go on to page 17 and the
19 level 4b indicators, again we have the same general
20 comment at the top:

21 "If you suspect a child is ... at high or very high
22 risk of harm to others, follow Child Protection
23 procedures."

24 Then again, over the page, and the "Safe from harm"
25 box, please. We see a number of the same indicators as

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1 through it line by line but, just briefly, three key
2 sections I wanted to ask about. First of all,
3 Section 17 of the Children Act. Help us with that.

4 **A.** So, Section 17 of the Children Act is a larger area of
5 work and, in the Children Act, it's actually quite vague
6 and very broad.

7 As you move through into Working Together to
8 Safeguard Children, we start to see the specifics of
9 that. So, in the Children Act it really covers
10 everything we do, including Early Help, through to our
11 more statutory services and it's really when we get to
12 working together that we start to see a little bit more
13 clarity around what might be the work of Early Help and
14 what might be the work of Children's Social Care.

15 **Q.** We'll come to Working Together shortly. You've
16 mentioned Section 47 already, often mentioned in the
17 same breath as Section 17 as well. That is, in effect,
18 a form of statutory enquiry where there are reasonable
19 grounds to suspect that a child is at risk of
20 significant harm?

21 **A.** It's a child having experienced significant harm or
22 likely to experience significant harm.

23 **Q.** Thank you. The outcome of a Section 47 enquiry can be
24 intervention by a local authority, up to and including
25 under Section 31, which is the power of the court to

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1 make care orders?

2 **A.** Yes.

3 **Q.** While on Section 31, that defines harm as an:

4 "Ill treatment or the impairment of health or

5 development, including, for example, impairment suffered

6 from seeing or hearing the ill treatment of another."

7 **A.** Yes, it's the -- yeah, impairment.

8 **Q.** Could that kind of harm include a child putting

9 themselves into a dangerous situation by virtue of their

10 own actions?

11 **A.** Yes.

12 **Q.** One example might be, if they are seeking to harm

13 others, they are exposing themselves to risk of physical

14 harm through self-defence or retaliation?

15 **A.** Yes.

16 **Q.** More broadly, they may also be bringing harm on

17 themselves through exposure to adverse experiences, such

18 as custody or being brought into the Criminal Justice

19 System?

20 **A.** This has been a really interesting form of inquiry and

21 just something that I was hoping to have a conversation

22 about. So in my career, we have never considered the

23 risk of being in prison as something that we would

24 consider as something that would equate to significant

25 harm. It's been a really interesting line of inquiry

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1 perhaps from carrying a knife, perhaps from expressing

2 an intention to use it, it's very likely that the people

3 who are at risk in that situation are going to be other

4 children?

5 **A.** Quite often they are other children.

6 **Q.** By not addressing at the point you can address it, with

7 this identified child who poses a risk, the risk of harm

8 to other unidentified children simply goes unaddressed?

9 **A.** So one of the other things on this point is just being

10 clear about the other mechanisms that are in place to

11 manage that risk, that Children's Social Care work with.

12 So there are a number of other places where we manage

13 that part of the risk within our system. So, to be

14 clear, public safety in terms of violence, right up

15 until 2022, sat squarely within the realm of public

16 health. Post-2022 and when we came out of lockdown, we

17 began to have more conversations about that in social

18 work and, in Working Together 2023, there was a shift

19 with regards to violence and the role of the social

20 worker and that was very much linked to contextual

21 safeguarding.

22 But the other places where we worked together on

23 this are in places like MAPPA, through our Youth Justice

24 Service, in terms of Prevention and Diversion, we have

25 MASPs and these are all other places -- and of course

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1 and I think I absolutely agree that a child going to

2 prison is harmful but, in terms of the way that we work

3 in Child Protection, we haven't really thought of that,

4 in my opinion, as a form of significant harm and

5 I really just wanted to share what that would mean for

6 our profession if we were to.

7 So 140,000 children in the UK between the ages of 13

8 and 17 are believed to carry knives; 3,698 knife

9 offences in the UK for that age category. There are

10 children who are at risk of committing other offences,

11 like sexual assault, physical harm, different types of

12 physical harm, drug related, burglary related --

13 **Q.** Ms Anderson, I'm grateful for the detail. I think that

14 the answer to the question was that that would be a form

15 of harm to the child but --

16 **A.** But not significant harm.

17 **Q.** Whether it would be significant harm or not might depend

18 on the duration or the circumstances but I think your

19 answer is that, effectively, Child Protection Services

20 are simply not set up to consider the level of risk that

21 might arise or that kind of risk?

22 **A.** I don't think it's the primary work of Children's Social

23 Care to.

24 **Q.** Would you agree with this as a proposition, that if you

25 have a child who is posing a risk of harm to others,

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1 Prevent -- and these are all other places where we

2 together, as a multi-agency system, look at managing

3 children who are at risk of harm to others.

4 **Q.** The challenge with that, I would suggest, is that,

5 certainly in the period that we are looking at but also

6 perhaps to an extent now -- *(Pause)*

7 The challenge with that is that, very often, it is

8 Children's Social Care leading a Child Protection

9 process that is focused around questions of risk of harm

10 to the child, as you've described, that is making

11 decisions about whether thresholds based on risk of harm

12 to the child are met and is there not a danger in that

13 situation that the fact that a child poses a risk of

14 harm to others becomes downgraded, diluted or

15 overlooked?

16 **A.** So what I'm saying is that, in those other meetings,

17 like our MASP meetings and the MAPPA meetings, those

18 agencies have a duty together to assess what risk that

19 child poses to other people. They are multi-agency

20 meetings that usually include -- similarly to Child

21 Protection, they include health, CAMHS, FCAMHS, police,

22 they are police-led, because they are dealing with

23 matters of whether a child is about to commit a crime,

24 and that is where those risks are clearly named and

25 clearly managed by the partnership.

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1 Q. The risk or the criteria for a child to be within MAPPA
 2 though is typically a custodial sentence having been
 3 received. So you are already dealing with a very high
 4 threshold before those procedures are able to take
 5 ownership of that risk?
 6 A. That's correct but MASP --
 7 Q. Below that level, do we not again run the risk of
 8 falling between two stools, as a Child Protection
 9 multi-agency framework, essentially, as we saw in this
 10 case in December 2019 to March 2020, takes the lead and
 11 the result of that is that risk to others is seen as
 12 a less significant, less important factor or overlooked
 13 entirely?
 14 A. I agree but, in 2022, there was new legislation that
 15 created MASPs --
 16 Q. Help us with what that stands for?
 17 A. Multi-Agency Safeguarding -- can I send it to you later,
 18 sorry?
 19 Q. By all means.
 20 A. So they are places where anyone can make a referral,
 21 they are police led -- I do have it written here, I'll
 22 find it in a second -- they are police led. They
 23 receive referrals from schools, Children's Social Care,
 24 from police, et cetera, Youth Justice and they are
 25 a place where children who are at risk of being

1 A. I agree.
 2 Q. Because there can be cases where the welfare of the
 3 child, firstly, might be best advanced by something that
 4 they don't want. There might also be cases where, even
 5 though the welfare of the child is obviously crucial --
 6 "paramount", as it puts it in the first principle
 7 there -- there are other needs that ultimately outweigh
 8 it?
 9 A. Yes.
 10 Q. We have talked a little about how, in some cases, that
 11 might be the needs of other unidentified children.
 12 There may be cases where, for example, a child needs to
 13 be removed from a class at school because they pose
 14 a risk of physical harm, sexual harm or indeed a risk to
 15 the education of other children. Again, you nod your
 16 head. Only for the transcript, Ms Anderson, we need to
 17 have your answer on the record.
 18 A. Yes, I understand that, although I'm not in education,
 19 but yes.
 20 Q. Consistently with what you have told us, neither in this
 21 document nor in the 2018 version of Working Together to
 22 Safeguard Children, does it address the potential risk
 23 of harm from children to others, does it?
 24 A. No, it doesn't, as far as I know.
 25 Q. At that time, so looking at 2019 to 2023, if it was not

1 criminalised in a number of ways, that that risk can be
 2 managed by a multi-agency group, and there is -- have
 3 you heard about prevention panels yet that are being
 4 trialled at the moment?
 5 Q. I don't think we have. I think we are at risk of moving
 6 onto questions of what the system is now. If we can
 7 come back slightly to the system as it was in the period
 8 that we are dealing with.
 9 We've talked already about some of the points
 10 I wanted to come to, which I think is going to let us
 11 move slightly faster through them. Could we have
 12 LCC001898, please. I may be at risk of committing the
 13 very sin I've just called out but this is the December
 14 2023 Children's Social Care National Framework. Was
 15 there an earlier version of this?
 16 A. No.
 17 Q. Could we look to page 13, please. It's a helpful
 18 one-page summary. It underlines, doesn't it, the extent
 19 to which Children's Social Care is centred on the
 20 welfare wishes and feelings of the child themselves; is
 21 that right?
 22 A. It is, yes.
 23 Q. We ought to bear in mind that the welfare of the child
 24 doesn't simply mean doing what the child says. You're
 25 nodding your head.

1 Children's Social Care's responsibility to identify or
 2 address those risks, whose responsibility was it?
 3 A. So, if we think about expertise, in terms of that
 4 multi-agency group, I think we have already heard that
 5 FCAMHS are the agency that have the training to be able
 6 to assess whether a child is a risk to another person or
 7 not and so they are key in that role. I think we have
 8 already heard that police have powers, in terms of
 9 investigation, to understand if a child is participating
 10 in criminal activity or spending time with other people
 11 who are participating in criminal activity.
 12 Our Youth Justice Service, at the time, was just
 13 beginning to move into the Prevention and Diversion
 14 space, so in 2018, the prevention arm of Youth Justice
 15 was launched and, I believe, maybe two years later the
 16 Diversion arm was launched.
 17 So there were a number of agencies who would lead on
 18 the identification and then the work and the
 19 intervention.
 20 Q. Again, at that time, is it right that the only formal
 21 multi-agency forum to bring all of those agencies
 22 together would have been the Child Protection process
 23 under Working Together to Safeguard Children?
 24 A. In this case, no, because there would also have been
 25 Prevent.

- 1 **Q.** By that, I take it you mean the scope for a Channel
2 panel bringing together multiple agencies?
3 **A.** Yes.
4 **Q.** We know that, in this case, it was never taken on to
5 a Channel panel. Putting that, therefore, slightly to
6 one side, acknowledging it would have been possible had
7 the case been taken on, without that mechanism intended
8 to address the risk of radicalisation, was there any
9 other multi-agency forum to bring those agencies
10 together to look at risk to others, other than Child
11 Protection multi-agency work under Working Together to
12 Safeguard Children?
13 **A.** Not consistently across the country. So, in some areas,
14 yes, but not all.
15 **Q.** In Lancashire?
16 **A.** I don't think so. I'm not 100 per cent sure where
17 Lancashire were at with their multi-agency exploitation
18 work at the time.
19 **Q.** If I can put it this way, we haven't seen any evidence
20 that there were any other multi-agency forums either
21 engaged in this case or that were considered to be
22 engaged in this case, putting Prevent to one side. That
23 would suggest that the answer to the question is no, it
24 was only Working Together to Safeguard Children,
25 wouldn't it?

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- 1 **Q.** They were, I think, both produced, though, on a Child
2 and Family Assessment form, which perhaps was
3 a paperwork error?
4 **A.** Yes, but some authorities don't -- although they are
5 different assessments, some authorities don't have
6 separate assessment forms or didn't back then.
7 **Q.** Two assessments though, one in February 2020 by
8 Ms Jameson and one that was completed in September 2021
9 by Ms Haydock?
10 **A.** Agreed. The difference in what the social worker's role
11 was to do in those assessments is really key.
12 **Q.** We'll come onto the specifics of the assessment. For
13 now, I just want to chase some of the information flows.
14 As well as those assessments, there's also the general
15 case notes for the child, and we've heard that there is
16 essentially a Children's Social Care element of
17 Liquidlogic, or LCS, and a Children and Family Wellbeing
18 element of it, the Early Help module.
19 When Children's Social Care are engaged, that should
20 record certainly all substantial contacts involving the
21 child on that system; is that right?
22 **A.** Yes.
23 **Q.** I think Ms Jameson candidly accepted that her note
24 taking was not adequate in the period in which she was
25 involved. A number of contacts not recorded in the

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- 1 **A.** Agreed.
2 **Q.** That then does create the risk that I was trying to put
3 to you earlier, that where you have a forum which is
4 wholly set up around a Child Protection system focused
5 on risk to the child, risk from the child ultimately
6 doesn't receive adequate attention?
7 **A.** It might not but, in an ideal situation, the
8 contribution from CAMHS and their assessment into that
9 meeting, and the contribution from police and their
10 assessment into that meeting and latterly the
11 contribution from Youth Justice into that meeting should
12 really make sure that risk to others is also considered.
13 **Q.** We'll come to how that process operated shortly.
14 Before we do, can I just deal briefly with the way
15 Children's Social Care in Lancashire in this period
16 understands and transmits information. You've mentioned
17 the assessments carried out by the Duty and Assessment
18 team. That's a Child and Family Assessment, primarily?
19 **A.** Yes.
20 **Q.** I think there is also, as you say, a carer's and needs
21 assessment, although in this case, ultimately, there
22 were two Child and Family Assessments done?
23 **A.** No, so there was one Child in Need assessment done.
24 **Q.** Yes.
25 **A.** Then there was one carer's assessment completed.

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- 1 notes that were made, not recording key information, for
2 example, AR's comments about the Manchester Arena
3 bombing being a "good battle".
4 In Ms Haydock's statement, at LCC001772, page 15 and
5 paragraph 67, she says:
6 "I regret and I am disappointed with myself that
7 I do not seem to have kept comprehensive notes of my
8 meetings with the family."
9 Is it concerning that both of the social workers
10 within the Duty and Assessment team who completed
11 assessments in this case did not keep adequate notes?
12 **A.** Sorry, could you say that again?
13 **Q.** Both of the social workers within the Duty and
14 Assessment team who had contact with this case have
15 accepted that they did not keep adequate notes; is that
16 concerning?
17 **A.** Yes.
18 **Q.** Is it a sign of a wider issue over note taking/record
19 keeping within Children's Social Care?
20 **A.** I don't think so. So Lancashire County Council, as you
21 will have read in my statement, has over this period of
22 time been on quite a large improvement journey. At the
23 beginning of this work in 2019, the local authority had
24 just become "Requires Improvement to be Good", and that
25 was where that authority was at the beginning of this.

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1 In November 2022, they had made some significant
2 improvements and became a "Good" local authority.

3 However, I know that, as -- our systems and
4 recording is improved, even more since then for lots of
5 reasons that I am sure I'll come to. So, it is
6 disappointing. It is likely that that was a concern at
7 the time, given where they were in their inspection
8 judgement, but I don't think it is the current case.

9 **Q.** Can we look at one of Ms Haydock's assessments.
10 LCC000247. We've spent some time looking at
11 Ms Jameson's assessment, Ms Anderson, so unless you want
12 me to show you specific parts of that, I will summarise
13 it.

14 Ms Haydock's assessment, if we go to page 3, it
15 refers, in the course of this assessment, to the facts
16 underlying AR's convictions, which of course were around
17 about 18 months earlier at this point. It doesn't
18 mention the fact of the conviction itself and it
19 doesn't, in contrast to Ms Jameson's assessment, record
20 AR's intent to kill.

21 Ultimately, despite recording recent examples of
22 AR's extreme reactions, it talks, as you will know,
23 about, while a social worker was there AR pouring milk
24 over his parents' bed because he'd become upset. It
25 doesn't record any concerns that services may be

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1 treating them as a way into the case. So if those,
2 because of the function that they have, are not
3 recording all relevant information, then that is where
4 the risk then comes that information is lost; is that
5 fair?

6 **A.** It is fair but what we should have is a really good
7 concise chronology that outlines risk factors, that is
8 really -- which means that when somebody picks up the
9 child, they are able to see really clearly what
10 significant events have happened and what those
11 significant risks have been. That would be a more
12 concise way to make sure that we transfer the facts. It
13 would mean that they didn't have to read all of this.
14 That's where it should be, in my opinion.

15 **Q.** It is where it should be; it isn't where it was in this
16 period?

17 **A.** I agree.

18 **Q.** Is it where it is now?

19 **A.** We are almost there, we are much better than we were and
20 we are actually now about to use AI to make sure it's
21 perfect.

22 **Q.** Thank you. I want to turn now to some of the specific
23 episodes of CSC contact with AR. We know that on
24 7 October 2019 Lancashire Constabulary made a high risk
25 police safeguarding referral to the MASH as a result of

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1 required or the child may be at risk due to socially
2 unacceptable behaviour.

3 When looking at the way in which this assessment in
4 2021 draws or does not draw on the earlier assessment in
5 2020, is there a risk that important information is
6 becoming diluted or lost as we move through the system?

7 **A.** So, this was a carer's assessment and it was
8 an assessment that was about "Does AR and his brother
9 have eligible needs for services?" And those services
10 would have been things like direct payments, PAs
11 (personal assistants), those types of things. So
12 I think that context is important but also social
13 workers are really asked to think in their assessments
14 about the information that they are providing and they
15 are asked to think carefully about historic information
16 and whether that should be in that particular assessment
17 or not.

18 I agree with you that not seeing it in here -- and
19 I agree with the comments that you have made throughout
20 this process in terms of dilution of risk but, whether
21 it should have been in this assessment or really clearly
22 in a chronology, are two different matters.

23 **Q.** The difficulty with that is a number of LCC employees
24 have referred, for example, to going back and reading
25 for previous Child and Family Assessments, effectively

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1 AR repeatedly carrying a knife to school and indicating
2 that he may use it.

3 Again, we have looked at the referral a number of
4 times and I am sure you will be familiar with it. The
5 officer identified that this shows potential for huge
6 escalation and it was obvious cause for serious concern.
7 That officer was not wrong, was he?

8 **A.** No.

