

## **IN THE SOUTHPORT INQUIRY**

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### **CLOSING STATEMENT ON BEHALF OF THE FAMILIES OF THE PHYSICALLY AND PSYCHOLOGICALLY INJURED CHILDREN**

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#### **INTRODUCTION**

1. This Closing Statement is made on behalf of 19 families of those children who were physically and/or psychologically injured on 29<sup>th</sup> July 2024. They wish to express their gratitude to the Chair and to the Inquiry Legal Team for the approach taken to them, to their concerns and to their ongoing trauma. They have felt able to engage positively with the Inquiry process and have confidence that it will achieve its aims as set out in the Phase 1 Terms of Reference.
2. To assist the Chair, this Closing Statement focuses on AR's life in terms of three domains: (1) life online (2) life at home and (3) life in the community. In each domain, there were serious failings such that the escalating risk posed by AR was not identified properly or at all and accordingly inadequate steps were taken to respond to it.
3. We have addressed these three themes in sections. Our fourth and final section addresses the attack and related topics. We have designed our submissions with the aim of assisting the Chair to identify and to make clear, meaningful and attainable recommendations to prevent such an atrocity from ever happening again.
4. We have complied with the Chair's directions in respect of Closing Statements<sup>1</sup>.

#### **SECTION ONE: LIFE ONLINE**

##### **Gaps in understanding AR's activities online**

5. During the period he was not attending school, AR spent most of his waking time online (up to 18 to 20 hours per day).<sup>2</sup> His parents took no steps to understand what he was doing online or to control his activity, even though they were on notice of him seeking out harmful material, in

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<sup>1</sup> Directions set out within the letter to Core Participants from the Solicitor to the Inquiry, dated 9<sup>th</sup> October 2025

<sup>2</sup> IWS000058 p55 paragraph 276 (witness statement of Alphonse R)

part because they feared a violent outburst by AR if they sought to intervene.<sup>3</sup>

6. Despite DCI Pye's assertion that Merseyside Police had a '*good understanding*' of AR's internet browsing,<sup>4</sup> there remain significant gaps in our understanding of what AR was doing online prior to the attack:

(1) The police's forensic analysis was focused solely on in-browser activity. This gave no insights into what AR was doing within the apps he had installed on his devices, including Telegram, Discord, Reddit and Twitch<sup>5</sup> (each of which is known to host violent or extreme content at times).<sup>6</sup>

(2) The detailed review of AR's devices focused on the short period between 15<sup>th</sup> and 29<sup>th</sup> July 2024, plus key word searches and a review of multimedia.

(3) The police's access to AR's Instagram and X accounts was limited. X continues to refuse to provide any content covering AR's use of its platform.<sup>7</sup>

7. These gaps in the post-attack investigation mirror the serious gaps in the police's capability to understand AR's online activity in the years prior to the attack:

(1) Searches of AR's devices seized after the Range attack were perfunctory. Key words were limited to the name of the school, intended victim and teachers, together with the words '*shooting*' and '*beheading*'.<sup>8</sup> Merseyside Police failed to consider serving a notice under section 49 RIPA 2000 to require AR to unlock his iPhone and enable its contents to be reviewed.<sup>9</sup>

(2) Officers dealing with AR's Prevent referrals should have taken account of AR's online activity in assessing his risk profile,<sup>10</sup> but had almost no technical capability to analyse the browsing data provided by his school. They were reduced to making manual copies and pasting a '*dip sample*' of some of the links provided<sup>11</sup> and had no automated capability to

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<sup>3</sup> Alphonse R 5/11/25 p118 line 3 – p121 line 6; Muzayire 6/11/25, p129 line 12 – p130 line 2.

<sup>4</sup> Pye 29/9/25 p23 lines 10-23.

<sup>5</sup> MERP000769

<sup>6</sup> See, e.g., 'Telegram pushes extremist groups to users – study', BBC News, 16 December 2024: <https://www.bbc.co.uk/news/articles/cvgrvw29x4jo>; 'Discord accused of exposing kids to graphic, violent content in lawsuit', The Hill, 18 August 2025: <https://thehill.com/policy/technology/5256251-discord-sued-over-parents-concerns/>; 'Reddit ban 'watch people die' subreddit after New Zealand mosque video is posted to the site', Fortune, 16 March 2019: <https://fortune.com/2019/03/15/reddit-banned-watch-people-die-new-zealand-mosque-video/>; 'Gunman kills 10 in live-streamed racial attack [on Twitch] at supermarket in Buffalo', Reuters, 15 May 2022: <https://www.reuters.com/world/us/ten-killed-three-wounded-mass-shooting-grocery-store-buffalo-ny-2022-05-14/>.

<sup>7</sup> XIUC000130

<sup>8</sup> MERP008359 p115

<sup>9</sup> Murphy 6/10/25 p96 lines 12-23

<sup>10</sup> Thompson 9/10/25 p79 lines 1-12

<sup>11</sup> Officer B, 8/10/25 p146 line 25 to p147 line 9

review the data. Further, FIMU had failed to identify AR's Instagram account despite its details being included in the second referral.<sup>12</sup>

(3) Although III checks are fundamental to Prevent assessments given the importance of online activity as a driver of risk,<sup>13</sup> a recent review identified that those checks are still not being done in the majority of referrals involving an interest in extreme violence.<sup>14</sup> DAC Evans declined to say what level of assurance CTPHQ has that even those basic checks are being done properly.<sup>15</sup>

8. Similarly, social workers engaging with AR – for whom, like most teenagers, online life was a key part of his identity – failed to take steps to understand his online behaviour and the risks this was generating:

(1) After the Range High School attack, social workers were on notice of AR searching for school shootings online but conducted no assessment of the risk of harm to AR from his online activity.<sup>16</sup>

(2) AR's own (irrational) concerns about his social media accounts motivated him to go missing from home on 17 March 2022 with the intent to '*stab someone*', but there was no follow-up by social workers as to what he had been seeing or doing online and no discussion at all about AR's online activity in the missing from home interview.<sup>17</sup>

(3) Ms Lewis, the family support worker engaging with AR in September 2021 to March 2022, had no knowledge of any of AR's online activity at all until these matters were put to her by CTI.<sup>18</sup>

(4) The attitude of social care towards AR's online activity generally was worryingly complacent. For example, Early Help made the unsafe and naïve assumption that AR would be supervised whilst online, based on very little information about his actual internet use.<sup>19</sup>

9. Against that background, AR was able to pursue his fascination with extreme violence by reviewing a range of graphic, violent and gratuitously offensive content online. The extent to

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<sup>12</sup> CTPNW000126 p4

<sup>13</sup> Evans 14/10/25 p75 lines 7-15.

<sup>14</sup> CTPNW000169\_0032 § 7.8

<sup>15</sup> Evans 14/10/25 p75 line 22 to p76 line 8

<sup>16</sup> Jameson 28/10/25 p105 line 19 to p106 line 9

<sup>17</sup> LCC000159

<sup>18</sup> Lewis 28/10/25 p150 lines 5-15

<sup>19</sup> Barrett 29/10/25, p98 line 2 to p100 line 7

which his exposure to that material led to his decision to conduct the horrific attack of 29<sup>th</sup> July 2024 will never be known. What is clear is that the material AR was accessing would now be considered ‘*primary content*’ and subject to the requirement for age assurance controls pursuant to the Online Safety Act 2023. Whilst those controls may prevent children causally coming across lawful but harmful material, they are very unlikely to prevent a teenager from gaining access if they choose to do so, given the ease with which anyone (including children) can masquerade as a user from a different country via a VPN.<sup>20</sup>

### **Suggested Recommendations to Improve Insights Into Online Risks**

10. The Chair is invited to consider making recommendations in two areas: culture and capabilities.
11. Culturally, professionals involved in AR’s case displayed a lack of professional curiosity as to what AR was doing online. Specialist training is required for professionals engaging with young people to keep up to date with the online environment in which young people are living their lives, to understand the right questions to ask, and to develop the tools to deal with children who are at risk (or who pose risk) because of their online activity.
12. As for capability, Dr Irani noted that there is currently no legislative framework that supports professionals in monitoring what young people are doing online unless they have been convicted of a crime.<sup>21</sup> The total reliance on parents in this area needs to change. The Chair is invited to consider whether:
  - (1) Police should be given powers to gain access to non-open-source internet use by at-risk children, with or without parental consent, in order to manage risk (whether in the context of Prevent or to reduce the risk of violent offending generally).<sup>22</sup> This may require consideration of whether the police’s existing powers, such as the power to obtain internet connection records to prevent or mitigate damage to a person’s mental health or in the interests of public safety,<sup>23</sup> are being used to their fullest extent.
  - (2) The Prevent function would benefit from an uplift in capability to ingest and analyse data about a person’s online activity, e.g. by using AI to triage and assess large amounts of browsing data of the type provided by Acorns in AR’s case.

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<sup>20</sup> Connolly 3/11/25 p229 line 15 to p230 line 8; Ellsmore 13/10/25 p91 line 18 to p92 line 6

<sup>21</sup> DRI000002 (supplementary report Dr Irani paragraph 1.2)

<sup>22</sup> DAC Evans was cautiously supportive of this suggestion, subject to human rights/proportionality considerations: Evans 14/10/25 p78 lines 9-16

<sup>23</sup> Investigatory Powers Act 2016 section 60A, 62

- (3) Police or local authorities should be granted the power to require an internet service provider to impose content blocks and/or alerts on a home IP address (filtered by device if necessary) where parents are unable or unwilling to control their child's actions online.
- (4) There is a case, given the invisibility of encrypted in-app activity to service providers, for on-device monitoring to be available for at-risk young people, whether as part of something akin to a violence reduction order (see below) or otherwise.
- (5) There is a case for requiring VPN software to be subject to age verification to prevent its use by children.

