THE SOUTHPORT INQUIRY

PHASE 1: CLOSING SUBMISSIONS ON BEHALF OF LANCASHIRE COUNTY COUNCIL

Introduction

1. LCC, in opening, committed to candour and transparency. It also committed to work with the Inquiry to answer questions the bereaved families and survivors have about AR's contact with it during the years prior to the attack in July 2024 and to assist the Inquiry in its important work. These closing submissions for Phase 1 reflect those commitments. The evidence in phase 1 has revealed serious problems with the multiagency system as a whole and individual failures within it. LCC wishes to acknowledge how challenging and traumatic it has been for the victims and bereaved families to hear that the multiagency system did not operate in a way that it should have done to understand and address the risk posed by AR. LCC said in its opening statement that it is sorry for its part in this. LCC recognises and accepts that there were important things that it could and should have done differently. Whilst we know that apologies offer little comfort, LCC is truly sorry. It wishes the families and survivors to know that it recognises the seriousness of what the evidence has revealed and the urgent need to address the problems. It is already engaged in change and will continue to do so.

2. In its written opening LCC accepted shortcomings in three key respects:
   a. There are times when LCC's role in holding and monitoring the multi-agency plan around AR was not as robust as it should have been.
   b. In the spring of 2022 (i) AR should have been given continued support from CFW as he transitioned to Presfield School; and (ii) following the incident on the bus in March 2022 AR should have been referred to CSC and a multi-agency assessment should have been undertaken to identify intervention to meet AR's needs.
   c. The ASC SW did not complete a transitions assessment when she should have.

3. LCC also accepted within the body of its written submissions other matters, in particular regarding AR's education, the work of CYJS and record keeping generally. Further concessions have been made in the course of the evidence, which are addressed below.

4. The focus on recommendations and the importance of phase 2 requires LCC to address in some detail how its services operate, their statutory foundations and the limits of their scope. LCC wishes to be plain that this is not done to be defensive or to avoid criticism. It is vital that the Inquiry engages with the difficulties of those frameworks so that proper recommendations might be made about a more robust system for the future.

5. In these written submissions LCC will first set out some overarching themes and considerations that it perceives arise from the evidence. It will then make submissions about the contact each of its services had with AR, acknowledging points in time when things could and should have been done differently. It will address the inherently difficult and speculative question of what difference any of those alternate actions might have made. Finally it will address possible areas of further enquiry for phase 2 and potential recommendations.

6. Without wishing to dilute the apology that LCC has made, it is fair to recognise two points:
   a. Unlike AR who perpetrated this awful crime, LCC's employees acted with an intention to do good. They do difficult and pressured jobs in challenging circumstances, motivated by vocation. The covid pandemic forms a backdrop to this Inquiry, where pressures on schools, social care, family support services and the criminal justice system were intense. The word "unprecedented" is overused, but it is appropriate to reflect the challenges of the pandemic. Where mistakes were made they were made in good faith and in challenging circumstances by committed people who wanted to do their best.
   b. The evidence has revealed the extent of the failure of multiagency working at an early stage. When dealing with AR, LCC's employees lacked insights and expert input that should have supported their work. In acknowledging this LCC is not seeking to shift blame to its statutory partners. The reasons for the multiagency failure are complex and multifactorial and LCC recognises its own role within this. Acknowledging the point is, however, important when it comes to the question of individual accountability.

Themes

7. In LCC's opening it made some introductory points that remain important. LCC considers that additional themes have emerged from the evidence. Themes 1 to 3 are connected:

a. Theme 1: It is apparent from the evidence[1] that the characterisation of the risk posed by individuals such as AR is and was not well understood nationally.

b. Theme 2: There was no specific multi-agency forum for considering and assessing risk posed by AR to others and the multi-agency structures that existed at the time were not targeted towards or well suited to this task.

c. Theme 3: There was no specific multi agency process for assessing, sharing and recording that risk. None of LCC's assessment tools, which accorded with national guidance, were geared towards the question of risk posed to others, save for CYJS which was focused on the short to medium term risk of reoffending in children. The absence of such a process to flag long term risk, led to loss of detail, dilution of risk information and placed an unrealistic burden on workers to pick through lengthy records to see and understand the enduring, and often latent, risk posed by AR.

