

IN THE SOUTHPORT INQUIRY
BEFORE SIR ADRIAN FULFORD

THE BEREAVED FAMILIES

CLOSING SUBMISSIONS

Introduction

1. The content of the opening statement is relied upon and repeated. It is respectfully submitted that the totality of the oral and written evidence concerning the “.. *circumstances surrounding the attack and the events leading up to it*” leaves just one overall, and devastating conclusion, “...*the Southport Murders were not only predictable, they were also preventable.*” AR should not have been allowed to graduate from homicidal ideation to committing ‘*one of the most egregious crimes in our country’s history*’¹.
2. There were multiple opportunities to respond to his known toxic combination of psychological traits². The failures of Lancashire Police, Lancashire County Council, Forensic and Sefton CAMHS, those responsible for the operation of Prevent and Alder Hey Foundation NHS Trust (amongst others) were manifest. A combination of individual professional failure and inadequate systems for the assessment of risk led directly to the outrage on 29 July 2024; yet, the increasing risk of serious violence against identified and/or unidentified victims at the hands of AR was, from 8 October 2019 at the earliest, and 17 March 2022 at the latest, not only (in the language of human rights) a real and immediate risk, it was in the language of the common law not merely foreseeable, it was foreseen.

¹ Transcript 8/7/25, page 1

² Autism, though not diagnosed until February 2021 was suspected from August 2019 and those needs were not addressed. Instead, his vulnerability became in the eyes of those responsible for protecting him and the public from the risk he posed, an excuse or explanation) for minimising that risk from his known homicidal desires along with a willingness to act upon his desire to kill and ability to carry out his threats.

3. Irrespective of the acts and omissions of the various State agencies, AR's parents, who irrespective of their motives, misled professionals and recklessly closed their eyes to the known fact that AR was a risk not only to them, but also to others outside the family home. They were equally complicit.
4. The bereaved families hope that this Inquiry will identify the professional and systemic failings analysed in these submissions which if accepted by the Government, will lead to genuine change. The evidence called and examined by the Inquiry team has revealed a system of public protection incapable of protecting the public from dangerous people, whether under or over the age of 18.
5. The fact that there were failings in virtually every interaction between AR and multiple state agencies indicates a wider failure that persisted for over four years from the time AR first appeared on the State's radar, age 13, following the Childline incident.
6. But for those failings, AR's attack could have been avoided. These systemic failings were nothing new, and although the core of this inquiry revolves around the risk from, not the risk to a child, these organisational failings mirror much-travelled ground in the various child death inquiries, where failings and fault have been repeatedly identified but the repetition of preventable tragedy demonstrates that these lessons have not been learnt. They re-emerge now, albeit for the first time in this context, and it is respectfully submitted that resources need to be channelled into a consideration of why, had these changes and recommendations been effective, the system is still failing in such spectacular fashion.
7. The historical learning in previous child protection inquiries is crucial to this Inquiries work. It can be traced back to the first child death inquiry into the death of Dennis O'Neill in 1945³; but the first real milestone was the Public Inquiry 51 years ago into the murder of Maria Colwell by her step-father⁴,

³ 'The Monckton Report', chaired by Sir William Monckton. It led to the Children Act 1948.

⁴ [History of child protection in the UK | NSPCC Learning](#) (Committee of Inquiry into the Care and Supervision Provided in Relation to Maria Colwell (1974); <https://share.google/ygGhwDcR2egAyUPn7>; [Maria Colwell death led to legislation over two decades | The Independent | The Independent](#);

findings noted, replicated and built upon time and again multiple previous investigations, inquiries and reviews most recently, the Child Safeguarding Practice Review in the Sara Sharif case⁵.

Main themes

8. The following overarching themes have emerged during the hearings:
 - 8.1. [1] Systemic Failures in Child Protection
 - 8.2. [2] Assessment and evaluation of the risk of serious violence to others
 - 8.3. [3] Fragmented knowledge / failure to share information
 - 8.4. [4] The definition of significant harm
 - 8.5. [5] The voluntary nature of engagement by a dangerous child
 - 8.6. [6] The duty to warn by private individuals
 - 8.7. [7] Civil liability of public authorities
 - 8.8. [8] Civil orders
 - 8.9. [9] The Internet
 - 8.10. [10] Knives and other offensive weapons; secure sites for children
 - 8.11. [11] Education
 - 8.12. [12] Resources

THEME 1

Systemic Failures in Child Protection

9. The recurring theme across 50 years of child-protection inquiries is brutally consistent: children die because of the same entrenched themes. Key agencies consistently failed to share information, failed to synthesise risk, and failed to act on obvious warning signs. From Maria Colwell (1974) to Sara Sharif (2024), every major review has identified the same structural defects:

- fragmented risk information
- professional over-optimism
- lack of escalation
- excessive deference between agencies
- siloed working
- absence of professional curiosity

⁵ [SS-CSPR-SSCP-Report-for-publication-13.11.25.pdf](#)

- failure to “join the dots”
 - absence of a single professional holding the full picture.
10. The general thrust of the evidence from the social work practitioners and senior managers who gave evidence was that the training and practice of the social work profession is to protect children from significant harm to the child caused by others. Indeed, that was the focus of each of the inquiries summarised below. However, even if that is correct and it is not the role of the social work / social services department to assess and manage the risk of significant harm posed by the referred child to others (and therefore indirectly to the child him/herself), the systemic failures revealed in the Southport case are very similar, if not the same as, the errors and failures exposed and addressed in the cases where violence and abuse is meted out to the child, rather than by the child.
11. In that respect, the core of the Southport case lies squarely within this long, well-known pattern of public authority failure seen with equally devastating effect in the inquiries / inquests into the mental health killings that also run on repeat; notable recent examples being the Forbury Gardens stabbings⁶ and in all probability similar findings in the Nottingham Public Inquiry, due to start oral hearings in February 2026.

Historical Milestones⁷

12. **Maria Colwell Inquiry (1974):** the first national child-death inquiry arising from parental abuse. Findings: (1) catastrophic failures to share information between social services, police, school, and health (2) no coordinated risk review (3) no professional challenge (3) welfare officers lacked full information about the stepfather’s violence and (4) the system prioritised parental rights over child safety. Maria’s death was described as a “failure of the system rather than of one individual.” This remains the leitmotif of all subsequent inquiries.
13. **Jasmine Beckford Inquiry (1985):** reiterated the dangers of fragmented information. The Chairman, Sir Louis Blom-Cooper QC highlighted⁸: (1)

⁶ Factual findings arising from the Deaths in the Forbury Gardens Terror attack, 24/6/20, chaired by Sir Adrian Fulford PC.

⁷ Press reports suggest there have been 70 major inquiries into child protection failures since 1945.
https://www.theguardian.com/commentisfree/2013/sep/17/jasmine-beckford-daniel-pelka-history-chaos?CMP=Share_iOSApp_Other

“optimism bias”; (2) inadequate supervision (3) professionals failing to challenge parental accounts. The Report emphasised cumulative harm. Professionals saw episodes in isolation, not as a coherent risk pattern.

14. **Kimberley Carlisle (1986):** Louis Blom Cooper’s report exposed: (1) siloed working between Brent and Greenwich social services departments; (2) inadequate communication with hospitals; (3) failures by hospital staff to communicate concerns and missed medical evidence of trauma; (4) lack of cross-agency oversight. It reinforced that child protection cannot depend on single-agency snapshots and emphasised the general principle that each agency must assume others may not know critical facts and must proactively share.
15. **Tyra Henry (1987):** Stephen Sedley QC found that: (1) agencies working in silos so no single agency had the whole picture; (2) missing information on violent adults in the home (3) risk misjudged due to professional tunnel vision. Accordingly, crucial information known to the police and health was not shared with social services; known risks from the father were inadequately considered. The report was a blueprint example of the need for multi-agency intelligence merging.
16. **Cleveland Inquiry (July 1988):** as is well known, this was an Inquiry into sex abuse in the Orkney Islands, in which Butler-Sloss LJ laid early foundations for the modern framework of child protection which fed directly into the content of the Children Act 1989, including (1) validated the need for consistent thresholds (2) recognised deep tensions between agencies (3) identified the necessity of formal inter-agency cooperation.
17. **Victoria Climbié Inquiry (2003):** in what has been described as the most significant safeguarding inquiry of the 20th century, the Chair, Lord Laming identified systemic failures of (1) information-sharing (2) inter-agency cooperation (3) risk analysis (4) management oversight. It established the modern principle that risk cannot be managed without shared information, shared responsibility, and professional challenge. The Laming recommendations for reforms led directly to:

- the statutory duty to cooperate
 - creation of Local Safeguarding Children Boards
 - Integrated Children’s System (ICS)
 - Significant changes to “Working Together to Safeguard Children”
18. **Richard Inquiry (2003):** investigated the Soham murders and, in summary, exposed severe systemic weaknesses and resulted in a comprehensive overhaul of national safeguarding practices, information management, and inter-agency cooperation to better protect children and vulnerable adults. The Inquiry found (1) critical failures in police record-keeping and communication, with different forces maintaining separate, fragmented databases. Although this led to the creation of the Police National Database (PND) in 2011, which allows police forces across England and Wales to share intelligence and data more effectively, the facts of the Southport case demonstrate how the system is inadequate and crucial information on risk is either not shared when on the PND or the PND system is not used effectively or criminal records are still not being accessed (2) risk information held in silos and led to mandatory information-sharing processes across criminal-justice agencies⁹; (3) the Inquiry fostered a lasting cultural change in the UK, reinforcing the principle that safeguarding is everyone's responsibility, not just the concern of a few specific agencies.
19. **The Peter Connelly (Baby P) Serious Case Review (2007):** this is one of the clearest examples of professional drift and deference to the parents' views (1) agencies repeatedly failed to escalate (2) disguised compliance was accepted at face value (3) “working with the family” overshadowed risk. Importantly, it triggered the Munro Review (2009–11) which diagnosed “over-bureaucratisation” and emphasised the essential components of (1) professional curiosity (2) a holistic assessment of cumulative harm and (3) the dangers of risk being broken into fragments. Professor Munro’s analysis remains directly relevant to the essential lessons that must be learnt and implemented following the Southport Inquiry.

⁹ New Code of Practice for Information Management: a clear code of practice, the Management of Police Information (MOPI) Code 2005, was introduced for all police forces, providing strict guidelines for recording, retention, review, deletion, and sharing of information and intelligence.

20. **Arthur Labinjo-Hughes & Star Hobson Reviews (2022):** these were National Panel Reviews identified the now-familiar features: (1) extensive information “in the system” but unsynthesised (2) agencies unaware of each other’s actions (3) over-optimism and minimisation (4) risk not “owned” by any single professional repeated failure to appreciate cumulative warning signs and strongly reaffirmed the duty of joined-up risk review.
21. **Sara Sharif Child Safeguarding Practice Review (2025):** is the most recent major review, whilst produced at a local level it has national significance and the findings include more of the same, indicating how these failures are repeated¹⁰: (1) fragmented intelligence across social care, education, police, and health (2) failure to track high-risk children moving in and out of education (3) repeated opportunities to identify domestic abuse, coercive control, and physical harm (4) absence of any coordinated multi-agency risk picture. The Sharif case again demonstrated that a failure to share information led to a fatal failure to protect.

Across every inquiry

- 21.1. Risk existed, but no one agency was able to assemble the full picture.
- 21.2. Multiple agencies knew pieces of the puzzle but failed to communicate them.
- 21.3. Assessments were made in professional silos.
- 21.4. Crucial warnings were minimised or normalised¹¹.
- 21.5. Cumulative harm was not appreciated.
- 21.6. No single professional or agency took ownership of the risk.
- 21.7. Over-optimism replaced professional scepticism.
- 21.8. Threshold decisions were inconsistent and poorly reasoned¹².
- 21.9. Domestic abuse and male-perpetrator risk were systematically underestimated.
- 21.10. The same errors recurred despite decades of guidance.

¹⁰ Press reports suggest there have been 70 major inquiries into child protection failures since 1945.

¹¹ Ms Hodson use of the word ‘sinister’ was removed from the EHCP report, Transcript 23/10/25 page 123 *et seq*; Ms Hodson was told she was ‘racially profiling’ AR, *ibid* page 206

¹² Relevant here to the interpretation and exercise of the power / duty pursuant to section 47 Children Act 1989

22. In this type of case (i.e. threat / risk to child as opposed to emanating from child), the failures were not unique to an individual set of facts, they were (and remain in the context of “harm to others”) structural, predictable, and emerge frequently, often, as in the Southport case, with devastating, life changing consequences.

Relevance to Southport

23. The failings here must be seen in this context as the inter-related themes identified in the previous Inquiries and between those emphasised at paragraphs 8 and 9 above, as expanded below, are systemic and individual issues identified repeatedly since 1974. Perhaps the most significant and frequently observed being incompetent information-sharing (see paragraph 8.2) and fragmented risk analysis, coupled with professional deference, poor escalation, and failures to act upon, sometimes even to even recognise obvious danger signals (see paragraph 8.4 above).
24. Albeit the bereaved families accept that the source of the risk was different and undoubtedly much rarer, they are precisely the failures that appear again in Southport. The murders of Alice, Bebe and Elsie were not an aberration, rather the latest manifestation of a national pattern repeated across the last 9 decades.
25. The evidence heard and analysed (briefly) below has demonstrated that:
- [1] there were multiple risk indicators that AR was very dangerous
 - [2] yet no one collated them into a coherent assessment,
 - [3] and no effective protective action followed.
26. The history of safeguarding inquiries shows that children do not die because nothing is known, they die because everything is known, but no one connects it¹³.

¹³ It may be that there is scope to consider whether a review of previous relevant learning from historic safeguarding inquiries could form part of the Terms of Reference

THEME 2

Existence, assessment, and evaluation of the risk of serious violence to others

27. It should have been obvious to any competent police officer, social worker, social work manager or mental health professional who knew the full facts, that AR's homicidal ideation and apparent and emerging willingness and ability to act upon those thoughts constituted a significant risk of potentially deadly violence to others.
28. There cannot be any doubt on the evidence that a significant risk existed and called for a suitable and professionally executed risk assessment, but we now, and it has not been seriously challenged by any of the core participant agencies represented, that such an assessment was never carried out, despite:
- 28.1. Childline: firstly, AR's disclosures (perhaps better described as per the American term "leakage") of his homicidal intent between 4 and 7th October 2019 in the calls to Childline¹⁴.
- 28.2. Hockey stick: Secondly, on 11 December 2019 he plans and executes his desire to kill but is intercepted in circumstances now too well known to require repetition (the "hockey stick incident")¹⁵.
- 28.3. Bus: Thirdly, the events of 17 March 2022, now too familiar to repeat, were the clearest evidence of risk to others. AR openly stated he wanted to stab / poison someone (with poison he was either "making" or had "made"¹⁶) for the ludicrous reason that the police would then remove social media posts he found embarrassing. Yet he was not arrested, returned home with advice to hide knives and contact the mental health services. Advice given by well-intentioned, young and inexperienced police officers who had fragmented knowledge due to a combination¹⁷ of individual and systemic failure.

¹⁴ See transcript of communications by AR to Childline [MERP000428](#)

¹⁵ See Murphy, Transcript 6/10/25 pages 87-88

¹⁶ See w/s PC Fairclough §38 [LANC000273_0009](#); re poison §42 et seq [LANC000273_0010](#), Transcript 7/10/25 pages 21-24

¹⁷ See Transcript evidence of PC Fairclough 6/10/25 page 99, just out of his probationary period, page 101; 7/10/25 page 1, PC Rhodes 7/10/25 page 61, police officer from Feb 2023, page 62; PS Clarke 7/10/25 page 101, response Sergeant from June 2021 page 103. PS Clarke had not been informed about the reference to poison. The combined significant admissions from these witnesses were to the effect that AR should have been arrested and his home address searched.

- 28.4. Before & after “Bus” up until the murders: for a combination of reasons and across all the agencies the known / discoverable risk of serious violence was never addressed as developed - particularly by FCAMHS / CAMHS and the psychiatric team involved from 2021 to 2014 - as developed in the next section on information sharing and fragmented knowledge.
29. Once a person under the age of 18 has been identified as posing a risk of serious violence to others:
- 29.1. There is no dedicated agency, or lead individual agency to take responsibility for the coordination of a suitable risk assessment, should there be, this is a clear question for Phase 2.
- 29.2. The lack of a single dedicated agency for managing high risk children like AR means that there is a danger of the case itself, or essential aspects of it, falling through the cracks. If professionals in one agency are concerned that the risk posed by an individual child (and this must equally apply to dangerous people over 18) is not being taken seriously / or has not been carried out by another agency, is there, or should there be a mechanism to ensure that a risk assessment is carried out?
- 29.3. The absence of an effective provision of services and subsequent management of that dangerous child / young person by one truly joined up Agency, to ensure that his or_her reasonable needs are met and that there is a consistent review that all reasonable steps are being taken to contain the risk the child / young person poses (to identified and unidentified members of the public), appears to be a real gap in the system.
- 29.4. MAPPA¹⁸ and MARAC¹⁹ exist. The former, save in exceptional cases, only takes referrals for adults who may commit serious offences. The latter deals with the risk of domestic violence. A question for Phase 2 is whether a similar body / agency needs to be set up to deal with children

¹⁸ Multi-Agency Public Protection Arrangements

¹⁹ Multi-Agency Risk Assessment Conference

on a more formal basis. Phase 2 needs to examine how accessible MAPPA is to a case like AR and whether and to what extent the system needs to be reformed / amended.

- 29.5. A point that cries out for full analysis (and some of this work may have already been done in earlier inquiries) is how the power / duty to cooperate and force an agency to carry out an adequate risk assessment would operate in practice.
- 29.6. For instance, if the professionals in one agency are concerned that the risk posed by an individual child (and this must equally apply to dangerous people over 18) is not being taken seriously / has not been carried out by another agency, is there, or should there be a mechanism to ensure that a risk assessment is carried out?
- 29.7. Whether such a duty (or even the exercise of a power) would be effective and in the public interest needs very careful consideration, something that the Home Secretary needs to consider as part of the terms of reference for Phase 2 of the Inquiry.
30. There is no space within the current page limit to fully analyse the statutory scheme and multiple pieces of guidance that exist across the safeguarding landscape, the task being to establish how the intricate web of existing legislation and guidance fits together; and, whether (because the focus, in child cases at least) is mainly on the risk of significant harm to the child by a 3rd party, not harm that might be caused by the child, that amendments / additions are required, and if so to which aspects of the scheme.
31. If the inquiry agrees that it is necessary to carry out a detailed audit of the scheme and how it intersects (particularly at the transition stage of child to adult) that is a task that must be part of Phase 2, or if required that work can be done over the next few weeks.
32. The development of the duty to co-operate and share information that has taken place as a result of the earlier Inquiries and the development / amendment of Working Together and KCSI needs to be fully understood, as does the need to amend section 47 CA89 and the supporting statutory guidance.

Leakage, Escalation and Missed Intervention Opportunities

33. A substantial body of behavioural-science and threat-assessment research, developed by the US Secret Service, the National Threat Assessment Center (“NTAC”), the Federal Bureau of Investigation (“FBI”), and academic experts identifies a consistent set of pre-attack behaviours in cases of adolescent, grievance-driven targeted violence.
34. A principal element of this pattern is “leakage”: the communication to third parties of an intention to commit violence²⁰
35. Leakage may take the form of explicit statements of homicidal intent, indirect hints, expressions of violent ideation, or requests for guidance about contemplated harm. NTAC’s 2019 study, *Protecting America’s Schools*, found that 83% of school attackers communicated their intent to harm others prior to the attack²¹.
36. The recognised “pathway to violence” comprises²² a sequence of developments: (i) grievance and fixation; (ii) ideation; (iii) research and planning; (iv) preparation, including weapon acquisition; (v) breach; and (vi) attack²³. Leakage is treated as a critical early-warning indicator that an individual is progressing along this pathway.
37. The FBI’s Behavioural Analysis Unit has observed that adolescents who later commit targeted attacks frequently “test the system” by disclosing violent thoughts or plans to adults, peers, counsellors, or helplines as a conflicted form of help-seeking²⁴. These moments represent acute intervention opportunities in the pathway to violence.
38. The empirical literature also identifies further behaviours that significantly elevate risk when they occur together. These include: (i) a grievance narrative; (ii) fixation on a specific antagonist; (iii) repeated expression of violent

²⁰ Deborah G. O’Toole, *The School Shooter: A Threat Assessment Perspective* (FBI, 2000)

²¹ Page 24, US Secret Service & NTAC, *Protecting America’s Schools: A US Secret Service Analysis of Targeted School Violence* (2019)

²² US Secret Service & NTAC, *Protecting America’s Schools: A US Secret Service Analysis of Targeted School Violence* (2019)

²³ Meloy, Hoffmann, Roshdi & Guldemann, “The Pathway to Violence” in *International Handbook of Threat Assessment* (Oxford University Press, 2014)

²⁴ FBI Behavioural Analysis Unit, *Making Prevention a Reality: Identifying, Assessing and Managing the Threat of Targeted Attacks* (2017).

fantasies; (iv) weapon-carrying in non-attack contexts (“rehearsal behaviour”); (v) active steps to obtain weapons; and (vi) communications indicating ambivalence or distress about violent intentions.

39. NTAC’s 2021 study, *Averting Targeted School Violence*, a high proportion of attackers engaged in weapons-seeking behaviour and many had carried a weapon to school prior to the attack.²⁵ This pattern of preparation and rehearsal is widely recognised as a precursor to serious violence.
40. When viewed through this framework, the behaviours exhibited by AR align closely with established warning patterns in international threat-assessment literature. His repeated contacts to Childline in early October 2019, involving multiple calls over several days expressing violent intent towards a named pupil is textbook leakage behaviour²⁶.
41. These were not ambiguous communications. They were explicit declarations of homicidal intent, directed towards a specific individual, repeated within a short timeframe, and made in the context of evident emotional crisis. In threat-assessment terms, this represents a point of maximum preventability.
42. The evidence that AR brought a knife to school on numerous previous occasions is particularly significant. This constitutes rehearsal behaviour: conduct demonstrating the convergence of intent, capability, and opportunity, an recognised indicator of imminent risk in the behavioural-science literature.
43. The cumulative pattern of behaviour therefore rendered the risk highly foreseeable. These were not isolated or opaque indicators; they formed a coherent set of pre-attack signals of the type extensively documented in the empirical literature.
44. Against that backdrop, the absence of a structured risk assessment and timely multi-agency response represents a clear systems failure. Established behavioural-science evidence demonstrates that the warning signs were present, identifiable, and capable of triggering an effective safeguarding intervention. A

²⁵ US Secret Service & NTAC, *Averting Targeted School Violence* (2021)

²⁶ On 4/10/19: “What should I do if I want to kill somebody?” [MERP000706_0002](#); On 7/10/19, “There is somebody who I hate in school and I want to kill them”, “When I see this person I want to kill him...”

detailed comparative study of the American approach, indeed approaches in other jurisdictions should form a major part of Phase 2. Indeed in relation to each of the 11 themes identified at paragraph 8, there is scope for comparative study, although it is accepted that this would be a huge undertaking.

THEME 3

Fragmented knowledge / failure to share information

45. There were gross failures in the sharing of information between agencies and accessing the information agencies actually had. The most significant examples are:

Between agencies

46. Information was lost between agencies:
- 46.1. PC McNamee’s report to both the Range High School (email traffic with Mr Cregeen) and his reports to the MASH²⁷ omitted the crucial content and significance of the “leakage” of his desire to kill²⁸. This was crucial as it allowed a narrative to build that AR was a vulnerable young black boy, with suspected autistic traits²⁹ and consequent peer / social communication challenges, a victim of bullying with racial undertones because he was black and had only carried the knife for self protection in the event of an attack.
- 46.2. Lancashire Police did not file a crime report with Merseyside Police after the Childline incident³⁰. PC Rhodes’ entry on the log after the bus incident at 6.05 pm did not refer to poison³¹; but the Encompass referral did but failed to mention any previous offending by AR³².

²⁷ [MASH-guiding-principles-Apr25.pdf](#)

²⁸ See i) PC McNamee’s rule 8 statement, [LANC000269](#) and statement in criminal proceedings, [LANC000020](#) ii) the ChildLine transcripts, [MERP000428](#) iii) the communications from the NCA to Lancs Police control room [LANC000065](#) and email from the NCA, [LANC000144](#) iv) allocation to the first available (very junior officer), [LANC000410](#) and transcript of radio call from the controller to PC McNamee, [LANC000411](#) v) emails to Mr Cregeen, DSL at the Range, [LANC000055](#) and vi) encompass referral, [LANC000126](#)

²⁹ Although there was no formal autistic diagnosis until February 2021 because of very long delays in obtaining a specialist assessment

³⁰ McNamee transcript 2/10/25 page 149; pages 165-168. AR’s home was in the Lancashire police area, but the Range School was in the Lancashire police area.

³¹ [LANC000082_002](#); Rhodes transcript 7/10/25 pages 95-96

³² [LANC000088](#); Rhodes transcript 7/10/25 pages 97-98

- 46.3. The YOT risk assessment was not shared with others, making it difficult to understand or challenge³³.
- 46.4. AR's full forensic history and character was excluded from the EHCP plan and not made known to Presfield before Presfield accepted AR at their school³⁴.
- 46.5. The EHCP plan did not therefore contain sufficient information about AR's risk to others. It was deliberately toned down ('diluted'), removing and altering appropriate wording from Acorns, at the suggestion / insistence of AR's father³⁵.
- 46.6. The school CPOMs system denied users (except the DSL) sight of a running record of a child's history³⁶.
- 46.7. Presfield failed to access the CPOMS information provided by Acorns after AR had been enrolled at Presfield³⁷.

Within agencies

47. Information failures occurred even when the agency had access to the information:
 - 47.1. The police failed to check AR's criminal antecedents after the bus incident³⁸.

³³ Callon transcript 27/10/25 pages 215-216

³⁴ A passage stating that "AR can also appear to be cold and calculating and when in meetings with staff did not appear to be concerned about the seriousness of the meeting" was stricken through completely, Hodson transcript 23/10/25 pages 123-124; AR's parents requested that a section detailing his involvement with the Youth Offending Team (YOT) be removed, on the basis that it was "not relevant" because he was no longer under the YOT team; detail of AR's homicidal intent in previous incidents was not included McCloughlin transcript 27/10/25 page 13

³⁵ Hodson transcript 23/10/25 pages 123-124

³⁶ Hodson transcript 23/10/25 page 207

³⁷ Smith transcript 23/10/25 pages 223-224

³⁸ PC Rhodes admitted she had not (saying she relied on PC Fairclough), transcript 7/10/25 page 78; with PC Fairclough there was no record of him making a PNC check (but he thought high chance he had done so on his Samsung device); he accepted he made no check of the Police National Database transcript 7/10/25 page 133-134 ; PC Clarke was unaware of his previous convictions but could have checked, transcript 7/10/25 pages 79-80; PCSO Correy did not take AR's name from the caller. Without this he could not have checked the PNC record, 7/10/25 page 165; PC Ward said he was unaware of AR's previous convictions when he responded to a domestic violence incident in Nov 21, transcript 7/10/25 page 188.

- 47.2. The initial PVP report after the bus incident, as noted above, contained no reference to poison; the later Encompass report contained no reference to previous offending.
- 47.3. As explained by Dr Killen³⁹, key records were not scanned into the CAMHS system, so they were not available to later practitioners⁴⁰.
- 47.4. Drs Ramasubramanian and Molyneux accepted they did not review the records sufficiently, or at all, to glean the salient features of AR's forensic history, contrary to standard operating procedure⁴¹. At one stage of his evidence, Dr Molyneux went as far as suggesting that it was acceptable for a consultant psychiatrist not only not to read or be briefed on the content of the notes, but to rely upon the patient / parent to rehearse back to the doctor, the relevant history of the case⁴².
- 47.5. The Early Help workers, Sharon Barrett and Louise Lewis, overlooked key risk information available to them in the records⁴³.
- 47.6. Amanda Chapman⁴⁴, the return home interviewer after the bus incident in March 2022, did not review the notes to identify AR's intent to use a knife or the reference to poison after the bus incident⁴⁵.
- 47.7. Carl Coughlan, the youth support worker, adopted a practice promulgated by a more senior manager of deliberately not reading the notes⁴⁶.
48. One reason for this is information-overload. Dr Molyneux suggested it simply was not possible or practicable to review the entire notes⁴⁷. Whether that is true

³⁹ Internal investigation report [AHCH000324](#)

⁴⁰ Killen transcript 20/10/25 page 185

⁴¹ Molyneux transcript 20/10/25, page 6 et seq

⁴² Molyneux transcript 20/10/25, page 17

⁴³ Barrett transcript 29/10/25: explaining away risky behaviour page 25; dilution of risk information page 55; inadequate Early Assessment, page 63; duty to refer AR's extremist views to Prevent page 108. Lewis transcript 29/10/25: dilution of risk information pages 144-146; lack of knowledge of intent to use knives page 157-158, failure to refer to Prevent in October 2021 page 168,

⁴⁴ A Grade 6 Missing From Home Support Worker, §2 w/s Amanda Chapman [LCC001857](#)

⁴⁵ Amanda Chapman transcript 28/10/25 pages 245-248

⁴⁶ Coughlan transcript 28/10/25 pages 198-199; a practice he said was widespread in West Lancashire, page 233

⁴⁷ Molyneux, transcript 20/10/25 page 6

or not (and standard operating procedure required it), it could be a heavy burden. Amanda Chapman suggested that a system of notes that rapidly identifies key information would be helpful. She thought there was no effective system for identifying risks that might emerge from a missing child episode⁴⁸. There is already a Liquid Logic feature that allows flagging of important information, but it was not done or was overlooked. In any event, what is important might change over time.

49. One obvious solution is a common chronology across agencies⁴⁹. There is some prospect that AI might provide valuable assistance across several fields: Ms Ashworth said, "*we are actually now about to use AI to make sure it's perfect*"⁵⁰; Mr McGarry said there is an AI system for monitoring what is typed by students in school⁵¹; Mr Ashworth accepted there was scope for AI in helping restrict the delivery of underage items⁵².
50. Information overload is not the complete explanation. What might be described as cultural problems that have become baked into the State's interaction with children:
 - 50.1. AR's risk to others was minimised and diluted over time because of human bias, error and negligent practice.
 - 50.2. A reluctance to criminalise or stigmatise a child.
 - 50.3. The failure of YOT to share its risk assessment with others was not due to too much information.
 - 50.4. A reluctance to criminalise or stigmatise a child with a neurodevelopmental disorder;
 - 50.5. A focus on the child's needs that fails to address the risk the child poses to others;

⁴⁸ Amanda Chapman, transcript 28/10/25, page 247

⁴⁹ Accepted by Ms Ashworth, transcript 30/11/25, page 127

⁵⁰ *ibid*

⁵¹ McGarry, transcript 22/10/25 page 178

⁵² Christopher Ashworth, transcript 1/10/25, pages 85-86

50.6. A fear that a professional might be castigated for stereotyping a child by reference to race or mental disorder⁵³. Misplaced sensitivities over race have been identified as failings in other inquiries and investigations:

50.6.1. *“...there was a widespread perception that messages conveyed by some senior people in the Council and also the Police, were to ‘downplay’ the ethnic dimensions of CSE. Unsurprisingly, frontline staff appeared to be confused as to what they were supposed to say and do and what would be interpreted as ‘racist’.”*, §11, Professor Jay, Independent Inquiry into Child Sexual Exploitation in Rotherham, 2014.

50.6.2. *“Instead of examining whether there is disproportionality in ethnicity or cultural factors at play in certain types of offending, we found many examples of organisations avoiding the topic altogether for fear of appearing racist, raising community tensions or causing community cohesion problems.”* page 125 Baroness Casey, National Audit on Group-Based Child Sexual Exploitation and Abuse, Jun 2025.

50.6.3. *“The neighbours of the family spoke to both the criminal investigation and the review, saying that they were worried about reporting concerns about what they heard within the family’s home. They feared being branded as being racist, especially on social media. While understanding their point of view, this is concerning that race was a bar to reporting possible child abuse and it needs to be overcome,”* §5.76 Wonnacott & Wate, Child Safeguarding Practice Review Sara Sharif

THEME 4

The definition of significant harm: the section 47CA89 issue

51. An issue which emerged during the evidence was whether Lancashire Children’s Services Department should have assessed AR pursuant to s47 CA89. The defence given by Ms Anderson was that the function of the child protection

⁵³ Hodson, transcript 23/10/25 pages 205-206; w/s Hodson §109 [LCC001773_0031](#)

system was to protect the child against the risk of significant harm from parents and other third parties, AR's case did not therefore qualify for a section 47 assessment⁵⁴. It was not the function of social work to assess and guard against the risk that a child might pose to others. If that were the case it would have major consequences for the profession.⁵⁵ When asked by the Chair if the additional responsibility of having to assess the risk posed by AR - who was the lead agency in effect - the answer was that it posed a difficulty⁵⁶.

52. As urged at various points by the bereaved families this was seen as a key point as it underscored one of the main failings of LCC, the working theory being:

52.1. AR had already suffered significant harm and there was a real likelihood of him suffering further significant harm because he had not only stated his intention to kill very clearly to ChildLine, but had subsequently acted upon them and clearly stated that if the hockey stick had not killed the alleged bully he would have used the knife⁵⁷.

52.2. It seemed to our team obvious that if a child is so disturbed as to be behaving in this way, the practical consequences (risk of criminality / custody) plus the psychological damage (risk of engagement with mental services / impact of committing acts of heinous violence on another child) should as a matter of common sense fit into the concept of significant harm. Whilst a matter of statutory construction, the bereaved families position was and remains that the threshold triggering the statutory obligation to carry out a full and detailed s47CA89 assessment and that the decision not to assess under s47 taken at the Strategy Meeting on 16 December 2019 was wrong and a significant missed opportunity.

52.3. The s47 process should have led to a full and proper risk assessment, and even if the decision taken (applying the guidance in Working Together) was not at that stage to convene a Child Protection Conference with a view (potentially) to a Public Law Outline and ultimately Care

⁵⁴ Anderson transcript 3/11/25 pages 108-109

⁵⁵ *ibid* , page 114

⁵⁶ *Ibid*, page 157

⁵⁷ "All this has been relayed to CJMHT and arresting officers to make contact in terms of safeguarding. His intention apparently was to kill the other student today with an adapted hockey stick and if that failed then he would use a knife." [MERP000186_006](#)

Proceedings, there would / should have been far greater scrutiny, inter agency cooperation and social services emerging as the lead agency. This would certainly have been so had child protection measures been taken (perhaps most probably a supervision order) following the bus incident in March 2022 (see paragraph 47.5 above).

- 52.4. At that stage (and arguably earlier) the matter having been wrongly downgraded to Early Help, it should have been “stepped up” as a full assessment would have revealed that AR was plainly out of “parental control”. The impression of both the brother, Dion, and the father, Alphonse, was that there was parental loss of control from December 2019⁵⁸.
 - 52.5. Without such an assessment there was no route through to child protection measures enabling the full coercive force of a local authority to protect the child from himself (not to say his potential victims). It is accepted that hindsight must be avoided, but there is no question that from 17 March 2022 the significance of what AR told PC Fairclough and Rhodes should have been known / discovered and passed on to the Department.
53. In addressing the need to ensure the system of public protection functions effectively, it is necessary to:
- 53.1. understand the existing case law on the meaning of significant harm in the context of section 31 and section 47 CA89;
 - 53.2. to then decide whether Ms Anderson (see paragraph 51 above) was correct in her interpretation of the s47 power / duty, irrespective of issues relating to where the main focus of social work protection lies.
 - 53.3. On that point, as stated earlier, it is accepted that the majority of cases local authorities have to deal with are child protection in its truest sense (i.e. harm from others) and that cases as stark as AR’s might well be rare or even exceptional but there must be a significant number of cases

⁵⁸ See Alphonse transcript 5/11/25 pages 178-180; Dion transcript 4/11/25 page 184, both suggesting parental loss of control from December 2019

where children referred to social services departments do have a propensity for violence and are in need of social services support and therapeutic services. A fundamental part of the social work / child protection armoury should not be closed to such children because of what we submit is a fundamental misunderstanding of the statutory scheme.

The Law

54. The local authority's duty to investigate is contained in s47 CA89: the relevant words of the section are "*47(1) Where a local authority - (a) are informed that a child who lives, or is found, in their area ... (b) have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.*"

"s47(3) The enquiries shall, in particular, be directed towards establishing — (a) whether the authority should (i) make any application to court under this Act; (ii) exercise any of their other powers under this Act .."

55. Whether or not Ms Anderson's defence of LCC's approach to s47 CA89 is correct is a question of statutory construction, upon which it is respectfully submitted this Inquiry is duty bound to determine. Given that the issue of not carrying out a s47 assessment was because significant harm must involve harm to the child rather than harm caused by the child it is necessary to focus intensely on the words of the statute only.

56. The term "significant harm emerges in both s47 and s31(2)(a) & (b) (and elsewhere in the Act but the crucial definitions are in s31(2) and s105.

57. Section 31(2) states:

"31(2) A court may only make a care order or supervision order if it is satisfied

(a) that the child concerned is suffering, or is likely to suffer, significant harm; and

(b) that the harm, or likelihood of harm, is attributable to—

(i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; or

(ii) ***the child's being beyond parental control.***"

[emphasis added]

58. "Harm" in section 31(2) has the same meaning as in section 31(9) and the question of whether harm is significant shall be determined in accordance with section 31(10).

31(9) states: "*harm*" means ill-treatment or the impairment of health or **development** [F7]⁵⁹ including, for example, impairment suffered from seeing or hearing the ill-treatment of another]"

And 31(9) states that "development" means physical, intellectual, **emotional, social** or **behavioural development**"

31(10) states: "*Where the question of whether harm suffered by a child is significant turns on the child's health or development, his health or development shall be compared with that which could reasonably be expected of a similar child.*"

59. LCC were under a statutory duty to carry out a s47 assessment (and the law allowed them on the facts of this case):

59.1. Firstly, the focus of the meaning of harm is on the child, not who caused the harm. It is irrelevant that it was AR himself who was the direct cause, but why he was psychologically attuned to that type of behaviour was complex and in urgent need of a specialist assessment.

59.2. It could have been down to his treatment by his parents, or have a connection with his understanding of his Rwandan heritage or even epigenetic causes.

59.3. None of this mattered to the threshold to engage the assessment duty so long as there was reasonable cause to believe, as Lady Hale explained in *Williams v Hackney LBC*⁶⁰:

⁵⁹ F7 S. 31(9): words in definition of "harm" inserted (31.1.2005) by [2002 c. 38, ss. 120, 148](#) (with [Sch. 4 paras. 6-8](#)); [S.I. 2004/3203, art. 2\(2\)](#)

⁶⁰ See *Williams and another v Hackney London Borough Council* (Coram Children's Legal Centre and others intervening) [2019] AC 421 per Lady Hale at para 39.

39. “Harm” is defined in [section 31\(9\)](#) as “ill-treatment or the impairment of health or development” including, for example, impairment suffered from seeing or hearing the ill-treatment of another. Whether harm is “significant” is to be determined in accordance with [section 31\(10\)](#) (see [section 105](#)) which provides:

“Where the question of whether harm suffered by a child is significant turns on the child's health or development, his health or development shall be compared with that which could reasonably be expected of a similar child.”

- 59.4. AR’s behaviour was bound to cause harm by impairing his health and development, particularly his **emotional, social or behavioural development**; it had already lost him his mainstream education which caused all manner of anxiety, regret (as explained in the family evidence - particularly Dion R and Alphonso R) as time went on through 2020, lockdown, 2021, 2022 (Bus), concerns about his father’s influence, there were ample grounds to step up and commence an assessment under s47. Quite plainly, there was an argument that the harm was significant.
- 59.5. Secondly, there was reasonable cause to believe that AR “*is suffering, or is likely to suffer, significant harm*” [s47] given the facts outlined already (ChildLine / Hockey Stick), one example being the Stephanie Halloran recommendation that FCAMHS should carry out a full psychiatric assessment for a conduct disorder assessment⁶¹ and another being the alarming information from Acorns School and what AR said to both Childline in October (narrative that got lost) and his statement to the arresting officer that had the hockey stick not killed the boy he would have finished him off with the knife. There was far more to establish that there was something very wrong and “dark” about AR relating directly to the fact that his own behaviour and the implications of further offences and the impact upon him would be likely to cause him significant harm. Yet, these red flags counted for nothing because s47, and therefore the

⁶¹ In relation to which the Inquiry is asked to conclude that whether it was Halloran or John Hicklin who were considering AR had a conduct disorder is immaterial, AR given his actions in October and December was plainly in need of a full forensic examination & the type of risk assessment recommended by Dr Irani designed to predict the likelihood of acts of real violence

pathway toward child protection processes and full engagement by LCC, did not apply because of the misunderstanding of the statutory scheme.

60. The House of Lords and Supreme Court have each considered the meaning of *harm* and *significant harm*, although never directly in a similar factual situation. The case law establishes that the interpretation of “significant harm” in s31(2)(a)-(b) CA89 is well-established. The statutory concept is deliberately broad, encompassing any impairment of a child’s health or development, whether manifested internally by the child’s behaviour or externally through acts of external abuse. The authorities confirm that the words of the statute relate to the state of the child, not exclusively on harm inflicted by a third party.⁶²

⁶² Re B (A Child) [2013] UKSC 33 per Lord Wilson [23-31; Lord Neuberger at para 55-56; and Lady Hale at para 177-193 and Lady Hale said this at page 66 of the Williams case:

“191. The second element in the threshold sheds some light upon these questions. The harm, or the likelihood of harm, must be “attributable to the care given to the child, or likely to be given to him if an order were not made, not being what it would be reasonable to expect a parent to give to him” (s 31(2)(b)). This reinforces the view that it is a deficiency in parental care, rather than in parental character, which must cause the harm. It also means that the court should be able to identify what that deficiency in care might be and how likely it is to happen.

192. Allied to this is the definition of “harm” itself (see para 178 above). It is wide, but it is not infinite. The focus is upon the child suffering that harm, so upon the child suffering ill-treatment or suffering the impairment of her health or development. Ill-treatment will generally involve some active conduct, whether physical or sexual abuse, bullying or other forms of active emotional abuse. Impairment may also be the result of active conduct towards the child, but it could also be the result of neglecting the child’s needs, for food, for warmth, for shelter, for love, for education, for health care. Generally speaking, however, the harm is likely to be the result of some abusive or neglectful behaviour towards the child. But this is not invariably the case, as is shown by the inclusion, by way of example, “impairment suffered from seeing or hearing the ill-treatment of another”. We now know that serious harm may be done to the development of children who see or hear domestic violence between their parents.

193. I agree entirely that it is the statute and the statute alone that the courts have to apply, and that judicial explanation or expansion is at best an imperfect guide. I agree also that parents, children and families are so infinitely various that the law must be flexible enough to cater for frailties as yet unimagined even by the most experienced family judge. Nevertheless, where the threshold is in dispute, courts might find it helpful to bear the following in mind:

(1) The court’s task is not to improve on nature or even to secure that every child has a happy and fulfilled life, but to be satisfied that the statutory threshold has been crossed.

(2) When deciding whether the threshold is crossed the court should identify, as precisely as possible, the nature of the harm which the child is suffering or is likely to suffer. This is particularly important where the child has not yet suffered any, or any significant, harm and where the harm which is feared is the impairment of intellectual, emotional, social or behavioural development.

(3) Significant harm is harm which is “considerable, noteworthy or important”. The court should identify why and in what respects the harm is significant. Again, this may be particularly important where the harm in question is the impairment of intellectual, emotional, social or behavioural development which has not yet happened.

61. In *Re H (Sexual Abuse: Standard of Proof)*⁶³ the House of Lords held that “significant” bears its ordinary meaning of “considerable, noteworthy or important”, and emphasised that the statutory definition of “harm” expressly includes both ill-treatment and impairment of health or development.⁶⁴ The definition of significant harm therefore extends to that manifested in the child’s own behaviour so long as there is a likelihood of harm **or the child is beyond parental control**. On these facts both threshold conditions are satisfied, there can be little doubt that AR would suffer harm himself if he had killed the alleged assailant, neither can it be seriously contended that he was anything other than “... being beyond parental control.”
62. The Supreme Court in *Re B (A Child)*⁶⁵ reaffirmed that “significant harm” is a non-technical, fact-sensitive concept, and that the court must evaluate the child’s actual developmental and emotional presentation. The judgment expressly recognises that the statute includes in the definition of “harm”, emotional or behavioural disturbance, this must be so whether expressed as violence, aggression, self-harm, dysregulation, or extreme ideation. All of these presentations can satisfy statutory threshold under both s47 and s32(2) CA89 .

(4) The harm has to be attributable to a lack, or likely lack, of reasonable parental care, not simply to the characters and personalities of both the child and her parents. So once again, the court should identify the respects in which parental care is falling, or is likely to fall, short of what it would be reasonable to expect.

*(5) Finally, where harm has not yet been suffered, the court must consider the degree of likelihood that it will be suffered in the future. This will entail considering the degree of likelihood that the parents’ future behaviour will amount to a lack of reasonable parental care. It will also entail considering the relationship between the significance of the harmed feared and the likelihood that it will occur. Simply to state that there is a “risk” is not enough. The court has to be satisfied, by relevant and sufficient evidence, that the harm is likely: see *In re J* [2013] 2 WLR 649. [emphasis added]*

⁶³ *Re H (Minors) (Sexual Abuse: Standard of Proof)* [1996] AC 563 (HL). Children Act 1989, ss31(2), 31(9), and 105; see also *Re H (Minors) (Sexual Abuse: Standard of Proof)* [1996] AC 563;

⁶⁴ Lord Nicholls stated at page 591:

“I must now put this into perspective by noting, and emphasising, the width of the range of facts which may be relevant when the court is considering the threshold conditions. The range of facts which may properly be taken into account is infinite. Facts include the history of members of the family, the state of relationships within a family, proposed changes within the membership of a family, parental attitudes, and omissions which might not reasonably have been expected, just as much as actual physical assaults. They include threats, and abnormal behaviour by a child, and unsatisfactory parental responses to complaints or allegations, and facts, which are minor or even trivial if considered in isolation, when taken together may suffice to satisfy the court of the likelihood of future harm. The court will attach to all the relevant facts the appropriate weight when coming to an overall conclusion on the crucial issue.” [emphasis added]

⁶⁵ [2013] UKSC 33; also see on s31(2) generally Lord Wilson at paras 23-31 / Lord Neuberger at paras 55-56 / Lord Kerr at para 108.

63. These authorities align with the statutory purpose of s47 CA 1989. A local authority has a duty to conduct s47 enquiries where there is “reasonable cause to suspect” that the child is suffering or is likely to suffer significant harm. The threshold for suspicion is a low, objective one⁶⁶. Behaviour such as carrying weapons, making threats to kill, or expressing sustained homicidal or suicidal ideation plainly constitutes reasonable cause to suspect significant harm, because such behaviour typically reflects (i) severe impairment of emotional or behavioural development; (ii) the child being beyond parental control; or (iii) unmet therapeutic needs. This was always a paradigmatic case for a s47 investigation.
64. There is no statutory or judicial support for the proposition advanced by LCC that s47 is only concerned with harm to the child and not harm the child may cause to others. Dangerous behaviour directed outwardly is legally and clinically inseparable from impairment within the child. The outward expression simply reveals the underlying significant harm. The language of the 1989 Act and the authorities quoted above support the submission that where a child poses a serious risk to others, that risk is evidence that he himself is already suffering or likely to suffer significant harm for the purposes of both s31 and s47.
65. On the facts of the present case, the indicators were unequivocal. In October 2019, Axel carried knives to school, made explicit threats to kill, and expressed a desire to kill. Each of these features constitutes clear evidence of severe emotional and behavioural disturbance amounting to “significant harm” within the meaning of s31, and was more than sufficient to trigger the s47 duty to investigate. A proper assessment would have identified unmet needs, risks, and protective deficits, and would likely have led to far more effective multi-agency safeguarding intervention via child protection measures not well meaning but largely ineffective family support and early help, CAMHS escalation, family support under s17 (never accessed), or if necessary respite s20 accommodation or care proceedings.
66. The failure to carry out any meaningful s47 enquiry in 2019, despite such acute indicators, represents a fundamental misapplication of the statutory scheme. The

⁶⁶ Re H (Minors) (Sexual Abuse: Standard of Proof) [1996] AC 563

law required LCC to focus on the impairment to AR evidenced by his violent ideation and weapon-carrying.

67. Instead, its senior management took (and maintain) the erroneous view that harm the child might inflict upon others was “not their business”. That proposition is inconsistent with statute, binding authority, national guidance, and basic safeguarding logic. It was a serious systems failure with grave and foreseeable consequences.
68. If these submissions are not correct and LCC’s view is seen as legally sound, then it will be necessary to consider this issue in Phase 2 and should be covered by the terms of reference.

THEME 5

The voluntary nature of engagement by a dangerous child

69. Throughout AR’s interactions with state services, he was, for the most part, free to disengage even when it was clear he needed a high level of intervention. The result was that it proved difficult or impossible to provide the necessary input from CAMHS or social services. Had AR been subject to a section 47 investigation, the powers available to social services would have been greater, but it would still not have resulted in positive engagement with CAMHS. Space prevents development of this theme, but it is worth noting that even if AR had been referred to Channel he could have withdrawn at any time and the authorities (short of him committing a crime) would have been powerless to stop him.

THEME 6

The duty to warn by private individuals

70. Neither the parents nor the taxi driver warned of AR’s immediate and fatal risk to others on the day of the attack. The parents additionally failed to report AR’s actions to the authorities the week before. It was as Alphonso R. finally accepted when questioned by the bereaved families, his “visceral” connection with his son overwhelmed him and he was unable to save the “little angels” from his son who had become a “monster”. Whilst his actions averted tragedy a week before the murders, morality if not the law mandated that any reasonable and “decent” person would have warned the authorities that he was likely to on his way to

commit an atrocity. The Inquiry is asked to make the findings as set in the Appendix. In the case of the taxi driver, it made no difference because others (Leanne Lucas was the first) raised the alarm, but the principle is the same and that was only chance.

71. There is little if any doubt that on the current state of the law of negligence, there is no general duty on either a private individual or a public authority to issue a warning of impending danger to persons or property (subject to very limited exceptions) which would not be in play on these facts, and equally no common law duty to warn of another's likely criminal actions to cause serious harm.
72. Whether this is sustainable and can still be acceptable to right thinking members of the public at large and whether there should be a call for change is another question for Phase 2. We say only this, that it is salutary to recall the words of Lord Goff in Smith v Littlewoods [1987] AC 241 quoting Lord Diplock in Dorset Yacht, where having explained that there is no civil liability at common law for pure omissions and quoted the parable of the Good Samaritan:

"Lord Diplock then proceeded to give examples which show that, carried to extremes, this proposition may be repugnant to modern thinking. It may therefore require one day to be reconsidered, especially as it is said to provoke an "invidious comparison with affirmative duties of good-neighbourliness in most countries outside the common law orbit" (see Fleming, The Law of Torts, 6th ed., p. 138)."

73. The wide question is whether there should be a duty to warn, and, if so, in what circumstances. This is a contentious and complex question. It travels beyond the singular facts of this case. The bereaved families', while reserving their position on the wide point for the Phase 2 arguments, hold the strong view at this stage that parents⁶⁷ should be liable in crime and tort for a complete dereliction of parental responsibility that causes severe harm or death to others. Parents are often the only people with real-time awareness of dangerous intentions. If the extension of a general duty to warn of an impending crime is *not* to feature in the Phase 2 terms of reference, we would urge the Chair to consider a more limited duty on parents. Where a parent has actual knowledge of, or is reckless about, their child's intent to commit a serious criminal act (whether or not that act amounts to murder) there should be a positive duty upon that parent to report

⁶⁷ Or those with parental responsibility

that information promptly to the police. This should become a statutory duty⁶⁸. A failure to impose such a duty would leave a critical gap in public protection.

THEME 7

Civil liability of public authorities

74. It is trite law that public authorities generally owe no greater duty at common law than a private citizen⁶⁹. The position here is as set out at paragraph 74 above; whilst the law is now tolerably clear, whether on these facts the lack of any common law remedy in tort is sustainable and still in the public interest is a huge issue. The Appellate Courts have a limited appetite for change and have rejected calls to liberalise the principles and expand the exceptions (notable the assumption of responsibility exception)⁷⁰, so it is only the pressure of public opinion, inquiries such as this one and then political pressure and legislative change that will effect change.
75. Given the level of protection provided by the common law and difficulties in seeking compensation for serious public authority failure, there is little financial incentive to make systemic changes⁷¹. Undoubtedly the vast majority of the Agencies, severely stressed as they are, do the best they can within a flawed system. Wider liability in tort would be in the public interest as the threat of civil litigation and significant awards would be a more effective engine for change. A lack of resources is often cited or used as an excuse for failure. But if it is right that a lack of resources is not an important explanation (Theme 12) for the failures in AR's case, it suggests considerable resources were wasted. Little progress was made with AR despite State involvement over four years.
76. There is only so much a public inquiry can achieve - from time to time - and always after the calamity. The focus is always on the extreme event, ignoring the many lesser tragedies that never make the news. The recommendations are necessarily general: detailed implementation, if adopted, must be left to those

⁶⁸ There is an existing analogue: s38B Terrorism Act 2000 imposes a duty to report information that may help prevent terrorism.

⁶⁹ The position at common law has solidified in several recent leading authorities: Michael v Chief Constable of South Wales [2015] AC 1732 (in relation to the police), CN v Poole Borough Council [2019] 2 WLR 1478 (in relation to social services).

⁷⁰ A notable exception being the Tindall case recently heard in the Supreme Court where a new exception was recognised

⁷¹ Referred to as 'moral hazard' in the literature.

running the organisations. The failures in AR's case have been severe and widespread across nearly all the agencies involved. It is complicated. The long history of public inquiries in the field of child protection - many making the same or similar recommendations - suggests the benefit of alternative ways of encouraging necessary change.

77. There is a range of opinion, based on research principally in the United States, about the overall likely cost-benefit of exposing public authorities to greater civil liability. Any change would be for Parliament. There is scope here for Phase 2 to examine the literature and academic research in this area and make recommendations.

Responsibility for assessing a child's risk to others

78. The multi-agency model has its strengths. It allows specialist skills to be concentrated, accessed, and used efficiently. Its weaknesses are i) important information is lost between agencies, ii) there is the appearance rather than the reality of a high level of input, iii) no one agency takes ultimate responsibility for the assessment of risk to others, iv) disputes between agencies are sometimes left unresolved in ways that leave the agency exposed to the risk (e.g. Acorns) 'left holding the baby'. The Family's view is that where the subject is a dangerous child, there should be one agency that assumes responsibility for that child's risk to others throughout: either social services or a MAPPA type agency for children.

THEME 8

Civil orders

79. There is a gap in the State's power to control the risk to the public where a) a child is identified as a high risk of serious harm to others b) but has yet to harm others seriously. In AR's case it would have been appropriate to have civil orders that i) restricted his access to the internet ii) imposed a curfew or at least a monitor on his movements.

THEME 9

The internet

80. A child using a VPN has access to all the harmful material in the least restrictive regime in the world. VPNs are readily available and easy to use⁷². AR used them from June 2021 (age 14) beginning with an application called “Hotspot Shield Basic – Free VPN”⁷³. A content provider has no knowledge of the ultimate user’s identity or the jurisdiction in which the ultimate user lives. A content provider is not liable under the Online Safety Act 2025 for content provided via a VPN⁷⁴.
81. Most of the world’s harmful material sits on foreign computers. The world’s largest content providers and search engines are foreign, mostly American. They generally emphasise the importance of freedom of expression⁷⁵. Ms Khananisho, speaking for ‘X’, the American social media platform, valorised the ‘global, digital town square’. Her own ‘X’ page stated, “Free speech more important than feelings”⁷⁶. She was zealous in her defence of free speech. In truth, organisations like ‘X’ regard access to harmful material as a price worth paying for freedom of speech. Apart from any ideological views on free speech, it is in content providers’ commercial interests to permit free access to their services.
82. The UK government and Ofcom are keeping the issue of VPN’s under review⁷⁷. It does not currently intend to restrict the use of VPNs. Doing so would likely require a politically unacceptable degree of state interference⁷⁸. VPNs have an important and legitimate purpose⁷⁹. This includes protecting children who wish to access help about ill-treatment⁸⁰.
83. X has no intention of restricting access to their services through VPNs: it is part of ‘X’s free speech mission’⁸¹. It is unclear if X has researched any link between harmful content and real-world harms⁸², but we suggest the Inquiry should request any such research for Phase 2. One inference from ‘X’s evidence is that

⁷² Transcript 4/11/25, page 145

⁷³ “Hotspot Shield Basic – Free VPN, dated 22/6/201”, [MERP001462_001](#)

⁷⁴ Connolly, transcript 3/11/25 page 233-234

⁷⁵ Transcript 3/11/25, page 235

⁷⁶ Transcript 5/11/25, page 69

⁷⁷ w/s Sarah Connolly, [DSIT000004_004](#), §122

⁷⁸ *ibid*, §123

⁷⁹ Transcript 5/11/25, page 146

⁸⁰ Transcript 3/11/25, page 230

⁸¹ Transcript 5/11/25, page 146

⁸² *ibid*, page 150-1

it would not matter even if there were a causative link: it is a price worth paying for free speech.

84. The limitations of the Online Safety Act are clear: the Act would not have prevented AR's access to harmful content from June 2021; at most, it would have created some friction. The Act creates a risk to children if parents are falsely reassured that their children are protected from accessing harmful content. Children interested in extreme material are likely to use a VPN.
85. The Act is likely to entrench the dominant position of established content providers. They can afford to comply with the regulations. New providers face an additional barrier to compete. For that reason, established providers like 'X' might welcome regulation that does not, in fact, restrict access to harmful content on their servers. The most that could be said for the Act is that it might reduce the risk of pre-teenage children coming upon harmful material by chance.
86. Dr Irani said this in her report, "One of the factors, whilst not referenced in this report, would probably be useful for the chair to consider, is the absence of a legislative framework on monitoring the use of the internet by a young person with known risks but no legal premise."⁸³ and in her addendum: "In cases where there are specific safeguarding or risk concerns, then the chair might want to consider what legal framework could support professionals monitoring and supervising internet access by young people in their homes." The Family agree.
87. The trial of Knife Crime Prevention Orders ('KCPO') in London was not rolled out nationally. There was no evidence it was successful in reducing re-offending⁸⁴ and there were concerns by the Youth Justice Service that it duplicated some of their powers under a referral order⁸⁵. The results of the evaluation studies were sufficiently counter-intuitive and faced such statistical limitations that the efficacy of such orders should be revisited⁸⁶. The difficulty with relying on powers available to the Youth Justice Service is that an Intensive

⁸³ §4.4.9 [DRI000001_0033](#)

⁸⁴ Evaluation studies by the police [HOM000085](#) and UCL [HOM000087](#).

⁸⁵ Transcript 14/10/25, pages 164-166

⁸⁶ Including the small sample and sample bias: "...the results need to be interpreted with care and may not reveal real causal effects" [HOM000085](#).

Supervision and Surveillance ('ISS') requirement is only available after the commission of an offence that passes the custody threshold⁸⁷.

88. One of the powers under a KCPO is to prohibit “the defendant from ...using the internet to facilitate or encourage crime involving bladed articles.”⁸⁸ On the face of it, this would have been of some utility in AR’s case had these powers been available following, for example, the Childline or hockey stick incident⁸⁹. To the extent this risks criminalising children who act like AR for breach of restrictions before they have committed index offences, that is necessary and appropriate.
89. The Family suggests the following factual findings:
 - 89.1. The use of VPNs undermines the regulatory regime. The Act will not achieve its desired aims. It might make matters worse. It would have made little difference to AR’s online access from June 2021.
 - 89.2. AR’s interest in extreme material was an indicator of his corruption. It should have been given much greater weight when assessing his risk of harm to others.
90. The Family suggest the following topics of relevance to Phase 2:
 - 90.1. Should children have access to VPNs, and how might that be restricted?
 - 90.2. Should attempts to restrict access to harmful material be targeted at individuals known to have a pathological interest in such material?
 - 90.3. Should the law require hardware providers (phones, tablets, computers) to set default “parental controls” on their devices that can only be removed by the purchaser?
 - 90.4. Should the efficacy of powers to restrict and monitor access to the internet, like that under a KCPO, be revisited?

⁸⁷ w/s Roberts-Bibby, §§106-107 [YJB000076_0024](#)

⁸⁸ section 21 (4)(e) Offensive Weapons Act 2019

⁸⁹ The relevant provisions of the Offensive Weapons Act were not in force at the time.

- 90.5. Does harmful material tend to corrupt children? This requires evidence from research⁹⁰.
- 90.6. Where an individual is known to have a fascination with violence, should the state have powers like those available for convicted sex offenders to monitor and restrict access to the internet? Should this power be available to child social services or only to the criminal justice system?
- 90.7. If the State faces insurmountable challenges in restricting access to harmful content on the internet, should parents bear a greater responsibility to monitor and limit their children's internet use?

THEME 10

Knives and other offensive weapons: secure access

91. AR had built up an arsenal of weapons before the day of the attack, not just knives. In the event, he chose a kitchen knife, probably because it was easy to conceal. It is true that if he had waited a week or more until he turned 18, he would have been able to buy such a knife legitimately. However, AR's easy ability to acquire such an arsenal of weapons from the age of 15 likely deepened his interest in offensive weapons, intimidated his family and heightened the risk of a major deadly event.
92. As the Home Office has already identified⁹¹, and has been confirmed in this Inquiry, there are frequent breaches of the law by online retailers and weak law enforcement. The Family second the recommendations by the Home Office⁹² in that review and the proposed 'Ronan's Law'⁹³ which includes stricter online age verification, stricter penalties for online retailers (including criminal liability for senior directors), a duty to report suspicious knife-buying patterns, a new offence of possession of a knife (even if legal) with intent to commit unlawful violence.

⁹⁰ Note i) Dr Molyneux's strong views that it does: see §§128-129 w/s Molyneux [AHCH000253_0047](#) ii) Ms Roberts-Bibby stated "research linking exposure to violent or extremist content online to 'real life' violence is limited and more evidence is needed to determine the impact this has on children and their likelihood to engage in real-life violence." §167 [YJB000076_0039](#)

⁹¹ Independent End-to-End Review of Online Knife Sales v3.0, 26/2/25, [HOM000160](#)

⁹² Ibid, [HOM000160_081](#)

⁹³ [HOM000125](#)

93. Unlike access to harmful content on the internet, it should be technically easier to restrict the sale of age-restricted items online. A key system failure is not ensuring that the person who buys age-restricted items online is the same person who takes possession of it. Ensuring a match between purchaser and recipient should avoid evasion by the use of fake IDs.
94. There is no legitimate reason to purchase a large knife such as a machete in the UK.
95. The Family are also concerned about the vexed question of securing access to places where children are gathered. There was no physical barrier to AR entering the Hart space and making his way directly to the yoga class. A magnetic lock with a video call feature on the outside door might have made a difference. It is doubtful that someone presenting like AR would have been admitted without further enquiry. At the very least there should be some additional guidance on the circumstances in which such systems should be deployed.
96. The following are suggested topics for Phase 2:
 - 96.1. Should the category of weapons forbidden for sale to under-18s should be expanded to include bows over a specific size and power.
 - 96.2. Should knives and bladed articles be permitted for sale online / at a distance?
 - 96.3. Should online purchases require identification of the purchaser (by a digital photograph or PIN, for example) so that the delivery driver can compare this with the recipient on delivery?
 - 96.4. Whether the sale of large knives like machetes should be banned from sale?
 - 96.5. Whether there should be a specific aggravating feature of the offence of possession of a knife to possess a knife with a pointed tip. There is no justification for the possession of such a knife in public.
 - 96.6. Should it be a requirement that public indoor spaces where children gather should be secured with video entry or other secure systems? If not,

what further guidance should be given to those hosting out of hours events like this?

97. The bereaved families are neutral about whether pointed knives should be banned from sale.

THEME 11

Education

98. Space means this topic (traversed during the hearing in detail) can only be addressed in a few words. Neither Acorns nor Presfield was a suitable school for AR. It is unclear from the evidence gathered so far what school it would have been. The result in AR's case is that he was allowed to fester, mostly at home, without proper education from the age of 13 (after the hockey stick incident). There was never any examination of whether he needed a specialist SEMH placement (Social, Emotional and Mental Health⁹⁴)

THEME 12

Resources

99. A lack of State resources is not the primary explanation for the failures in AR's case⁹⁵. AR had extensive state input from multiple agencies over more than four years. He was known, or should have been known, to be a high risk to others from the age of 13. AR was someone whom his own brother described as presenting like a sociopath⁹⁶. Ms Hodson described how shocked she was by him on her first meeting with AR⁹⁷. This is a case where the experts in mental health and child social care missed what was readily apparent to others.
100. Somehow, despite all the State's involvement, it failed to prevent one of the worst crimes in this country's history.

⁹⁴ The modern term for EBD schools - emotional & behavioural disorder placements.

⁹⁵ For example, see Dr Irani's comments on central failings identified in her report, transcript 22/10/25, page 85.

⁹⁶ DR, transcript 5/11/25 page 185. A clip of this character is here: <https://www.youtube.com/watch?v=nJxgv1IW02o>

⁹⁷ police w/s Ms Hodson, [MERP000509 0002](#); inquiry w/s Ms Hodson, para 17 [LCC001773 0005](#)

NICHOLAS BOWEN KC

WILLIAM CHAPMAN

APPENDIX

Criticisms

101. The Family anticipate that legitimate criticism will be made of the following individuals and agencies. It is a long list. Bullet point summaries are given only.

Online retailers and delivery companies

- 101.1. **Amazon (online retailer):** Amazon's age verification system allowed AR to use his father's details to bypass age restrictions. The system relied on Experian checks, which did not require the details submitted for age verification to match the purchaser's details⁹⁸. This loophole enabled AR to make purchases despite being underage. Amazon's browsing system allowed minors to view and purchase items that could be used as weapons, such as knives, sledgehammers, and arrows, without proper age verification. In short, "any child that could use a computer could bypass it"⁹⁹. Amazon's labeling and delivery processes did not clearly indicate that the items were age-restricted or bladed articles. Amazon's initial internal review incorrectly stated that smoke grenades purchased by AR did not require age verification, highlighting a misunderstanding of product restrictions¹⁰⁰.
- 101.2. **Knifewarehouse (online retailer):** Knifewarehouse sold a machete to AR, which was delivered to his home address. While the website had age verification measures, AR was able to bypass them using fake identification. The retailer admitted that their process for verifying the authenticity of IDs was inadequate¹⁰¹. Knives were advertised using names like "Predator", "Cold steel", "Walking dead", "Black panther"¹⁰².
- 101.3. **Springfields (online retailer):** sold a machete to AR, which was found in his parents' bedroom after the attack¹⁰³. AR used a driving license with false details to pass the age verification process. The retailer's system did not adequately verify the authenticity of the ID.
- 101.4. **Hunting and Knives:** Hunting and Knives allowed AR to circumvent its age-verification process using a fake driving license¹⁰⁴. The retailer failed to identify the fake ID and allowed the purchase of a machete¹⁰⁵.
- 101.5. **Tactical Archery:** failing to recognise suspicious enquiries from AR, who repeatedly asked about the age verification process and notably requested "discrete packaging" that would hide the contents, suggesting a non-legitimate use¹⁰⁶.

⁹⁸ Boumphrey transcript, 2/10/25 page 83; Hunt transcript 14/10/25, page 136

⁹⁹ Boumphrey transcript, 2/10/25 page 83

¹⁰⁰ Boumphrey transcript 2/10/25 page 61

¹⁰¹ Wheeler transcript 30/9/25 page 13

¹⁰² Wheeler transcript 30/9/25 pages 25, 35-36

¹⁰³ Bullock transcript 30/9/25 page 108

¹⁰⁴ Bullock transcript 30/9/25 page 125

¹⁰⁵ Bullock transcript 30/9/25 page 126

¹⁰⁶ Sutherland transcript 1/10/25 page 7 et seq

- 101.6. A number of foreign retailers failed to fully cooperate with the Inquiry: Top Archery, Recomoney EU and Hattila group¹⁰⁷
- 101.7. **SJ Henderson (Ruach), Whistl and Evri:** this complicated supply chain for delivering a machete ultimately facilitated the delivery of a machete from Hunting and Knives to AR without age verification. Evri's processes do not permit age-verification¹⁰⁸. Their involvement in the delivery chain via Whistl was a significant contributing factor to the non-age-verified delivery of a machete to AR. The information that the package contained a knife was available to Whistl. The company director of SJ Henderson admitted that they should have asked more questions when Hunting & Knives informed them they "specialise in knives" and operated the website "Hunting & Knives". Furthermore, the first consignment list showed the items were described as "knives," which should have "rung alarm bells"¹⁰⁹. The director was unaware of the specific legal requirements for online knife sales, such as the need for "18-plus" packaging labels or age-verified delivery. Each of these companies knew or should have known the contents of the package that was ultimately delivered without age verification.

Lancashire Police:

102. Officers were not adequately trained about when and how to make referrals to the Violence Reduction Network, Community Safety Teams, Early Action¹¹⁰. The police should have made referrals to Prevent after the Childline incident, the hockey stick incident, and the bus incident.
- 102.1. **PC McNamee:** failing to make clear that AR's possession of a knife at school was not for self-protection; failing to refer the Childline incident to Merseyside Police for their records; failing to inform PS Clarke about AR taking knife to school on multiple (x 10) occasions; failing to update the vulnerable child log; failing to record AR's lack of remorse and challenge from parents on the vulnerable child log.
- 102.2. **PC Fairclough:** failing to arrest AR after the bus incident; failing to act sufficiently to AR's reference of making poison; failing to search AR's house; assessing AR's risk as medium only.
- 102.3. **PC Rhodes:** failing to check AR's criminal antecedents after the bus incident; failing to log reference to poison in PVP report; failing to follow up appropriately to AR's reference to poison.
- 102.4. **PS Clarke:** failure to check AR's criminal antecedents after the bus incident; failure to recommend AR's arrest.

Comment: the critical failure by the police was failing to arrest and search AR's house following the bus incident in March 2022. It is probable that weapons, including the ricin-making kit, would have been found.

¹⁰⁷ CTI 16/9/25 pages 64-65, page 71

¹⁰⁸ Ashworth transcript 1/10/25 page 74

¹⁰⁹ Henderson transcript 1/10/25 page 177

¹¹⁰ ACC Winstanley, transcript 8/10/25 pages 14-16

Prevent

103. There was a failure to refer AR to Channel despite AR lacking clear ideology. There was an apparent lack of clear guidance to officers where an individual lacks clear ideology. A letter in the form of the one dated 25/6/19¹¹¹ was probably insufficient to change a mind-set that focussed on clear ideology.
- 103.1. **Rachael Trehearne (supervisor Prevent):** apparent failure to review the first referral on the receiving the second referral.
- 103.2. **Officer B (FIMU):** failure to update JAT with additional information received from Merseyside Police following AR's arrest following hockey stick incident; Intelligence report did not include reference to Prevent referral; misleading direction to 'can now be closed' suggesting referral could be closed.
- 103.3. **PS Thompson (Prevent referrals):** failure to challenge AR's account to her; failure to heed significance of repeat referrals; failure to refer to Channel.

Comment: Had AR been accepted under Channel¹¹², AR would have received early intense intervention. Consent is normally provided by parents¹¹³. Even if AR had disengaged there was the fall back of more robust intervention from a Police Led Partnership¹¹⁴; and his lack of engagement would have flagged him as higher risk.

FCAMHS

104. There was no follow-up mechanism to pull AR's case back.
- 104.1. **Mr Hicklin:** Failing to conduct a SAVRY risk assessment before discharging AR. Inappropriate tone and comments about 'crystal balls', '£5 bets' and 'left holding the baby' that tended to undermine and inhibit the legitimate concerns of Ms Hodson at Acorns. Failing to consider Mental Health Act assessment.

CAMHS

105. CAMHS took far too long to conduct an ASD assessment. CAMHS failed to conduct an ADHD assessment. CAMHS failed to diagnose a conduct disorder. CAMHS failed to challenge the police's reluctance to prosecute after the bus incident because AR had 'severe autism'. CAMHS kept poor records and lost others. CAMHS failed to carry out risk assessments or, when they did, the assessments were of poor quality.
- 105.1. **Dr Ramasubranian:** Failing to review the records of AR's forensic history adequately or at all. Failing to conduct a risk assessment. Failing to refer AR back to FCAMHS. Failing to consider Mental Health Act assessment.

¹¹¹ [HOM000048](#)

¹¹² "Had the referrals been sent to the Dovetail Channel team, it is my expectation, they would have passed the Section 36 consideration and progressed through to the Channel panel." §49 w/s Sakthi Karunanithi [LCC001928](#)-0013; Ellsmore transcript 13/10/25 page 57.

¹¹³ Ellsmore transcript 13/10/25 page 100

¹¹⁴ Ellsmore transcript 13/10/25 page 100

- 105.2. **Dr Molyneux:** Failing to review the records of AR's forensic history adequately or at all. Failing to refer AR back to FCAMHS. Failing to inquire about the Prevent referrals.
- 105.3. **Dr Killen:** failed to ensure adequate risk assessments were made.
- 105.4. **Kathryn Morris:** failed to raise safeguarding concerns with social services; failed to challenge AR and parents' narrative by reference to the information available; conducted poor risk assessments; failed to take adequate account of AR's forensic history.
- 105.5. **Lynsey Boggan:** failed to progress AR's assessment for ADHD.

Comment: the failure by CAMHS to recognise AR's high risk by reference to his forensic history was a catastrophic failure that meant AR did not receive the early intervention that would have been most effective for his constellation of conduct disorder, autism, (likely) ADHD and fascination with extreme violence¹¹⁵. This presentation for AR's constellation of mental health problems should have been diagnosed no later than February 2020.

Social Care

- 105.6. **Anna Jameson (social worker):** failed to investigate AR's circumstances under section 47 Children Act 1989;
- 105.7. **Sharon Barrett (Senior Family Support Worker):** failed to account for AR's intent to kill in the assessment of AR's risk to others; failed to refer information about AR's interest in extremism (like the Taliban) with Counter-Terrorism police; failed to reflect the concerns of professionals involved with AR about his father's tendency to mitigate and minimise his son's behaviour; failed to make a referral to Prevent or share information with others in November 2021¹¹⁶.
- 105.8. **Louise Lewis (family support worker):** overlooked key risk information available to her; failed to make a referral to Prevent or share information with others in November 2021¹¹⁷.
- 105.9. **Carl Coughlan (youth worker):** failed to read AR's notes¹¹⁸; adopting this 'plainly daft' practice¹¹⁹ that he said was widespread across West Lancashire¹²⁰.
- 105.10. **Amanda Chapman (return home interviewer)¹²¹:** failed to challenge AR's narrative about the bus incident by reference to information available to her. This information included AR's stated intention to use the knife and reference to poison.

¹¹⁵ Irani transcript 22/10/25 page 101

¹¹⁶ Louise Lewis, transcript 28/10/25 page 167

¹¹⁷ Louise Lewis, transcript 28/10/25 page 167

¹¹⁸ Coughlan, transcript 28/10/25 pages 198-199

¹¹⁹ Ashworth, transcript 3/11/25 page 97

¹²⁰ Coughlan, transcript 28/10/25 page 233

¹²¹ The Family accept that Ms Chapman made candid admissions and has personal mitigation.

- 105.11. **YOT:** wrongfully assessing AR's risk as medium on referral¹²². The assessment of AR's risk as 'low' after completion of the referral order as was deeply flawed¹²³. Failing to share their risk assessment with other agencies, including Acorns.

Education

- 105.12. **Paul Turner (Director of Education, Lancashire):** the local authority failed to take responsibility for AR's education, absence from school or to provide adequate support to Acorns and Presfield.
- 105.13. **Cheryl Smith (DSL, Presfield):** failed to read the email sent by Acorns on 22/5/22 with AR's CPOMs information; this was not an isolated incident. As a result, Presfield were kept in ignorance about AR's forensic history and danger to others.

AR's family

- 105.14. **The parents:** There is no significant distinction between mother and father except that the primary caring role was by the father. The mother made it clear in her police interview that she and her husband were 100% open with each other and regularly discussed AR¹²⁴. The father consistently downplayed the significance of AR's behaviour with professionals while knowing his son was, in fact, a danger to his own family and others. He failed to restrict his son's internet access. He took delivery of offensive weapons on his son's behalf. He provided AR with funds to make purchases of offensive weapons. He failed to check all the was delivered when he must have suspected they contained weapons. He failed to report to the authorities the serious incident on 22/7/24, a week before the attack. He failed to report to the authorities when his son left the house on the day of the attack.

Other

- 105.15. **Gary Poland:** failing to dial 999 when he knew a murderous attack was in progress by his passenger.

¹²² Callon transcript 27/10/25 page 210

¹²³ Callon transcript 29/10/25 page 37

¹²⁴ [MERP001432_0021](#)