### **Online sale of knives/weapons**

13. The detailed evidence that this Inquiry has heard about the online sale of knives in AR's case underlines the vulnerabilities in the current regime. Whilst some controls are in place, they are not delivering sufficient assurance that knives sold online will not fall into the hands of children:

- (1) The delivery of a machete to AR from Hunting & Knives illustrates the extent to which an unscrupulous retailer can avoid age verification at the point of delivery. In a long supply chain, a failure by the retailer to disclose that they are sending a bladed article creates a '*domino effect*' for others handling that package, who will be unaware of its contents.<sup>24</sup>
- (2) Whilst the Crime and Policing Bill will tighten the requirements for age verification on delivery, the level of compliance with the existing, looser, requirements is low: most companies are achieving 50% compliance or less.<sup>25</sup>
- (3) Age verification standards at point of sale vary enormously: Knife Warehouse regularly identified attempts to order knives using fake ID in the past,<sup>26</sup> whereas Hunting & Knives has never identified any such attempts.<sup>27</sup>
- (4) Machetes and other knives continue to be marketed with names that may encourage their use in violence, including by impressionable young people<sup>28</sup> – probably in breach of the marketing restrictions in the Knives Act 1997.<sup>29</sup>

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<sup>24</sup> Polglass 1/10/25 p150 lines 1-9

<sup>25</sup> AMA000068

<sup>26</sup> Wheeler 30/09/25 p8 lines 2-17

<sup>27</sup> Martínez 30/9/25 p58 line 20 –p59 line 6

<sup>28</sup> Hunt 14/10/25, p148 line 15 – p149 line 5

<sup>29</sup> See section 1 on the unlawful marketing of knives

(5) From a policing perspective it remains *'far too easy'* for young people to get access to weapons, including via online sales. As ACC Winstanley put it, young people *'have got what appears to be completely unregulated access to the internet, where, at the click of a button, they can see the most horrific and horrendous incidents, and they can go online and purchase things which, frankly, I see no legitimate purpose for'*.<sup>30</sup>

14. Other than the duties imposed by the criminal law there is currently no regulation of online retailers of knives.<sup>31</sup> There was broad consensus among responsible retailers giving evidence to the Inquiry that that needs to change.<sup>32</sup> The independent Clayman Review found that a licensing regime for knife retailers *'could deliver immediate benefits'*,<sup>33</sup> and the government has committed to consulting on the proposal.<sup>34</sup>

### **Suggested Recommendations in Respect of Online Knife Retailers**

15. The Chair is invited to consider recommending that any licensing regime for knife retailers should include the following requirements:

- (1) Membership of a shared digital platform, accessible by retailers and police, to host a *'watchlist'* of purchasers of concern, and to share intelligence on blocked or suspicious purchases,<sup>35</sup> underpinned by a statutory duty to report the same.<sup>36</sup> For very large retailers with significant data analysis capability, this should also include a duty to report suspicious combinations of purchases.<sup>37</sup>
- (2) Provision for parents to block their home address on the shared platform to prevent delivery of bladed items if there are concerns these may fall into the hands of an at-risk child.
- (3) The use of the new national Digital ID (once in force) in place of other photo ID for age verification purposes,<sup>38</sup> which would largely eliminate fake ID usage given the difficulty forging a cryptographic token.
- (4) Proof of address checks at the point of sale alongside a proof of age check.<sup>39</sup>

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<sup>30</sup> Winstanley 8/10/25 p100 lines 17-22

<sup>31</sup> Bullock 30/9/25 p110 lines 9-16

<sup>32</sup> Wheeler 30/9/25 p8 line 25 - p9 line8; Bullock 30/9/25, p139 lines 5-7; Jones 1/10/25, p63 lines 12-20

<sup>33</sup> HOM000160 p13

<sup>34</sup> Hunt 14/10/25 p145 lines 10-15

<sup>35</sup> Wheeler 30/9/25 p31 line 18 - p32 line 12; Jones 1/10/25 p64 lines 9-18

<sup>36</sup> Hunt 14/10/25 p154 line 18 - p155 line 10

<sup>37</sup> Bumphrey 2/10/25 p72 lines 11-16; p111 lines 1-7

<sup>38</sup> As mooted by Wheeler 30/9/25, p13 line 20 p14 line 2

<sup>39</sup> Wheeler 30/9/25 p29 line 8 - p30 line 1; Bullock 30/9/25, p129 lines 12-17

(5) Spot checks by online retailers, against a statistically significant sample of sales, to ensure age verification is taking place at the point of delivery.<sup>40</sup>

(6) Submission to a test purchasing regime, run either by Trading Standards or by fellow licensed retailers, to verify compliance with the above.<sup>41</sup>

16. In order to be effective, it is submitted that any licensing regime should be underpinned by clear criminal sanctions for retailers who fail to register, or who fail to comply with the requirements of the scheme. This, in turn, requires institutional clarity as to who has the lead responsibility for prosecuting the unlawful sale of knives.<sup>42</sup>

## **SECTION TWO: LIFE AT HOME**

### **Dynamics at 10 Old School Close, Banks**

17. It is acknowledged that AR's parents experienced painful and dramatic events in Rwanda before coming to the UK<sup>43</sup>. In heavily criticising their later conduct, we do not lose sight of their earlier traumas. Within a short time of moving from Cardiff to Southport, life at 10 Old School Close, Banks, became increasingly complicated. Dion R developed serious mobility issues and was dependent on a wheelchair and parental care. Both parents worked, often in shift patterns that meant only one of them was home with their two boys. Particularly following his permanent exclusion from the Range School, AR became increasingly introverted, anxious, aggressive and demanding. The tension in that family home appeared to be bubbling constantly in the background.

18. Dion R had outside interests and was motivated academically. He distanced himself from AR and became increasingly worried that AR's temper<sup>44</sup> and his capacity for serious violence<sup>45</sup> might result in him causing serious injury or even the death of his father<sup>46</sup>.

19. AR's mother, although undoubtedly caring deeply for AR, tended to take the path of least resistance. Occasionally, she could be a calming influence on AR but as time progressed, she became more and more frightened of him and of his explosive violent temper. She told the

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<sup>40</sup> Wheeler 30/9/25 p15 line 19 p16 line 19

<sup>41</sup> Bullock 30/9/25 p122 line 20 p21 line 3

<sup>42</sup> Hunt 14/10/25 p180 line 6 - p181 line 19

<sup>43</sup> Alphonse R 5/11/25 p77 lines 5-16

<sup>44</sup> IWS000060 paragraphs 11, 25, 27 and 29 (for example)

<sup>45</sup> Dion R 4/11/25 p165 line 5 - p166 line 2

<sup>46</sup> IWS000057 (text messages from Dion R to a friend), December 2022

Inquiry that AR could have up to *‘three outbursts a day’*<sup>47</sup>. She did not know how to manage or control AR. She made no attempt to monitor his internet use. She fell into a policy of appeasement. It is clear that if AR was reprimanded or if his parents were considering punishment, he would not have responded calmly and rationally<sup>48</sup>. Accordingly, acquiescence became the preferred parental option<sup>49</sup> (at times, to ensure that AR would not be removed from them)<sup>50</sup>. When AR left the house on 29<sup>th</sup> July 2024, (having not left the house alone since March 2022), his mother went upstairs to lie down,<sup>51</sup> having (according to Dion R) moved some knife packaging into an outside bin.

20. AR’s father took the leading role in seeking support for AR from schools and various agencies. His email requests were often unreasonable and increasingly desperate<sup>52</sup>. He frequently made unjustified complaints<sup>53</sup>. He showed anger and resentment when Acorns made the Prevent referrals<sup>54</sup>. Alphonse R seemed to take AR’s word over what he was being told by professionals<sup>55</sup>. A clash of personalities would often manifest itself: AR and his father would argue. Tension would sometimes turn to violence. AR’s father struck AR on at least one occasion. AR lashed out at his father on other occasions and carried out acts of property damage in such a way that both of his parents were very frightened<sup>56</sup>. AR issued threats to kill his father such that he instilled real fear<sup>57</sup>.
21. Against that background, the attitude and approach of AR’s parents contributed to AR’s dominance in that household. Their persistent failure to challenge AR, to install boundaries and discipline is suggestive of neglect. AR was permitted to acquire dangerous weapons and to view inappropriate content online<sup>58</sup>. In misguided loyalty to AR, his parents withheld important information from the authorities to protect AR and themselves. In July 2024, prior to the attack, Alphonse R contemplated that his son could be *‘killed or put in prison for good’*<sup>59</sup>. This, we submit, was a clear acknowledgement by Alphonse R of his son’s capacity to commit acts of extremely serious violence including murder.

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<sup>47</sup> Laetitia R 6/11/25 p127 lines 18-24 and p131 line 12 to p132 line 1

<sup>48</sup> Dion R 4/11/25 p179 line 13 to p180 line 6

<sup>49</sup> Alphonse R 5/11/25 p107 line 23 to p108 line 14

<sup>50</sup> Alphonse R 5/11/25 p109 line 16-19

<sup>51</sup> Laetitia R 6/11/25 p167 line 18 to p168 line 5

<sup>52</sup> For example, emails within PRE000695

<sup>53</sup> For example, re Childline, Alphonse R 5/11/25 p143 line 2 – p144 line 19

<sup>54</sup> Alphonse R 5/11/25 p185 line 13 – p186 line 19

<sup>55</sup> Alphonse R 5/11/25 p89 line 19 – p90 line 6

<sup>56</sup> For example, LANC000078 p3

<sup>57</sup> Alphonse R 5/11/25 p113 line 20 – p114 line 9

<sup>58</sup> Alphonse R 5/11/25 p116 line 24 – p117 line 5

<sup>59</sup> Laetitia R 6/11/25 p162 lines 13-21

22. AR's parents were not blind to the items being delivered to the family home. Events at the Range High School (in October 2019) had made perfectly clear to them that AR had an interest in knives and would leave the house in possession of such an item, with intent to do serious harm to a specified individual. The parents learned of AR's declared intentions (to 'kill' somebody at school) via the Childline referral. When AR went missing on 17<sup>th</sup> March 2022, the first thought of his parents was that he had taken a knife with him. When he left the house on 22<sup>nd</sup> July 2024, (having not left the house alone for over two years<sup>60</sup>), Alphonse R, having already been attacked by AR using a knife that morning, stopped his son boarding a taxi in possession of a knife, for fear that serious violence would be carried out at his intended destination: the Range School. Alphonse R had previously seen AR's bow and arrows and petrol can. (AR had asked his father to buy petrol, leading Alphonse R to conclude that AR wanted to start a fire at the Range School)<sup>61</sup>. That day, AR issued a clear and menacing threat to his father: if his father prevented him from leaving the house again, there would be 'consequences'<sup>62</sup>. Accordingly, neither parent even attempted to prevent AR from leaving the house on 29<sup>th</sup> July 2024. AR had created an atmosphere of terror at home. Those who loved him and should have been able to exercise control over him claimed to be too frightened to take steps against him. Those steps should have included contacting the police to report their fears that AR had left the house, armed with a knife and with likely murderous intent.

### **Suggested Recommendations in Respect of Parental Responsibility**

23. In what circumstances should the state impose duties or the prospect of sanctions on a parent/guardian<sup>63</sup> who fails to take steps to exercise control over a child in their care posing a risk of causing serious harm to others? In the current case, the existence of a cluster of *moral* duties was plainly insufficient. In general, there is no legal duty on a parent – or on any individual – to report crime, save in certain specified circumstances provided for by statute.<sup>64</sup> Whether AR's parents may be deemed to be criminally liable for AR's actions on 29<sup>th</sup> July 2024 under current law is beyond the scope of the Inquiry's Terms of Reference. It is submitted that the crucial issue for the Chair is whether it is ever appropriate to impose a legal duty on a parent/guardian to report their child's actual or anticipated criminal activity.