d. Theme 4: The multi agency systems that did exist were primarily for other purposes and were constrained by the rules within which they operated. The limitations of the statutory schemes gave rise to a number of difficulties:

   i. How risk posed to others is assessed and managed;

   ii. How risks from online harms can be monitored and addressed;

   iii. The difficulty of consent and the inability to compel cooperation;

   iv. Absence of remedies to address these risks.

e. Theme 5: Accepted failures of other agencies left LCC employees without important insights and information about how AR should be understood and, therefore, the risks that he posed both at the time and into the future. From late 2019 / early 2020 onwards, multiagency working had mostly failed[2]. LCC's employees do not have the knowledge and expertise of the police, counter terrorism, the mental health services or the forensic mental health service. They rely and are entitled to rely upon the contribution of these agencies, including when those agencies provide apparent reassurance by stepping away. It is perhaps not surprising that incidents and events that the Inquiry now rightly sees as highly significant were not understood, or not fully understood, at the time.

f. Theme 6: The dishonesty of AR's family is highly significant generally, but impacts LCC in particular towards from late 2022 and into 2023. During this period LCC's employees were working within a consensual framework to build a relationship with the family. They were reliant on what they were told about what was happening in the

[1] E.g. Ms Dixon for DfE day 28, p84 lines 4-11

[2] In particular the police, Prevent and, based on the evidence of Dr Irani, substantial input from FCAMHS

home. The evidence now shows that AR's parents lied and did so consistently and with purpose. Whilst CFW workers might reasonably be expected to treat families with scepticism on occasion[3], they had no reason to suspect that parents who appeared to be engaged and invested in supporting their child were misleading them about serious and significant issues such as internet use, violent behaviour and the delivery of weapons.

g. Theme 7: Reality and hindsight. Many of LCC's factual witnesses were questioned not only about what they *could* have known about the risk posed by AR and the dysfunction of this family, but about what they *should* have known. Questioning was based on detailed analysis of the records that has been carried out in the knowledge of what AR went on to do. LCC submits that at times it did not reflect what workers might reasonably have been expected to understand, when they were impacted by the issues in themes 1 to 6 and where many of the needs they were to address with AR[4] were not out of the ordinary. There is a risk that if hindsight is allowed to creep into the analysis and make the unclear and tenuous seem obvious, then recommendations for the future will ignore or underestimate the challenges of the work LCC's employees do. There is also a risk that conclusions about individual accountability may lack balance.

h. Theme 8: Lack of available remedies: both in terms of effective interventions and also ways to mitigate risk (see LCC's submissions below about child protection remedies and recommendations needed about effective interventions).

Submissions in respect of LCC's contact with AR

8. LCC adopts the framework used by the Inquiry during the hearings: by department / service rather than purely chronologically. It is not possible, within the page limit, to address all the issues in detail. Instead LCC will focus on key points.

Education

Corporate

9. As the LEA with statutory obligations to AR, LCC has accepted the following:

   a. For a period of two years from 2022 AR (age 15 to 17) was without education[5].

   b. LCC did not provide support to address this, due to a lack of resource at the time[6].

[3] And there is evidence that when appropriate, they did E.g. Evidence of AW, day 30, pg. 132 lines 12-20
[4] Social isolation, school refusal, some history of knife carrying.
[5] Opening Statement 26/32a; LCC001802_0017 para 49
[6] Evidence PT, day 26, pg.146 line 5 – pg.147 line 13

c. There was a lack of consideration of alternative placements in Jan 2023 when Presfield was unable to meet need[7]. There was unacceptable confusion over whether AR was on the role at Presfield. LCC should have reviewed the EHCP.

d. Alternative placements could potentially have been considered for AR sooner than 2022 (i.e. when he was at Acorns). There would have been a range of options to consider from a maintained or independent special school to measures such as tutoring / EOTAS. There would though have been issues of both availability and suitability[8].

e. Within the LEA, there was potential for ineffective cross-team working because there was too much work and not enough employees, particularly because the volume and complexity of work have increased exponentially since 2020[9]. LCC has recruited more staff but the issue is not yet fully resolved.

f. There can be issues with the process by which schools can contact the Education department at LCC, due to the complexity of teams and with the service at times being overwhelmed by the sheer number of emails. Schools have contacts within the LEA and an EHCP portal has been implemented to allow more effective communication[10]. Teams are also being restructured to support district areas, rather than having responsibility for the LCC footprint as a whole.