9 **Q.** By lunchtime the next day, the case had been stepped
10 down to level 2 for Early Help. There was then further
11 information received from David Cregeen of The Range
12 High School, the same day, reporting, in effect, the
13 same incident but from the school's perspective -- they
14 having been alerted by the police themselves -- but
15 adding the further information about AR having recently
16 said "That's why teachers get murdered", following
17 receipt of a detention.

18 Again, he expressed great concerns about the risk AR
19 posed to himself and others. Again, he was not wrong,
20 was he?

21 **A.** No.

22 **Q.** But there was no reassessment and this was simply left
23 as open at level 2. Given the level of risk, given the
24 kind of risk identified by two different agencies, would
25 it have been, first of all, at least open to the MASH to

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1 have referred it to the Duty and Assessment team within
2 CSC, rather than stepping it down to Early Help?

3 **A.** So I think here it's really -- again, a really
4 interesting point and there are some things to balance.
5 So, firstly, the issue of it being stepped down
6 straightaway to Early Help. So in terms of what the
7 social worker was dealing with in terms of information,
8 there would have been some things that were a factor
9 there, the main thing being that this was a child who
10 had never been known to Children's Social Care before
11 and, usually, in our practice experience, it's uncommon
12 for children to go from 0 to 100. So no behavioural
13 concerns before, et cetera.

14 The police did describe him -- and I know that that
15 was challenged later -- but the police described him as
16 having an appropriate response, he was crying, he was
17 upset. The reason being bullying would have -- the
18 reason that he was saying he was going to do that being
19 bullying would have played a part in their thinking and
20 the fact that mother had said that she was going to make
21 sure that the knives were put away would have created
22 some instant safety.

23 Then the other bit is about the people in our system
24 who work well with children like AR and they are
25 usually, at that time, workers, like youth workers, who
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1 been, at the meeting a day or so beforehand, very
2 obvious concerns about Alphonse R downplaying or
3 minimising AR's behaviour.

4 If we can see LCC000024 on page 5, please. At the
5 very bottom of the page, we can see the response from
6 the MASH received on the 6th. Then just over the page
7 for the actual content of it, response from a MASH
8 education officer:

9 "The concerns do not present as level 4. The
10 concerns regarding [AR] searching on the internet for
11 violent images can be managed with level 2 support such
12 as police Community Safety Officer and emotional
13 wellbeing services/CANW."

14 Do you think that was an appropriate assessment at
15 this stage?

16 **A.** Yes. Our Early Help workers absolutely can work with
17 children around not accessing violent images on the
18 internet, trying to divert their attention, get them
19 interested in different matters and, yes, I would expect
20 that a Police Community Safety Officer to be able to do
21 some direct work around the other elements that we are
22 talking about.

23 **Q.** It goes on to say:

24 "Children with autism (which [AR] may have) often
25 develop obsessions around death, violence and crime.
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1 are fantastic at building a rapport and diverting
2 children. We also have our intensive family support
3 workers, who sit down with children and do the behaviour
4 work, and so the people in our system, in terms of the
5 plan that we thought -- that that social worker probably
6 thought would make a difference, they sit in Early Help.
7 So I understand that thinking.

8 If you look at the 2019 CON, I could see how there
9 were elements of the -- what was level 2 in that 2019,
10 that he would look like he fitted, but I agree there are
11 also parts of that level 3 that he looks like he fitted
12 as well.

13 **Q.** So, the answer then is that it would have been open to
14 the MASH to hold it at level 3, as would have been, but
15 equally you would say that the decision to step it down
16 to level 2 was one that you can understand?

17 **A.** Yes.

18 **Q.** Thank you.

19 By the time we get to 6 December 2019, there's been
20 just under two months of attempts by Early Help to
21 engage unsuccessfully. There's further concerns from
22 Acorns, which they shared with the MASH, about AR's
23 inappropriate behaviour on the internet, searching for
24 violent imagery, school shootings, guns, asking about
25 access to pictures of beheadings, and there had also
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1 This is due to their neurodevelopment and I was not sure
2 whether [AR] was being assessed for autism by the
3 community paediatrician."

4 There's no apparent recognition there that, in some
5 cases, an autism spectrum disorder, combined with
6 a fixation on death, violence and crime, can become
7 extraordinarily high risk, is there?

8 **A.** There isn't and I agree with you that that is something
9 that we need to make sure is understood. So, at the
10 time, there were some research that was being produced
11 from universities that was talking about the risk of
12 criminalising children with autism and misunderstanding
13 them because of the way that they present and sometimes
14 talk about these types of issues.

15 They were over represented in Prevent and there was
16 concern about that. The messages out to the workforce
17 at the time were about, "Don't misunderstand this child
18 with autism and don't necessarily make a referral to
19 Prevent" because there was a sense that the traits that
20 some children have with autism make them look like they
21 could be a risk but they are not and so -- but I agree
22 it's really important that we understand that, for some
23 children, where they have autism and similar traits in
24 their behaviour, and then also are fixated on violence,
25 there is increased risk.
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- 1 Q. That wasn't properly understood at this stage by this
2 person?
- 3 A. I don't think it was well understood across the whole
4 system at the time.
- 5 Q. You have said that -- my summary -- this was
6 an appropriate way to deal with this issue at this time.
7 There doesn't seem here to be any connection to the
8 earlier October incident with carrying knives, or the
9 fact that Early Help are, in fact, the ones who have
10 pointed the school in the direction of the MASH, or the
11 fact that Early Help have spent two months trying to
12 engage with the family without success. Do you really
13 think this is an adequate response to the level of risk
14 that AR was presenting with at this time?
- 15 A. So, when I looked at the file, I was concerned at how
16 long it took Early Help to start their work with the
17 family. As you know, we now do seven-day visits and we
18 engage families quickly. We know that that helps with
19 engagement. I don't think that the slow start was
20 solely the fault of the family, on reading this file.
21 The important thing though is the plan and whether the
22 workforce was trained and equipped to deliver the plan,
23 and I believe that non-qualified workers absolutely can
24 do really good direct work on these points.

25 Q. The reality is that AR was at such high risk at this

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- 1 after he has been arrested for that violent offence,
2 where he has caused harm to another child, she tries to
3 refer it to the MASH.
- 4 You will see, five lines up from the bottom:
5 "Stephanie shared that she had spoken with MASH and
6 they would not accept the case at level 4 and that it
7 was open to CFW."
8 Accepting that the case was shortly afterwards
9 stepped up, after Children and Family Wellbeing spoke to
10 the MASH, to the duty social worker, the picture that
11 starts to emerge here, Ms Anderson, is a MASH that is
12 wholly reluctant to accept any case based on risk to
13 others and, instead, always seeks to step it down and
14 push that responsibility away from CSC; is that fair?
- 15 A. I don't think so.
- 16 Q. What possible explanation could there be for the MASH on
17 12 December refusing to accept the case at level 4,
18 where AR has carried out a violent attack on another
19 pupil with an intent to kill, he has caused harm to his
20 victim and where he is, at this point, either in custody
21 or just out of it?
- 22 A. Sorry, apologies, I thought you were before the incident
23 not after.
- 24 Q. No, this is just after.
- 25 A. And, apologies, I haven't seen this one before. I would

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- 1 point that, five days later, he did in fact carry out
2 an attack on a pupil at The Range High School with
3 weapons, with a knife in his backpack, saying that he
4 would use it if the hockey stick hadn't worked. He was
5 very high risk at this point, wasn't he, and that should
6 have been recognised?
- 7 A. With the benefit of hindsight, he was high risk, given
8 the amount of children that we work with who present
9 with these types of behaviours. So let's not forget the
10 amount of children that carry knives. We have some
11 children that say they will use a knife and never do and
12 we have many children who would look me in the eye and
13 tell me I will never use a knife, and do use a knife.
14 We provide resources on this to Designated
15 Safeguarding Leads, Early Help workers, lots of people
16 who are not qualified, youth workers, and so I think
17 that the plan around those workers doing the work,
18 I know it wasn't effective; I think it could have been
19 effective.
- 20 Q. Can we look at LCC002302, page 12, please, the bottom
21 entry. This is just after the attack, the day after,
22 because Ms Hallaron, who was the mental health nurse in
23 the Criminal Justice Liaison and Diversion team -- if we
24 can have the last complete entry on that page expanded,
25 please -- she attempts, having dealt with AR in custody,

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- 1 obviously expect the MASH to take and accept referral
2 when someone has just committed a crime.
- 3 Q. That was a wholly unreasonable breach to the assessment
4 by the MASH at that stage?
- 5 A. Yes, and it is strange because we obviously would
6 receive the PSR from the police and then begin.
- 7 Q. Being fair, Ms Anderson, as I said, we must recognise
8 that it was very shortly afterwards stepped up and that
9 the Duty and Assessment team became involved but, as
10 an initial response, that was wholly unreasonable?
- 11 A. Agreed.
- 12 Q. We have heard from Ms Jameson directly about the Child
13 and Family Assessment that she conducted. Could we look
14 at your witness statement LCC001855, page 41. I want to
15 pick up here on what you said earlier about different
16 agencies having the expertise or the lead on risk to
17 others, paragraphs 186 to 188, please.
- 18 You characterise Ms Jameson's assessment as rightly
19 including:
20 "... information from Prevent, the police, CYJS and
21 FCAMHS. These agencies provided information pertaining
22 to the level of risk AR could pose to others and what
23 work should be done with him as a result of this."
24 Just working through those. Prevent had said, "We
25 don't think this is a case that reveals a risk of

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1 radicalisation, though he is clearly very vulnerable".
 2 So they were not providing any input, other than saying
 3 "We don't think it is a radicalisation case"; is that
 4 fair?
 5 **A.** Agreed.
 6 **Q.** At the point that the assessment was done, 19 February
 7 2020, Child and Youth Justice Service were not or would
 8 only just have become engaged because that was the date
 9 the referral order was imposed, so they didn't have any
 10 meaningful input into this assessment. They hadn't, for
 11 example, been invited to the strategy meetings that had
 12 taken place in December and January?
 13 **A.** Yes.
 14 **Q.** The police, Lancashire Community Safety Team, hadn't
 15 been invited back to the second strategy meeting and
 16 Merseyside Police were of the view that, given that AR
 17 didn't live in their area, their responsibility was
 18 limited to the criminal investigation that they were
 19 conducting. So there was no meaningful long-term input
 20 from the police as to these risks, was there?
 21 **A.** No.
 22 **Q.** FCAMHS, though there'd been a meeting with FCAMHS on
 23 21 January, had effectively said, "This is something
 24 that we can leave to CAMHS", they haven't provided
 25 a risk assessment and they haven't provided suggested

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1 remember the exact sentence. I think it was wider than
 2 what you just said and I think that that led the social
 3 worker to believe that the work that CAMHS would do with
 4 him would address the needs identified by FCAMHS.
 5 **Q.** By the point CSC became involved, because they, of
 6 course, took part in the Child in Need meeting on
 7 4 March, they were assessing AR as medium to high risk
 8 and a key element of that was the fact that he wasn't
 9 attending school and, therefore, there was a lack of
 10 opportunity.
 11 Do you think that there would have been a continued
 12 role for CSC at this stage?
 13 **A.** CSC?
 14 **Q.** For Children's Social Care, at this point?
 15 **A.** At the end of the assessment when it was stepped down?
 16 **Q.** Yes.
 17 **A.** Again, I'm just going to talk about the plan that was
 18 proposed at the time. So, I felt that in terms of the
 19 violence and the knife crime, that it was the role of
 20 CAMHS and the Youth Justice Service to address those
 21 needs. His neurodiversity needs were being met by SEND
 22 and his educational placement needs were being met by
 23 education.

24 So the outstanding social care needs were around his
 25 isolation and support in accessing the community and so,

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1 interventions.
 2 **A.** Agreed. I understand that from here. What I saw in the
 3 assessment was a recommendation around what they thought
 4 the work that CAMHS should be doing. I didn't know
 5 before that that they didn't have a detailed risk
 6 assessment.
 7 **Q.** The work that CAMHS were doing, the update that
 8 Ms Jameson received prior to completing her assessment,
 9 other than, of course, the fact that AR was still
 10 awaiting an autism assessment and diagnosis, was,
 11 essentially, "I feel that in time he will be able to get
 12 better at dealing with social interactions". It didn't
 13 suggest any interventions and it wasn't a risk
 14 assessment.
 15 Accepting that those other organisations, of course,
 16 have a part to play, there was no process here in this
 17 assessment by Ms Jameson of drawing together risk to
 18 others and ensuring that that was included in what was
 19 going to be the only central assessment of this child?
 20 **A.** I'm just trying to recall the information from FCAMHS.
 21 I think that FCAMHS had said that they did believe that
 22 he was a risk to others. I think they had said that
 23 he -- it wasn't for them because they didn't -- he
 24 didn't have a mental health issue but that they felt
 25 that CAMHS should be doing work with him -- and I can't

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1 again, the people in our system who are good at meeting
 2 that social care need are in Early Help, they are not
 3 really positioned in the same way in the higher end
 4 Child in Need.
 5 So, given that those were the two identified social
 6 care needs, I think it was right for Early Help to
 7 deliver those.
 8 **Q.** Looking at paragraph 188 of your witness statement on
 9 the screen, first sentence:
 10 "With hindsight it is recognised that a more robust
 11 multi-agency plan, with clear monitoring arrangements,
 12 should have been developed to address the risks."
 13 If you will forgive me saying so, there are two
 14 examples of the passive voice in that sentence. When
 15 you say "it is recognised", do you mean it is your view?
 16 **A.** So, I was trying to be helpful when I wrote that
 17 sentence because I've been a social worker for well over
 18 20 years, a lot of experience, and social work and our
 19 knowledge has moved on since 2019 to now. So I was
 20 pointing out some things that I think would have made
 21 the plan stronger.
 22 **Q.** Ms Anderson, I'm going to ask you to answer the question
 23 please. When you say "it is recognised", do you mean
 24 that is your view?
 25 **A.** I do mean it is my view.

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1 Q. When you say "a more robust multi-agency plan with clear
2 monitoring arrangements should have been developed", who
3 should have developed it?

4 A. So I just want to be really clear on this point, so the
5 plan that I suggest is not necessarily one that I would
6 have expected a social worker to suggest in 2019, with
7 the level of training on this subject that we had and
8 where we were at, as a country, in terms of
9 understanding internet safety, et cetera.

10 So, it is absolutely what I would expect a social
11 worker to do now. I'm not sure that this matter was
12 being -- that the training had been made available at
13 that time across our systems, but it is what I would
14 absolutely expect now.

15 Q. Would this have been a moment, with an assessment of AR
16 as medium to high risk -- one of the main protective
17 factors being lack of opportunity -- for a Section 47
18 inquiry on the basis of suspicion as regards significant
19 harm?

20 A. No.

21 Q. Why not?

22 A. Because we didn't have evidence that he was at risk of
23 significant harm himself. There were no immediate
24 actions to be taken. So when we do a Section 47 inquiry
25 it is about taking immediate action to safeguard the

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1 Care, effectively steps away. It's the lead agency
2 within that existing multi-agency forum that should be
3 coordinating, guiding, ensuring that that robust
4 multi-agency plan is put together?

5 A. So that's not my view. So at the time, if there wasn't
6 a role for Children's Social Care -- and I've just
7 listed what the needs of the child were and how they
8 could be met, and even the other things that I say, that
9 I think would have been helpful in terms of somebody
10 doing direct work with him to divert him into another
11 area of interest, in terms of someone doing direct work
12 with him around monitoring that -- his interest in
13 serious violence, all of those things could have been
14 achieved through the Early Help plan that he had.

15 It wouldn't have needed, in my view, a social worker
16 to allow those things to happen.

17 Q. All right. I'm going to move now to the June to
18 September 2021 period, which is the next time CSC have
19 any significant involvement, other than through the
20 Child and Youth Justice Service. This is the point
21 where Alphonse R makes his statutory request for a needs
22 and carer assessment, and we've spoken a little bit
23 about that. We have that at LCC000108, recording the
24 request and how it's handled. We don't need to bring it
25 up. It comes to the Duty and Assessment team and it

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1 child. So, there are a number of actions that might
2 happen as a result of that: the local authority, if the
3 child was at risk imminently, we might go to the court
4 and ask for an EPO; the police might use their
5 protection powers; the police might take criminal
6 action, they might, as part of their investigation,
7 decide that they are going to take action against the
8 adults; we, in some cases with exploitation, might have
9 to take an immediate action in terms of place of safety.

10 So we use Section 47 inquiries to make sure that
11 nobody is immediately going to be harmed, significantly
12 harmed.

13 Q. If I was to suggest that, given that the sole
14 multi-agency forum at this point was the Child
15 Protection forum under Working Together to Safeguard
16 Children, that the responsibility really fell to the
17 lead agency in that, which was Children's Social Care,
18 you wouldn't accept that, you disagree?

19 A. I'm not sure I understand that question.

20 Q. You are saying that a more robust multi-agency plan
21 should have been developed, the only multi-agency forum
22 for this is the Child Protection one that has been
23 operating to this point.

24 A. Yes.

25 Q. Then the lead agency within that, Children's Social

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1 comes to Ms Haydock.

2 In the course of that assessment, it came to her
3 attention that AR had made a number of allegations of
4 violence against Alphonse R, his father. Ultimately,
5 those were assessed as being either unfounded or, at
6 most, extremely historic, relating back to when AR had
7 been a small child.

8 It doesn't appear that any link was made to the
9 January 2021 report of violence in the home that had
10 been recorded by Children and Family Wellbeing and the
11 Child and Youth Justice Service. Ought those dots to
12 have been connected?

13 A. They would but I'm not sure they would have made
14 a difference.

15 Q. There were a number of signs during the assessment that
16 AR himself was still struggling with extreme
17 responses -- I have touched on one of them: pouring milk
18 over the bed -- and the information that CSC received
19 was that AR used to throw plates at his father but would
20 now throw water instead.

21 It was obvious then that AR was still unable to let
22 go of real or perceived injustices and there are still
23 concerns over access to knives because that's a topic
24 that Ms Haydock explored with Alphonse R, who refers to
25 them only having one knife available in the house.