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<sup>60</sup> IWS000060, paragraph 48 – Dion R stated that AR had 'a profound fear of the outside world...even opening the door would trigger panic'

<sup>61</sup> Alphonse R 6/11/25 p57 line 13 to p58 line 19

<sup>62</sup> Dion R 5/11/25, p42 line 24 to p43 line 3

<sup>63</sup> To include those who have 'parental responsibility' as defined by section 3(1) Children Act 1989.

<sup>64</sup> Such as failure to disclose relevant information - see section 38B of the Terrorism Act 2000 – or section 330 of the Proceeds of Crime Act 2002, or failure by those engaging in a relevant regulated activity (this would not cover parents/guardians) to report child abuse as contemplated by section 72 of the Crime and Policing Bill.

24. The Chair is invited to consider whether, where a parent/guardian knows or suspects, or has reasonable grounds for knowing or suspecting, that there is a real and immediate risk that a child in their care may be intent in engaging in serious violence, there should be a legal duty to disclose that fact to a police officer or to social services (who would then be fixed with knowledge and would have a duty to pass on the report to the police). Whether a *parent/guardian's* failure to discharge that duty should carry a criminal sanction is a matter that the Chair may wish to consider, despite this being an obvious incursion into the private life of citizens. Whether a *professional* (such as a social worker) fixed with such knowledge but failing to act on it should find themselves facing criminal liability is also a matter we invite the Chair to consider.
25. The current law allows for a court to make Parenting Orders and Parenting Contracts<sup>65</sup> in certain circumstances. Aside from cases involving truancy,<sup>66</sup> the former can only be imposed where there are extant court proceedings in respect of the child, and only if the order is desirable to prevent any repetition of the kind of behaviour which led to those proceedings.<sup>67</sup> In that sense, a Parenting Order is not a truly preventative measure. Parenting Contracts, under section 25 of the Anti-social Behaviour Act 2003, are a voluntary agreement between a Youth Offending Team and a child's parents where that child has been/is likely to become involved in crime/anti-social behaviour. The interventions are supportive rather than punitive. The Contract is a voluntary measure. There is no penalty for failure to comply. However, currently, a Parenting Contract still requires the child to have *already* been referred to the Youth Offending Team.
26. We submit that there needs to be a three-step approach to cases in which there is a real risk that a child may be intent on engaging in serious violence: (1) the presumption is that parents take responsibility for their children without state intervention; (2) parents who struggle to do so should be offered support under a Parenting Contract; (3) parents who are unable or unwilling to exercise adequate control over their children, even with support, should be subject to a Parenting Order, which should be available on the application of a local authority even if there have been no previous court proceedings in respect of the child. It does not seem to be out of step with the legislative aim that a Parenting Order imposed in those circumstances might require a parent to monitor their child's internet use for a period of 12 months, for example (because the order requires a parent to comply with '*such requirements as are specified*').
27. Finally, it is noted that PC Fairclough and PC Rhodes did not confiscate the knife that had been

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<sup>65</sup> Ministry of Justice, 'Parenting Contracts and Orders Guidance', available online at <https://dera.ioe.ac.uk/id/eprint/7949/7/parenting-contracts.pdf>

<sup>66</sup> Part 3 of the Anti-social Behaviour Act 2003

<sup>67</sup> Crime and Disorder Act 1998 section 8

in the possession of AR whilst on the bus in March 2022. It is unclear why they did not. They had power to do so under sections 1(1), 1(6) and 1(7) of the Police and Criminal Evidence Act 1984<sup>68</sup>. The Chair may wish to consider whether seizure, confiscation and deprivation of a knife or other unlawful weapon should be the norm even in cases where a suspect is not arrested.

### **SECTION THREE: LIFE IN THE COMMUNITY**

#### **Schools**

28. AR attended three schools in the Southport area. Whilst at the first of those schools, The Range High School, AR, aged 13, disclosed to Childline that he wanted to kill a fellow pupil. He admitted that he had taken a knife to school on some 10 occasions<sup>69</sup>. Childline referred AR to the police<sup>70</sup>. The Range School permanently excluded AR. A member of staff noted AR's '*significant lack of emotion and awareness [of] the risk posed to himself and the school community*'<sup>71</sup>. It is also of note that in September 2019, AR made reference to teachers being murdered and on another occasion that month, he struck a fellow pupil<sup>72</sup>. Separately, AR made reference to the Manchester Arena attack being a '*good battle*'. It was the Designated Safeguarding Lead, Mr Cregeen, who made the CAMHS referral in October 2019<sup>73</sup>.
29. AR moved to the Acorns School, a Pupil Referral Unit. There had been delay in information being passed to Acorns from The Range High School<sup>74</sup>. Furthermore, whilst Acorns used CPOMS, (Child Protection Online Management System), the Range High School used an *alternative* system for logging safeguarding issues<sup>75</sup>. In any event, Acorns had not received the headteacher's report and could not read the safeguarding records until AR was *already* on the roll. As Mrs Hodson told the Inquiry, '*it is a kind of chicken and egg thing*'.<sup>76</sup> A new school would not be put completely in the picture *prior* to the arrival of an incoming student<sup>77</sup>. Information about AR's alarming behaviour at the Range High School appeared to have been sent to the local authority (Lancashire County Council) to be forwarded to AR's new school (the Acorns). However, there was a delay of some weeks<sup>78</sup>. That information might have impacted on Acorns'

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<sup>68</sup> [Police and Criminal Evidence Act 1984](#)

<sup>69</sup> RAN000014

<sup>70</sup> MERP001868 (Action log re Childline)

<sup>71</sup> AHCH000120

<sup>72</sup> Cregeen 22/10/25 p219 lines 11-13

<sup>73</sup> RAN000008

<sup>74</sup> Cregeen 23/10/25 p17 lines 2-25 and p22 line 13

<sup>75</sup> Hodson 23/10/25 p130 line 8 to 22

<sup>76</sup> Hodson 23/10/25 p132 line 23 to p133 line 8

<sup>77</sup> Hodson 23/10/25 p207 lines 17-25

<sup>78</sup> Cregeen 23/10/25 p20 line 20 to p22 line 12

decision on whether to offer a place to AR.<sup>79</sup> AR's behaviour deteriorated at the Acorns School. On 15<sup>th</sup> November 2019, during a lesson, he was found to be researching mass shootings<sup>80</sup>. In another lesson, he requested a picture of a severed head<sup>81</sup>. He had made attempts to override security settings on school computers<sup>82</sup>.

30. Because of AR's behaviour at the Acorns School, staff were extremely worried about AR. The Inquiry heard from Joanne Hodson, (SENCO, DSL, deputy headteacher and, from July 2022, headteacher). She received extremely limited support from Lancashire County Council and made the very significant remark that *'with a West Lancs address and a Sefton GP, he is going to fall between the cracks'*. She knew, even then, that there was potential for a serious incident<sup>83</sup>. She had a *'visceral sense of dread'*<sup>84</sup>. Whilst a student at the Acorns, AR took a taxi to the Range High School on 11<sup>th</sup> December 2019, armed with a knife and a hockey stick. He attacked a child, someone he said he had liked, although his intention was to kill a different pupil (the alleged bully). Prosecution and conviction resulted (see below). The Acorns School referred AR to Prevent on three occasions (see below). Mrs Hodson described her experience at a multi-agency meeting (21<sup>st</sup> January 2020) at which she felt *'unsupported'* by other public bodies (CAMHS, police, Prevent and social services) and considered that there was truth in an observation made by an attendee that she had been *'left holding the baby'*<sup>85</sup>.
31. In April 2022, AR moved to the third school, Presfield, which was a special school for children with Autism. The Acorns sent (by email) the CPOMS record, AR's pupil risk assessment and his EHCP<sup>86</sup>. However, only the headteacher, the deputy head and the DSL had access to CPOMS<sup>87</sup>. In any event, the DSL, Cheryl Smith, (for reasons explained to the Inquiry<sup>88</sup>) failed to open the email containing that information until September 2024 (weeks after the incident at the Hart Space). Presfield was therefore in a position of ignorance in respect of the full extent of AR's history<sup>89</sup>. The evidence of Lucy McLoughlin reveals her frustrations with the late provision of key information<sup>90</sup>. She said that *'our professional curiosity was narrowed....we were looking at him as a*

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<sup>79</sup> Hodson 23/10/25 p101 lines 11-24

<sup>80</sup> LCC000010

<sup>81</sup> LCC000010

<sup>82</sup> Lewis 23/10/25 p62 lines 19-21

<sup>83</sup> LANC000059

<sup>84</sup> Hodson 23/10/25 p105 line 14

<sup>85</sup> Hodson 23/10/25 p140 line 11 and see LCC000031

<sup>86</sup> Lewis 23/10/25 p86 line 17-22

<sup>87</sup> Smith 23/10/25 p213 lines 11-16

<sup>88</sup> Smith 23/10/25 p224 line5 and p.225 lines 1-4

<sup>89</sup> For example, McLoughlin 27/10/25 p18 lines 6-17, p19 lines 14-20 and p20 lines 2-10 (re perceived deficiencies in the EHCP)

<sup>90</sup> McLoughlin 27/10/25 p26 lines 2-22

*vulnerable child...without having seen the information that was in CPOMS*<sup>91</sup>. AR's time there is characterised by spectacular non-attendance. Over the 26 months of him being on the roll at Presfield, his attendance was 0.7%. During this period, support received by the school from Lancashire County Council was '*virtually non-existent*'<sup>92</sup>. (This chimes with Mrs Hodson's feelings during the Acorns period of schooling.) Staff at Presfield made supreme efforts to try to accommodate AR's needs and to adapt to his wishes (regarding subjects taught, food provided, teaching spaces and one-to-one learning). The school made repeated but unsuccessful efforts to visit AR at home<sup>93</sup> (often at the expense of other students).

32. By the summer of 2024, AR had been removed from the roll at Presfield. His interaction with social care/the transitions team was practically non-existent. His home life permitted him to be unmonitored, isolated and very much in charge of family dynamics at home. Against that background, the dreadful events of 29<sup>th</sup> July 2024 occurred.