EHCP – parental request for EHCP and also for mainstream school

10. LCC submits that whilst the EHCP could have been started by a request from Acorns, the reasons for deciding that it should be a parental request (all other things being equal this could be quicker) was reasonable. Criticisms of this approach are with hindsight based on what is now known about the delay that was caused by the parental request for mainstream school, and the disputes that came to happen over what information should be contained in the EHCP.

11. In terms of the options available to LCC when the parents requested a mainstream placement, there is a presumption of mainstream education in the Children and Families Act 2014. It can only be overridden where that placement would be incompatible with the efficient education of others *and* there are no reasonable steps the local authority could take to avoid this[11]. Whilst Ms Hodson expressed reservation about the likelihood of a mainstream school

[7] Evidence PT, day 26, pg.162 line 15 – pg.163 line 5
[8] Evidence PT, day 26, pg. 158 lines 5-25
[9] Evidence PT, day 26, pg. 109 lines 7-24
[10] Evidence PT, day 26, pg.110 line 7- pg.111 line 23
[11] Children and Families Act 2014 s. 33

placement, it was not obviously the case that it was not an option at the time the EHCP process began. As Mr Turner said, "there are children who are successfully placed in mainstream schools with significant factors in their lives and some are successful, others are not"[12]. LCC also notes the evidence of Ms Dixon of DofE:

"…I do know that the direction of travel is a greater assumption that mainstream settings can do more for the growing… demand for EHCPs and the presumption that mainstream education could and should be able to do better, and that the rising parental choice around EHCPs is probably an unsustainable direction of travel."[13]

12. It is LCC's position that it was reasonable for the LEA not to take steps to overrule parental request and the EHCP followed a not uncommon path of parental preference changing over time. It is accepted that the consequence of parental preference was that the EHCP process took longer before it was finalised, but it does not follow that the effect of this was to keep AR out of some other more suitable form of education. LCC notes that AR's most successful secondary school experience was at Acorns. The PRU put in place provision for him for substantial periods of time that he was mostly willing to work within[14]. The placement broke down not because of Acorns' suitability, but because of the family's views about the later Prevent referrals and the father's decision to allow AR to see what was in them against advice. The evidence from Presfield was that if the full details of AR's history was known, they would never have accepted him. Had the EHCP contained the information Acorns wished to include from the outset and even if a parental preference had been for a specialist setting from the beginning, it is likely that LCC would still have encountered significant difficulties placing AR elsewhere. This is an issue that LCC invites the Inquiry to consider in phase 2.

EHCP – risk information

13. It was the evidence of both Paul Turner of LCC[15] and Kate Dixon of DfE[16] that the EHCP would not be the expected place for risks posed by a child to others to be shared. Mr Turner explained that including this information was not in the SEND Code of Practice[17]. This is in

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[12] Evidence PT, day 26, pg. 153 line 23 – pg. 154 line 19
[13] Evidence of KD, day 28, pg. 77 line 23 on
[14] Note evidence of Kate Dixon DfE day 28 p79 line 4 "Acorns did a really impressive job... in terms of trying to tailor their offer to AR. They tried a number of different things and engaged him, so I'd like to acknowledge the work they did."
[15] Evidence PT, day 26, pg.159 line 18 – pg. 162 line 4
[16] Evidence KD day 28 pg.77 line 8: "to rely on an EHCP, for that to be the place where the risk is put down, would be the wrong thing to do. There are other parts of the process and system where that risk should be written down and transferred and those are the appropriate places."
Evidence KD, day 28, pg. 80 line 25: "I think it is in Keeping Children Safe in Education, so I think where there is risk that should be known to a new school, then there's a detailed paragraph about how that information should be shared.
[17] Evidence of PT, day 26, p159 line 18 – pg.162 line 4

accordance with Keeping Children Safe in Education, the current version of which (September 2025) provides guidance on "Information sharing and managing the child protection file" that is in accordance with this evidence[18]. It is a matter for the Inquiry whether a recommendation is made about this, but LCC can see logical justification for the current position, where the EHCP is concerned with the child's needs and child protection and risk information is stored and communicated separately.