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1 Do you think that those sorts of factors should have
 2 cued -- and, again, bearing in mind all you say about
 3 the purpose of this assessment -- some concern within
 4 CSC as to how this case should be handled?
 5 **A.** So, two points. You're absolutely right: this was
 6 a completely different type of assessment. It wasn't
 7 an assessment that was about assessing risk of harm at
 8 all but, being a social worker, if you see risk of harm
 9 then you should do something about it. That said,
 10 I think there is some further context that we need to
 11 understand about the everyday life of a social worker.
 12 So, we work with a lot of children with autism. There
 13 are 5,000 children in Lancashire at the moment with
 14 autism as their primary need with an EHCP plan.
 15 What we know is that, if you look at various
 16 reports, anywhere between 50 and 60 per cent of parents
 17 report violent outbursts from their children and
 18 aggression from their children. When we are considering
 19 risk, we think about frequency and severity and, sadly,
 20 many parents with children with SEND needs/autism
 21 needs -- and there has been a national conversation
 22 about this -- many parents face real difficulties in
 23 their home in terms of behaviour at a much higher
 24 frequency and with much greater severity.
 25 And so when a social worker -- and by this, I mean

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1 the impact of Covid -- and I know that you haven't
 2 talked about that with me -- but the impact of Covid on
 3 children who really struggle to be in the public was
 4 huge and there is a generation of children that we talk
 5 about who we say never returned and there are lots of
 6 them.
 7 So, again, what we were facing here, what the social
 8 worker was seeing, wasn't uncommon because we had
 9 a number of children that hadn't returned to school.
 10 The numbers of children in this country that are not in
 11 school right now are huge: 140,000 children not in
 12 school today.
 13 They are really, really big and what we were
 14 seeing -- with children with autism, when we came out of
 15 lockdown, we really struggled to get them back into
 16 school. So their sensory needs are such that they found
 17 it difficult.
 18 **Q.** One thing that was identified by Ms Allred in the course
 19 of this assessment to Ms Haydock, was that AR would
 20 require a very:
 21 "... skilled, trusted professional to slowly build
 22 a rapport with [AR] at home for approximately three to
 23 six months, as the main barrier for [AR] was distrust.
 24 [Ms Allred] felt it would take approximately 12 months
 25 for [AR] to be ready to access social activities and

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1 children who are regularly damaging the home and who are
 2 regularly assaulting and causing harm to their parents.
 3 So child and parent violence is huge in this country now
 4 and, in Lancashire, we now have a programme for parents
 5 that is all about child and parent violence and how to
 6 manage that.
 7 So, yes, very concerning when you take on everything
 8 that we've seen for this child but, for a social worker
 9 who is seeing much higher levels of frequency and
 10 intensity, this wouldn't have necessarily triggered her
 11 to think, "I need to do something like a Section 47".
 12 **Q.** We've got a number of indicators here, and we looked at
 13 what they were earlier on the Continuum of Need: we've
 14 got chronic social isolation; refusing to leave the
 15 home; we've got an obviously poor family parental
 16 relationship; we've got those elements of violence in
 17 the home, though bearing in mind the context that you
 18 have just given us; we've also got the forensic history
 19 around violence outside the home as well. Was there not
 20 an opportunity to recognise AR here as a Child in Need
 21 or a child in need of protection?
 22 **A.** Yes, there was an opportunity. I think everything that
 23 I have just said just stands and, again, isolation:
 24 sadly we are working with many children with autism that
 25 absolutely are isolating themselves. So, we talk about

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1 would need a graded approach."
 2 You're nodding: you are familiar with that element
 3 of the report?
 4 **A.** Yes.
 5 **Q.** Ms Haydock's plan was for that to be met via a carer?
 6 **A.** Yes.
 7 **Q.** But, ultimately, that was downgraded as a plan to
 8 effectively say, this can be met through Targeted Youth
 9 Support. We have heard that Targeted Youth Support was
 10 never going to be more than, at most, a 6 to 12-week
 11 programme. You suggested having Targeted Youth Support
 12 carry that out appears to be a rational decision. Do
 13 you think that was perhaps somewhat overly optimistic?
 14 **A.** Two things though: one, it wasn't downgraded; it is
 15 a parallel-type service.
 16 **Q.** My word, and if that is the wrong word and I'm being
 17 disrespectful to Targeted Youth Support, there was no
 18 intention of that, but the plan was altered from one
 19 that potentially could have been in place for
 20 a sustained period of time to one that was inevitably
 21 going to be highly time limited to far less than AR's
 22 teacher, who perhaps was one of the professionals who
 23 knew him best, thought was going to be necessary?
 24 **A.** So I agree and I think I've said some of this in my
 25 report and I know you want me to absolutely make this

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1 point.

2 If you had had the support worker, I just want to be
3 clear what would have happened: he would have received
4 potentially a direct payment, Dad would have appointed
5 the worker to do that work and he would have closed to
6 Children's Social Care with an annual review. So I just
7 want to be clear what that process looks like.

8 It was never going to work with a 6 to 12-week
9 programme and I agree with you that either we should
10 have used the support worker or we should have been
11 clear with Early Help that this was a piece of work that
12 was going to take six to 12 months. I think that the
13 team around the child could have worked really well, if
14 CAMHS had worked with the youth worker, which is what we
15 would want them to do now, and help them do the work
16 with AR over a 6 to 12-month period.

17 So, in theory, it could have worked really well. It
18 didn't and it was never going to work for a 6 to 12-week
19 period.

20 **Q.** Thank you. I'm going to come now to the March 2022
21 missing episode and I will cover that and then perhaps
22 we'll take a break.

23 There were two notifications received from the
24 police about this episode on 17 March 2022: one that
25 related to AR going missing, that was the one from

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1 **A.** Agreed.

2 **Q.** She didn't have enough information about the
3 circumstances of AR going missing and then being found.
4 She didn't challenge AR sufficiently in the interview,
5 including when he obviously lied about not having
6 a weapon, and your view is, at paragraph 210:

7 "Exploration of these issues should have led to
8 a safeguarding referral from the [Missing from Home]
9 worker."

10 **A.** Agreed.

11 **Q.** Would you accept that it went rather beyond this
12 Ms Anderson? First of all, the expectation on Missing
13 from Home workers to conduct up to eight Return Home
14 Interviews per day inevitably meant that they were
15 unable to properly prepare or explore issues adequately?

16 **A.** So, I agree, but we come back to the issue of -- so with
17 a Missing from Home, in that workload of eight
18 children -- and it wouldn't be eight every day, I don't
19 believe -- within that context, there will be some that
20 are more complex than others and there will be some that
21 are just not known to us at all, and so a worker
22 wouldn't have to read extensive histories on every child
23 but we now absolutely make sure that our Missing from
24 Home workers have the history before they go out.

25 **Q.** As at 2022, the system was one which treated Return Home

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1 PC Fairclough that we have, and again we have looked at
2 it a number of times, LANC000088. As I understand it,
3 that would, in effect, go direct to the Missing from
4 Home team and they would conduct a Return Home Interview
5 once it was updated with the fact that AR was found.

6 **A.** Yes.

7 **Q.** Then, secondly, there was a high-risk police
8 safeguarding referral raised by PC Rhodes, after AR was
9 found and returned to the home address, and that is the
10 document that refers to AR's possession on the bus of
11 a knife, to his intent to stab somebody or to get social
12 media accounts deleted and to AR having made poison,
13 though there's some issue over made or whether he simply
14 referred to it. That report refers to him making it.
15 That was considered by the MASH and closed at level 2,
16 after unsuccessful attempts to contact AR's parents; is
17 that right?

18 **A.** Yes.

19 **Q.** That's the one we have at LCC000157. Sir, you may
20 recall we looked at this with Ms Chapman?

21 **SIR ADRIAN FULFORD:** We did.

22 **MR GOSS:** If we could have page 44 of your witness statement
23 up, please, paragraph 208 to 210. As Ms Chapman
24 candidly accepted, you also accept that the first strand
25 of that process was badly inadequate.

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1 Interviews as little more than a tick-box exercise; is
2 that fair?

3 **A.** I wasn't here. I can't say.

4 **Q.** You are speaking as the Director of Children's Services,
5 giving corporate evidence on behalf of the Council. On
6 the evidence that you have heard about this, it treated
7 them as little more than a tick-box exercise, didn't it?

8 **A.** That's not my understanding when I arrived at the
9 Council.

10 **Q.** At paragraph 211, I think you accept that there was also
11 a failure within the MASH to consider this case
12 properly?

13 **A.** Absolutely.

14 **Q.** "... AR's historic involvement with [children's Social
15 Care] and [Early Help] should have been more thoroughly
16 considered. It would also be expected that the MASH
17 would have initiated a conversation with EH and MFH,
18 including consideration of the detail supplied about
19 this incident."

20 Just unpicking that slightly. What we have here is
21 two referrals from the same agency on the same day about
22 the same child and the same incident and they should
23 have been linked and considered together; is that right?

24 **A.** Yes.

25 **Q.** There's no evidence that that was done, is there?

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- 1 A. No.
- 2 Q. But the information on PC Rhodes' high-risk referral, in
3 and of itself, should have been treated more seriously,
4 not just closed at level 2 when there was no response
5 from the parents?
- 6 A. Absolutely.
- 7 Q. As you go on to set out at 212, had any of these
8 failings in either strand not occurred, you would have
9 expected AR's case to have been looked at in more
10 detail, further assessed, both in terms of risk to
11 himself and risk to others?
- 12 A. I would have expected a strategy discussion.
- 13 Q. Yes. We don't have it on screen at the moment but you
14 go on to set out what you think would have occurred:
15 I think, potentially, referral to Child and Youth
16 Justice Services, Prevention and Diversion teams?
- 17 A. Yes, I think things would have gone differently with
18 what we know now because we would have had a joint
19 Section 47 investigation, I think, which would have
20 involved both the police and social care visiting the
21 child's home.
- 22 Q. Involve Acorns and Presfield?
- 23 A. Yes.
- 24 Q. And likely CAMHS as well?
- 25 A. Yes.

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- 1 A. It was a failure.
- 2 Q. It was not just a failure, it was an extremely grave
3 failure, wasn't it?
- 4 A. Yes.
- 5 Q. It fell a long way short of what was acceptable in this
6 context?
- 7 A. I think we have covered that it was a failure.
- 8 Q. Ms Anderson, I'm asking because, again, you're speaking
9 as LCC's corporate witness on Children's Social Care.
10 As you say, as a result of the evidence heard in the
11 Inquiry, you now have a broader and wider perspective on
12 what happened. Is there anything else you want to say
13 about that failure?
- 14 A. I would love if you would ask me that after the break.
- 15 **MR GOSS:** All right.
16 If we could take 15 minutes, sir?
- 17 **SIR ADRIAN FULFORD:** Certainly. I will sit again at
18 3.25 pm.
19 (3.09 pm)
- 20 (A short break)
- 21 (3.25 pm)
- 22 **SIR ADRIAN FULFORD:** I think you wanted to provide the
23 answer.
- 24 A. I did.
25 So I believe that Lancashire had an opportunity to

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- 1 Q. Potentially a further Prevent referral --
- 2 A. Yes.
- 3 Q. -- in light of the reference to poison?
- 4 A. Yes.
- 5 Q. This was an opportunity for Lancashire County Council to
6 identify the very serious risk that AR posed to others
7 and to himself, to share that information with other
8 agencies and for steps to be taken to address it, wasn't
9 it?
- 10 A. It absolutely was an opportunity for the police and for
11 us to do a joint investigation.
- 12 Q. We have spoken to the police about this.
- 13 A. Agreed.
- 14 Q. I'm asking about your role, your organisation's role.
15 It was an opportunity, on the information that LCC had
16 available to it, for that information to be shared with
17 other agencies, the risk identified and steps taken,
18 wasn't it?
- 19 A. Yes.
- 20 Q. Do you think that what you say at 212 adequately
21 reflects the consequences of this failure?
- 22 A. I think it reflects what we knew at the time when
23 I wrote it.
- 24 Q. It would be right to characterise this as an extremely
25 grave failure on the part of LCC, wouldn't it?

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- 1 convene a multi-agency risk assessment which, with what
2 we know now, would have made a huge difference to what
3 happened in the future.
- 4 We absolutely take responsibility for our part and
5 we want to say sorry and I want to say sorry.
- 6 **SIR ADRIAN FULFORD:** Thank you.
- 7 **MR GOSS:** The last period where CSC had any involvement,
8 Ms Anderson, was in May 2022 and that was after police
9 made a further safeguarding referral following AR
10 throwing food around the house, flooding the house,
11 causing the electricity to short-circuit, all in the
12 middle of the night as part of a dispute over access to
13 a laptop.
- 14 Again, you are nodding. I sense you are familiar
15 with it?
- 16 A. Yes.
- 17 **MR GOSS:** Sir, for your note, LCC000170.
- 18 **SIR ADRIAN FULFORD:** Thank you.
- 19 **MR GOSS:** That was assessed by the MASH it looks like
20 without reference to what had happened two months
21 before; is that fair?
- 22 A. Yes.
- 23 Q. And I think while it was still being dealt with by the
24 MASH, there was further concern expressed by Presfield
25 School about AR's refusal to attend school (and this, of

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1 course, was just after the transition) and also his
2 behaviour at home, which they described as pouring milk
3 into father's bed to prevent him from sleeping, tipping
4 dad's dinner over his head, and pouring water over dad's
5 laptop which has caused it to break.

6 Again, sir, just for the note, LCC000165.

7 **SIR ADRIAN FULFORD:** Thank you.

8 **MR GOSS:** Ultimately, this episode was closed by the MASH on
9 the basis that there wasn't any consent from the parents
10 because they didn't respond to communications.

11 Presfield followed it up with a formal referral,
12 rather than just the provision of information but it
13 doesn't appear to have been taken forward; is that fair?

14 **A.** Yes.

15 **Q.** And the case was closed at level 2. By this stage, of
16 course, level 2 means neither CFW nor CSC involvement.

17 **A.** Mm-hm.

18 **Q.** Can you help us with why that was the outcome in that
19 case?

20 **A.** So, I agree that we didn't have what we would have
21 needed to override consent. That said, because of our
22 interactions with the family already, it's my view that
23 we should have chased consent. We could have asked
24 a worker to go out and knock the door and ask for
25 consent. We do that now and I think we should have done

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1 going on here?

2 **A.** Agreed.

3 **Q.** That's perhaps particularly the case where there's
4 a difficulty with parental consent in this context
5 because it's the parents who are refusing to allow the
6 school into the house in the first place. That rather
7 suggests that relying on the parents to consent might
8 not be the most appropriate way forward.

9 **A.** It is but without the threshold for Section 47, so
10 without risk of significant harm which we've established
11 we don't have.

12 **Q.** It's a difficult one with risk because, of course,
13 nobody knows what's going on behind a closed door. But
14 where you have a child who hasn't been seen for, by this
15 point, two months, is it unreasonable to think that
16 there is reasonable grounds to suspect they may be
17 suffering or likely to suffer significant harm?

18 **A.** So we would need more than that. So if we were to go to
19 the police -- so the only way to get into a house is
20 with the police and we would need a higher threshold
21 than this to get us through the door. So parents and
22 families have the right to not have State intervention,
23 as I know that you're aware, and we have to have
24 evidence of experiencing significant harm or likely to
25 experience significant harm to force parents to let us

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1 it then.

2 **Q.** Moving forward to March 2023, by this point Presfield
3 expressing very serious concerns to a number of agencies
4 about the fact that they haven't seen AR since May 2022
5 and no professional has seen him since January 2023, and
6 AR's parents are refusing to allow them in saying that
7 if they do, they will "pay the price".

8 Thinking about where matters reached in March 2023,
9 it must follow, mustn't it, that had there been the
10 chance to intervene earlier in that process in May 2022
11 that would have been beneficial?

12 **A.** Yes.

13 **Q.** Presfield were now raising the issue again and, again,
14 LCC000186. And, again, there's attempts made to contact
15 the parents but they don't respond to a number of
16 telephone calls over a couple of days. The episode is
17 closed then on 23 March, the day after Presfield's
18 referral is received, saying "it doesn't meet threshold
19 for Section 47 and there is no consent".

20 Again, should we take it that your answer to what
21 should have happened on that occasion is similar to what
22 should have happened in March 2022, that although there
23 is nothing to indicate let's open a Section 47, let's
24 override consent, there should have been more done,
25 given the history of the case, to understand what was

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1 in. And I just think, just recalling some of the
2 information I shared earlier, just with regards to the
3 number of children that don't go to school and the
4 number of children that are severely absent, not seeing
5 a child for this amount of time that on its own, for
6 a child of this age, doesn't give us significant harm.

7 **Q.** Thank you. Again, to be fair, Presfield had approached
8 the police who had declined to become involved at this
9 point?

10 **A.** Yes.

11 **Q.** Because this is the last occasion when there was any
12 direct contact in CSC with AR and his family, there's
13 obviously a later episode with CFW because in fact what
14 happens is Alphonse R does contact the MASH after they
15 write to say, "We are here if you need us" -- my
16 paraphrase.

17 **A.** Yes.

18 **Q.** But because this is the last occasion when CSC had that
19 last contact, or the MASH, can I just invite some
20 overall reflections.

21 One way of looking at the various contacts that the
22 MASH in particular, but also CSC, have had with the
23 family is that the risk is consistently either
24 underestimated or downgraded, transferred to a lower
25 level than it should have been. Other than after the

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1 hockey stick incident, there's no examples of the case
 2 being moved up. Is that a fair characterisation?
 3 **A.** So I don't agree with all of that sentence, as I've
 4 shared throughout the conversation today.
 5 **Q.** It might be thought to indicate that the MASH and the
 6 CSC are applying too high a level of risk but, again,
 7 for the reasons you have explained, you wouldn't accept
 8 that?
 9 **A.** Exactly.
 10 **Q.** We obviously know that there were very many referrals
 11 into the MASH at various stages by different agencies.
 12 Is the fact of repeat referral something that's given
 13 weight when considering risk?
 14 **A.** Yes. So, we now, and for a number of years, if we have
 15 more than three referrals we also undertake an
 16 assessment in the MASH. We do receive a lot of
 17 referrals that don't meet level 3 or 4 and so we do have
 18 to be careful with that, but we always undertake an
 19 assessment at three referrals now.
 20 **Q.** Thank you. But that wasn't something that was in place
 21 in the life of this case?
 22 **A.** No.
 23 **Q.** If I could just deal very briefly then with the final
 24 episode, at the end of the final episode, of CFW
 25 support.