### **Suggested Recommendations in Respect of School Issues**

33. The themes that arise from AR's school experiences that are or may be relevant to recommendations for change are as follows:

- (1) The transmission of information about a child who transfers from one school to another. Some schools appear to use the CPOMS to record safeguarding issues; others do not. If CPOMS is used, not all staff can access it<sup>94</sup>. The Chair may wish to recommend a universal information management system used by all schools – public/private/special – and to recommend that all information is shared at an early stage by one school to another school contemplating offering a place to a child (as one would see with, for example, medical records).
- (2) The lack of lead agency when numerous public bodies are involved with a child. Mrs Hodson should never have been made to feel that she and/or Acorns had been '*left holding the baby*'. Kate Dixon (DFE) recognised the deficiencies in multi-agency working and in information-sharing in this case<sup>95</sup>. The Chair may consider that there ought to be a lead agency with a specially-trained lead individual with oversight of all records. That person ought to have ultimate responsibility for coordination of approach and decision-making to

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<sup>91</sup> McLoughlin 27/10/25 p35 lines 5-13

<sup>92</sup> McLoughlin 27/10/25 p51 lines 5-6

<sup>93</sup> McLoughlin 27/10/25 p40 line2 to p41 line 4

<sup>94</sup> Lewis 23/10/25 p37 line 11-24

<sup>95</sup> Dixon 27/10/25 p109 lines -21

reduce the risk posed by a child. An analogy may be made with MAPPA (multi-agency public protection arrangements) for the management of violent and sexual adult offenders. MAPPA is non-statutory body. It coordinates the responsibilities of the police, probation service, prison service and other agencies with a focus on information-sharing, risk assessment plans, multi-agency meetings, a secure database and more<sup>96</sup>. A similar body with oversight of the multiple agencies involved in AR's life would have assisted with risk assessment, information-sharing and, ultimately, risk reduction and risk management. The Children's Wellbeing and Schools Bill<sup>97</sup> seeks to strengthen arrangements for multi-agency working and information-sharing, giving prominence to safeguarding issues over confidentiality concerns<sup>98</sup>. It aims to establish MACPTs (multi-agency child protection teams), creating a duty for safeguarding partners (local authorities, police and health) to support local authorities in discharging child protection duties. The Chair may feel that MACPTs will only be successful where there is a lead agency/individual shouldered with the responsibility of ensuring successful adherence to the statutory aims. It was the view of Kate Dixon that the Bill will help but that *'it doesn't solve the whole problem'*<sup>99</sup> unless individuals input the correct data, share information properly and *'talk to each other'*. Such an approach can only come from rigorous training which, it is submitted, should form part of the Chair's recommendations.

- (3) The general responsibility taken by one local authority when a child resident in one local authority area attends school in another. There needs to be a clear arrangement with one local authority taking ultimate responsibility, leaving no child, its family or the various agencies (including schools) in the dark about where to seek assistance and support. In AR's case, there was buck-passing between two local authorities and their *'missing from education'* teams<sup>100</sup>, leading to exasperation by Presfield staff about how they might *'have eyes on'* AR in the glare of the *'frightening'* *'red tape'*<sup>101</sup>.
- (4) The need for there to be a clear standardised approach to an EHCP and its contents with a specific section for detailed risk assessments, particularly where a child presents or may present a risk to others<sup>102</sup>.

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<sup>96</sup> [Multi-Agency Public Protection Arrangements - MAPPA](#)

<sup>97</sup> [Children's Wellbeing and Schools Bill: policy summary notes](#)

<sup>98</sup> Dixon 27/10/25 p111 line 2 to p112 line 2

<sup>99</sup> Dixon 27/10/25 p112 lines 11-12

<sup>100</sup> Smith 23/10/25 p240 line 7 to p243 line 11

<sup>101</sup> Smith 23/10/25 p242 line 19 to p243 line 11

<sup>102</sup> Dixon 27/10/25 p78 lines 5-21

- (5) The level of monitoring of a child in circumstances where the child is not attending school and whether there should be a minimum requirement, and a *lower* threshold test, for welfare checks carried out by a local authority and/or the police<sup>103</sup>.

## **Lancashire County Council**

### Social Care's Response to AR

34. In their opening LCC sought to provide reassurance that there is now '*a greater focus...on the assessment of risk posed by children and young people to others*'. It was said that '*a serious violence toolkit has been developed which offers evidence-based resources and responses*' and that '*Children's Social Care is now supported by an autism support team to ensure that the service can better meet the children who are neuro-diverse*'<sup>104</sup>. A degree of caution may be required when considering these broad statements. The witness testimony and review of the extensive documentation reveals inconsistent record-keeping, gaps in information-sharing, weaknesses in quality assurance systems and an inability consistently to identify the risk of violence. These failings, together with excessive workloads, removed the ability of these agencies properly to identify escalation or patterns of risk.
35. AR came to the notice of the Child Services in LCC in October 2019 when Lancashire Constabulary made a high risk safeguarding referral to MASH, (the Multi-agency Safeguarding Hub, run by LCC). Going in to MASH, the level of need was assessed as 4<sup>105</sup>. MASH focuses on early intervention within the community to ensure a joined-up response to safeguarding concerns. This did not take place. MASH referred AR on to the Early Help team, a newly-formed team operating within the Child and Family Wellbeing Service. The Episode record dated 8<sup>th</sup> October 2019 identified AR as 2b - Early Help (High Complexity) on the Continuum of Need. This was at odds with the police assessment of 'high risk' but also at odds with their own Continuum of Need<sup>106</sup>.
36. There were a plethora of issues with Early Help, including, but not limited to, the disparity in risk grading. It was said by Katherine Ashworth, Head of CFWS, that despite what she described as teething problems, this was a '*robust resource ...that hadn't previously been there to any significant extent, that was able to respond at the newly defined level in the Continuum of Need of level 3.*' The evidence suggests

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<sup>103</sup> LANC000291 – statement of PC Robert Correy whose decision not to arrange a welfare check having applied the appropriate test on 21<sup>st</sup> March 2023 was endorsed by ACC Winstanley

<sup>104</sup> LCC Opening Statement 17/9/25 p52 lines 1-2

<sup>105</sup> LCC000230

<sup>106</sup> LCC001926

otherwise.

37. Within this new construct, there was a key skill set loss (the loss of consultancy and supervision from social workers), and it would seem that the Early Help team adopted their own risk criteria, ignoring the classification set out in the Continuum of Need.<sup>107</sup> Without a consistent risk assessment (for example a shared risk dashboard) there was a significant possibility that children at risk would be lost.
38. Throughout the course of Phase 1 it has become apparent that at LCC, the record-keeping and information-sharing has been, for the most part, inadequate<sup>108</sup>, in some cases inaccurate and in others, missing altogether<sup>109</sup>. Even where notes were available, some case workers considered they did not have time or a need to review the notes<sup>110</sup>. The Chair is invited to consider whether there is a need within LCC for mandatory training in this area.
39. AR was discussed at a multi-disciplinary strategy meeting on 17<sup>th</sup> December 2019<sup>111</sup>. There were no standardised minutes kept from that meeting: rather, some of those attending kept their own notes. Without standardised minutes there could be no clearly defined agenda and no clear strategy. Key information would be missed and lost to those both in and not in attendance<sup>112</sup>.
40. At that strategy meeting, Paula Murphy, the investigating officer, reported that AR was known to have been researching violent acts online (which he had denied in interview). It was said that there were some concerns within the interview that he would laugh at inappropriate times and there was not really any challenge from his mother. When Stephanie Halloran interviewed AR in custody he had confirmed that he had intended to kill the intended victim and *'he showed no remorse'*. It was said that *'dad was dismissive when contacted by police...stated he couldn't get there as he was busy.'* LCC attendees noted that when they visited, AR was *'quite a force in the household'* and he gave a different account as to why he had taken the knife to school. At that stage it was known by the professionals that AR had attended his previous school and had attacked a pupil with a hockey stick. It was known that he had been in possession of a knife, had researched violence online and had shown no remorse. AR's father was dismissive of these issues. AR was not challenged by his mother. And AR had later lied about why he had taken the knife to school.

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<sup>107</sup> LCC001926, page 15 on

<sup>108</sup> Jameson 2/10/25 p114 lines 6-8

<sup>109</sup> LCC000020 Acorns recorded the FCAMHS meeting, LCC did not.

<sup>110</sup> Lewis 28/10/25 p142 lines 8-10

<sup>111</sup> LCC000234

<sup>112</sup> Jameson 28/10/25 p228 lines 21-25

41. Anna Jameson explained to the Inquiry that *'at this point I'm looking at risk of harm to him.'*<sup>113</sup> It may be of some note that during the FCAMHS meeting on 21<sup>st</sup> January 2020 she reported that *'she had been directed to carry out a risk assessment but she didn't think she could do this, it should be education.'*<sup>114</sup> The informal nature of the strategy meeting resulted in a lack of clear allocated action and no proper follow up to ensure actions were taken. This should not excuse Ms Jameson's failure properly to assess risk and in particular her failure to consider the risk AR posed to others.
42. What was missing from that strategy meeting was a clear, consistently-applied risk threshold, which could have been supported with appropriate training and audits to ensure reliable application. This left LCC unable to implement any effective response, missing key information and the chance to prevent AR from re-offending or causing harm. AR was high-risk and he required co-ordinated, intensive, timely intervention.
43. The Chair is invited to recommend that at such strategy meetings (as well as standardised minuting and a consistently applied risk threshold) consideration should be given to a nominated 'high-risk child panel', where those in attendance consider whether the child exhibits escalating violence and thereafter set down clear support and therapy with a timetabled plan aimed at reducing the risk.
44. At the follow-up meeting in January 2020,<sup>115</sup> AR was described as *'very autistic'* but remained without a diagnosis, something Dr Irani confirmed should have been challenged<sup>116</sup>. It was recorded that Prevent had *'no concerns that he was being led into criminality or radicalised, but it was noted that he showed no remorse.'* It was said that *'CSC are completing C&F assessments...this will comment on the risk he poses...specifically the appointment with FCAMHS which will comment on the risk he will pose.'* It was then recorded as *'no further action.'* This was wholly inconsistent.
45. At the FCAMHS meeting on 21<sup>st</sup> January 2020, John Hicklin, Clinical Nurse Specialist from FCAMHS was *'concerned that AR may become frustrated by being cooped up in the house all day and this could lead to another incident.'*<sup>117</sup> He was the only practitioner to have considered that in the years of involvement with LCC. Mr Hicklin also identified that AR needed *'structure and a robust education package with other services supporting him'*<sup>118</sup>, but he did not take the lead in this process as he should

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<sup>113</sup> Jameson 2/10/25 p62 line 25 and p63 lines 1-2

<sup>114</sup> LCC000385

<sup>115</sup> LCC000235

<sup>116</sup> Irani 22/10/2025 p37 lines 9-10

<sup>117</sup> LCC000020

<sup>118</sup> LCC000031

have done.