14. If local authorities are to be made responsible for auditing the transfer of safeguarding information between schools this would place a significant additional burden on services that are already stretched. LCC has 628 schools and may have 800 children moving in any given month. Thought would need to be given both to how such a demanding system could be implemented and it would require additional resourcing (and therefore funding). There is also a risk that the system is weakened rather improved by introducing a third party into what ought to be a straightforward transfer between schools.

Suitable alternative provision for AR

15. It was put to Paul Turner (and accepted) that more could have been done to seek suitable alternative provision for AR sooner. He set out some of the potential alternative options but identified a concern over availability and suitability. The question of alternative provision is a difficult one and LCC cautions the Inquiry against an assumption that there was some available alternative that would have been easily and rapidly accessible and should therefore have been secured for AR. LCC considers that the following issues would have arisen:
    a. Some of the more straightforward (and therefore achievable) alternatives - one to one tutoring or online learning – would not have addressed social isolation and engagement.
    b. AR was likely to be difficult to successfully place in a mainstream setting because of his history of carrying a knife and assaulting a pupil at school.
    c. This was also a barrier to his placement in a specialist setting (see Presfield's evidence that they would not have accepted him had they been aware of the full risk information) and this would have been a problem in the independent sector.

16. The Inquiry will need to consider whether it wishes to investigate this issue in Phase 2. There is a tension between the need to have children in school, in particular those who have presented as a risk to others but for whom education is a protective factor that ameliorates

[18] LCC001943_173

risk, but the difficulty of finding schools willing to accept such children (other than PRUs). In practice, placing these children in an appropriate setting presents a real difficulty for LEAs.

Risk assessments for schools

17. It was clear from the evidence from Acorns that they do risk assess the children who attend their school and that this is a usual practice for them. This is not surprising bearing in mind the cohort who attend PRUs. The issue that arose with AR appears to have been the concern that his risk was of a complex nature that was not adequately understood.

18. The Inquiry may wish to consider the question of how risk posed by children to others should be assessed in education. The input of police and FCAMHS seems essential. The evidence of Dr Irani about the role that FCAMHS should have fulfilled is important. Had Acorns had available the information and advice that Dr Irani suggests should have been provided then Acorns may have felt better able to understand, assess and manage AR's risk in their setting. They would also have had recourse to an appropriate agency for further advice about the risk if required. LCC submits that, whilst more support could potentially have been offered, the view of CYJS and CSC/CFW that they were not equipped to risk assess AR in the Acorns setting because this was not the role or expertise of either agency and they did not have experience of the PRU, was reasonable.

Acorns

19. LCC invites the Inquiry to endorse the opinion expressed by Kate Dixon that Acorns did positive work to understand AR and to educate him. In terms of areas of challenge:
    a. Ms Hodson was questioned about whether an inappropriate level of absence by AR was permitted without being escalated to the LEA. Ms Hodson highlighted that, as a PRU, Acorns were allowed to implement a bespoke timetable (albeit subject to the limitations of the statutory guidance). She also accepted that it would have been good practice to make a formal absence report to LCC[19].
    b. Ms Lewis and Ms Hodson were asked about the Prevent referrals. The first issue was that a Prevent referral could have been made sooner. Ms Hodson maintained[20] that for the referral to have the best chance of success it was justified to accumulate evidence[21].

[19] Evidence of JH, day 27, p149 line 1 – p151 line 1
[20] LCC001773_40/149-152]
[21] Evidence JH, day 27, pg. 184, line 2-10

c. Ms Lewis accepted that she should have shared information about AR's attempts to bypass internet security at Acorns[22].

d. It was put to Ms Hodson that further information became known to Acorns that should have been shared with Prevent after the first Prevent referral; in particular, use of the internet and a search for "nunchucks". LCC queries the accuracy of this question[23] and therefore whether Ms Hodson should have been invited to make a concession.

e. Ms Hodson was asked whether the internet browsing history was shared with Prevent and gave evidence of her belief that it was[24].

f. It was accepted by Ms Hodson[25] that wording of the second Prevent referral could have been more robust. She also accepted that the incident in January 2021 of AR kicking his father could have been shared[26].

g. AR's references to the holocaust did not cause Acorns to make a Prevent referral. