IN THE SOUTHPORT PUBLIC INQUIRY
SIR ADRIAN FULFORD

Phase 1 Closing Statement on behalf of
Leanne Lucas
Heidi Liddle
John Hayes

Summary

1. In making these submissions we are mindful of the 'terms of reference'[1] and the three objectives of any Public Inquiry:
    a. To establish a definitive factual narrative,
    b. To identify failures and accountability,
    c. To make recommendations for future improvements, and to prevent similar failures or wrongdoing, so far as is possible.

2. Where we propose recommendations, we are mindful that phase 2 is yet to come, but the line between phase 1 and 2 recommendations is likely to be blurred. So far as any proposed recommendations trespass on the remit of phase 2 we hope that they can assist in directing that work.

3. Our submission is set out in the following sections:
    a. Introduction
    b. John and the premises
    c. Leanne and Heidi
    d. Knife crime and control
    e. The parents and AR
    f. The services

Introduction

4. Leanne, Heidi, and John reiterate their clear understanding of the devastating consequences of the attack: the loss of life, the severe injuries, and the lifelong trauma inflicted on children, and their families. Their suffering is beyond comprehension, and not a day goes by where the three do not reflect on what has happened.

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[1] https://www.southport.public-inquiry.uk/terms-of-reference/

5. Leanne, Heidi and John are also victims and survivors of the attack. As the Inquiry has seen from their written statements, and their oral impact evidence, each has been very severely affected and their trauma persists. Leanne and John suffered severe and life-threatening physical injuries.

6. There can be no doubt that the attacker is solely responsible for the outrage which was visited on those attending the Hart Space on 29 July 2024. No one else knew or could have foreseen what happened. However, that does not mean that the actions or omissions of others could not have prevented the attack.

7. The events of the day have made Leanne, Heidi and John reflect on whether their actions or planning could have prevented or mitigated the attack. Each seek answers and accountability. They have each called for maximum openness, transparency, and candour from all who can assist the inquiry: witnesses, services, public authorities, retailers, social media and delivery companies, government, and the attacker's family. In looking at their own role, each has done their utmost to assist the Inquiry regarding the premises, risk assessments, organisation of the event, safeguarding, and the immediate response to the attack. However uncomfortable, they recognise the importance of the Inquiry carefully considering their roles and actions, as it must do for others.

8. The attack was remarkable for its senselessness and savagery. What followed has been remarkable for the misinformation and false narratives promulgated in the immediate aftermath which in turn led to the appalling racist violence and rioting which rocked not just Southport but many other places in the weeks after. Sadly, politically-motivated fake news has included victim-blaming in particular on social media, which has caused further substantial upset.

9. Whereas it is always the role of a Public Inquiry to allay public suspicion, there has rarely been an occasion where this has been more important. Through its thorough and comprehensive interrogation of the evidence the Inquiry now has the material to set out authoritatively what did and did not happen, what could and could not have been done differently, who and which services are accountable for failures and what needs to change.

10. From the perspective of the three adult survivors, they look forward to the forthcoming report and recommendations as an opportunity to put the record straight, make changes to minimise the possibility of recurrence of such horrific attacks, and to redress the abuse and victim-blaming which has been a feature of the aftermath to this point. They are confident that the evidence has shown that an attack of this nature, on an event of this sort, in a nondescript premises tucked away in an office complex, was unforeseeable, and no other reasonable steps could have been expected of them to prevent or mitigate the attack.

11. So far as the various public services are concerned, it is clear that the attacker's risk to others was well known at various points from at least October 2019 onward. Key issues for the Inquiry have been whether multi-agency collaboration operated

appropriately, and whether lack of resources for public services played a significant role.

12. In terms of interoperability, was there sufficient information-sharing, were IT systems fit for purpose and efficient, was there sufficient control and management of the known risks to others? Were known risks lost in the system because they were buried in other records without acute incidents being highlighted and apparent to new people coming into the case? Were multi-agency arrangements too often used to inappropriately offload known risks to other agencies? Were agencies too keen to reject their own involvement because the attacker's case did not sufficiently fit within their self-defined remit, hoping that other agencies would take responsibility? Was multi-agency working sufficiently solution-driven?

13. In terms of resourcing, unlike the deference by public law courts to the democratic arena, it is very much for a Public Inquiry to identify and bring to the fore the lack of public funding and the consequent stress that public services are under[2]. If it was not fit for purpose, or incapable of being shared or linked with other services, then the Inquiry should say so. If there were and are staffing shortages, or posts unfilled, which impacted on services' performance relevant to this case, then again, that must be highlighted. Unless it is, nothing will change.

14. From the outset, the Inquiry has demanded candour from all those involved in the events leading up to and the attack itself. In opening, on behalf of the three adult survivors, we noted disappointment at what we perceived to be a lack of candour from some of the public services involved. In evidence, there have been admissions that some of the written evidence had not acknowledged,or had minimised shortcomings. We urge the Inquiry to make clear conclusions on where this has happened. Minimisation before the Inquiry bodes ill for the response to what recommendations the Inquiry may make at its conclusion.

15. Continuing with the theme of minimisation, we recognise that there is no statutory or regulatory mechanism for ensuring that Inquiry recommendations are properly considered and actioned once the process comes to an end. We urge the Inquiry to adopt its own process for ensuring recommendations are carried forward, as has happened in a number of recent similar processes[3].

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[2] R (Smith) v Asst Dep Coroner for Oxfordshire [2011] 1 AC 1, at [127].

[3] The follow-on process of the Manchester Arena Inquiry is perhaps the best example, where senior leadership witnesses were recalled to give evidence on oath some months after the publication of the reports, as to what their authority or corporation had done in terms of acting on recommendations. The Infected Blood and Covid Inquiries have similarly adopted processes to follow-up on their recommendations.

John and the premises

16. Evidence relating to the premises comes primarily from the statements of Helen Hayes[4] who is the sole director and shareholder of JGH Developments which owns the building, and Jennifer Scholes[5] the lessor of the Hart Space, who hired out the studios for the relevant dance class. Helen is married to John Hayes whose business, Calculus Legal Costs Holdings, is based within the complex, and he manages the building day-to-day.

17. The Inquiry has the lease and other documents relating to the Hart Space. All the evidence points to the fact that this was a normal legal arrangement and that both parties fully complied with their legal and regulatory obligations, including fire risk assessments and other security arrangements. The building had appropriate locks and roller shutters, and was covered by CCTV. The building had adequate fire escapes, and was kept in good order.

18. Similarly, the evidence of Jennifer Scholes indicates that she was a responsible lessee. Not only did she meet all her legal and regulatory obligations but it is clear she kept a tight ship, only hiring out the space to those whom she knew were themselves responsible and had insurance.

19. Those connected to the building have been asked to address with hindsight whether any different arrangements should have pertained or changes made. Although there has been consideration of whether there should have been internal CCTV or an intercom system on the outside door, neither measure was required or would have been likely to have made any difference regarding the attack.

20. The reality is that appropriate or reasonable measures relating to safeguarding and security must be approached from the perspective of foreseeable risk. Some risks are obvious and ever present such as fire. Some known risks such as terrorist attacks are less prevalent but provide particular challenges because their effects are extreme. The instant case – a 17 year old targeting a children's event to which he had no connection whatsoever – was simply not foreseeable on any level.

Leanne, Heidi and the event

21. As with the building, arrangements for the event fulfilled all legal and regulatory obligations. Leanne was an experienced teacher and Heidi a Teaching Assistant. They both had a DBS and training in safeguarding. Leanne had an appropriate hire agreement and insurance, she had undertaken risk assessments, properly planned the event, and had a register.

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[4] IWS000001

[5] JSC000003

22. As noted above, the nature of this attack was entirely unforeseeable, and therefore it could not be met or mitigated via the risk assessment.

23. A number of points have been raised: was the adult to child ratio reasonable, should doors have been locked, was the event properly advertised, could more have been done once the attack started? These are all proper questions given the terms of reference, the need for accountability, the concerns of other victims and survivors and the public, and allaying misinformation.

24. It is clear that Leanne properly considered and limited the adult:child ratio. There were two adults and twenty-five children with one teenage helper. The ratio was far lower than most school classes. There are no regulations or official guidance relating to ratios for out of school events. The NSPCC confirms the fact that there is no such guidance, but on its website does have recommended ratios which are significantly lower than that adopted by Leanne[6].

25. With due deference to the NSPCC, no basis or reference for this ratio guidance is provided. It does not relate to the type of activity, the expertise of the adults involved, or the geographical location or type of space used. It does not appear to draw a distinction between indoor and outdoor activities, or those in public or private spaces. The application of the NSPCC ratios may well be entirely appropriate to events organised by parents untrained and unskilled in safeguarding, for outdoor events in public spaces. Their application to tightly controlled events in less accessible spaces, with experienced teachers, is less understandable and in many cases would mean that the events would not take place for reasons of cost, or would be available only to children with affluent parents. It is beyond argument that safety and safeguarding trumps commercial interests, but the importance of community events to the overall development of children and their socialisation must not be ignored.

26. We note that the National Education Union website provides its own guidance for class and after school event sizes[7]. The applicable ratios are all substantially higher than the 15:1 ratio set by Leanne (which she reduced to 13:1 for this event). Whereas different ratios are not stated for before/after school clubs and physical education, the union expressly advise that the appropriate class sizes should be determined through risk assessments taking account of the nature of the activity, whether it is indoor or outdoor, and the ages and characteristics of the child group. It is submitted that this should be the preferred view and is precisely the approach taken by Leanne. The fact that she reduced her 'default' ratio for this event is evidence that she considered class size specifically for this event.

27. The communal front door was habitually unlocked because it gave access to more than one space. Of course, it would be possible to secure that door, or for some kind of entry system to have been installed. There was no legal or regulatory requirement to do so. It may have raised fire regulation issues, although those would not have been

[6] NSPCC000001

[7] https://neu.org.uk/advice/classroom/class-sizes

insurmountable. However, it was reasonable to have open access at that point and it would have raised other issues had it been locked. Children and parents arrived at different times, both before and after the start time of the class. The class involved the use of both the ground floor and first floor studios, and movement between the studios (and the toilets) required access through the front door. If there had been an intercom system it would have involved control from both the Calculus office and the Hart Space. Its operation would have distracted Leanne and Heidi from supervision of the children in the class. It is unlikely that such a system would have prevented a determined attacker. It will be remembered AR had targeted the class, he had taken a taxi for a considerable distance to get there, and having initially gone to the wrong premises he persisted.

28. The studio doors were capable of being locked, however, that would have raised considerations of fire safety as they were the single point of access and egress, and would therefore have been a breach of fire regulations[8]. As above, parents and children arrived before and after the start time, and parents were welcome to come and go during the class. No doubt some would have arrived early and late to pick up at the end of the session. The toilets were outside of the studio. It was therefore an issue under fire regulations and impractical on other grounds, and potentially detracted from overall supervision.

29. Furthermore, the need to lock the studio was not indicated by any assessed or foreseeable risk, and again it is unlikely to have prevented the attack. The doors were solid and it is clear that Leanne or Heidi would have unlocked and opened the door to a visitor. Given AR's actual actions it is obvious what would have then happened.

30. The event was advertised only on social media. The evidence suggests that AR happened upon an advert and he may have targeted the event because it involved children and the organisers were two women. There is no other evidence connecting AR to the event, the organisers, the location, or anyone else involved. Once again, this shows that an attack of this sort could not have been foreseen.

31. There is no doubt that many community events are advertised word of mouth or through schools or closed networks, but many are not. Community events of all types are an essential part of community cohesion, and children's holiday and leisure events are an essential part of their development and socialisation. Whereas the extent of advertising is a matter which is relevant to risk assessment, the advertising in this case was limited.

32. Drawing these threads together, both the owners and operators of the premises and the organisers of the event, which include John, Leanne and Heidi, not only acted fully within the law and regulations, but they did so responsibly. There are literally millions of community and children's events across the country every year. They are an essential part of the functioning of a healthy society. It is plainly right that everything reasonably possible should be done to ensure security, safety and safeguarding on

[8] Day 14, page 26, lines 1-5

many different levels, but equally there must be a degree of proportionality to ensure that such horrific and tragic events do not undermine the fabric of our communities. Requiring unrealistic staff to child ratios, or confining children's events to secure facilities such as schools would substantially reduce access to normal, healthy activities, and they are measures which are unlikely to have a real effect on risk reduction.

33. In terms of recommendations, we submit that there is a lacuna in official guidance for children's events in the community, which should include risk assessment and management. We urge the Chair to consider making such a recommendation to the Secretary of State for Education.

Leanne, Heidi, John and the attack

34. The Inquiry has carefully and sensitively investigated what a number of adults did as the attack unfolded, including but not limited to Leanne, Heidi and John. Given the unexpected nature and horror of the attack, none of those present or witnessing the events could be expected to have a perfect recollection of events. The police investigation, through examination of CCTV, dashcam, and telephone evidence has however provided many incontrovertible facts.

35. From the evidence of the taxi driver, Gary Poland, and phone and dashcam evidence, there is no basis to determine that he had any idea that AR was travelling to the Hart Space with any malicious intent, and nor did he or others present at the garage where AR was initially dropped off see any weapon. Mr Poland's focus was on the fact that AR refused to pay his fare, and he followed him to the front door of the building intent on being paid.

36. The earliest point of concern arose when AR refused to pay his fare and became somewhat aggressive, asking the men at the garage "What are you going to do about it?" when they told him to pay[9]. The decisive moment however, was when Mr Poland thought he heard gunshots, connecting them to AR[10]. Although it is difficult to comprehend why he thought he heard gunshots it is clear that he did, from the transcript of the phone call he made to his friend very shortly thereafter, a minute after driving off[11]. It is obvious that this was the point when Mr Poland should have called 999, however his failure to do so was compounded by the fact that he also saw injured and fleeing children but chose to drive off without assisting or calling for help.

37. It is at least arguable that it was not unreasonable for Mr Poland to leave the immediate scene and he had no legal obligation to do otherwise. However, it is incomprehensible on any level why he did not stop when he had reached a safe

[9] MERP000303 p.4

[10] Day 13 p.62lines 17-21

[11] Day 13, pages 37-38, lines 14-51 and ILT000017

distance, and call 999, as he acknowledged in evidence[12]. As we know, he only called the emergency services about 50 minutes later[13], having picked up and dropped off his next fare.

38. The Inquiry has led evidence regarding taxi regulation and licencing. There are already conditions in place which should have required Mr Poland to call 999, but we urge the Chair to make a recommendation that the regulations and licencing should be considered further with regard to whether it can be made even clearer that taxi drivers have a responsibility to report, and whether training and appropriate sanctions should be required in order to ensure that the responsibility is discharged in the future.

39. With respect to Leanne and Heidi, the evidence shows that they were both quick-witted. They shepherded as many children as possible toward the exit. Heidi spotted a child DPA entering the toilet and followed her to save her from the attack, locking the door to prevent AR getting to them. The horror of being trapped in that position until the police arrived and removed the threat will undoubtedly stay with the child and her family and Heidi for evermore.

40. By this point, Leanne had suffered a number of life-threatening stab wounds but still managed to call 999, making the first vital emergency call, and she helped as many of the children escape as was possible. From the CCTV footage it is clear that 9 children escaped ahead of Leanne, and another 13 children emerged from the building with her or following her within seconds. When paramedics arrived, she was concerned that injured children were treated first.

41. As the attack unfolded, John was sat at his desk at the far end of the office from the entrance door. Hearing the commotion and the horror of what was occurring he emerged from his office to be confronted by AR, who stabbed him in the leg causing a really serious wound. Although John had not managed to disarm or stop AR he had certainly distracted him in circumstances where his attack on others, including Heidi and Child X may well have continued. John's colleagues managed to close the office door and a quick acting employee applied a tourniquet, which may have saved his life.

42. Leanne, Heidi and John have no wish for their actions to distract from the loss of life, severe physical injuries and massive trauma suffered by children and their parents and families, however, it should be recognised that each of the three acted with great bravery to mitigate the consequences of the attack. In our respectful submission it is important that the Inquiry should recognise that they could have done no more.

[12] Day 13, page 37, lines 9-15
[13] MERP000647

Knife crime and control

43. Some of the most shocking background evidence heard by the Inquiry came from the Home Office regarding the prevalence of knife-carrying, primarily by young boys.[14] It is shocking not only in its extent but also because of the apparent ineffectiveness of the raft of knife control legislation and regulation which has been enacted and brought into force over many years.