46. On 14<sup>th</sup> February 2020 Skott Morgan, CAMHS wrote to Anna Jameson<sup>119</sup> highlighting AR's lack of emotion and his need for routine. This advice does not appear to have been followed. In fact AR was exposed to constantly changing services and people. There was very little, if any, routine.
47. In March 2020<sup>120</sup> Mr Hicklin identified issues that should have been taken into account but unfortunately, CAMHS was not there to listen. Again Mr Hicklin did not take the lead, he did not help coordinate the risk assessment or handover the work that was required, something Dr Irani explained was within his role.<sup>121</sup> AR was stepped down to Early Help following a call with Andrea Fontaine on 24<sup>th</sup> March 2020. He continued to be assessed as 2b – Early Help (High Complexity) although there appears to be no information as to why he had been stepped down from level 4. What had changed?
48. Dr Janet Ramsay, Educational Psychologist attended a TAF meeting on the 19<sup>th</sup> May 2020 with Andrea Fontaine, key worker and Anna Croll, Social Worker. At that time it *'was identified that AR would benefit from work around social interactions with peers and appropriate responses particularly to situations he doesn't like...effective through face-to-face support.'*<sup>122</sup> On 27<sup>th</sup> May 2020, Dr Ramsay assessed AR by telephone and concluded that he would require *'coordinated involvement of a range of agencies to ensure his safety and promote his social and emotional development as well as reinforcement by specialist support outside the school day to enable him to have guided situational practice so that he can develop and internalise models of positive behaviour'*<sup>123</sup>. This was an informed opinion that should have been used to assess risk and guide interaction with AR.
49. Only two weeks later, on 9<sup>th</sup> June 2020, when contacted by AR's school, Andrea Fontaine refused to support the school, contrary to Dr Ramsay's recommendations. The school pleaded saying *'there is a real need for services to work together'*<sup>124</sup>. This plea was ignored and AR's case was closed at the request of AR's father. This is further evidence that the services were not willing or able to work progressively, to see the bigger picture or at the very least to follow the guidance of experts.
50. On 14<sup>th</sup> September 2020 AR was re-referred to Early Help<sup>125</sup> and an assessment on 22<sup>nd</sup>

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<sup>119</sup> LCC000029

<sup>120</sup> GMMH00007

<sup>121</sup> Irani 22/10/25 p22 lines 13-21

<sup>122</sup> LCC000061

<sup>123</sup> LCC000058 p.13

<sup>124</sup> LCC000998

<sup>125</sup> LCC00008

September 2020<sup>126</sup> recorded that *'parents responded appropriately around the time of the incident last year.'* That was not accurate. Sharon Barrett, during the course of her evidence, agreed that crucial information was missing from the assessment and that the assessment of risk was either incomplete or *'plain wrong'*<sup>127</sup>. Andrea Fontaine-Smith confirmed that *'some of the detail about risk had fallen away...diluted through the process of cases closing and re-opening'*<sup>128</sup>. A robust system that allowed cross-service consideration of notes and proper preparation by professionals would have avoided this. The Chair is invited to consider that as part of his recommendations.

51. What is clear is that CFW had determined to close the case. Despite there being reports of violence in the home (which was denied by AR's father), by 10<sup>th</sup> February 2021, AR's case was closed with it being recorded that his *'needs were met'*<sup>129</sup>. As accepted by Sharon Barrett there was a culture of being too *'process-driven'*<sup>130</sup>. There was an urgency to close cases with ineffective intervention that led to inevitable re-referrals.
52. On 24<sup>th</sup> June 2021 AR was referred to the Transitions team along with his brother. This was to establish a transition plan to ensure that AR's needs were catered for<sup>131</sup>. That did not take place. The Transitions team were wholly ineffective. There was extensive delay and unjustified inaction. Their involvement culminated with notes being written up *after* this heinous attack, months after the appointment, which is, at best, a derogation of duty.

### Family Engagement

53. There is substantial evidence of a lack of engagement and co-operation by the family and AR. Visits to the home were repeatedly declined and although calls and texts were sent by professionals, on occasion, receipt of these was denied.<sup>132,133</sup> Although it is recognised that practitioners do not have a right of access, the persistent reluctance to admit visitors could and should have been escalated.
54. When there *was* engagement with AR and/or his family, there was not only an over-reliance on family reports but in some cases an *'unrealistic parental preference'*<sup>134</sup>. When initially referred, there was no meaningful engagement with the family until 5<sup>th</sup> December 2019 and at the C & F

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<sup>126</sup> LCC000083

<sup>127</sup> Barrett 29/10/25 p57 lines 9-15

<sup>128</sup> Fontaine-Smith 29/10/25 p190 lines 4-8

<sup>129</sup> LCC000305

<sup>130</sup> Barrett 29/10/25 p81-2

<sup>131</sup> NICE NG43 Social Care Guideline Transition Care

<sup>132</sup> Ashworth 3/11/25 p19 lines 13-22

<sup>133</sup> LCC000226

<sup>134</sup> Dixon, 27/10/25 p12-13

assessment on 19<sup>th</sup> February 2020 where AR's parents' parenting capacity was considered, the previously-expressed concern that AR had dominating parents was downplayed, stating that they managed boundaries effectively<sup>135</sup>. Amanda Chapman, social worker conducted the 'return home' interview on 22<sup>nd</sup> March 2022. AR controlled that interview, directing the course it took. After that, the referral to Lancashire County Council was closed<sup>136</sup>.

### Medical Involvement

55. Dr Ramasubramanian met AR in July 2021. She confirmed to the Inquiry that she would rely '*heavily on information on the electronic patient records and verbal kind of information from the case manager*<sup>137</sup>.' She was reliant on those other agencies to provide her with accurate information that would enable her to formulate a safe risk assessment. They would be '*highly relevant to her understanding of how he was presenting*<sup>138</sup>.' Dr Ramasubramanian suggested that a '*standardised information handover to psychiatry, specifically focusing on the key areas of risk, risk to self, risk to others, risk of self-neglect and risk of vulnerability. . . . in a one-page format could really, really alert the psychiatrist to key information that you need before you see a patient*<sup>139</sup>. We invite the Chair to consider this suggestion.
56. On 27<sup>th</sup> September 2021 there was a case discussion.<sup>140</sup> The notes reveal quite clear risk dilution, (something accepted by Andrea Fontaine-Smith in her evidence to the Inquiry). Ms Fontaine-Smith agreed that this '*person-centred approach allowed AR to deflect questions about risks he posed to others*<sup>141</sup>. Such a blinkered approach to assessment was bound to fail.
57. Towards the end of 2021, AR was increasingly aggressive at home, but at the TAF meeting on 12<sup>th</sup> January 2022 there was an assumption that the case would be closed to CFW once sessions were delivered by youth support. How can that be right? This is an assumption of success without any evidence. This time-limited service closed to AR on 14<sup>th</sup> March 2022. Complex needs cannot be solved on short timelines. This interaction was bound to fail. Focusing on compliance with timings left no time for any effective preventative work; the lack of continuity would inevitably lead to repeated referrals. Only a few days later AR was found on a bus with a knife. Louise Lewis, the CFW case handler, didn't make any enquiry as to whether AR had been found and she did not engage with other agencies to understand what had happened or to

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<sup>135</sup> LCC000027

<sup>136</sup> Ashworth 3/11/25 p20 line 19 to p21 line 7

<sup>137</sup> Ramasubramanian 20/10/25 p101 lines 18-24

<sup>138</sup> Ramasubramanian 20/10/25 p116 lines 2-5

<sup>139</sup> Ramasubramanian 20/10/25 p120 lines 12-17

<sup>140</sup> LCC000249

<sup>141</sup> Fontaine-Smith 29/10/25 p193 lines 19-25

consider what should be done. Ms Lewis accepted that that was *'very poor'*<sup>142</sup>.

58. Returning to November 2021, at that time the supervisor of the Targeted Youth Support Team Carl Coughlan, met AR. He did not review any notes in advance of that meeting. That approach was extremely concerning. Safe, ethical and effective practice depends on being fully-informed. When Mr Coughlan met with AR, much of what he was told was untrue or half-truths<sup>143</sup> and he had no metric against which to measure the information he was receiving. Mr Coughlan accepted he was entirely wrong in his assessment of AR.<sup>144</sup>
59. We invite the Chair to consider a recommendation that training across the board is mandated to ensure that notes are read, considered and information gathered prior to meeting service-users. It is of grave concern that a supervisor felt able to ignore what to many would appear to be the appropriate starting point for interaction with a service user.
60. Dr Ramasubramanian had prescribed medication to AR but she identified a pattern: that when demands were placed on him, AR would meddle with his medication. She therefore felt it was safer to stop the medication<sup>145</sup>. When Dr Molyneux took over, he ignored that approach or *'momentarily overlooked it'*<sup>146</sup> and, despite there being *'lots of chopping and changing with medication'*,<sup>147</sup> he simply prescribed medication at the request of AR's father, despite knowing that AR was not complying with the medication instructions.
61. Dr Ramasubramanian said that it was the very first time in her career that she *'had to request a change of psychiatrist because of how I was made to feel by a parent. It is quite unprecedented, in my opinion, and I vividly remember the level of distress I went through at the end of the appointment'*<sup>148</sup>. Despite that, Dr Molyneux who was assigned as a replacement psychiatrist confirmed that the *'sole conduit for information was Alphonse'*<sup>149</sup> but went on to suggest that it was the family systems and family dynamics that were at fault<sup>150</sup>. We suggest that this is a bizarre situation where Dr Molyneux was relying on a parent for all the information but considered that parent to be the source of the problem.

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<sup>142</sup> Lewis 28/10/25 p192-3

<sup>143</sup> LCC02302 p53

<sup>144</sup> Coughlan 28/10/25 p227 lines 13-19

<sup>145</sup> Ramasubramanian 20/10/25 p140 lines 13-19

<sup>146</sup> Molyneux 20/10/25 p41 line 19

<sup>147</sup> Molyneux 20/10/25 p47 lines 17-18

<sup>148</sup> Ramasubramanian 20/10/25 p141 lines 4-8

<sup>149</sup> Molyneux 20/10/25 p59 lines 14-16

<sup>150</sup> Molyneux 20/10/25 p52 lines 1-17

## Neurodiversity and Lancashire County Council

62. Sharon Barrett<sup>151</sup> set out that she did not know that ASC could increase the risk to others. This demonstrates ineffective knowledge and training for which LCC must be held accountable. Without accountability they cannot learn. It is clear that the increased vulnerability of children with special educational needs and who are neurodiverse was not sufficiently responded to. At the start of the diagnostic process, the ASD assessment took many months. The ADHD assessment never took place. Faster access to diagnostic health assessments and tailored interventions may well have made a difference here. Louise Lewis confirmed that she had developed her experience over time rather than receiving specific training<sup>152</sup>. The responsibility for this lack of knowledge lies at the door of LCC.
63. It became clear during the course of the evidence that LCC had not sufficiently adapted the risk recognition or responses for those children with neurodiverse presentations. Dr Irani explained that autism is a *'social communication difficulty...what you need is adaptations to the processes around you'*<sup>153</sup>. The delay of 45 weeks in achieving a diagnosis of ASD was a failing by LCC. There should be a system of auditing that enables adequate and expeditious monitoring of cases.
64. Dr Irani was clear in her criticisms that there should have been a risk assessment that informed the management plan<sup>154</sup>. The need for specialist interventions which are sensitive to neurodiversity are mandated.
65. It is important to note at this stage that the failure by the Transition team is of grave concern to the families we represent. For those who are neurodiverse, an abrupt change in approach on reaching their 18<sup>th</sup> birthday would be particularly challenging.