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1 should have at least been discussed at that stage when
 2 CFW have run out of options, there are serious
 3 unaddressed needs that no one can work out how to engage
 4 AR on?
 5 **A.** So I think given some of the information I shared
 6 earlier just with the level of complexity, the degree of
 7 complexities and difficulties that children face, that
 8 list is a huge list. That said, most of the children
 9 that we work with in Children's Social Care have greater
 10 needs than that.
 11 That said, the other thing that was really important
 12 from here was his age and him being 17 and, therefore,
 13 his consent and his willingness to work with us. So
 14 from a Children's Social Care perspective, outside of
 15 Section 47, we wouldn't have been able to force him to
 16 work with us either. And so I just think that's
 17 a really important thing to think about when we think
 18 this through.
 19 **Q.** Can we take it from that that you agree with Ms Ashworth
 20 that this was something that should have been discussed
 21 but also perhaps agree with Ms Williams that it was not
 22 necessarily a case where, even if it were discussed,
 23 there would have been anything you could have done?
 24 **A.** Agreed.
 25 **Q.** Stepping back and thinking about that long list of

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1 As I have said, AR's parents did make contact in
 2 April 2023. There was then Early Help Support for them
 3 through to September 2023. But at the end of that
 4 episode, it was agreed by all agencies involved that AR
 5 had serious ongoing needs but that they were unable to
 6 work out a way to engage him and the case closed to CFW
 7 as a result.

8 Just to remind ourselves, he was refusing to leave
 9 the house; he was refusing to engage with CAMHS, despite
 10 apparently very severe anxiety; he was refusing to
 11 attend any form of education; the only way his school,
 12 on which he was on the roll, could ensure he was safe
 13 was to attend with a police officer, otherwise they were
 14 refused entry again; and he was engaged in no
 15 constructive activity whatsoever.

16 Ms Ashworth this morning took the view that, at the
 17 very least, this should have been discussed as a case
 18 for stepping up but said whether or not it would have
 19 gone on to meet thresholds determined by level 4 would
 20 be another matter.

21 Ms Williams' evidence last week, as the Family
 22 Support Worker who was engaged in that episode, was that
 23 she didn't think to do that because she didn't think it
 24 would have met that threshold.

25 First of all, do you agree it was something that

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1 needs, and of course also the wider history with which
 2 we're all familiar now, is it concerning to you that
 3 there would have been nothing that could have been done
 4 in that situation? Does that not suggest something of
 5 a gap in powers, capabilities, to take action?
 6 **A.** It is really concerning to me. I hope we find some
 7 different answers.
 8 **Q.** Appreciating that you have to work within the statutory
 9 structure that exists, but the effect of it, in this
 10 case, is that serious risks or needs that everybody
 11 could see simply had to be left unaddressed?
 12 **A.** Would you -- I'm not sure what I'm saying yes to there,
 13 sorry.
 14 **Q.** Well, would you agree that the effect of it, the effect
 15 of the scheme in which you have to operate, was that
 16 there were serious unaddressed needs, recognised by the
 17 agencies who were involved, but with no way to address
 18 them?
 19 **A.** Yes, I think that there is a real question for us around
 20 how we help children with special educational needs and
 21 autism, who struggle to access the community to have the
 22 right services and interventions that reintegrate them
 23 into our communities. I think you've talked about the
 24 role of CAMHS in helping us with a formulation that will
 25 help us help those children reintegrate into

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1 communities, and I think we do need a system that
2 enables us to meet that need and I also think we need to
3 find a way to be able to monitor the risk that might be
4 happening in private in a home in a bedroom and those
5 will be questions for the State.

6 **Q.** You set out in your statement, Ms Anderson, at
7 paragraphs 213 onwards some of the reviews and
8 improvements that have occurred. I'm going to take
9 those as read, if that's all right.

10 I did want to come back to one point that you raised
11 earlier, which was from 2022 onwards. You referred to
12 changes to how risk to others is held in a multi-agency
13 context and you pointed out the MASPs, which I think is
14 Multi-Agency Support Panels?

15 **A.** Thank you.

16 **Q.** Am I right that that is a result of the serious violence
17 duty that was introduced in the Police, Criminal Courts
18 and Sentencing Act 2022 (*sic*)?

19 **A.** Yes.

20 **Q.** That's not a topic that's covered in your witness
21 statement?

22 **A.** No.

23 **Q.** Could I ask that you, in conjunction with your legal
24 team, put together something for the Inquiry by the end
25 of the month?

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1 page 16. Could you expand the part in red down the
2 bottom, please.

3 Now, I make it clear this is not a trick question,
4 all right? When Mr Goss took you to this and in
5 particular focusing on the high risk of harm to others,
6 risk of harm, high risk of harm to others, you very
7 understandably wanted to place the question he was
8 asking in context and the context was that historically
9 the work of agencies such as yours has been to focus on
10 risk to the child or young person, not the risk that
11 they may pose to others, and I think that has been
12 a very clear theme of your evidence, if I may say so.

13 Of course you will follow instructions such as this
14 as to the test that's to be applied. I completely
15 understand that and I'm not for a moment questioning it.
16 But in terms of how situations like this realistically
17 can be addressed, do I detect strongly from you that you
18 think, given all of the other responsibilities that your
19 organisation and brother and sister organisations have,
20 having the additional responsibility of having to assess
21 and then take action in relation to the risk of harm
22 that the child or young person presents for others is
23 a difficulty?

24 **A.** Yes.

25 **SIR ADRIAN FULFORD:** Don't say yes just because I have asked
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1 **A.** Yes.

2 **Q.** To set out what those are, how they work and the risk
3 that they are intended to address now?

4 **A.** Yes.

5 **Q.** Thank you.

6 **A.** I will add to that, the pilot that's happening at the
7 moment, in terms of prevention panels, which to me looks
8 like MASPs with a little bit more teeth.

9 **Q.** If that could be covered as well, then that could be
10 most helpful.

11 Before I see if anyone else has any questions,
12 Ms Anderson, do you have anything else you would like to
13 say?

14 **A.** I'd like to say that I think the work of this Inquiry is
15 incredibly important. LCC, and me as an individual,
16 want to do the best that we can to make sure that this
17 never happens again in England and I hope that you come
18 to some great recommendations that will help our
19 multi-agency system ensure that no other families have
20 to experience what these parents have experienced.

21 **MR GOSS:** Sir, do you have any questions?

22 **Questioned by THE CHAIR**

23 **SIR ADRIAN FULFORD:** You are nearly there, just one final
24 thing from me.

25 Could we have LCC001900 up on the screen and
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1 the question.

2 **A.** No, I couldn't have put that better myself.

3 **SIR ADRIAN FULFORD:** Because I have a sense that it would
4 only be, for instance, in the very rarest of cases, if
5 at all, that children would actually be removed from the
6 home and placed into care as a result of a process that
7 had assessed them as posing a high risk of harm to
8 others.

9 **A.** Under Children Act legislation, yes.

10 **SIR ADRIAN FULFORD:** And if you were able to express
11 a preference, you would be saying that, although Social
12 Services should contribute to the process of assessing
13 the risk, actually what you do with it should be left to
14 other organisations?

15 **A.** I think it's a criminal matter.

16 **SIR ADRIAN FULFORD:** Your evidence has been very helpful.
17 Thank you very much for coming. You are free to go.

18 **A.** Thank you very much. Thank you.

19 *(The witness withdrew)*

20 **MR GOSS:** If we could call Ms Coombes, sir.

21 **SIR ADRIAN FULFORD:** Certainly.

22 If you remain standing for a moment.

23 **HELEN COOMBES (sworn)**

24 **Questioned by MR GOSS**

25 **SIR ADRIAN FULFORD:** Thank you very much. Please have
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1 a seat.
 2 Yes, Mr Goss.
 3 **MR GOSS:** May it please you, sir. Could you give us your
 4 full name, please.
 5 **A.** Helen Ruth Coombes.
 6 **Q.** If we could have LCC001856, please. Is that your
 7 statement to the Inquiry?
 8 **A.** It is.
 9 **Q.** You have signed it on, I think, 12 September this year.
 10 Are the contents of it true to the best of your
 11 knowledge and belief?
 12 **A.** Yes.
 13 **Q.** If I could also introduce LCC001805. That's the witness
 14 statement of Suzanne Walmsley, signed on the same day,
 15 12 September. Obviously I'm not asking you to adopt
 16 that as her statement, but are you familiar with that
 17 document?
 18 **A.** I am.
 19 **Q.** Ms Coombes, if you just want to try and keep your voice
 20 up a little bit. It's a large room and the sound can
 21 disappear somewhat.
 22 In terms of your experience and role, you're the
 23 director of Adult Social Services at Lancashire County
 24 Council and have been since December 2024?
 25 **A.** Correct.

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1 support.
 2 **Q.** Who can refer into that team?
 3 **A.** Children services, education, health services, the
 4 public, the family, and the individual themselves.
 5 **Q.** So a broad approach to who can refer in. Ms Williams,
 6 who was a Family Support Worker within the Children and
 7 Family Wellbeing Service, told us last week that she was
 8 of the understanding that a child needed to be open to
 9 Children's Social Care for a referral to be made to the
 10 Transition Team. Was she mistaken about that?
 11 **A.** She was.
 12 **Q.** What sort of age is it appropriate for a referral to be
 13 made to the Transition Team for a child?
 14 **A.** You would start to think about commonly referring from
 15 the age of 14 for two reasons. One because at the age
 16 of 14 you will start to understand, particularly if
 17 a child has got significant disabilities, the length of
 18 time that they will need to be worked through in terms
 19 of post 16 options, particularly if people have
 20 continuing health care from the NHS and social care
 21 support. But between the ages of 16 and 18 is when the
 22 detailed planning would start to commence.
 23 In addition, the family, particularly, would need to
 24 be supported to understand the difference between having
 25 eligibility for Adult Social Care and the arrangements

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1 **Q.** You were previously a qualified social worker and you
 2 have been a director of Adult Social Services in various
 3 local authorities for, I think, the past ten years?
 4 **A.** That's correct. I'm currently still a social worker.
 5 **Q.** Thank you. I think your statement might suggest
 6 otherwise but thank you for the correction.
 7 Just in terms of the role of Adult Social Care in
 8 this case, we know that there was a referral made to
 9 what's called the Transition Team in February 2022 by
 10 Louise Lewis of Children and Family Wellbeing Service.
 11 We've heard a great deal about Children's Social
 12 Care. Am I right that Adult Social Care is essentially
 13 the process of providing and administering the support
 14 that someone above the age of 18 might be entitled to
 15 under the Care Act, the Mental Health Act, the Mental
 16 Capacity Act? Those are probably the three main ones.
 17 **A.** Correct.
 18 **Q.** Because there is an obvious potential issue at the point
 19 somebody moves from the social care that is available to
 20 them as a child, to becoming an adult at 18 and the care
 21 that may be available to them beyond that point, the
 22 Adult Social Care Team runs a Transition Team?
 23 **A.** Correct.
 24 **Q.** That is, I think, staffed by qualified social workers?
 25 **A.** Qualified social workers and forum qualified workers to

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1 that surround that.
 2 **Q.** When you say detailed planning would start to commence,
 3 is it right that one of the first stages within that is
 4 a Care Act assessment?
 5 **A.** So there are two parts to the Care Act assessment. The
 6 first part is an understanding and an assessment about
 7 will information, advice and guidance, both to the
 8 individual and the family, be the first step before you
 9 go into a full Care Act assessment. But, yes, the
 10 second part is to complete the Care Act assessment.
 11 **Q.** It seems that it was the practice in LCC's Transition
 12 Team that where referrals in were received as you say
 13 from the age of 14 or so onwards, that work generally
 14 wouldn't take place until the individual was near or
 15 just after their 17th birthday.
 16 Is that in accordance with good practice in
 17 transition teams?
 18 **A.** No.
 19 **Q.** One issue with it might be that it creates something of
 20 a challenge if the situation has changed between the
 21 point of the referral and the point the assessment is
 22 carried out. There's going to be a good deal of ground
 23 that may need to be covered. Are there any other issues
 24 with that as an approach?
 25 **A.** So one of the main areas that as children move into

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1 adulthood and become young adults is that you're
2 switching to the voice of that young person and
3 particularly allowing enough time to do advocacy, to
4 make sure there are individual opportunities for that
5 person to contribute to their assessment, but also to do
6 the liaison work with other agencies.

7 And for all young adults, there's a lot of change
8 that happens between the ages of 16 to 25. If you have
9 a disability or you have a whole range of family
10 circumstances, it's really important that you allow
11 enough time to do that work.

12 **Q.** One other important factor for anyone carrying out an
13 assessment of what needs somebody might have as an adult
14 on the transition from childhood is they ought to have
15 access to information about that child; is that fair?

16 **A.** Absolutely.

17 **Q.** I put that very generally but I'm thinking here of the
18 fact that, as of July 2024, the Transition Team didn't
19 have access to the children's element of the Liquidlogic
20 record system; is that right?

21 **A.** That's correct.

22 **Q.** That was a significant and obvious shortcoming; is that
23 fair?

24 **A.** It was.

25 **Q.** I think that is now one that has been rectified so that

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1 practice would be to make sure that the manager was
2 looking at the whole work of the team and prioritising
3 it correctly, rather than allocating it on to
4 a caseload.

5 **Q.** But that doesn't appear to have been happening in this
6 2023 period?

7 **A.** No.

8 **Q.** Is the situation now different?

9 **A.** It is.

10 **Q.** Just give us an outline of how.

11 **A.** So, the business process, if you like, has been
12 completely refreshed, so that when notifications are
13 made, there is huddles where the whole team looks at it,
14 the timing at any that person might need to be seen,
15 looks at risk, looks at prioritisation and the team
16 managers are very actively managing the caseload, so
17 that they're in line with the rest of Adult Social Care.

18 You ideally wouldn't want a social worker actively
19 working with somebody. You wouldn't want them to have
20 more than 25 to 30 cases at any one time, you certainly
21 wouldn't want them to be having 60, and you certainly
22 wouldn't want them allocated to people that they didn't
23 need to be seeing at that point.

24 **Q.** Can we turn to the referral itself, LCC001810. This is
25 the referral that was made on 8 February 2022, as I say,

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1 they do have the ability to read the notes on both
2 Children's Social Care and the Early Help module?

3 **A.** That's correct and also to be able to link the family.
4 So it is understood all the different interventions,
5 including carer support.

6 **Q.** Thank you. Ms Walmsley in her statement, on page 12,
7 sets out serious resourcing concerns in the Transition
8 Team in late 2023. She describes excessive caseloads
9 which were becoming increasingly unmanageable and
10 significant under-staffing due to long term sickness and
11 people leaving the team but not being replaced.

12 Recognising that you joined LCC in December 2024,
13 would you agree that's not an acceptable state of
14 affairs for a team to be under that much resourcing
15 pressure?

16 **A.** Yes.

17 **Q.** It is inevitably going to have an impact on the quality
18 of work that's carried out?

19 **A.** That's correct. The referrals were being allocated
20 rather than necessarily being notifications at some
21 point somebody might need to -- the work needed to
22 start.

23 So, they had 50 to 60 cases but some of those young
24 people might still be only 13 and 14. So we had
25 caseloads which were not correctly allocated. Normal

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1 by Ms Lewis.

2 Overall, it provides relatively limited information
3 about AR; is that a fair characterisation of it? It
4 doesn't, for example, attach his EHC plan which we know
5 he had. It doesn't talk about AR's forensic history or
6 any risk to others. There's no space for that
7 specifically on the form but it does, for example, talk
8 about his fractured relationship with his father but
9 without going into any more detail than that.

10 It doesn't -- if we go over the page, and I think if
11 we go over one more -- it doesn't, despite a prompt,
12 include contact details save for the CFW worker for any
13 of the other professionals who have been involved.

14 Not perhaps the most helpful referral for the
15 transitions team to receive?

16 **A.** Not the most helpful referral for the transitions team
17 to receive. However, our objective under the Care Act
18 is to do two things. One identifies the interventions
19 we can do to prevent the need for care and support. So
20 for post-16 options, how do we get somebody into
21 employment, how do they have meaningful activity, what
22 is the family support there? And the second is to do
23 the Care Act assessment.

24 So there are some things in here that you would
25 expect an adult social worker under the Care Act to

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1 explore further. Just because there isn't something on
 2 a form doesn't necessarily mean we shouldn't be taking
 3 it into account.

4 **Q.** Thank you. This referral, I think, was assigned to
 5 Matthew Embley in February 2022. Mr Embley then left
 6 LCC in August 2022. I think it is right there had been
 7 no work done on it in that period?

8 **A.** That's correct.

9 **Q.** For some of that period, Mr Embley wasn't at work. Were
 10 there supervision or cover or reallocation arrangements
 11 in place for those kinds of circumstances?

12 **A.** There should be. But this again reflects the dangers of
 13 allocating people, allocating cases when you know that
 14 people haven't got the capacity to do it.

15 **Q.** I see. We might also bear in mind that at this point,
 16 AR would still have been 16 years old and, in line with
 17 the Transition Team's practice at the time of not
 18 particularly picking up a case until 17, it may be that
 19 even if he had been in work, nothing would have been
 20 done?

21 **A.** That's correct.

22 **Q.** It is then reallocated to Ms Walmsley on 10 August 2022
 23 and she set out her dealings with it in her witness
 24 statement. I'm not going to take you through
 25 line-by-line. Her first substantial dealings with it

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1 2023, that a first visit would have happened sooner?

2 **A.** Yes.

3 **Q.** In terms of her preparation for the assessment, she very
 4 candidly accepts she didn't review the Child and Family
 5 Assessment from September 2021 that had been made
 6 available to her. She didn't access any notes on the
 7 children's side of Liquidlogic and indeed she wouldn't
 8 have been able to do so. There was a telephone call
 9 with Alphonse R two days before and there was some
 10 limited contact with the SEND team within LCC and some
 11 discussion with another transitions team worker who had
 12 been involved with the family.