44. With respect to AR there are a number of questions on this topic. How and why did he go from being an apparently normal 12 year old, to a 13 year old who habitually carried a knife to school and himself alerted authorities through his call to Childline in October 2019? Not only had he become a habitual knife carrier but he had murderous intent. Only two months later, this escalated to the shocking attack perpetrated at the Range school in December 2019. Although there were plainly periods of relative calm, thereafter he displayed worrying behaviour at school, with searching for disturbing images and websites online, and episodes of violence at home. In March 2022 he was reported missing, to be picked up on a bus in possession of another knife. Once again, from his own mouth, there was little doubt as to why he had the knife as he told officers he wanted to stab someone and had made or wanted to make poison.[15] There were multiple attempts, some successful, to purchase knives and machetes online, despite supposed age restrictions and required safeguards. The week before the attack, his father had prevented him from setting off to the Range school once again, and with a knife.[16]

45. We will return to consider the fact that there were so many warning signs regarding knives, AR and his intent, but before doing so we address the more general issues.

46. If the Home Office figures are correct, there is a disturbing normalisation of knife-carrying within a significant section of our youth: the problem is endemic. Legislation has either curbed an even more serious problem or it has not worked. Either way the figures display an unacceptable position, about which knife control legislation has been ineffective. There will be those who call for ever longer prison sentences or more restrictive laws, but there is no evidence that such measures will address this issue.

47. We do recognise that there may be a need to improve legislation to consolidate knife control measures in one place, and to make the banning or restriction of certain classes of knives such as zombies and machetes easier, swifter and more streamlined, but equally this is not without complexity. Machetes do have legitimate uses, although it is beyond doubt that many are purchased as fearsome weapons. Furthermore, unlike firearms, knives are essential every day domestic items. As in the instant case, kitchen knives are often the murder weapon.

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[14] Day 23 Pg 118 line 11 to pg 120 line 10

[15] Day 19, Pg 27-28, Lines 21-4

[16] IWS000058 Pg 49

48. Given that knife crime tends to be committed by young people, but not necessarily those under 18, we have considered whether purchase restrictions could be imposed on a higher age limit, perhaps 21 or 25 years of age. However, at a general level this would be difficult given that many young adults live independently and have entirely legitimate domestic uses for knives. In our submission, in addition to knives with no legitimate use being banned, consideration should be had to restricting the purchase of other fearsome knives which do have some legitimate use to those aged over 25, and to require purchasers to certify to the vendor the name and address of the recipient, that the knife will be kept securely, and for what purpose they are being purchased.

49. The Inquiry has heard a significant amount of evidence regarding the online availability of knives, and the problems of age verification and ensuring that delivery is made to an adult. At the relevant time, it appears that insufficient age verification checks were made, and insufficient scrutiny was made on delivery. A number of witnesses have indicated that the position has improved. However, it is far from clear that all reasonable efforts have been made or instituted.

50. Age verification is not practically straightforward and there is a reasonable proportionality argument. In our submission the restrictions on the purchases of knives for under-18 year olds is uncontroversial. In order to ensure that such prohibition works, we urge the Inquiry to recommend that all online and in-person knife purchases should be verified by selfie videos of the purchaser with a government-issued photo id, and the vendor should be required to securely retain the verification video for a specified period of time. The same should apply to all deliveries of such items. Packages containing knives should be clearly marked, and the delivery driver trained to ensure age verification by a similar method. There should be clear regulations on vendors and delivery companies, with meaningful sanctions, to ensure this approach works. From the evidence, although not foolproof, the above age verification requirement would appear to be as reasonable as possible at the present time and operationally proportionate for vendors and delivery companies. The easy availability of VPNs makes other forms of verification much less effective.

51. In terms of the general issue of knife carrying and control we urge the Inquiry to recognise that this is an enduring and well known problem which has not been solved by legislation and ever greater penal sanctions. We urge the Inquiry to recommend more research into how to effect culture change, and to recommend the concentration of resources on evidence-based educational programmes, and effective community diversion schemes for those found to have carried knives.

52. During the Inquiry we drew attention to the campaign to encourage the domestic use of blunt knives, and the schemes already being rolled out to help families where problems have been identified, to exchange their domestic knives for safer ones[17]. It was disappointing to learn from ACC Winstanley that Lancashire police appeared to

[17] Day 20, Pg115, Line7. This is a scheme for which Leanne Lucas has been a strong advocate: https://www.college.police.uk/support-forces/practices/kent-and-medway-safer-knife-replacement-scheme

be unaware of such project even at the time of giving evidence to the Inquiry.[18] We do not pretend that such schemes are panaceas, but they are innovative ways of making a difference.

53. The Inquiry may consider the phase 1 evidence is sufficient to make some recommendations regarding the regulation of knife purchases and deliveries, but the Chair may also consider the question of affecting cultural change in this area to be particularly suited to further exploration in phase 2.

The Parents

54. The Inquiry has called both parents and the attacker's younger brother, Dion R, to give evidence relating to the family history and dynamics, their version of how AR's behaviour deteriorated from age 12 or 13, and of the various incidents and interactions with services thereafter.

55. The parents were refugees from the Rwandan genocide, and it is clear that they suffered terrible losses of multiple close family members and immense personal trauma. Having been granted asylum in the UK they built good lives for themselves and their family. CTI explored with the parents and Dion R the extent to which there was discussion of their background and the horror of their experiences in the 1990s, with AR and Dion as they were growing up. We encouraged the Inquiry to sensitively investigate this subject to discover whether there was evidence of inter-generational trauma. The evidence suggests that although there was such discussion, the children were not party to graphic detail or the full horror of what had occurred, and there was no hint from the family (or other witnesses) that this history had had any discernible effect on AR or his actions.

56. The evidence from the family members indicated that at times there was engagement with services, and that AR posed an extremely challenging problem within the family. However, there were a number of very substantial failings, in particular by the father, Alphonse R. Those failings included:

    a. Minimising the seriousness of AR's behaviour at various times, in particular with respect to the carrying of knives.
    b. Excusing AR's dangerous behaviour by accepting his account that it was due to bullying.
    c. Antagonism with services. Two incidents stand out: when Alphonse R attended the Range High School in December 2019, in the immediate aftermath of AR's attack on a pupil with a hockey stick. The police evidence indicates that Alphonse was so antagonistic that they considered arresting him.[19] Secondly, he was so hostile to the CAMHS psychiatrist, Dr Ramasubramanian, that she

[18] Day 20, pg 115, lines 7-14
[19] Day 26, pg 203, lines 21-24

stood aside and transferred the case to another doctor, the only time this had happened in her career.[20]

d. Manipulation. There is clear evidence from Sharon Barratt, Senior Support Worker for LCC Family Services, that Alphonse R viewed the YOT as an agency punishing AR, and was demanding that Family Services did not share information with them or indeed the schools.[21] Ashleigh Williams, Family Support Worker, also gave evidence of the limitation on provision of services because of a refusal of consent[22].
e. Taking delivery of packages for AR including knives, and failing to take action.
f. Failing to monitor online activity or purchases over a long period.
g. Failure to alert the police or other services regarding AR's attempt to travel to the Range High School on the 22 July 2024 in possession of a knife.
h. Failure to take any action when AR left the house on 29 July 2024.

57. Both parents have acknowledged some of their failings and no doubt the Inquiry will be forthright in this respect, and rightly so.

58. The fact that AR's developmental disorder significantly contributed to his difficult behaviour at home and elsewhere is not an excuse for the parents' failures, but it is the context. It is undoubtedly the case that they should have taken his actions at various times more seriously, they should have taken steps to monitor and supervise his activities online from an early age, and they should have engaged properly with services, rather than compounding the problems. They did not.

59. Even more clearly, they should have taken direct action to prevent him ordering knives and other dangerous items, and reported the concerning purchases to the police and other services. The failure of Alphonse R to report the events of 22 July is inexcusable.

AR

60. AR presented a known and persistent risk to others. Although not everyone knew all of his actions at every point, a substantial amount was known to all involved with him, and at number of junctures he was quite open about his murderous intent, and his interest in extreme violence and mass killings. It was known he had accessed extremist material. His purchases and attempted purchases of weapons were apparently only known to his family, but his accessing knives on numerous occasions was known to all services. The police and some other services knew of his claim to have made or be wanting to make poison, following his apprehension with a knife on a bus in March 2022.

61. AR's intent was not aspirational, as the shocking incident at the Range School evidenced in December 2019. Aged 13, he had returned to the school from which he had been permanently excluded for persistently carrying a knife with intent to use it

[20] Day 24, Pg140, Line20
[21] Day 30, Pg66, Lines8-25
[22] Day 30, 154, Line5

on a known victim. He again had possession of a knife which he intended to use, and in fact struck another child with a hockey stick when he could not find his intended target.

62. There were a number of failures to intervene or engage. The school PREVENT referrals were a call for expert help in addressing his worrying online activity and other warnings, set against his history. The referrals were rejected because AR was not seen to have an ideology, and at that time a fixation with mass violence or incidents of extreme horror was not a sufficient reason to meet the threshold for that service. We note the Home Office letter to the contrary which predated these rejections[23]. Furthermore, no alternative was offered or signposted, leaving the repeated concerns and obvious need unmet and unaddressed.

63. When found on the bus with a knife, telling the officers of his intent to stab someone and mentioning poison, an arrest would plainly have been appropriate, given his previous conviction and history. PC Fairclough and PC Rhodes both acknowledged as much in evidence.[24] PS Clarke unequivocally agreed, in particular had he known about the poison reference he would have advised arrest.[25] He noted that sending two probationary constables to deal with an incident such as this was inevitable due to resourcing constraints.[26] A subsequent search would probably have disclosed the attempt to make ricin, and possibly the Al Qaeda manual AR had downloaded. ACC Winstanley also acknowledged there had been "a very serious missed opportunity". He agreed that appropriate action would have triggered CTP involvement and a likely custodial sentence, two years before the attack.[27]

64. The misplaced rationale for not arresting, appears to have been based upon AR's youth and his autism.[28] Had arrest been made, it would have triggered other engagement not only from CTP but also from the CJS and no doubt social care services. As stated, given the previous conviction (and the ricin), custody would have been an option, as would Care Act proceedings if it were seen that the family were unable to cope with AR's specific needs and risks.

65. There were undoubted difficulties regarding the engagement with CAMHS, including the attitude of Alphonse R as noted above. Further, AR did not have a mental health diagnosis. Dr Irani noted that where there are difficulties of engagement with a young person and clinicians are worried about risk to others and safeguarding, due consideration should be given to using the Mental Health Act for assessment. But she also noted there may be a gap in the legislation in this regard.[29]

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[23] HOM000048 dated 25 June 2019
[24] Day 19, Pg17, Line6, Pg30, Line2, Pg82, Line3
[25] Day 19, Pg125, Line14
[26] Day 19, Pg132, Line5
[27] Day 20, Pg78, Line10
[28] Day 19, Pg18, Line10, Pg31, Line1
[29] Day 26, Pg 90, Lines 11-19

66. It is of note that the Government is progressing the Mental Health Bill 2025 which will further limit the detention of persons with autism or learning disabilities. Against this direction of travel, the Inquiry may think it appropriate to recommend that consideration should be given to extending powers to require engagement, including assessment, therapy, and supervision, where a developmental disorder is deemed to be relevant to a high risk to others, or to trigger a care assessment.

67. Whereas it may be tempting to look at more draconian measures to address the problems presented by AR, there were existing provisions available (including arrest and prosecution, and care assessment) which were not utilised. It is important to consider what extra powers will actually be effective, where the real problems may lie elsewhere: under-resourcing and a failure of multi-agency interoperability.

Services

68. The Inquiry has looked at a wide range of public services which had involvement in this case prior to the attack. A key part of the investigation has been who knew what and when, but it has also looked at who *should have known* what and when. All inquiries are exercises in hindsight with the important distinction that consideration of decisions taken in real time must also be looked at from the perspective of what was then actually known. Hindsight may lead to better decisions next time, but it can also lead to misplaced criticism, if one service failed to provide information to another.

69. Given the evidence from the parents, it is clear that some key information was not reported, and that Alphonse R in particular posed difficulties for various services with whom he engaged. The Inquiry will pay due attention to this, however we urge the Chair to recognise that services often deal with dysfunctional and disadvantaged families, and they should have compensated for the obvious communication difficulties, minimisation and unreliable reporting that was evident to them. In short, the deficits of AR and his family were obvious to services. They are a factor in explaining some failures by those services, but not an excuse. For example, the perceived failure of AR to understand the seriousness of his own actions in carrying a knife to school, and the minimisation of his father in excusing his behaviour because he believed the account of bullying, should have been a clear flag not only with respect to AR but the extent to which his family was a protective factor.

70. The Inquiry has rightly focussed on whether services adopted the right approach to AR, or whether the risk he very obviously posed to others was ignored or minimised in concentrating on his needs and development. Witness A, LCC Social Worker, who was part of the Children's Services Duty and Assessment Team at the time of the hockey stick incident, gave clear evidence that the role of Children's Social Care was to look for significant harm to the child, and they were reliant on other agencies – the police, Youth Justice and CAMHS – for their expertise in risk to others.[30]

[30] Day 29, Pg63, Line4

71. We have no hesitation in accepting that supporting children and young people and their development should be at the heart of the work of services of all kinds, from law enforcement to social care and healthcare. However, this is not mutually exclusive. At various points his risk to others was plainly considerable. At some points this was considered, for example the actions of the Range High School after being alerted to the habitual knife carrying in October 2019, and the subsequent multi-agency strategy meetings. At other junctures far less so, as evidenced by the minimal response to AR being found on a bus with a knife in March 2022, and volunteering to officers that he was intent on stabbing someone and had or was going to make poison. We urge the Inquiry to determine that this was a key failure in this case. If the risk to others had been taken more seriously at various points, would there have been a more proactive response? In our view, the evidence is clear. Inaction allowed the risk to others to go largely unaddressed with catastrophic consequences.

72. The persistent carrying of knives to school and elsewhere, the known intent, the actual physical violence in the shocking context of a return to the Range from where he had been permanently excluded, multiple violent incidents and outbursts at home, multiple online searches of mass killings and extremist material were all known to services. The diagnosis of ASD and the interactions with his father undoubtedly posed difficulties, but these only compounded the potential risks and made prioritisation of his case more necessary.

73. Whilst recognising that all young people who carry knives or weapons pose a risk to others, AR was not just another case. It is not only a hindsight view that he posed a particularly high risk. In our view the Inquiry should recommend that where an individual child or young person poses such a high risk there should be very clear prioritisation, and a concentration of resources on managing the risk. What happened in fact, was recognition of risk at certain points, which became diluted with failure to carry through the historical context: the actuarial risk. Too often, multi-agency involvement involved deflection of responsibility to others or a concentration on closing the case for a particular service, and a failure of leadership and ownership of responsibility. It is trite but obvious to observe that all public services are stretched: resources are scarce. Information-sharing and data management was poor at times, with important information buried in case notes, systems not compatible with each other, and one service being unable to access the information of another. All of these issues must be addressed.

74. This brings us to the issue of consent. It is relevant to how AR was dealt with in two distinct ways. Firstly, we heard from a number of witnesses that the service they provided was subject to consent and that if the family did not give consent, the case would be closed[31]. It seems remarkable that a child can be assessed as having particular unmet needs and the parents are known to minimise the seriousness of the issues involved, yet there is no obligation on the family to work with the services to help resolve those issues. In our view, in such circumstances refusal of consent should raise consideration of care proceedings. Secondly, we have seen documentation

[31] Day 30 page 18 line 10 to page 9 line 22

where one service is requesting information from another, only to be told that the information cannot be provided unless consent from the family is provided [32]. It seems to us that this is a particular flaw in any solution that relies on information sharing. We understand that a degree of confidentiality is required if families are to engage in and trust the services who are there to provide support, however where a child a poses a potential risk to others a balance needs to be struck that lands in favour of protection rather than confidentiality. In our submission there should be Government guidance (HO, and other relevant departments) that where a child is assessed as a high risk of harm to others, normal confidentiality and consent for sharing between relevant services (police, Children Social Services, Healthcare, PREVENT) should be overridden by necessity.

Resources

75. With respect to resources there is key evidence of cause and effect. Dr Molyneaux gave stark evidence that it would be "impossible" to read through the full case notes before an interview. When asked why, he said it was a combination of having too many cases and under-resourcing[33] . In social care also, it is clear that there was a turnover of staff with posts left unfilled and social workers having too many cases. The effect in that regard was not only unread case notes, but a failure to record meetings or follow through with actions[34].

76. Paul Turner, LCC Director of Education, informed the Inquiry that staffing levels in Lancashire were low for the number of children in the area, and specifically with respect to AR this impacted on the management of the EHCP[35]. He also noted that LCC did not have the resources to audit school safeguarding arrangements across the county[36], or home welfare visits, and he acknowledged that support to the school was non-existent and there was a 2year period where "AR had next to no educational provision", and that he became increasingly isolated during that period[37].

Institutional deflection

77. In some instances, it appears that resourcing constraints led to institutional deflection. When AR had failed to attend school for an extended period and the school was unable to gain access to the home for a welfare check, because the parents were refusing entry, it called unsuccessfully on a number of services at Lancashire County Council and the police to assist. Robert Correy of Lancs Constabulary told the school that the matter did not meet the algorithm for a call out. Despite the history and the fact that this was a call of concern regarding a young person with a diagnosis of ASD,

[32] LCC000345 pg 4
[33] Day 24, pg 92-92, lines 24-4
[34] Day 24, pg 93, lines 8-14
[35] Day 26, pg 131, lines 20-23
[36] Day 26, pg141, lines 3-6
[37] Day26,pg 165-166, lines 9-15

there was no professional curiosity or engagement as to what action should indeed follow[38].

78. Even where multi-agency action was triggered, as in October 2019, insufficient action followed. A key agency, FCAMHS insisted on there being an actual ASD assessment before progressing their involvement[39], and there is evidence from the Acorns School which reflects a degree of frustration that FCAMHS were unwilling to engage at a strategy meeting on 21 January 2020, despite the obvious "really, really, high risk factors" in AR's case[40], and deterred them from a re-referral later[41].

79. Further down the line, the involvement of some services such as CFW came to an end prematurely because they were time-limited: evidence of Andrea Fontaine-Smith[42]. Katherine Ashworth of Early Help acknowledged that working practices at the time put the threshold for triggering some statutory services too high, or cumulative concerns were not sufficiently considered for continuity of service[43].

Risk responsibility

80. The triggering of a multi-agency response involves the recognition of a problem or risk which requires the engagement of more than one agency and collaboration and interoperability between them. The initial multi-agency strategy meeting following the 7 October 2019 Childline report was both swift and appropriate, and it involved most, if not all, the relevant services. Whereas events moved on with the December 2019 attack and subsequent criminal justice process, there is evidence of services engaging in a number of different ways. What did not emerge however, was a coherent strategy beyond the immediate responses and then the Referral Order.

81. Dr Tina Irani identified the lack of a lead agency as a key problem[44]. In answer to a question from the Chair, DC Paula Murphy, Merseyside Police investigating officer after the hockey stick assault, and representative at the multi-agency meetings, agreed that there was a danger that nothing would really get assessed if no agency was responsible for risk assessment[45]. In our view the Inquiry should consider a recommendation that in high-risk cases there should be 'ownership' of overall multi-agency responsibility until or unless that risk is deemed to have substantially reduced, not simply responsibility for arranging the initial strategy meetings as appears to have been the limit of leadership here. The lack of lead agency was starkly evidenced by Joanne Hodson, Head teacher at the Acorns School, who commented about what happened after the strategy meetings in late 2019/early 2020:

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[38] Day27,pg 239-243, lines 22-10 and PRE000223
[39] Day 27, pg 163, lines1-5
[40] Day 27, pg 159, lines 14-25
[41] Day 27, pg169, lines18-25
[42] Day 30, pg 164, lines7-16
[43] Day 31,pg22, lines 15-23; pg 44, lines2-11; pg 66, lines 13-20
[44] Day 26, pg 80 , lines 2-16
[45] Day 18, pg 98, lines 20-25

> "I don't think there was a lead agency. We just managed the risk ourselves because we were kind of left to get on with it. There wasn't any input. So from the last meeting of 4 March 2020, CAMHS weren't involved again until February 2021, when he got his diagnosis. The police weren't involved. PREVENT weren't involved. YOT were carrying out the Referral Order and Early Help were kind of dipping in and out but it was just us dealing with him"[46].

82. A multi-agency response was appropriately triggered at the start, and a very high risk to others should have been determined. The persistent knife carrying to school, expressed intent, lack of insight into how serious this was, and then the actual return to school and use of significant violence, should have left little to doubt.

83. If there had been such a multi-agency lead – to own the responsibility rather than merely the arrangement of strategy meetings - there would have been knowledge across services as to the engagement or closure of the case by others, enabling service provision, information-sharing, and representations as to how one service could work in collaboration with others. The welfare check referred to above is a simple example of this. If the school were unable to successfully undertake the check, and the police were unwilling on policy grounds, a multi-agency approach with proper leadership responsibility may have led to a solution, rather than the problem falling between cracks.

84. Similarly, despite the school making three referrals to PREVENT, due to concerns about AR and his online activities set against the known risks, those referrals were not taken on. Irrespective of whether those decisions were correct, there was an identified risk and need left unaddressed. A multi-agency lead would have been able to go back to PREVENT and discuss: if not your service, which is appropriate? Is there a lacuna in the criteria? Is there another service which could address the online risks, for example CSC? The strong suspicion that AR was ASD (and subsequent diagnosis) coupled with his known fixation with mass killings and violence should have compounded the assessment of serious risk to others, as later acknowledged by a number of witnesses[47]. Those factors would have concentrated the approach of a lead agency to find solutions, rather than what actually happened: individual agencies determining that AR did not fit their criteria: not their problem.