### **Suggested Recommendations in Respect of Social Care**

66. The lack of sufficient professional curiosity permeated the services at LCC. Assessments were often inadequate, escalation did not happen and there was little to no challenge when decisions were made. The urgency to close cases resulted in a pattern of deflection and redirection, without any noteworthy intervention. We invite a review of Social Care and their approach to assessment of risks that children may pose to others.

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<sup>151</sup> Barrett, 29/10/25

<sup>152</sup> Lewis, 28/10/25

<sup>153</sup> Irani 22/10/25 p36 line 20

<sup>154</sup> Irani 22/10/25 p70 lines 19-24

67. We invite the Chair to recommend that a referral into Social Care should lead to the allocation of a highly-experienced and specially-trained care co-ordinator who can ensure that with referral, progress is made. As Dr Ramasubramanian said during the course of her evidence *‘There are so many agencies involved in his care, which is positive if you look at it. However, it posed immense challenge in terms of interagency communication and interagency working and there was lack of clarity on who offers leadership for assessment in these cases.’*<sup>155</sup>

### **AR’s Referral Order**

68. Following his conviction for offences committed at the Range High School, AR was made the subject of a Referral Order by the Youth Court. Such an order is intended to provide *‘concentrated intervention’*<sup>156</sup> by the YOT and particularly so for a child with *‘complex needs’*, including a suspected ASD diagnosis and an EHCP with SEND involvement<sup>157</sup>. One of the statutory functions of a Referral Order is to promote good practice in the prevention of offending by children and young persons<sup>158</sup>. Stephanie Roberts-Bibby told the Inquiry that a Referral Order should be both *‘inspirational and aspirational’* for that child<sup>159</sup>. In AR’s case, it was neither.

69. In AR’s case, the Referral Order was ineffective in achieving its aims. The information initially provided to the YOT was incomplete. It did not present a true picture of what AR had done at the Range High School and what his true intentions had been<sup>160</sup>. YOT officers frequently took AR’s word at face value and did not seek to challenge him sufficiently or at all. Officers accepted AR’s parents’ assertions that they had *‘no ongoing concerns’* about AR or his behaviour. The YOT were not provided with all available information about AR due to Information Technology deficiencies (recording and sharing), leading Stephanie Roberts-Bibby to declare to the Inquiry: *‘Without the right information, you aren’t then able to make an informed assessment of risk and I’m speechless at how much information was available in an uncoordinated, scattered way that means that there were several opportunities that weren’t grabbed.’*<sup>161</sup> AR’s Referral Order endured during the Covid restrictions but despite that, its component parts were woefully inadequate with short-lived contact between YOT officers and AR. Brief weekly telephone calls (some ineffective; some as short as 10-15 minutes<sup>162</sup>) could not possibly have achieved the aims of CYJS<sup>163</sup>. Nor could three 30-minute

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<sup>155</sup> Ramasubramanian 20/10/25 p149 lines 5-12

<sup>156</sup> YJB000076 p2 paragraph 7 (statement of Stephanie Roberts-Bibby)

<sup>157</sup> LCC000452 p5 (Referral Order Initial Panel Report)

<sup>158</sup> YJB000076 p8 paragraph 36.5(iii)

<sup>159</sup> Roberts-Bibby 4/11/25 p12 lines 14-15

<sup>160</sup> LCC000452 p3-4 (YOT Initial Panel Report)

<sup>161</sup> Roberts-Bibby 4/11/25 p59 lines 1-5

<sup>162</sup> LCC000488 – various pages (Youth Justice Contacts Print Report)

<sup>163</sup> LCC001712 paragraph 31 (Statement of Sarah Callon)

*'worksheet interventions'* on knife crime, anger management and victim awareness.<sup>164</sup> Astonishingly, for the final three months of the 10-month order, contact was reduced to once a month.<sup>165</sup> AR's risk (which had been assessed as *'medium'*) was wrongly downgraded to *'low'*.

70. Yet the *current* legal framework meant that a Referral Order was the *inevitable* result of AR's conviction, due to his age and the nature of his offending<sup>166</sup>.

### **Suggested Recommendations in Respect of Youth Justice/Referral Orders**

71. The Chair is invited to consider the current adequacy of a Referral Order for children who have committed serious crime, including knife crime. Whilst it is acknowledged that under section 84 of the Sentencing Act 2020, certain offences would not lead to a Referral Order (such as an offence for which the sentence is fixed by law)<sup>167</sup>, the reality is that the vast majority of first-time child offenders will receive such a disposal (either as a mandatory order or as a discretionary order).<sup>168</sup> It should be noted that the Referral Order was created by section 1 of the Youth Justice and Criminal Evidence Act 1999 at a time when knife crime generally and youth knife crime in particular was far less prominent than today<sup>169</sup>.
72. For a person over 18 years who has been convicted of a *'specified'* offence, the police may apply for a civil Violent Offender Order<sup>170</sup>. AR would not have been eligible for such an order. There appears to be a gap in the law into which a person under 18 years who poses a risk of harm to others and has not been convicted of any or any specified offence may fall.
73. The Chair may wish to consider if there should be an *'enhanced'* version of a Referral Order tailored to children who have committed certain categories of crime, including knife crime<sup>171</sup>.
74. For adult offenders, the criminal law deems certain offences as particularly serious<sup>172</sup>. The Chair is invited to consider whether the criminal law should distinguish certain offences committed by *first-time child offenders* such that they may be made the subject of an *'enhanced'* Referral Order.

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<sup>164</sup> LCC000454 p4 (Referral Order Review Panel Report)

<sup>165</sup> LCC000454 p5 (YOT Referral Order Review Panel Report)

<sup>166</sup> YJB000076 p28 (statement of Stephanie Roberts-Bibby)

<sup>167</sup> Sentencing Act 2000 section s84(1)(c)

<sup>168</sup> Section 85(1)(b), (c)

<sup>169</sup> HOM000123 (54,587 knife/sharp instrument crimes recorded for year ending December 2024) and see <https://researchbriefings.files.parliament.uk/documents/SN04304/Knife-crime-statistics-data-tables-Oct-2025.xlsx> (41% of homicides were caused by a knife/sharp instrument for the year ending December 2024 compared to 31% for the year 1998/9)

<sup>170</sup> Section 98 of the Criminal Justice and Immigration Act 2008

<sup>171</sup> For the year ending March 2024, 17% of the 18,560 knife crime offences resulting in conviction or caution were related to those under the age of 18 years (YJB000076, p18 paragraph 74)

<sup>172</sup> See, for example, *'specified'* violent, sexual or terrorist offences (schedule 18 of the Sentencing Act 2020) and the *'dangerousness'* test under section 267 and 280 of the Act

Specially-trained YOT officers could be reserved for such cases, providing intense, bespoke in-depth and meaningful course components with focussed deterrence and mentoring<sup>173</sup>. This would be in keeping with the Sentencing Council's Guideline on Sentencing Children and Young People<sup>174</sup> which reminds sentencers, at paragraph 1.1, that the principal aim of the Youth Justice System is to prevent offending by children and young people<sup>175</sup>. Furthermore, the Chair may wish to consider the observation by Stephanie Roberts-Bibby that '*the challenge posed by children in justice is that there is no firm placement or central touchpoint*'<sup>176</sup>. The BOLD project (Better Outcomes Through Linked Data) suggests that the effectiveness of a Referral Order would be greatly enhanced if the current inadequacies in information-sharing between agencies were addressed. There should be a single case-management system for all agencies with one single agency (either an existing agency or a new agency created for the purpose) acting as '*lead*' agency to ensure timely and effective information-sharing. There should be an improved information technology system that brings all relevant information into one place so that it is easily available to all professionals tasked with monitoring a child, assessing risk and overseeing court orders.

75. In addition, where multiple organisations are involved, as in AR's life, there ought to be a single individual who has complete oversight of the work of all agencies and who has access to all information. That person ought to be shouldered with ultimate responsibility as to steps to be taken to reduce or eliminate the risks posed by a subject.

### **Missing From Home Incident – 17<sup>th</sup> March 2022**

76. On 17<sup>th</sup> March 2022, AR left his home in possession of a small knife. His parents contacted the police and alerted them to their concern that AR may have taken a knife. AR was located later that afternoon on a bus in Rufford (halfway between Banks and Ormskirk).<sup>177</sup> AR was not in possession of his medication (Sertraline)<sup>178</sup>. When challenged by the two attending police officers (both in their probationary period), he was argumentative and very reluctant to get off the bus, protesting that he had '*done nothing wrong*'<sup>179</sup>.
77. Despite being in possession of a knife, AR was not arrested (nor detained under section 136 of the Mental Health Act 1983). The attending police officers simply did not have sufficient access

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<sup>173</sup> YJB0000076, p32, paragraph 148 and YJB000112

<sup>174</sup> [Sentencing children and young people](#)

<sup>175</sup> Section 37(1) Crime and Disorder Act 1998

<sup>176</sup> YJB0000076 p4 paragraph 16

<sup>177</sup> ILT000021 (map of key locations)

<sup>178</sup> MERP000607 (PC Fairclough's pocket notebook entry)

<sup>179</sup> LANC000019, p1-5

(on their Samsung device) to the full information/intelligence about AR at that time<sup>180</sup>. They were unaware of his previous convictions in relation to his attendance at the Range High School (the hockey stick incident), nor of his earlier admissions to having taken a knife to the Range School on ten occasions, nor of the Prevent referrals by the Acorns School. Despite being told by AR that he had intended to stab someone, and that he had thought about poisoning people, the officers maintained their decision not to arrest AR, because they concluded that he did not have capacity/was too ill. Nor did they engage their professional curiosity by pressing AR on his intended final destination (and intended target). They simply drove him home, returned the knife and provided AR's parents with advice. The attending officers did not reveal to their sergeant AR's remarks about his intentions, although they did include that information on a high-risk vulnerable child form<sup>181</sup> (submitted the following day) and shared the information with the MASH, child social-care, education and health services. The Inquiry heard from ACC Mark Winstanley who confirmed that a police officer is not qualified to assume that a child threatening an act of violence does not have capacity<sup>182</sup> and that AR *should* have been arrested that day.<sup>183</sup>

78. Had AR been arrested, there would have been grounds to search his home. Even by March 2022, incriminating items would have been found (for example, Ricinus seeds, purchased on 19<sup>th</sup> January 2022<sup>184</sup>, Isopropyl alcohol, purchased on the same date<sup>185</sup>, pestle and mortar, conical flask, goggles, funnels, 3ml droppers purchased on 25<sup>th</sup> January 2022<sup>186</sup>). In the light of AR's admission to the officers about having thought about poisoning people, such items, if found, would surely have led to prosecution.