13 This was by no means sufficient in terms of
 14 preparation for carrying out an assessment on this
 15 child, was it?

16 **A.** Yes and no. So I think it was important that she did go
 17 out and visit and make that first contact because you
 18 also need to be able to meet the family and just
 19 physically see the environment.

20 But I think that would had to have been followed
 21 very quickly with then further work done and that wasn't
 22 completed, as we know.

23 **Q.** So it might be appropriate to do an early stage visit to
 24 the family to take the lay of the land, but what isn't
 25 acceptable is to not do the follow-up work, not read the

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1 aren't until a year later, on 14 August 2023, just after
 2 AR's 17th birthday when she begins trying to arrange
 3 a Care Act assessment with AR's parents.

4 Should there have been something done with this
 5 earlier?

6 **A.** Yes.

7 **Q.** How much earlier?

8 **A.** Given our relationship with the family, what we knew
 9 based on this transition form, it was always going to be
 10 quite a lot of work in order to engage with him as
 11 a young person to access advocacy, to make sure that
 12 there was the opportunities, particularly given needing
 13 that independent voice to do this work.

14 So it was never going to be a quick assessment and
 15 I'll go back to one of our jobs is to identify, whether
 16 through information advice and guidance and support,
 17 looking at post-16 options, we can prevent the need for
 18 long-term care and support. It's a core part of our
 19 wellbeing duty.

20 **Q.** The first visit that Ms Walmsley conducts doesn't take
 21 place until 9 November 2023. She set out some of the
 22 personal reasons in her witness statement why that took
 23 some three months to arrange.

24 Notwithstanding those, would you have hoped that
 25 even after the point she first picks it up in mid-August

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1 previous assessments, not engage with the other agencies
 2 that are involved in-depth and, because that didn't
 3 happen, this ultimately was inadequate preparation?

4 **A.** Correct.

5 **Q.** If we think briefly about what was not known as a result
 6 of this by Ms Walmsley: she wouldn't have known about
 7 the most recent episodes of CFW contact because the
 8 referral had come before that final episode; she
 9 wouldn't have known about the Missing from Home episode
 10 in March 2022 -- again, came after the referral; she
 11 wouldn't have known AR's forensic history, which wasn't
 12 mentioned on the referral; she wouldn't have known about
 13 the Prevent referrals that weren't mentioned on the
 14 referral. There were enormous gaps in her knowledge on
 15 this case?

16 **A.** Correct.

17 **Q.** In terms of her visit on 9 November, she spoke to AR's
 18 parents but she didn't speak to AR, as he was too
 19 anxious to see her. I think the position is that it's
 20 not a mandatory requirement that a young person is seen
 21 for an assessment but they do have to be involved in it
 22 in some way, their voice needs to be heard?

23 **A.** Correct.

24 **Q.** So refusal by the subject of the assessment to engage
 25 should lead to consideration of how to proceed,

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1 potentially you are looking at a multidisciplinary team,
2 discussion, a capacity assessment, some sort of steps to
3 try and engage the young person, even if they refuse to
4 be seen face to face?

5 **A.** Correct, and that's standard practice for us.

6 **Q.** But none of that happened in that case?

7 **A.** No.

8 **Q.** Ms Walmsley makes clear in her statement she wasn't
9 aware of any history of violence or aggression, any risk
10 to the wider public or inside the home and wasn't told
11 anything about that by AR's parents. She's accepted
12 that her exploration of the case was inadequate. Would
13 you agree?

14 **A.** Correct.

15 **Q.** Had she been aware of those factors, she says she would
16 have referred the case to a line manager and looked to
17 contact Children's Social Care. At the very least this
18 might have enabled a broader more holistic view of AR's
19 circumstances, even if the conclusion was that any risk
20 of harm was historic rather than ongoing?

21 **A.** Correct.

22 **Q.** Nonetheless, on the basis of her visit and her
23 discussions with the parents, she reached a view that
24 support under the Care Act would be available primarily
25 around AR's isolation. I think you think that was

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1 it you are trying to achieve in your life?" Because
2 what the Care Act says is that we must be really clear
3 about one or two outcomes -- two outcomes must be
4 identified that a person wants to achieve and that it
5 will be significantly impaired and, at that stage, based
6 on the information, we believe -- I could see that he
7 did not have Care Act eligibility. That doesn't mean
8 that we didn't need to prevent the need for care and
9 support. Obviously, there's far more information now
10 available.

11 **Q.** I see. When you say not exhibiting mental health needs,
12 such as schizophrenia, et cetera. He was obviously
13 displaying signs of, apparently, very severe anxiety.
14 Are you drawing a distinction between schizophrenia as
15 a major mental illness and anxiety as a different kind
16 of condition?

17 **A.** So, I'm drawing the distinction between the only power
18 that we could have used was a -- and could consider was
19 the Mental Health Act. In the adult world, we often
20 have to consider harm to others as well as to self and
21 we need to consider very clearly which powers we can use
22 and the reason that specifically talked about mental
23 health needs, such as schizophrenia, is, at this point,
24 there was no reason for Suzanne or anybody else to be
25 thinking about the Mental Health Act could have been

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1 a premature decision to reach, first of all?

2 **A.** That's right.

3 **Q.** I think, potentially, you disagree with the substance of
4 that decision as well. If we could have page 15,
5 paragraph 71 of your statement up, please, LCC001856.

6 Paragraph 71, you say:

7 "... whilst [he] was identified to have needs, at
8 this time he did not present as a priority or someone
9 with significant needs ... because of factors including,
10 but not limited to ...

11 "AR was housed.

12 "AR lived with his parents who cared for him.

13 "AR was not exhibiting mental health needs such as
14 schizophrenia, et cetera."

15 No issue over him being housed.

16 Lived with his parents who cared for him: does that
17 perhaps give rather too little weight to the very
18 fractured relationship that's apparent from the records
19 between him and his father?

20 **A.** I don't think so. At that point, we would be wanting to
21 understand what did he want, which is why I keep
22 referring to our duty to prevent the need for care and
23 support. So the outcome -- his outcome and his voice
24 advocacy, "Do you want to continue living with your
25 parents; are you looking for supported living; what is

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1 used in any way shape or form. That information wasn't
2 there.

3 **Q.** Whatever the outcome of the assessment then -- your view
4 perhaps being that this was a case that needed to be
5 dealt with more by way of looking to prevent the need
6 for Care Act support; Ms Walmsley's being that Care Act
7 support would be available -- what would you have
8 expected to happen following an assessment?

9 **A.** So, providing -- being eligible under the Care Act
10 doesn't necessarily mean that the only option is to
11 provide a package of care.

12 **Q.** It's my fault because I think I have asked too broad
13 a question. Would you have expected the outcome of this
14 assessment, whatever it was, to be taken back and
15 discussed with a manager?

16 **A.** Absolutely.

17 **Q.** Would you have expected there to be further professional
18 engagement between the Transition Team and the family,
19 again whether that is as part of looking to put in place
20 a support package or whether that is part of looking to
21 prevent the need for a support package, further
22 professional engagement between the Transition Team and
23 the family and AR himself?

24 **A.** So, I would have expected further professional
25 involvement with the family. I would have expected

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1 access to advocacy self-assessment options and I would
 2 have expected further liaison with all the other
 3 professionals involved, particularly our health
 4 colleagues as well and with the wider Adult Social Care
 5 Team. We have mental health teams, we have learning
 6 disability teams, we work -- this is our space and those
 7 are the things I would have expected to happen.

8 **Q.** That engagement could have taken place, even though AR
 9 was not yet 18?

10 **A.** Absolutely.

11 **Q.** In fact, what happened is -- although Ms Walmsley
 12 undertook multiple supervision sessions with her line
 13 manager between November 2023 and July 2024, none of
 14 them identified that the visit hadn't been written up,
 15 that the assessment hadn't been completed or had been
 16 completed prematurely and without seeing AR, and that
 17 follow up was outstanding.

18 **A.** Correct.

19 **Q.** Just dealing with note taking, LCC001567, this, I think,
 20 is the notes that Ms Walmsley made in the assessment
 21 itself, typed up onto what's referred to as a face
 22 assessment. Those might be adequate if they are then
 23 supplemented immediately after the event, bearing in
 24 mind these are notes being written in the address, but
 25 they are quite limited in terms of content, aren't they?

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1 to convey the true position, I'm not suggesting anyone
 2 sought to suggest that they had written up the note or
 3 had taken actions that they had not in fact done, it is
 4 far from ideal that there was this process of notes
 5 being written up, entries being made, in the aftermath
 6 of an attack where it would have been clear that what
 7 had or hadn't been done was going to be the subject of
 8 scrutiny?

9 **A.** Correct.

10 **Q.** There should have been a rather more considered and
 11 structured process to preserving and recording the
 12 information that was held at the time, rather than the
 13 slightly *ad hoc* approach that appears to have been
 14 taken; is that fair?

15 **A.** And there is now a clear and structured process.

16 **Q.** Thank you. The course of events here represents not
 17 only failures on Ms Walmsley's part but also on the part
 18 of her supervisor, Emma Clough, doesn't it?

19 **A.** It does.

20 **Q.** Ms Clough, I think, had been appointed in October 2023
 21 as a team manager, having only been a registered social
 22 worker since May 2022. That's quite limited experience
 23 to be a team manager, to be in that role; is that fair?

24 **A.** It depends on the experience somebody has had before.

25 **Q.** The fact that the supervision system as a whole was not

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1 **A.** Content and his voice.

2 **Q.** I think we have confirmation at LCC001831 that there
 3 were no handwritten notes taken. So these were the
 4 extent of the contemporaneous notes?

5 **A.** Correct.

6 **Q.** They weren't written up into any sort of fuller form
 7 until after the attack took place on 29 July, were they?

8 **A.** Correct.

9 **Q.** At that point, there was a process whereby these notes
 10 appear to have been supplemented and then an entry was
 11 made onto the Liquidlogic adult system, LCC000438,
 12 page 3, which then had a further note appended to it
 13 saying:

14 "This is a retrospective entry."

15 **A.** Correct.

16 **Q.** First point, it's obviously seriously inadequate that
 17 notes of a visit were not written up at all, until more
 18 than seven months after the visit took place?

19 **A.** Correct.

20 **Q.** The fact that it was prompted by the attack means we can
 21 have no confidence at all that it would ever have
 22 happened but for that?

23 **A.** Correct.

24 **Q.** Though clearly there was an attempt in making the entry
 25 on the system that flagged this as a retrospective entry

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1 picking up the failings in this case is concerning,
 2 there ought to be a process by which outstanding
 3 actions, inadequate assessments are picked up, even if
 4 the supervisor doesn't pick them up; is that fair?

5 **A.** So there was a supervision policy in place. Was there
 6 a system and process that puts all the checks and
 7 balances and brought all that together in one place?

8 **No.**

9 **Q.** There should have been and I suspect you are going to
 10 tell us that there is now.

11 **A.** Yes.

12 **Q.** Putting it quite starkly, other than a single visit on
 13 9 November 2023, which wasn't written up until after the
 14 attack, the engagement of the transitions team achieved
 15 nothing, as regards AR?

16 **A.** Correct.

17 **Q.** I think there have been three different reviews
 18 undertaken of this and you set them out in your witness
 19 statement.

20 There was a practice review summary and action
 21 plan -- LCC000435, sir.

22 **SIR ADRIAN FULFORD:** Thank you.

23 **MR GOSS:** A report on the Transition Team's involvement with
 24 AR, LCC000462. Those quite shortly after the attack and
 25 they led to various elements of remedial work around

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1 existing caseloads and retraining?
 2 **A.** Correct.
 3 **Q.** Then I think you commissioned an independent management
 4 review from an independent social work consultant,
 5 Mr Addams, which reported in March 2025.

6 We have that at LCC001954, sir.

7 **SIR ADRIAN FULFORD:** Thank you.

8 **MR GOSS:** Why three separate reviews, please, Ms Coombes?

9 **A.** I think the first review dealt with some of the very
 10 technical issues and focused on the immediate actions
 11 that needed to be taken.

12 I think the second review started to talk about the
 13 lessons learnt and reflections and how to manage,
 14 particularly, some of the practice issues. I wasn't
 15 satisfied that I had assurance that all of that work had
 16 delivered some of the changes and I wasn't satisfied
 17 that I completely understood the rationale for, not just
 18 the immediate issues that needed to be, but where is
 19 this whole service going? And, in particular, I also
 20 wanted to understand and be assured that we'd dealt with
 21 all of the individuals practice issues in the context of
 22 the regulator.

23 **Q.** Yes, because I think it was only after the third review
 24 that any consideration was given to any referrals to
 25 Social Work England?

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1 what I did.

2 And also to make sure that Suzanne herself was
 3 supported and enabled through this process. So I make
 4 no apology for the fact that it was done very carefully
 5 it was done in a manner that doesn't mean that
 6 practice -- people feel that there would be necessarily
 7 a very punitive reactive approach to them, that when we
 8 do things, we need to learn but also, as registered
 9 social workers -- and I am still a registered social
 10 worker -- that it is for the social worker regulator to
 11 make decisions, not for the employer, and that we need
 12 to refer to them and allow them to help us think and
 13 explore where practice might not have been where it
 14 should be.

15 **Q.** Thank you. I follow. I ought to say that Ms Walmsley
 16 in her statement sets out some of the personal
 17 difficulties she was undergoing at the time she was
 18 working on this case. That is in evidence and of course
 19 can be taken into account.

20 You have set out in your statement on page 19 from
 21 paragraph 89 some of the improvements in this case. We
 22 have obviously touched on some as we've gone through
 23 your evidence. Ms Walmsley has also set out some of the
 24 changes in the Transitions team or Young Adults team, at
 25 paragraph 38 of her statement. Again, those stand as

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1 **A.** Correct.

2 **Q.** I think a referral has now been made to Social Work
 3 England in respect of Ms Walmsley. Wholly a matter for
 4 social work England, of course, how they handle that,
 5 but that, I think, was not made until July 2025, some
 6 four months after Mr Addams recommended that it be
 7 considered.

8 Why was it almost a year before there was any
 9 referral and almost four months after Mr Addams'
 10 recommendation that contact was first made with Social
 11 Work England?

12 **A.** So I can't -- the original decision was it would be
 13 dealt through management action and I needed the
 14 opportunity to reflect and understand the rationale
 15 behind that. Once that was completed, it was also
 16 really, really important that if further incidents
 17 happened, things go wrong all the time, we can't always
 18 predict what will happen, but it's really important that
 19 our social work teams are able to embrace a culture of
 20 learning.

21 I was very aware that, in order to overturn that
 22 management decision to work with this team, who is
 23 currently going through a significant change in terms of
 24 culture and practice -- they are now called a Young
 25 Adults team -- that how I did it was as important as

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1 your evidence and as hers.

2 Before I see if anybody else has any questions for
 3 you, do you have anything else you would like to say?

4 **A.** So the only thing I would say is that when this
 5 statement was written, that was a point in time. The
 6 team is now called a Young Adults team. We have four
 7 key pathways, which are very much focused on how do we
 8 support young adults irrespective of whether they have
 9 got a disability, whether they are at risk of harm to
 10 themselves or whether they're a risk to others and we
 11 are trying to evolve the way that we work so that those
 12 pathways start to walk with young people and make sure
 13 that particularly advocacy and working with other
 14 agencies is right at the heart of what we do.

15 It is unsustainable for a young person to be living
 16 a life that isn't full of aspiration, isn't full of
 17 positive work, at the point of 16. CAMHS support cannot
 18 be the answer in terms of packages of care and managing
 19 people within very tight environments. So we continue
 20 to try and work through particularly the risk of things
 21 like online -- for young people who have got diagnosis
 22 of autism and our thinking is evolving around that.

23 **MR GOSS:** Thank you. Sir, anything from you?

24 **SIR ADRIAN FULFORD:** There isn't.

25 Ms Coombes, thank you very much for your evidence.

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1 You are now free to go.
 2 **THE WITNESS:** Thank you.
 3 *(The witness withdrew)*
 4 **SIR ADRIAN FULFORD:** Yes, Mr Boyle.
 5 **MR BOYLE:** Sir, the next witness is Ms Connolly. I know she
 6 has kindly expressed a preference to complete her
 7 evidence today and I know you've kindly said you're
 8 prepared to sit late.
 9 **SIR ADRIAN FULFORD:** We'll do everything we can to help.
 10 **MR BOYLE:** I'm grateful for your patience and also that of
 11 the other participants.
 12 **SIR ADRIAN FULFORD:** If we need to take a five-minute break
 13 at some stage when the hour and a half point is reached.
 14 **MR BOYLE:** Yes, I'll ask Mr Goss to let me know at 4.55.
 15 *(Pause)*
 16 **SARAH CONNOLLY (sworn)**
 17 **Questioned by MR BOYLE**
 18 **SIR ADRIAN FULFORD:** Thank you very much, Ms Connolly.
 19 Please have a seat.
 20 **MR BOYLE:** Ms Connolly, thank you for waiting patiently.
 21 Could you give your full name, please?
 22 **A.** Sarah Connolly.
 23 **Q.** Thank you.
 24 Could we have up on screen, please, DSIT000004.
 25 Ms Connolly, do you recognise that as your statement?

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1 **Q.** Would that have been with, first of all, DCMS and then
 2 moving into DSIT when it was created?
 3 **A.** Correct.
 4 **Q.** Then from January 2024 to August this year, you were
 5 Director of Digital Infrastructure; is that right?
 6 **A.** Correct.
 7 **Q.** Can I ask you about DSIT, please. So DSIT was created
 8 on 7 February 2023, correct?
 9 **A.** Yes.
 10 **Q.** Is this right, digital policy was effectively
 11 transferred from, as I said before, DCMS -- Digital
 12 Culture, Media and Sports -- to DSIT?
 13 **A.** Correct.
 14 **Q.** That included, within your portfolio, responsibility for
 15 online safety?
 16 **A.** Yes.
 17 **Q.** Now, we have heard from Ms Ellsmore from the Home Office
 18 and Ms Dixon from DfE. They, I think, have
 19 responsibility for areas in respect of the Home Office
 20 for online terrorism and extremism; is that right?
 21 **A.** Yes.
 22 **Q.** And obviously DfE for online educational and social
 23 development tools, correct?
 24 **A.** Yes.
 25 **Q.** How does DSIT work together with the Home Office and DfE

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1 **A.** I do.
 2 **Q.** Thank you. We see it is dated 3 September 2025. Is it
 3 true to the best of your knowledge and belief?
 4 **A.** Yes.
 5 **Q.** Thank you. Could we also have, please, DSIT000002,
 6 thank you. Ms Connolly, I think we have a helpful
 7 chronology here, particularly of the process of the
 8 introduction of the Online Safety Act, which we will
 9 come to. Can you confirm that is also true to the best
 10 of your knowledge and belief?
 11 **A.** Yes.
 12 **Q.** Thank you. I want to start, please, by asking about
 13 your background. You are, I think, now Interim Director
 14 General for Digital Technologies and Infrastructure
 15 Group within DSIT, the Department for Science,
 16 Innovation and Technology; is that right?
 17 **A.** Yes.
 18 **Q.** Can you just briefly tell us what that role entails?
 19 **A.** I'm responsible for the Department's digital technology
 20 and infrastructure, that includes cyber, data and
 21 security and online harms.
 22 **Q.** Thank you. I think you give us a longer career history.
 23 So between 2017 and 2023, you were Director of Security
 24 and Online Harms; is that right?
 25 **A.** Yes.

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1 in these areas?
 2 **A.** So we have the overarching responsibility for online
 3 safety. They have the specialism, if you like, in those
 4 areas and some others, Home Office does child abuse,
 5 amongst other things. It's a fairly close working
 6 relationship. Certainly through the passage of the
 7 legislation, we have almost daily contact with the
 8 Departments.
 9 **Q.** Thank you. I want to ask you now about the regulation
 10 that was in place prior to the Online Safety Act 2023
 11 coming into force. First of all, the Online Safety Act
 12 gained royal assent on 26 October 2023; is that right?
 13 **A.** Yes.
 14 **Q.** But as we'll come to, it wasn't actually enforceable
 15 until Ofcom had published codes of practice which took
 16 place this year; is that right?
 17 **A.** Yes.
 18 **Q.** So before this year, in effect, the OSA wasn't in force;
 19 is that right?
 20 **A.** Correct.
 21 **Q.** I think you frankly accept that the position before the
 22 OSA came into force was fragmented in relation to the
 23 regulation that was in place?
 24 **A.** Correct.
 25 **Q.** Thank you. That's your paragraph 12. Just to pick up

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1 on a couple of elements of that.

2 There was the EU's eCommerce Directive, which
3 I think required platforms to act quickly to remove any
4 illegal content they hosted, if they became aware it was
5 on their site; is that right?

6 **A.** Yes.

7 **Q.** What would the process be for them becoming aware of
8 that?

9 **A.** It could be drawn to their attention by anyone,
10 including law enforcement -- but anyone. Once they
11 became aware of it, they then became liable for removing
12 it. Until that point, they won't.

13 **Q.** I think there is some discussion in perhaps the
14 statement of Ms Ellsmore about Counter Terrorism
15 Policing units, who have an online presence. Might
16 they, for example, report illegal content if they found
17 it?

18 **A.** Yes.

19 **Q.** In terms of illegal content, obviously the clue is in
20 the name, that's content that amounts to an offence.
21 Are you able to give a short précis of what sorts of
22 material that might include?

23 **A.** It could have included anything that was illegal, so it
24 may be imagery, it may be videos, it would have a wide
25 range of meaning. So it may be some terrorist material

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1 implemented in part by the Communications Act, correct?

2 **A.** Yes.

3 **Q.** That gave Ofcom the powers to regulate video on demand
4 services and video sharing platforms; is that right?

5 **A.** Yes.

6 **Q.** In terms of video sharing platforms, that did include
7 firms that might be considered social media platforms,
8 like TikTok; is that right?

9 **A.** Yes, though you would need to speak to Ofcom, who can
10 give you chapter and verse on exactly what is included.
11 I would also note that many social media platforms were
12 not regulated in the UK by AVMSD; they were regulated in
13 the EU country that they were registered, which often
14 for social media was Ireland.

15 **Q.** Is this right, it only operated for platforms that had
16 a kind of corporate link to the UK; is that right?

17 **A.** Exactly.

18 **Q.** To the extent that it was brought into UK legislation?

19 **A.** Yes.

20 **Q.** So it didn't then apply to all social media platforms.

21 TikTok was just an example that happened to have that
22 corporate link; is that right?

23 **A.** Very few social media platforms were caught by the UK
24 end of it.

25 **Q.** Sir, there is a list at OFC000006 to the extent that's

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1 or child abuse.

2 **Q.** Or material that, for example, incited racial hatred?

3 **A.** Perhaps.

4 **Q.** Is this right: there might be some offences in the
5 terrorist context where publication or dissemination of
6 the content is the offence --

7 **A.** Correct.

8 **Q.** -- and others where possession or viewing of the
9 material is the offence?

10 **A.** Correct.

11 **Q.** So it's perhaps a relatively wide-ranging suite of
12 possible measures but focused purely on what is illegal?

13 **A.** Yes.

14 **Q.** The platform then, if this content was identified to
15 them, could be liable for a criminal defence, if they
16 didn't remove it quickly; is that right?

17 **A.** Yes.

18 **Q.** But there was no obligation at that time on platforms to
19 proactively monitor their content?

20 **A.** Exactly.

21 **Q.** Were, at this period, platforms doing that to your
22 experience?

23 **A.** Not to my knowledge.

24 **Q.** There's then a suite of measures under the EU
25 Audiovisual Media Services Directive, which I think was

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1 helpful.

2 In terms of the obligations on video sharing
3 platforms, is this right: that there was an obligation
4 to protect all users from what was called relevant
5 harmful material?

6 **A.** Yes.

7 **Q.** So, it went wider than purely material that was illegal;
8 is that right?

9 **A.** Yes.

10 **Q.** The fact that relevant harmful material came within that
11 provision, that applied to adults as well as children,
12 correct?

13 **A.** Yes.

14 **Q.** So there was an obligation, for example, on TikTok to
15 regulate the provision of relevant harmful material and
16 prevent that from being provided to adults?

17 **A.** Yes, that's my understanding.

18 **Q.** We will come onto the position now under the OSA.

19 I think in addition there was also a requirement to
20 protect under 18s? Thank you.

21 You set out a further range of legislation and
22 regulation at your paragraph 14. I'm not going to go
23 through that but it includes things like the Gambling
24 Commission, data protection, et cetera, and it might be
25 said that the length of that list does ring true to your

200

1 suggestion that it was a fragmented position before the
2 OSA; would you agree?
3 **A.** Yes.
4 **Q.** Within that context, I want please to ask you about two
5 aspects of material that AR accessed. We heard evidence
6 from DCI Pye some weeks ago about material that AR had
7 when it was searched after the attack. That included
8 the Al-Qaeda training manual which had been downloaded
9 more than once in 2021 and, on top of that, a range of
10 material that related to violence which included images
11 of bodies, victims of torture, beheading and also
12 academic material relating to war, weapons and genocide.

13 Sir, you will remember that evidence from DCI Pye
14 that was given on 22 and 23 November.

15 **SIR ADRIAN FULFORD:** Yes, thank you.

16 **MR BOYLE:** We don't know where, in relation to that
17 material, I think AR, obtained it. But, to the extent
18 any of it was illegal, steps could have been taken to
19 remove it by identifying it with the website that was
20 hosting it; is that right?

21 **A.** Yes.

22 **Q.** Just one discrete point on this, which is take down
23 powers. We heard from Ms Ellsmore at the Home Office
24 who said at the relevant time there was no take down
25 power. I think this is right that under section 3 of

201

1 a matter that you can answer for. I think CPS would be
2 the organisation you would expect to bring
3 a prosecution?

4 **A.** Exactly.

5 **Q.** Thank you. Much of that content shows extreme violence
6 but doesn't obviously relate to a terrorist cause on its
7 face. I think you tell us that nearly depicting
8 a criminal offence, that in and of itself wouldn't
9 necessarily be an offence in terms of hosting the
10 material; is that right?

11 **A.** Exactly. It could be a range of things, so news
12 reporting, for instance.

13 **Q.** We will come on to the video, as perhaps you anticipated
14 in your statement, of the stabbing of Bishop Mar Mari
15 Emmanuel but you tell us at your paragraph 76 that
16 a video of person being violently attacked would not
17 necessarily be an illegal content even where the attack
18 itself is clearly a criminal offence; is that right?

19 **A.** Yes.

20 **Q.** So is that material that might be called legal but
21 harmful?

22 **A.** It might.

23 **Q.** And in terms of that phrase, which perhaps we will use
24 a bit more, are you just able to expand on what sort of
25 material that might encompass?

203

1 the Terrorism Act 2006, police were able to issue and
2 are able to issue removal notices for online content
3 which is unlawfully terrorism related; is that right?

4 **A.** Yes.

5 **Q.** At the time Ms Ellsmore had written her statement,
6 I think she said that that authority had not actually
7 been exercised. Understanding that this is perhaps more
8 within the Home Office scope of things, are you able to
9 comment on why that hasn't been used?

10 **A.** It is a Home Office matter, I'm afraid. I don't know.

11 **MR BOYLE:** Sir, just the reference from Ms Ellsmore
12 statement, HOM000078, paragraph 337.

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

14 **MR BOYLE:** In relation to this material, we have covered
15 illegal material and take down notices.

16 The other question is whether the material was not
17 illegal, and I think you tell us at your paragraph 111
18 that the way things were at that time it would have been
19 for the individual platform to assess the content and
20 decide whether it was a breach of terms of service, for
21 example, to continue to host it. Is that right?

22 **A.** Yes.

23 **Q.** And I think you say elsewhere in your statement that it
24 is not DSIT's role to assess whether content is illegal.

25 So, in looking at this question, that's not perhaps

202

1 **A.** It is exactly as it says: anything which is not illegal
2 but may cause harm.

3 **Q.** When we say "harm" that obviously includes material
4 centred around violence and perhaps that's the relevant
5 question here?

6 **A.** Yes.

7 **Q.** Are there any other categories that we ought to be
8 considering in the context of this Inquiry?

9 **A.** That is probably the major one.

10 **Q.** At that time, we've covered the sort of situation for
11 video service providers but there was no wider system of
12 legislation or regulation in place designed to prevent
13 an adult or a child from accessing legal but harmful
14 material, correct?

15 **A.** Correct.

16 **Q.** We will come on to the OSA, as I have said, but the
17 material AR accessed was extremely disturbing for anyone
18 who has seen it. It might be thought very troubling
19 that AR, as a child, was able to access that material
20 without there have been any sort of legal framework or
21 system of regulation in place to prevent that; would you
22 agree?

23 **A.** Yes.

24 **Q.** Just putting the OSA to one side, was there an earlier
25 case for putting in some sort of system of regulation

204

1 for this sort of material?

2 **A.** The case was there. The solution was the Online Safety
3 Act.

4 **Q.** Thank you. What about the provisions for video sharing
5 platforms under the Communications Act. Are you able to
6 comment on whether there was any thought about making
7 that wider in scope?

8 **A.** By the time that legislation was in force, which
9 I believe was November 2020, we were quite far down the
10 path of online safety. We published a Green Paper and
11 White Paper, both of which indicated our Government's
12 intention to be more fulsome than AVMSD.

13 **Q.** I want to move on, please, to the Bishop Mar Mari
14 Emmanuel video. We heard from DCI Pye that AR carried
15 out searches on X for the stabbing of Bishop Mar Mari
16 and that the MerPol officer who replicated those
17 searches after the attack found that those searches led
18 to videos of the stabbing on X.

19 I think that the question is whether hosting this
20 video in 2024 was consistent with the fragmented system
21 of regulation that was in place at the time. The first
22 question in answering that is whether the content was
23 illegal, correct?

24 **A.** Correct.

25 **Q.** And, as I've said, you have, I think, fairly demurred
205

1 to this content?

2 **A.** Yes. In the absence of powers of regulation, all we
3 could do was ask.

4 **Q.** Thank you. Can we have that letter up, please. It's
5 HOM000092. It is dated 24 January 2025. Just while
6 that's pulled up, are you able to explain why it was
7 sent in January of 2025?

8 **A.** No, I'm not. Sorry.

9 **Q.** We see the letter, just reading the first paragraph:

10 "This week the Home Secretary announced a Public
11 Inquiry [that might be our clue perhaps] into the
12 failures that led to the Southport attack. As the Prime
13 Minister said, there are grave questions to answer,
14 including about how easy it was for the Southport killer
15 to access violent online content in the years, and
16 indeed days, before the horrific murder of three young
17 girls."

18 Could we zoom out because there's I think then a bit
19 of description about the measures in the next few
20 paragraphs about the Online Safety Act that we will come
21 to.

22 Can we look please then at the penultimate paragraph
23 and the paragraph below. There is a reference there to
24 the Al-Qaeda training manual and a reference to the fact
25 that possession of this document is a criminal offence
207

1 from answering that in terms of saying it's not DSIT's
2 role to determine whether it was illegal, correct?

3 **A.** Yes.

4 **Q.** I think you say that because X decided to continue
5 hosting the video, your analysis is that they determined
6 that it was legal because clearly it had been brought to
7 their attention; is that right?

8 **A.** Yes.

9 **Q.** Thank you. As we covered, because the video might be
10 defined as legal but harmful, we then come to the
11 question as to whether it was in line with X's terms of
12 service to keep it up; is that right?

13 **A.** Yes.

14 **Q.** At that time, DSIT had no powers, and nor did anyone
15 else in HMG, to remove the video; is that right?

16 **A.** Yes.

17 **Q.** And there was no provision to suggest that X was failing
18 in meeting any sort of regulatory obligations by
19 continuing to host it, correct?

20 **A.** Correct.

21 **Q.** After the attack, one of the responses by DSIT and the
22 Home Office was a joint letter which was sent by the
23 Home Secretary and the Secretary of State for DSIT. Was
24 that thought to be the best, can I put it this way,
25 leverage that DSIT and the Home Office had in relation
206

1 under Section 58 of TACT 2000 and, indeed, AR went on to
2 be prosecuted for that.

3 There is a request we see, I think, in the last line
4 to "swiftly remove any unlawful material on this list
5 available to your services". Is that the sort of
6 notification that should have been sufficient to require
7 a platform to remove material?

8 **A.** The letter doesn't determine that something is illegal,
9 although it is clear that some of it was -- is illegal
10 under TACT. So it would certainly be enough to get the
11 platforms to look carefully at that material.

12 **Q.** But what is it that sort of starts, puts the platform on
13 notice formally that they have to take an item down?

14 **A.** It is the clarity about the criminal offence.

15 **Q.** Thank you.

16 Could we move over the page please and just expand.
17 It moves on then to the video of the Bishop Mar Mari
18 Emmanuel stabbing and it says:

19 "This video has been removed in Australia following
20 the issuance of a clause 1 removal notice."

21 I think we will hear from Ms Khananisho from X
22 tomorrow but, is this right: that wasn't the ongoing
23 status quo?

24 **A.** That is right. My understanding is that it was removed
25 initially and then came back, was put back up on the
208

1 platform.

2 **Q.** Thank you. We'll hear about X's litigation in Australia
3 about that tomorrow. The letter goes on:
4 "However, it is still available to view in the UK.
5 We are therefore urgently asking you to ensure this is
6 removed from your platforms to ensure that it is not
7 used to inspire other attacks.
8 "This trial has laid bare the potential consequences
9 of failing to act on such content. We would now urge
10 you to urgently review again the specific content
11 accessed by [AR] and the options available to you to
12 remove all instances of this specific material found to
13 be materially relevant in this tragic case present on
14 your services."
15 We see there the rationale for urging this to be
16 taken down, correct?
17 **A.** Yes.
18 **Q.** In terms of responses that were received from social
19 media companies, do I summarise this correctly: Meta and
20 TikTok replied saying that the video had been removed
21 from their services?
22 **A.** Yes.
23 **MR BOYLE:** Sir, those letters are at HOM000194 and
24 HOM000193.
25 I think TikTok also confirmed removal of the manual
209

1 however been marked with a sensitive content warning in
2 response to X UK law enforcement requests."
3 I think we see then the reference to the litigation
4 in Australia, correct, in the next paragraph?
5 **A.** Yes.
6 **Q.** We then see if we look, same page, looking at the fifth
7 substantive paragraph and below:
8 "X has clear policies ... we also recognise that
9 sometimes it may be in the public interest to allow
10 people to view posts where this directly contributes to
11 understanding or discussion of a matter of public
12 concern.
13 "We uphold it is in the public's interest to view
14 this footage should they wish to do so. Additionally,
15 the bishop himself has expressed that the public should
16 be allowed to see the footage."
17 Finally, if we could just move over to the final
18 page, we see "Thank you for the correspondence", and
19 that the letter is just signed from X.
20 You say in your statement that DSIT has
21 a constructive relationship with the major platforms
22 which have the largest reach in the UK. So that's
23 paragraph 129. But would you agree that, at least in
24 relation to X, this wasn't an example of that in action?
25 **A.** No, I'm not sure that I would. I'm not sure that
211

1 and Meta said that it would remove elements of the
2 original Al-Qaeda manual relating to poisons or
3 explosives, correct?
4 **A.** Yes.
5 **Q.** Can we have up, please, the X response, HOM000196.
6 Thank you. So we have the response there. I think if
7 we look at the fourth paragraph, the letter from X says:
8 "We are committed to being fair, informative,
9 responsive, and accountable ensuring that our measures
10 are targeted and proportionate."
11 And that X takes its:
12 "... responsibility to combat terrorism and violent
13 extremely seriously."
14 Can we turn over the page, please. Looking at the
15 bottom of the page, I think that we see an explanation
16 that the training manual would likely be enforceable
17 under X's policies, correct?
18 **A.** Yes.
19 **Q.** If we turn over the page to page 3, please, looking then
20 at the response to the footage of the terrorist knife
21 attack on Bishop Mari Emmanuel, we see in the second
22 substantive paragraph, last sentence or, sorry, two
23 sentences:
24 "The content reported has not been found to be in
25 violation of the X terms of service. The material has
210

1 personally I agree with what -- the conclusion that they
2 have come to but they are operating within their own
3 terms and conditions and with the regulatory framework
4 that exists.
5 **Q.** So it wasn't a breach of regulation for them to do this
6 at the time but the letter was actually an attempt to
7 get them to take it down regardless of the regulatory
8 position, wasn't it?
9 **A.** Yes.
10 **Q.** And it made reference to the linking of the video to
11 this attack?
12 **A.** Yes.
13 **Q.** You said that you didn't agree with the conclusion. Are
14 you just able to expand on that?
15 **A.** Personally I have seen the video and it is horrific. So
16 I can absolutely understand why the then Secretary of
17 State and the Home Secretary asked X to remove it. So
18 I am deeply sympathetic to that point.
19 **Q.** From DSIT's perspective, this response was
20 disappointing, to put it mildly?
21 **A.** Yes.
22 **Q.** It is clear from the letter that this response was not
23 what DSIT was seeking X to do?
24 **A.** Correct.
25 **Q.** But was DSIT at that time able to do anything about the
212

1 response?

2 **A.** No.

3 **Q.** The letter refers to a sensitive content warning that X

4 put over the video, and we will hear more detail about

5 this tomorrow, but is this right: that meant that an

6 under 18 shouldn't be able to access the video?

7 **A.** Yes.

8 **Q.** Were you aware of that?

9 **A.** Yes.

10 **Q.** But is this right: at that time, before the OSA had come

11 into place, there were no requirements on the way in

12 which a social media company had to determine someone's

13 date of birth?

14 **A.** Correct.

15 **Q.** So I think at that time the measures X had was simply

16 requiring someone to enter their date of birth; is that

17 right?

18 **A.** Yes.

19 **Q.** We know that, although we don't have a date of birth in

20 the X material, we know that AR gave a false date of

21 birth to Meta in which he effectively suggested he was

22 18-year old, which presumably would have bypassed the

23 measures in place on Meta?

24 **A.** Yes.

25 **Q.** So the response of X in this letter certainly wasn't

213

1 adults, correct?

2 **A.** Yes.

3 **Q.** Although it is also true to say that the Online Safety

4 White Paper, in April 2019, said that most children had

5 a positive experience online; is that right?

6 **A.** Yes.

7 **Q.** In terms of the steps that were taken to implement that,

8 that White Paper was April 2019. We have already

9 covered, I think, that the Act received royal assent in

10 October 2023. Are you able to help us with the

11 four-year period from that White Paper announcing the

12 new regulatory framework to it actually coming into

13 force?

14 **A.** There were -- there was a response -- consultation

15 response to the White Paper. There was then a draft

16 Online Safety Act that had pre-legislative scrutiny and

17 then the passage of the Bill itself was long and

18 slightly fraught.

19 **Q.** Why was it fraught?

20 **A.** It's a deeply contentious subject and the issue that we

21 kept coming back to, that Parliament kept coming back

22 to, was the balance between protections online and

23 freedom of expression.

24 **Q.** I think is this also right, you talk about a level of

25 Government churn as well, providing a challenge. So

215

1 a whole answer to the risk that children might view this

2 video; would you agree?

3 **A.** Yes.

4 **MR BOYLE:** Sir, we have nearly been going for an hour and

5 a half, and that's probably a good time to take a short

6 break, if we can, we're making good progress.

7 **SIR ADRIAN FULFORD:** Can I look at the stenographer: 5 or 10

8 minutes?

9 10. We will sit again at 5.05 pm.

10 **(4.55 pm)**

11 **(A short break)**

12 **(5.05 pm)**

13 **SIR ADRIAN FULFORD:** Yes, Mr Boyle.

14 **MR BOYLE:** Ms Connolly, I think I asked you about the

15 letter. I think we saw that it implied that the Inquiry

16 had been announced on that date. I think it also came

17 the day after AR's conviction. So that was my

18 oversight.

19 Can we move onto the Online Safety Act, finally,

20 please. You have given very helpfully a long background

21 to the introduction of the OSA in your statement, as

22 well as in the chronology. Can I summarise it as

23 follows: there were quite a considerable series of

24 papers and reports from 2017 onwards that raised

25 significant issues with online harms for children and

214

1 I think you say that when Mr Sunak became Prime Minister

2 he changed the way in which the Act worked. Do

3 I oversimplify that?

4 **A.** A little. There was change, there was churn, there were

5 seven Secretaries of State between 2016 and 2023. So

6 obviously each one required briefing, had views, we

7 discussed the policy positions with the new ministers;

8 that took some time. In addition, you are correct,

9 when -- it was actually Liz Truss became Prime Minister,

10 the new Secretary of State at that point, Michelle

11 Donelan, wanted to make some slightly more significant

12 changes to the legal but harmful portions of the Act,

13 which we then worked through and brought in -- made the

14 changes and recommitted that part of the Act when Rishi

15 Sunak was Prime Minister.

16 **Q.** Putting the political challenges to one side, from the

17 DSIT's own perspective was there anything that could

18 have been done from the officials' perspective, do you

19 think, to speed up the process?

20 **A.** I genuinely don't think there was.

21 **Q.** After the Act came into force, as we've already covered,

22 Ofcom had to provide codes of practice and I think the

23 first of those codes, which was illegal online harms,

24 came into force in March of this year, and in relation

25 to protection of children in July of this year; is that

216

1 right?

2 **A.** Yes.

3 **Q.** So we have another almost year and a half for the first

4 code to come into place and a little longer in relation

5 to children, correct?

6 **A.** Yes.

7 **Q.** But I think you tell us that the legislation required

8 Ofcom to go through a series of steps to put those codes

9 into practice; is that right?

10 **A.** Yes.

11 **Q.** Did DSIT have any concerns about the time that it took

12 Ofcom to do that?

13 **A.** No, we worked closely with Ofcom. It's a challenging

14 regulatory statement. It's very different to the kind

15 of thing that we've done before in this phase. So it

16 did take Ofcom some time to do what was required.

17 **Q.** Ofcom now has a very expanded role in terms of

18 regulation of online material. Are you satisfied that

19 Ofcom is suitably resourced to be able to carry out its

20 new role?

21 **A.** Yes. Ofcom received 281 million from 2020 to the end of

22 this financial year. We started funding it unusually

23 before the regulatory regime, indeed before the Bill was

24 passed. So, yes, I think it is well resourced.

25 **Q.** From the White Paper to the codes being enforced was

217

1 certain defined categories of illegal content, correct?

2 **A.** Correct.

3 **Q.** So these were the first measures to require a platform

4 to have its own system for detecting that sort of

5 information; is that right?

6 **A.** Exactly.

7 **Q.** Also we see the duty to take that content down swiftly

8 at (c). Could we move over the page, please. Then we

9 see some of the measures for children. So:

10 "A duty for all regulated services to assess whether

11 children are likely to access the service."

12 Then if the service is:

13 "... likely to be accessed by children, to assess

14 the risk of children encountering harmful content ..."

15 Then we see, I think, three duties on social media

16 platforms likely to be accessed by children. The first

17 is to:

18 "Put in place proportionate systems and processes

19 designed to prevent children of any age from

20 encountering certain types of content, which the OSA has

21 defined as primary priority content."

22 Pausing here. This is not illegal content, correct?

23 It is what would be called "legal but harmful"?

24 **A.** Correct.

25 **Q.** So I think primary priority content includes

219

1 around six years. Was that a satisfactory timeframe

2 from your perspective?

3 **A.** It would have been wonderful if we could have done it

4 faster.

5 **Q.** Of course, this wouldn't have been known to politicians

6 or legislators but, if the Act had been passed around

7 a year earlier, it might have prevented AR from

8 accessing the Bishop Emmanuel video; is that right?

9 **A.** Yes.

10 **Q.** Could we have up, please, Dr Higham's statement from

11 Ofcom. It is OFC000002. Ms Connolly, you have provided

12 a lot of helpful detail about the OSA, I'm just going to

13 Dr Higham's statement as a brief summary of the measures

14 that are in place in the interests of time.

15 Could we have page 9, please, and paragraph 36. So,

16 this sets out the duties on regulated service providers.

17 Just deciphering some of the language that's used here.

18 A user to use a platform: that would include a social

19 media platform; is that right?

20 **A.** Exactly.

21 **Q.** It puts a duty on a social media platform, for our

22 purposes, to assess the risk of illegal content and to

23 put in place proportionate systems and processes to

24 reduce the risk of individuals encountering types of

25 illegal content defined by the Act, and there are

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1 pornography, content relating to suicide and self harm

2 or material relating to eating disorders; is that right?

3 **A.** Yes.

4 **Q.** The next bullet point is perhaps the most relevant for

5 our purposes:

6 "Put in place proportionate systems and processes to

7 protect children in age groups judged to be at risk of

8 harm from other content that is harmful to children from

9 encountering it by means of the service."

10 So we have there harmful material which is not

11 primary priority content; is that right?

12 **A.** Yes.

13 **Q.** Within that basket of material, that includes what's

14 called priority content, correct?

15 **A.** Yes.

16 **Q.** Thank you. That includes content which encourages,

17 promotes or provides instructions for acts of serious

18 violence --

19 **A.** Yes.

20 **Q.** -- or content which depicts real or realistic serious

21 violence against a person, depicts real or realistic

22 serious injury of a person in graphic detail; is that

23 right?

24 **A.** Yes.

25 **Q.** So, the OSA requires platforms to have proportionate

220

- 1 systems and processes to protect children from accessing
2 that material, correct?
- 3 **A.** Correct.
- 4 **Q.** We can see from this that the legal but harmful
5 protections are for children, not for adults, correct?
- 6 **A.** Not quite. You have -- we thought of it much more as
7 three separate buckets when we talked about -- when we
8 were doing the Bill. There was the illegal harms, there
9 was legal but harmful, we then had a separate bucket for
10 children. So you were right that it is legal but it is
11 worth pausing because the protections -- and perhaps you
12 will come onto this -- but the protections around age
13 verification and age estimation apply for children.
- 14 So we deliberately dealt with it slightly
15 differently from the rest of legal but harmful. It is
16 also worth saying that, through the passage of the Bill,
17 Parliament was very clear that measures were children
18 were different from legal but harmful.
- 19 **Q.** Thank you.
- 20 So, there was, I think, a lot of political debate
21 about whether adults should be protected from legal but
22 harmful material; is that right?
- 23 **A.** Correct.
- 24 **Q.** Are you able to explain briefly the arguments that were
25 at play there?

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- 1 **Q.** Perhaps putting it more directly, to the context of this
2 Inquiry, what about the risk presented by someone who is
3 violence fixated?
- 4 **A.** Violence fixated is a matter for the Home Office. We
5 didn't, through the passage of the Bill, consider that
6 in any detail. We focused very strongly on the 18
7 cutoff.
- 8 **Q.** One can understand the debate about free speech but is
9 there the technological capability to consider the
10 position for different approaches to adults of different
11 classes or that prevent certain risks of harm?
- 12 **A.** Perhaps but the devil would be in the detail, I think.
- 13 **Q.** What about persons who might have been already
14 identified as violence fixated?
- 15 **A.** Again, I think it would depend on exactly what you
16 wanted to do.
- 17 **Q.** Is that something that you think is potentially
18 feasible?
- 19 **A.** I think I'd want to work very closely with the Home
20 Office to determine what the options were.
- 21 **Q.** I think you said that that is an area for the Home
22 Office to work on. We know that the Home Office is
23 doing work on violence-fixated individuals. Do you have
24 any awareness of that work?
- 25 **A.** No.

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- 1 **A.** Freedom of expression. So there was a strong contingent
2 in Parliament and within ministers who felt that, for
3 an adult, it was right that they could choose to see
4 something but that material shouldn't be -- they
5 shouldn't be protected from seeing harmful content by
6 the State.
- 7 **Q.** So in the case of the Bishop Emmanuel video, we've seen
8 from the letter that that remains viewable to adults on
9 X. But we know that AR carried out the attack very
10 shortly before his 18th birthday, so even if the OSA had
11 been in place at that time, with an additional
12 age-verification measure, it would have been accessible
13 to him within a period of weeks; is that right?
- 14 **A.** Yes.
- 15 **Q.** Is that of concern to DSIT?
- 16 **A.** There was a very clear Parliamentary steer as the Bill
17 went through that, for lots of things, 18 is the cut
18 off, when you become legally an adult and, therefore --
19 your ability to decide for yourself, what you want to
20 see is, rightly -- you have the right to choose at 18.
21 So the same is true in this context.
- 22 **Q.** So I think you talk in your statement about the idea of
23 was a consideration given to a different position for
24 vulnerable adults, for example?
- 25 **A.** Briefly.

222

- 1 **Q.** Is that something that DSIT could usefully link in on,
2 do you think?
- 3 **A.** Potentially.
- 4 **Q.** Is that something you might take away?
- 5 **A.** Happy to.
- 6 **Q.** Thank you. I mentioned age verification, as did you.
7 So under the Act now, a platform which hosts content
8 which is legal but harmful to children has to have
9 what's called highly effective age assurance in place;
10 is that right?
- 11 **A.** Yes.
- 12 **Q.** That includes age assurance to prevent access to the
13 priority content that we discussed, which would be
14 material depicting or encouraging serious violence or
15 injury, correct?
- 16 **A.** Yes.
- 17 **Q.** Thank you. In practice, what does highly effective age
18 assurance involve?
- 19 **A.** Ofcom has set out quite detailed guidance earlier this
20 year, which says exactly what is included or not. There
21 are broadly two kinds: age verification, in which an age
22 is verified -- there are lots of ways to do that, like
23 credit card data, driving licences; or age estimation in
24 which an age is estimated. That technology might be
25 facial recognition or the way that someone moves. It's

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1 getting better. But, as I said, Ofcom has published two
 2 quite detailed documents on what constitutes age
 3 verification, age estimation.
 4 **Q.** Thank you. So, previously, as we said, AR simply had to
 5 enter a date of birth on X and I think we'll hear
 6 tomorrow that there are age-estimation tools used by X
 7 but also can be a requirement for a live selfie or the
 8 provision of a Government-issued ID. Is that a change
 9 that the Online Safety Act has brought about?
 10 **A.** Yes.
 11 **Q.** I'm slightly simplifying -- I think perhaps more than
 12 slightly simplifying -- the Online Safety Act because it
 13 has different measures for different sizes of platform,
 14 correct?
 15 **A.** Yes.
 16 **Q.** It's only platforms of a certain size which are obliged
 17 to introduce all the measures that Ofcom proposes?
 18 **A.** Yes, that is correct. But for illegal content and for
 19 children, those duties apply to every platform.
 20 **Q.** Thank you. That is to all mainstream social media
 21 providers, is it?
 22 **A.** Yes.
 23 **Q.** Thank you. Enforced by Ofcom?
 24 **A.** Yes.
 25 **Q.** Does DSIT have confidence that those provisions are
 225

1 intended to -- the Act is intended to, over a period of
 2 time, make the internet safer and the best way to do
 3 that was to make sure that those processes worked.
 4 **Q.** So it creates the framework, it doesn't seek to search
 5 out and take down material; is that right?
 6 **A.** Exactly.
 7 **Q.** I think it's also, is this right -- of course, we have
 8 talked about social media platforms -- but also search
 9 services and services that host pornography, correct?
 10 **A.** Correct.
 11 **Q.** So it's those three areas that come within the Online
 12 Safety Act?
 13 **A.** Correct.
 14 **Q.** I said before that we don't know where AR found a large
 15 portion of this material but it doesn't seek to regulate
 16 the wider depths, can I put it that way, of the
 17 internet?
 18 **A.** That is correct. I would just point out you have
 19 shortened user-generated services to social media.
 20 You're right, social media is user generated, but it's
 21 not just that. There may be other things.
 22 **Q.** Can you expand on that?
 23 **A.** So any platform that has a chat function is
 24 user-generated content. Nowadays, that's quite a lot.
 25 So, although the focus is the large social media
 227

1 being complied with?
 2 **A.** Yes, though you will want to ask Ofcom that question.
 3 **Q.** So, in terms of the Act, the duty is to take
 4 proportionate measures to protect children from
 5 encountering harmful content, correct?
 6 **A.** Yes.
 7 **Q.** It's not to actually stop access?
 8 **A.** Correct.
 9 **Q.** In terms of Ofcom's role, they can assess whether the
 10 providers follow the correct approach but they are not
 11 expected to reach a definitive conclusion on each piece
 12 of material nor substitute their own judgement; is that
 13 right?
 14 **A.** Yes.
 15 **Q.** Are you able to explain why that is the measures that
 16 are in place?
 17 **A.** Volume and speed. There's a statistic that we used,
 18 certainly when the act was going through Parliament,
 19 that there's 500 hours of footage uploaded to YouTube
 20 every minute. That means that any regulator that is
 21 seeking to regulate all of that is bound to be judged,
 22 Parliament judged, to be overwhelmed by material. So
 23 the act focuses on systems and processes, not individual
 24 pieces of content. But the individual bits of content
 25 might indicate a system and process failure but it was
 226

1 platforms, many companies can fall into scope and,
 2 indeed, that was one of the areas of pressure as we took
 3 the Bill through Parliament, whether or not the scope
 4 was too large.
 5 **Q.** There are, would it be fair to say, significant
 6 limitations on the reach of the Act. In your view, is
 7 it strong enough to ensure that children are adequately
 8 protected from harmful content online?
 9 **A.** There are, I'm sure, areas that it could go further. It
 10 is the most significant step in the right direction that
 11 there has been and we should always look to improve but
 12 it is a strong step in the right direction.
 13 **Q.** In terms of looking to improve, what areas are you
 14 considering at DSIT?
 15 **A.** At the moment, we are focused on making sure that it is
 16 properly implemented and it's sort of fully functional
 17 and then, as that happens, and as new harms inevitably
 18 emerge or new technology inevitably emerged, we will
 19 work with Ofcom to look at whether or not more powers
 20 need to be brought in.
 21 **Q.** Just keep your voice up. Sorry, I'm guilty of the same
 22 and we're late in the day. I have three brief discrete
 23 topics just to go through, please, with you now.
 24 The first is algorithms, and so the risk on social
 25 media that algorithms push more violent content at
 228

1 someone that has taken an initial interest, what does
2 the OSA seek to do about that?
3 **A.** If they are a child, the algorithm should not push any
4 content that is violent to them. If they are an adult,
5 then there is choice. So what the Online Safety Act
6 does about that legal but harmful bucket is effectively
7 try and give as much choice as possible, so that -- we
8 called it user empowerment tools -- the user is
9 empowered through a bunch of choices that are given to
10 them by the platforms proactivity to not engage with
11 content.

12 The challenge is, as you have indicated, if someone
13 is inclined to look at it and seeks it out, then the
14 Online Safety Act will give limited protection.

15 **Q.** Thank you. The next is virtual private networks or
16 VPNs. We know AR used a number of VPNs through the
17 evidence of DCI Pye. Obviously, those can be used to
18 bypass geographical restrictions. So they could be
19 used, couldn't they, to bypass the age verification
20 restrictions that have resulted from the Act?

21 **A.** They could.

22 **Q.** So, where illegal or harmful content is accessible
23 through the VPN there is no measures in place to stop
24 that; is that right?

25 **A.** That's correct. We debated it briefly or it was debated
229

1 freedom of privacy versus protection from harm, and that
2 is where Parliament came out.

3 **Q.** Is DSIT looking into solutions to the ability to
4 manoeuvre around the OSA restrictions or is the position
5 that that was the conclusion reached?

6 **A.** So, I know Ofcom is looking at sort of usage and trying
7 to do some research into it. I imagine it is something
8 that we will continue to look at.

9 **Q.** Obviously, the risk might be that material is accessible
10 to people in other countries. Is there any sort of
11 steps being taken to draw a kind of international
12 consensus or set of measures that might address that?

13 **A.** We talked to a series of countries about online safety,
14 and have done for years. The Australians have an Online
15 eSafety System Commissioner. The Irish -- there's also
16 EU, which is broadly in the same sort of space. So we
17 talk to other countries but not quite an international
18 consensus.

19 **Q.** The final topic was the role of parents. So we've heard
20 about the DfE position and the control in schools and
21 I think your answer would be that's not a DSIT issue in
22 terms of the measures that are in place but, at home,
23 obviously, it's parents who can play an important role
24 in supervising a child's online use. I think we can
25 take from their statements that AR's parents suggest
231

1 briefly during the passage of the Act. Again, it was
2 felt at that time that adults who wanted to use a VPN
3 should be allowed to use a VPN and there are
4 circumstances in which the uses of a VPN is perfectly
5 legitimate and, indeed, may be helpful, even for
6 children, in a child trying to look at material to get
7 help from an abusive situation. So there are instances
8 where a VPN might be entirely legitimate.

9 **Q.** Can you just help on what those are?

10 **A.** So if you had a child -- for instance -- there were two
11 different examples. If you had a child who wanted to
12 seek out material but perhaps didn't want a parent to
13 know -- fleeing abuse in a family or trying to seek out
14 private information -- then there may be circumstances
15 where it is legitimate for them to use a VPN to hide
16 their IP address.

17 The other example that was used in the Bill passage
18 was around journalists in war zones, or otherwise
19 hostile situations, who might legitimately want to mask
20 their whereabouts.

21 **Q.** But they wouldn't be using it in the UK would they?

22 **A.** The example that we used at the time: women fleeing
23 domestic violence. There may be instances where the
24 usage of a VPN is reasonable. The debate, as it went
25 through Parliament, was where did we want to come out on
230

1 that they had very limited visibility on AR's internet
2 use, for reasons that will be explored.

3 In terms of the position pre-OSA, there was no sort
4 of regulation or system in place to give parents the
5 ability to specifically take a role in their child's
6 internet use. Does the OSA affect the role of the
7 parent, in any way?

8 **A.** No.

9 **Q.** Is that something that DSIT is aware of and considering?

10 **A.** Yes, is the short answer. Media literacy is a big part
11 of this. Regulation, legislation, will, I think, only
12 take us so far. So supporting parents to be aware and
13 be active in their children's use of the internet is
14 important. We will publish a media literacy strategy at
15 some point over the next few months and, alongside that,
16 a campaign to support parents in doing so, so yes.

17 **MR BOYLE:** Thank you. If you could provide that to the
18 Inquiry that would be helpful.

19 Those are all my questions. Is there anything else
20 you wish to add?

21 **A.** No, I don't think so.

22 **MR BOYLE:** Thank you.

23 **Questioned by MR CHAPMAN**

24 **SIR ADRIAN FULFORD:** Yes, Mr Chapman.

25 **MR CHAPMAN:** Thank you. VPNs. A content provider serving
232

1 up harmful material, arguably, through a VPN: would they
 2 fall foul of the Act?
 3 **A.** It would depend, I think, on the VPN, where it was and
 4 what it was doing and was it in the UK -- I would have
 5 questions.
 6 **Q.** Suppose the VPN is in a very permissive country?
 7 **A.** But where is -- I think the answer to your question is
 8 it would depend, but the usage of a VPN -- if someone
 9 was in the UK trying to use a VPN in a permissive
 10 country and accessing other material or harmful
 11 material, then there would not be anything to stop that.
 12 **Q.** But am I right in saying this is a technical problem,
 13 that the content provider doesn't know who the ultimate
 14 user is?
 15 **A.** Correct.
 16 **Q.** So how could they fall foul of the Act?
 17 **A.** I'm not sure I understand the question.
 18 **Q.** Let me do it this way: supposing you are a child in the
 19 UK, you decide to access a VPN in a very permissive
 20 country. It's all encrypted. It goes to the VPN in the
 21 permissive country. That sends a request to the content
 22 provider. The content provider thinks, "I'm permitted
 23 to serve up content to that permissive country" --
 24 **A.** Correct.
 25 **Q.** -- "and I wouldn't know that it was going off to a UK
 233

1 **A.** Well, I would say that the Online Safety Act has made
 2 some changes and will continue to make some real changes
 3 to what children or adults in the UK are able to see.
 4 **Q.** But you saw the outcome of the litigation in Australia,
 5 which was that X ultimately prevailed, didn't it, in
 6 that litigation?
 7 **A.** Yes.
 8 **Q.** Isn't it right that the content providers are ultimately
 9 going to determine what is harmful or not?
 10 **A.** Not in the UK. In the UK, we have decided what is
 11 harmful for people to view here.
 12 **Q.** But you take the point about the VPN?
 13 **A.** Yes.
 14 **Q.** Would I be right in saying that big content providers
 15 emphasise freedom of expression in general?
 16 **A.** By "content provider", do you mean the social media
 17 platforms?
 18 **Q.** Yes.
 19 **A.** Okay. Some do more than others.
 20 **Q.** You wouldn't say there's a general tendency. We hear
 21 people like Elon Musk who are very keen on freedom of
 22 expression?
 23 **A.** Yes.
 24 **Q.** So is the general point true, that they tend to
 25 emphasise freedom of expression?
 235

1 child"?
 2 **A.** Correct.
 3 **Q.** So is that an offence under the Act?
 4 **A.** No, it's not an offence under the Act.
 5 **Q.** Sorry?
 6 **A.** It's not, no.
 7 **Q.** How could they be liable, if they can't even know where
 8 the content's going?
 9 **A.** Because they are in another country, I assume, in your
 10 example.
 11 **Q.** Supposing the harmful content is in the USA?
 12 **A.** It would still not be an offence under the Act.
 13 **Q.** But how do you prove it? How would you prove they
 14 knew --
 15 **SIR ADRIAN FULFORD:** You're saying it's not an offence under
 16 the Act. There is a no in there.
 17 **MR CHAPMAN:** I'm sorry. Understood.
 18 Australia was a classic example, was it not, of the
 19 litigation in Australia. I don't think the material
 20 was, in fact, ever taken down, was it, it was just
 21 geoblocked?
 22 **A.** That's my understanding.
 23 **Q.** Is the reality this: that although the UK leads the
 24 world in this type of legislation, it will only be
 25 effective so far as other people follow?
 234

1 **A.** Yes.
 2 **Q.** And these are often very large companies --
 3 **A.** Yes.
 4 **Q.** -- with large commercial interests?
 5 **A.** Indeed.
 6 **Q.** And they can pay for litigation?
 7 **A.** Hmm.
 8 **MR CHAPMAN:** And lobbying?
 9 All right, thanks.
 10 **Questioned by THE CHAIR**
 11 **SIR ADRIAN FULFORD:** The debate around VPNs, did that come
 12 down to a stark choice as to whether to permit them or
 13 not to permit them or was it more nuanced than that?
 14 **A.** The honest answer is that I don't recall it being a huge
 15 part of the debate through Parliament. It was
 16 discussed. Certainly, it was discussed with ministers,
 17 but it wasn't the focus, I think I would say, of the
 18 debate in Parliament.
 19 **SIR ADRIAN FULFORD:** We have kept you waiting for a very
 20 long time. Thank you very much for your attendance.
 21 I think we are now going to rise, Mr Boyle; is that
 22 right?
 23 **MR BOYLE:** Yes.
 24 **SIR ADRIAN FULFORD:** What time tomorrow?
 25 **MR BOYLE:** Sir, 10 o'clock please.
 236

1 SIR ADRIAN FULFORD: Certainly. I will rise until 10.00 am
 2 tomorrow.
 3 (5.37 pm)
 4 (The Inquiry adjourned until 10.00 am the following day)

1 had unexpectedly got into a different taxi [LCC001773
 2 (witness statement of Joanne Hodson) at para. 58]. That
 3 second taxi then did not arrive at Acorns [LCC001773 at
 4 para. 58].
 5 5.The school then spoke with Alphonse R [LCC001773
 6 at para. 59]. Both he and the school made unsuccessful
 7 efforts to find out from local taxi companies where this
 8 taxi -- which they found out had been booked by AR the
 9 previous night -- had taken him [LCC001773 at para. 59].
 10 6. The Acorns School decided to call Lancashire
 11 Constabulary, because they were concerned about the risk
 12 posed by AR given his history at the Range [LCC001773 at
 13 para. 59]. Lancashire advised the Acorns to contact the
 14 Range in case AR showed up there, which Acorns did
 15 [LCC001773 at para. 59].
 16 7. A further call from Acorns was then received
 17 from Alphonse R who informed them that he had been
 18 contacted by the Range, who informed him that AR was on
 19 the premises and Merseyside Police were in attendance
 20 [LCC001773 at para. 60].
 21 8. Acorns then called Lancashire Police back to
 22 inform them of this latest conversation with Alphonse R
 23 [LANC000073 (Acorns/Lancs Constabulary call transcript),
 24 p.1]. Within that call, Ms Martindale, the Acorns
 25 School Business Manager, who was calling from the Acorns

1 NOTE FROM COUNSEL TO THE INQUIRY
 2 CORRECTING VARIOUS MATTERS RAISED
 3 IN CTI'S OPENING STATEMENT

4 1. The purpose of this note is formally to record
 5 two sets of corrections to our Opening Statement. The
 6 first arises from an inadvertent elision on our part of
 7 different pieces of evidence, which justifies
 8 correction. The second arises from errors in the
 9 information that Amazon provided to the Inquiry. The
 10 published transcript of our opening will be overlaid
 11 with a cross-reference to this correcting note.

12 2. In our opening, in relation to AR's assault on
 13 a pupil at the Range High School on 11 December 2019, we
 14 said that "Lancashire Constabulary were also informed by
 15 Acorns School that AR was travelling to the Range from
 16 which he had previously been excluded and that he had
 17 a knife and was "hell bent" on causing harm. In turn,
 18 Acorns School had got this information from a call from
 19 AR's father."

20 3. We apologise for the fact that this was to take
 21 matters too shortly and risked inadvertently giving
 22 an inaccurate impression in relation to Alphonse R, AR's
 23 father. The fuller and correct position is as follows.

24 4. On 11 December 2019, a taxi company, booked to
 25 take AR to the Acorns School, informed Acorns that AR

1 stated: "He's turned up at his ... old school and
 2 they've called the police ... he was, he was quite like
 3 ... hellbent on, on teaching staff and causing them harm
 4 ... so then we, we thought he may turn up ... at his old
 5 school so I was gonna pass that over to you and then
 6 dad's rang us to tell us that they've actually called
 7 the police as [AR], they've got [AR] at the minute
 8 I think" [LANC000073, p.1].

9 9. Later in the call, the operator for Lancashire
 10 Police asked Ms Martindale what the Acorns concern was
 11 about (in terms of AR attending the Range school)
 12 Ms Martindale replied "... the reason he got permanently
 13 excluded from the Range High School is he took a knife
 14 into school ... and then since then he, he came to us
 15 ... He's quite hellbent on causing damage to ... like
 16 establishments, like educational establishments ..." [LANC000073, p.4-5].

17 10. Accordingly, though there was telephone contact
 18 between Acorns and Alphonse R about this matter prior to
 19 Acorns contacting Lancashire Constabulary, it was the
 20 school's own well-founded concerns about the risk posed
 21 by AR that led to them doing so -- they were not merely
 22 passing information on from Alphonse. It is right to
 23 acknowledge that the source of the "hellbent" comment
 24 appears on its face to have been Ms Martindale passing
 25

1 on their overall impression, rather than her citing
2 anything said specifically or directly by Alphonse R.
3 Alphonse R will of course give his own account of these
4 events.

5 11. In our opening statement we stated that:
6 (i) On 4 March 2022, AR had ordered archery
7 material from an Amazon seller Top Archery which
8 comprised of 2 sets of "DZGN Carbon Hunting Arrows with
9 Removable Tips" along with a "53" Traditional Recurve
10 Wooden Handmade Mongolian Horsebow Hunting Bow"; and
11 (ii) On 28 March 2022, AR ordered further archery
12 material - arrows and an archery bow, from another
13 Amazon seller, Recomoney EU.

14 12. This information was drawn from AR's Amazon
15 order history data which was disclosed to the Inquiry in
16 a spreadsheet by Amazon [AMA000056].

17 13. On 22 September 2025, Amazon wrote to the
18 Inquiry to inform it that a clerical error had occurred
19 which affected the accuracy of some of the data in the
20 spreadsheet disclosed to the Inquiry.

21 14. A third witness statement from Mr John
22 Boumphrey, the Vice President of Amazon UK, was produced
23 (dated 29 September 2025), at the Inquiry's request, to
24 explain the nature of the error and how this error came
25 about [AMA000110].

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1 stated, a "53" Traditional Recurve Wooden Handmade
2 Mongolian Horsebow Hunting Bow" was purchased from the
3 Amazon seller Top Archery on 4 March 2022, the "DZGN
4 Carbon Hunting Arrows with Removable Tips" purchased by
5 AR within the same order on the same date, were in fact
6 purchased from the Amazon seller Chuhuikang and not Top
7 Archery. Amazon's order data shows that both items were
8 marked on its systems as "returned/refunded";

9 20. Secondly, on 28 March 2022, AR placed an order
10 for arrows, a bow, and a duffel bag. The bag was
11 purchased from an Amazon seller, Recomoney EU, but the
12 arrows were purchased from a different Amazon seller,
13 Ping Jianqiang/Hunting Door, and the bow was purchased
14 from another Amazon seller, Jiankangyi/Top Archery.
15 Neither the arrows nor the bow were purchased from
16 Recomoney EU as was previously stated. Amazon's order
17 data shows that all of these items (ie the bow, arrows
18 and bag) were delivered and were not returned or
19 refunded.

20 21. As a result of this new information coming to
21 light, on 8 October 2025, the Inquiry sent requests for
22 witness statements to Chuhuikang, Ping Jianqiang/Hunting
23 Door and Jiankangyi/Top Archery. All of these Amazon
24 sellers appear to be based in China. Because the items
25 ordered by AR from these companies were arrows and

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1 15. Mr Boumphrey has explained that the spreadsheet
2 of AR's order history was manually created by Amazon and
3 an error occurred when seller information from Amazon's
4 system was copied into the spreadsheet which meant that
5 some of the sellers listed within the spreadsheet were
6 incorrect. In addition, Mr Boumphrey has also explained
7 that if AR purchased multiple items in the same order,
8 but cancelled or returned only one of the items in the
9 order, all items in the order were labelled within the
10 spreadsheet as either 'cancelled' or 'complete', which
11 was inaccurate.

12 16. Amazon have produced an updated version of the
13 spreadsheet [AMA000096] which corrects these errors.
14 Amazon has informed the Inquiry that these errors also
15 affected the spreadsheet disclosed to the Inquiry by
16 Amazon which set out the purchase history of AR and his
17 family members [AMA000049] and a corrected version of
18 this spreadsheet has now been disclosed [AMA000097].

19 17. On behalf of Amazon, Mr Boumphrey has
20 apologised for the fact that Amazon inadvertently
21 provided inaccurate information to the Inquiry.

22 18. As a result of this correction by Amazon, it is
23 necessary to make two corrections to the opening
24 statement of Counsel to the Inquiry:

25 19. First, while it is right that, as previously
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1 an archery bow (which was not a crossbow), these were
2 not age verified items that could not be sold to
3 under 18s.

4 22. The Inquiry has asked these sellers whether
5 they knew that the person ordering these items was
6 a child using a pseudonym email address, whether the
7 packaging contained any warning, and whether any age
8 check was carried out even though it was not a legal
9 requirement. We have also asked what legitimate purpose
10 a child would have with this type of archery equipment.
11 The Inquiry asked to receive the requested statements by
12 22 October 2025.

13 23. To date, the Inquiry has not received
14 a response from these sellers. Since they are based in
15 China, we have no powers of compulsion. The Inquiry
16 will update core participants if it does receive
17 a substantive response from any of these sellers.

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