85. If the services of the lead agency are no longer required, lead responsibility should transfer to another. If one or more engaged services deem that their involvement should be closed, their rationale should be shared with the other agencies to inform but also to allow them to tailor their own involvement or raise issues with the closing agency. In other contexts, multi-agency risk management is arranged around similar concepts, for example Local Resilience Forums. Without ownership of responsibility, multi-agency collaboration and interoperability is rudderless and far less likely to work in practice.

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[46] Day 27, pg199-200, lines 21-4

[47] For example, Louise Anderson, CSC: Day 31, pg132, lines4-9

Closure

86. Following from the resourcing and responsibility deficits discussed above, there is evidence of a concentration on closing a case for a particular service. There are a number of clear examples here, including by FCAMHS, and CFW.[48]

Record-keeping

87. As already noted, the Inquiry has exposed a number of areas of poor record-keeping. There are stark examples, for instance where the social worker failed to record a meeting with AR until after the attack, despite it occurring many months previously.[49] Other examples are of dilution where description of risk has diminished over time, rather than the risk itself.[50]

88. Apart from poor record-keeping there is also evidence of sanitising of records resulting in them being misleading by omission. A particularly worrying example of this was the editing of the EHCP, as evidenced by Lucy McLoughlin, Head at Presfield School, which meant that risk assessments would be made without reference to the detail of previous incidents including use of knives and intent[51].

89. Furthermore, and importantly, there were clear systemic problems. On both healthcare and social care systems there appears to have been a lack of highlighting of crucial historical information. Health and social care services typically engage multiple clinicians and other workers with a particular case, and the individuals involved, turnover and change over time. Complex and enduring cases necessarily generate substantial records, making it difficult for those clinicians and workers to keep up with the detail of the case and the extent of the issues and risks. For at least some of those involved, the fact or detail of historical incidents and risks appear to have been missed because they were buried in voluminous records and were not highlighted. We have already referred to the evidence of Dr Molyneaux in this regard.

90. Sarah Callon, Senior Manager LCC Youth Justice Service, was asked about a handover note where there was a change of case worker, which had a number of significant omissions including the number of times AR had admitted carrying a knife into school, or the concerning internet use reported by Acorns, or the expressed intention to use the knife. Ms Callon accepted this was "potentially" a risk of dilution of information in such circumstances, although workers were expected to read the full notes and not just the handover[52]. Louise Anderson, Children Social Care, acknowledged that all relevant information was not recorded by her service and there should have been "a

[48] Day 25, pg 155, lines 17-23; Day 30, pg 81, lines 21-24
[49] Day 31, pg 188, lines 12-16
[50] Day 31, pg 51, lines 11-19
[51] Day 28, pg14, lines 23-25
[52] Day29, pg 6, lines 5-16

really good concise chronology that outlines the risk factors", to assist a worker who picks up the case. This was not what happened at the time[53].

91. A record is pointless unless it is accessible both literally and in terms of its organisation. A number of witnesses did give evidence that this problem has been addressed since the attack, through use of a traffic light system, or the provision of a critical information field on a record, however, this issue is of such importance that we urge the Inquiry to recommend each relevant service review this issue and report as to how precisely it has been addressed. As above, this may be a wider issue which should be revisited in phase 2.

92. There were significant problems within police systems too, with officers deployed to the March 2022 bus incident having difficulty accessing systems, and ACC Winstanley acknowledging that the officers did not have access to the police events from 2019, and that needed to change[54].

Communication and information-sharing

93. Any multi-agency collaboration and interoperability requires the best possible communication and information-sharing between services. The evidence before the Inquiry indicates there was communication and some information-sharing through the MASH and multi-agency strategy meetings. There was good practice in terms of some information-sharing, for example the immediate reporting of the Childline information with the Range by PC McNamee.[55] However, there was scant evidence of consideration of shared access to records and information across agencies.

94. These are complex and resource-intensive issues. There are legal and policy implications of sharing information across agencies, and practical issues relating to IT systems and their compatibility.

95. In this case there have been a number of information-sharing failures, and examples of IT incompatibility which has complicated sharing. For example, Michael McGarry, Head Teacher of the Range, acknowledged that the sharing of important information relating to comments about the Manchester Arena attack and teachers getting murdered, was delayed after his exclusion and transfer to the Acorns[56]. Cheryl Smith, of Presfield School, noted the real difficulties in even getting a response to emails from Lancashire County Council, or getting a response that the relevant person had left the service[57]. Lucy McLoughlin, also of Presfield, noted that due to objections by the parents, the school was excluded from meetings about healthcare, which proved a barrier to receiving information from CAMHS[58].

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[53] Day 31,pg 127,lines 6-7
[54] Day20, pg86, lines 1-7
[55] Day 17, pg 145, lines 6-13
[56] Day 26, pg195, lines12-21 and Day 27, pg 130, lines2-22
[57] Day 27, pg244 lines,14-22
[58] Day28, pg 42,lines 12-17

96. The complexity and resource implications do not make collaboration or information-sharing any less important, they simply inform the extent of the work that should be done. Where an individual with a diagnosis of ASD requires family, education, and/or social care support, they may or may not need mental health services too. Where there is a risk to others from a child as here, the police, CSC, CAMHS and multiple other agencies are likely to be involved. The need for optimum communication and information-sharing systems and practice is obvious.

97. We therefore urge the Inquiry to recommend that communication and information-sharing systems, IT and policy need to be reviewed at both local and national levels by each of the services and at multi-agency and governmental levels. Again, this may be a matter for further consideration in phase 2.

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