### **Suggested Recommendations in Respect of Policing**

79. It is submitted that the above incident shines a spotlight on deficiencies in policing that might be addressed by recommendations:
- (1) Improved access to information on handheld devices used by police officers when on duty in public (although ACC Winstanley indicated that there had been a trial of Samsung tablets (rather than smaller devices) for response officers)<sup>187</sup>.

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<sup>180</sup> Winstanley 8/10/25 p65 line 24 to p66 line 16

<sup>181</sup> MERP0001343 (safeguarding referral form)

<sup>182</sup> Winstanley 8/10/25 p17 lines 7-25

<sup>183</sup> Winstanley 8/10/25 p70 lines 2-4

<sup>184</sup> MERP000757 – found under the bed in the front bedroom

<sup>185</sup> MERP000471 – found on the floor in the front bedroom

<sup>186</sup> MERP000767 p5 – found in a box at the foot of the bed

<sup>187</sup> Winstanley 8/10/25 p67 lines 2-11

- (2) Intensive training of police officers to address lack of professional curiosity and to encourage much more pro-active information-sharing within forces, across force boundaries and with other agencies. At all points, officers should be trained to ask themselves, '*who else needs this information?*'
- (3) A responsible individual with complete oversight of all relevant information. When the police were contacted at various times by AR's parents due to incidents of violence and criminal damage, there was no police officer or police team who had an overview of the developing and emerging picture and therefore no person/body with overall responsibility<sup>188</sup>.
- (4) The Crime and Policing Bill gives important food for thought. It seeks to expand the scope and range of powers to tackle anti-social behaviour currently contained in the Anti-social Behaviour, Crime and Policing Act 2014. The Bill seeks to create new '*Respect Orders*', (Clauses 1(1)-(3)), a form of behavioural control order (a civil tool that imposes limitations on a person's liberty and daily activities in an attempt to prevent unwanted behaviour). However, such orders can *only* be imposed on adults over the age of 18. The Chair is invited to consider recommending that a similar such order is made available to those *under* the age of 18. It might be imposed by the County Court or High Court upon application by a local authority, police force or housing provider, where a court is satisfied (on the civil standard of proof) that the child or young person has engaged in *or appears likely to engage* in violent conduct (rather than 'anti-social behaviour') and where it is '*just and convenient*' to do so to prevent violent behaviour by that child/young person. The court could then impose a range of restrictions, at its discretion, including curfews (with or without electronic monitoring), travel restrictions, monitoring of their use of the internet/social media and notification requirements. Breach of conditions could lead to criminal sanction (fine/imprisonment).
- (5) The Bill also seeks to introduce the Youth Diversion Order (Part 14). This would be a new diversionary civil order to better manage terrorist risk from young people (aged 21 or under). The Order would be available upon application to the Youth/Magistrates' Court if, on the balance of probabilities, the court assesses that there is evidence that the young person has committed a terrorism-related offence or has conducted themselves in a way that was likely to facilitate the commission of a terrorism offence (subject to the tests of necessity and

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<sup>188</sup> Winstanley 8/10/25 p59 lines 1-13

proportionality). Breach of the order could lead to criminal sanctions<sup>189</sup>. Although there has been much opposition to the proposal from pressure groups<sup>190</sup> (due to the impact of criminalising children and labelling them as ‘terrorists’), the Chair may feel that in the light of AR’s acts of extreme violence, it would be proportionate to consider a modified similar order that would cover children/young persons presenting with such risks as AR.

- (6) AR would not have been eligible for such an order (see conclusions of the three Prevent referrals), but the Chair may wish to consider recommending a like-order with a wider test: where the court assesses that there is evidence that the young person may be contemplating committing a terrorism-related offence or an offence involving mass violence or has conducted themselves in a way that was likely to facilitate the commission of such an offence. It is submitted that the public interest in managing those who pose such risks outweighs the intrusion into civil liberties.
- (7) Finally, it may be instructive to consider how other jurisdictions have sought to tackle knife crime<sup>191</sup>. School-based educational programs, police-youth community interaction to encourage trusting relationships between the public and law-enforcement officers may be longer-terms solutions, (as per the German and Australian approach).

## Prevent

80. The Chair has heard evidence on two particular weaknesses in the Prevent system: the distorting effect of neurodivergence and mental health upon decision-making, and the strategic confusion about how to deal with cases in which ideology is unclear or absent. The first is a problem internal to Prevent. The second goes to how Prevent should be integrated into a wider system to prevent serious violence.
81. It is clear that, in AR’s case, officers handling the Prevent referrals failed to seek specialist input (initially from the Vulnerability Support Hub)<sup>192</sup> to help them understand how his neurodivergence might be driving his risk presentation and to inform the appropriate next steps.<sup>193</sup> Senior police witnesses were clear that these issues require careful, case by case analysis, drawing on specialist input.<sup>194</sup>

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<sup>189</sup> [Crime and Policing Bill: counter-terrorism and national security factsheet - GOV.UK](#)

<sup>190</sup> [68fa2e7376e990f8e8234174 Formatted JUSTICE Coalition YDO Briefing - Crime and Policing Bill - Part 14 - HoL 2nd Reading.pdf](#)

<sup>191</sup> [International Comparisons: How Other Countries Handle Knife Crime • Knives For Lives](#)

<sup>192</sup> Thompson 9/10/25, p86: lines 4-10

<sup>193</sup> Kenwright 13/10/25 p146 line 19 – p147 line 12

<sup>194</sup> Evans 14/10/25 p66 line 14 – p67 line 10; p69 line 8 – p70 line 22

82. This is a systemic problem and is not unique to AR's case. The recent Prevent Thresholds Review found that, in some cases, practitioners were writing off potential CT risk as *'just a mental health issue'*<sup>195</sup> and police were dismissing radicalisation risk on the basis of prior mental health problems.<sup>196</sup> Unlike other safeguarding options, Prevent considers the potential harm *from* a person as well as harm *to* them, but despite this some practitioners remained reluctant to make referrals for vulnerable people.<sup>197</sup>
83. Whilst the Thresholds Review has captured the challenges faced in Prevent in this area, its main recommendation – to improve understanding of mental health and neurodiversity policy in relation to radicalisation risk<sup>198</sup> – does little to move the dial. What is required is a root and branch review of how, within Prevent, practitioners can have access to the tools and expert advice necessary to assess the extent to which mental health and neurodivergence may be driving risk, and what interventions are likely to be effective.
84. The second weakness in Prevent concerns cases involving no clear ideology. The Home Office and CTP's 2019 letter made clear that, in order to prevent people being drawn into terrorism, support should be provided to *'all individuals who are at risk, irrespective of whether that risk is being driven by a true belief in an ideological cause or group, or... other vulnerabilities and complex needs'*.<sup>199</sup> But this message did not get through to those on the ground dealing with AR. Officer B was not aware of the guidance in the 2019 letter when assessing AR's risk.<sup>200</sup> PC Thompson's visit was expressly arranged to establish an ideology.<sup>201</sup> Whilst she was briefed on the 2019 letter, her focus was on whether AR was fascinated with extreme violence *'in a Prevent way... trying to promote a grievance or ideology of any sort'*.<sup>202</sup> The complete absence of any reference in her witness statement<sup>203</sup> to unclear, unstable or mixed ideology suggests it simply did not feature in her thinking at the time.<sup>204</sup> She was looking for ideology and not finding it, influencing her decision on whether to refer to Channel.<sup>205</sup> More worryingly, DCS Kenwright, a senior CTP officer, gave confused evidence on the relevance of ideology, appearing to suggest that officers would consider cases with an *absent*

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<sup>195</sup> HOM000090 p38 paragraph 158

<sup>196</sup> HOM000090 p39 paragraph 162

<sup>197</sup> HOM000090 p40 paragraph 16

<sup>198</sup> HOM000090 p12

<sup>199</sup> CTPHQ000056

<sup>200</sup> Officer B 8/10/25 p158 line 15 to p159 line 8

<sup>201</sup> LANC000175 p152; CTHPQ000087; Officer B 8/10/25 p162 line 17 – p163 line 6

<sup>202</sup> PS Thompson 9/10/25, p71 lines 5-13

<sup>203</sup> CTPNW000148

<sup>204</sup> PS Thompson 9/10/25 p103 line 13 – p104 line 10

<sup>205</sup> PS Thompson 9/10/25 p99 line 19 – p100 line 1

or *unclear* ideology under the banner of ‘CT/DE ideology’.<sup>206</sup>

85. Cathryn Ellsmore understandably described this failure by CTP to put the 2019 policy into practice as ‘*frustrating*’.<sup>207</sup> But it reflects a longstanding confusion at the heart of Prevent about its scope and purpose:

(1) The ‘narrow’ model, recommended in the 2023 Shawcross Review, focuses on the ideology underpinning terrorism, and is sceptical about the Prevent relevance of ‘*individuals who have no clear ideology, given that acts of violence committed by such people would not be regarded as terrorist in nature*’.<sup>208</sup> Shawcross recommended that ‘*referrals should have an identifiable ideological element*’. The government agreed: ‘*we will clearly communicate to frontline sectors, policing and Prevent practitioners, that Prevent referrals should only be made where they believe there are genuine concerns of radicalisation and that ideology is a critical consideration in that decision*’.<sup>209</sup>

(2) The ‘wide’ model is that set out in the 2019 letter, and focuses on vulnerability to exploitation and radicalisation rather than looking for ideological markers. It is unclear how the 2019 policy, which remains current, could be considered consistent with the government’s post-Shawcross policy above.

86. Previous attempts to change operational practice have failed: CTP ‘*didn’t communicate [the Shawcross Review] as a change of direction in any significant way to our workforce*’ and continued to follow the ‘wide model’, focusing on vulnerability to being drawn into terrorism.<sup>210</sup>

87. There is broad consensus that the system needs to change. There needs to be a ‘*big front door*’ through which any individual at risk of engaging in serious violence can be referred, for their risk to be triaged, and for appropriate interventions to be planned (whether through Prevent or otherwise). Such an approach would ‘*let Prevent be Prevent*’, focused on cases requiring input from CT specialists, whilst ensuring that individuals who do not pose CT risks are handed off or stepped down to another multi-agency pathway to reduce risk. That pathway would offer ‘*something in the middle*’, between MASH and Prevent, which picks up individuals posing a risk to others which ‘*isn’t just about terrorism*’.<sup>211</sup>

88. Cross-government work on this recommendation, originally made in Lord Anderson’s review,

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<sup>206</sup> Kenwright 13/10/25 p162 lines 3-17

<sup>207</sup> Ellsmore 13/10/25 p41 line 23 – p42 line 11

<sup>208</sup> HOM000071 p56 paragraph 4.57

<sup>209</sup> HOM000069 p21

<sup>210</sup> Evans 14/10/25 p18 – p19 line 3

<sup>211</sup> Kenwright 13/10/25, p179 lines 6-16

is already underway.<sup>212</sup> The challenges of implementing it will be significant. The Chair is invited to consider taking a deeper look at the detail in the course of Phase 2, to ensure that any changes implemented are fully-informed by the findings/recommendations made in Phase 1.

## SECTION FOUR: THE ATTACK

### Taxi Drivers' Duties

89. A starkly memorable feature of the evidence received by the Inquiry related to the taxi journey that AR made from home to the Hart Space on 29<sup>th</sup> July 2024. Gary Poland, an experienced and licensed taxi driver with Sefton Council, collected AR from his home address and drove him to Hart Street. AR left the taxi without paying and ignored Mr Poland's requests to settle the fare. Mr Poland followed AR into the Hart Space. Recorded video and audio dashcam footage confirms that Mr Poland would have seen AR walking into and upstairs in the Hart Space. He then heard loud noises (which he believed were gun shots) and then the sounds of children's screams (which he later described as '*barrowing*<sup>213</sup>'). He then observed a line of very young children running out of the building in a panic ('*it was like a stampede for their lives*<sup>214</sup>'). Mr Poland simply drove away. He contacted a friend by telephone<sup>215</sup> and expressed relief that he himself had not been shot by the gunman (as he then believed AR to be). Mr Poland took another fare, made a further telephone call to his friend and then eventually – some *50 minutes*<sup>216</sup> after the incident – contacted the police<sup>217</sup>. Mr Poland could have been the *first* person to call the police. Instead, he was the *last*.
90. As a Sefton licensed taxi driver, Mr Poland was bound by duties and *guidance* within the relevant handbook<sup>218</sup>. Mr Poland failed to comply with the guidance in that handbook (p8) in the sense that he did not contact the police (or the MASH) immediately. Yet at the time he believed that his passenger had been carrying- and then had discharged - a gun in the vicinity of small children. He did not know if injury had been caused but he could have given the police a description of the passenger and details of the pick-up address. There would also have been a forensic opportunity for the police arising from testing of the seat in which AR had been sitting. Mr Poland maintained however that he nevertheless acted as a '*fit and proper*' taxi driver<sup>219</sup>. He also

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<sup>212</sup> Ellsmore 13/10/25, p73 line 21 – p74 line 3

<sup>213</sup> Poland 25/9/25 p9 line 13

<sup>214</sup> Poland 25/9/25 page 34 line 6

<sup>215</sup> Poland 25/9/25 p7 line 7 to 25

<sup>216</sup> At 12.36 hours (Poland 25/9/25 p8 line 17)

<sup>217</sup> MERP000647 (transcript of 999 call)

<sup>218</sup> SEF000169 (Sefton Council Hackney Carriage Private Hire and Omnibus Licensing Scheme Handbook) at p8

<sup>219</sup> Poland 25/9/25 p10 line 4

told the Inquiry in evidence that ‘*Nowadays it’s easy, they let anybody have a licence*’<sup>220</sup>.

### **Suggested Recommendations in Respect of Taxi Drivers**

91. It is submitted that the Chair may wish to consider recommending that heightened duties should apply to taxi drivers. As the handbook states, ‘*drivers of hackney carriages and private hire cars are in a good position to help keep children and young people safe....drivers will often see things that seem strange or troubling....if so [the driver] has a responsibility to report this to the relevant authorities*’<sup>221</sup>. Breach of that guidance may lead to a review of a driver’s taxi licence. It is submitted that there should be a regulatory requirement that drivers *must* report suspicious activity or crime, with licences being revoked for drivers who fail to do so. That duty would also deter taxi drivers from turning a blind eye if, for example, asked to transport known drug dealers or asked to deliver suspicious packages. Furthermore, a positive duty on taxi drivers to report crime would deter criminals from using their services in order to avoid driving their own vehicles which may be observed by police or captured by Automatic Number Plate Recognition devices. The Chair may also wish to recommend an enhanced and more rigorous good character check for new or renewing<sup>222</sup> applicants.

### **Security of the Building**

92. The families of the surviving children consider that the security of the building was not appropriate. What this attack has highlighted is how vulnerable some ‘*soft target*’ venues are and why security should be taken so very seriously. Had access to the premises been subject to tighter controls, AR may have been unable to access the children. By combining access control, staff preparedness, emergency planning and ongoing risk assessment, the risk of a similar tragedy will be drastically reduced.

### **Suggested Recommendations in Respect of Such Venues**

93. The families we represent maintain that a communal area that was unsupervised, with unrestricted access to the property and to those children inside, was not safe. We respectfully invite the Chair to consider recommending regulation of venues hosting children’s events, to protect the most vulnerable members of our society particularly in circumstances where they have nowhere to run. Such regulation could include the following requirements:

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<sup>220</sup> Poland 25/9/25 line 22-23

<sup>221</sup> SEF000169 (Sefton Council Hackney Carriage Private Hire and Omnibus Licensing Scheme Handbook) at p8

<sup>222</sup> SEF000191 (Gary Poland’s licence renewal application)

- (1) A security policy for events with minors;
- (2) Staff training for threat response;
- (3) Emergency routes and emergency roles clearly designated to include multiple exit routes that should be well signposted (*'safe exit paths'*);
- (4) Communication of safe exit paths and emergency roles to all children attending an event such as this;
- (5) Visible signs reading *'no public access'* or *'authorised personnel only'*;
- (6) Controlled entries to the premises to enable verification of attendees at the entrance. Even with fire safety requirements doors can be designed so that they remain locked but can be rapidly opened from inside;
- (7) Restricted areas that cannot be accessed freely by members of the public. In this case there should have been a secure foyer or reception area to prevent AR walking straight into the class space without being *'vetted'*;
- (8) A dedicated security operative or a door supervisor to provide a deterrent and immediate response capability;
- (9) Regular security audits.

### **Out of School Settings ('OOSS')**

94. The families we represent continue to grapple with questions about whether, had things been different at the Hart Space, the horrific events of 29<sup>th</sup> July 2024 would not have taken place. Had access to the venue been controlled differently, if more adults had been present, if arrangements for collection had been different, if an evacuation plan had been in place, would this horrific event have occurred?
95. It is accepted that none of these issues goes to a failure to comply with the applicable legislation and statutory guidance. Rather, it is the lack of regulation for OOSS which gives rise to concern. The Department for Education has previously consulted on regulation and inspection of OOSS, but concluded that a voluntary code of practice would be sufficient.<sup>223</sup> A pilot exploring better multi-agency working at local level to identify and deal with OOSS of concern noted that existing powers were piecemeal and not well understood.<sup>224</sup> Although many parents assume OOSS are regulated,<sup>225</sup> the burden is in fact on them to assure themselves their child will be safe at the OOSS in question. They are expected to work through an detailed checklist before deciding

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<sup>223</sup> DEF000082 p19

<sup>224</sup> DEF000083 p7

<sup>225</sup> DEF000083 p8

whether their child can be safely left with the provider.<sup>226</sup> That is unrealistic and unreasonable.

96. The limited, voluntary, guidance that is available lacks clarity on what risks OOSS providers are expected to assess and what plans they should have in place. It fails, for instance, to distinguish between the plans which should be in place in the event of fire versus an emergency evacuation for any other reason.<sup>227</sup> It also fails to set out, even at a high level, the categories of risk which providers need to be mitigating.
97. Whilst the OOSS sector is large and diverse, and whilst the desire to avoid stifling the important contribution of volunteers to children's activities in the community is understandable, the families we represent struggle to understand why a person or organisation who assumes responsibility for children in their care should not be held to a minimum set of regulatory standards and subject to periodic inspection to check that those basic standards are being met. The DfE's current approach also overlooks the role of venue providers, and the responsibility they have for ensuring their venue is reasonably safe for children to use.

#### **Suggested Recommendations in Respect of OOSSs**

98. The families welcome the DfE's proposal to set out in the voluntary code of practice those considerations which OOSS providers should bear in mind when choosing a venue.<sup>228</sup> They acknowledge the challenges in introducing regulation into a very large and varied sector.<sup>229</sup> But more is required to keep children safe in OOSS. The Chair is invited to consider recommending:
- (1) Strengthening and clarifying the contents of the existing OOSS code of practice in relation to risk assessment and emergency planning by OOSS providers.
  - (2) For OOSS providers who take responsibility for more than 5 children, putting the duty to comply with the code onto a clear statutory footing.
  - (3) Expanding the code of practice to include requirements which venue operators/owners should comply with before allowing their venue to be used for OOSS, underpinned by a statutory duty to comply with that part of the code.
  - (4) Establishing a clear lead for periodic inspection of those providers subject to the statutory

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<sup>226</sup> DFE000077

<sup>227</sup> DFE000254 p34; Dixon 27/10/25 p127 lines 5-16.

<sup>228</sup> Dixon 27/10/25 p135 lines 4-19.

<sup>229</sup> DEF000256 p107 paragraph 422 (witness statement of Kate Dixon)

duty (both OOSS providers and venue owners/operators).

## CONCLUDING REMARKS

99. Paragraph 2 of the Southport Inquiry's Terms of Reference for Phase 1 states: *'It is of vital importance that there is a clear understanding of how [the brutal knife attack] was able to happen, and the lessons identified, so that we can take appropriate steps to minimise the risk of a future tragedy'*.
100. It is submitted that at this stage, following the painstaking analysis of a wide range of evidence, the Inquiry will be able to establish a definitive account of events leading to the attack and the attack itself. It will be in a position to form a view about AR's history and his interactions with various state systems. It is submitted that local service agencies missed a spectacular variety of opportunities to intervene in AR's life and to manage the escalating risk he posed to the public. On many occasions, AR *'fell through the cracks'*. In the months leading up to the attack, he was seriously isolated, unsupervised, unstimulated by outside agencies and unchecked by his family in his unhealthy and dangerous interests.
101. Accordingly, by 29<sup>th</sup> July 2024, AR would have been confident that no agency, no authority and no member of his own family would prevent him from carrying out such a catastrophic and devastating attack on innocent children who had woken up that morning looking forward to an exciting, creative, positive and safe summer holiday activity.
102. We hope that the submissions within this document are of assistance to the Chair in drafting the report and in identifying *'comprehensive, sensible and achievable recommendations'*<sup>230</sup>. This will ensure compliance with the Prime Minister's aspiration that *'Southport must be a line in the sand...and will lead to change'*.<sup>231</sup>

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**EXCHANGE CHAMBERS, LIVERPOOL, MANCHESTER & LEEDS**  
24<sup>th</sup> November 2025

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<sup>230</sup> Chair's Opening Statement 8/7/25 p2 lines 13-14

<sup>231</sup> Chair's Opening Statement 8/7/25 p9 lines 4-10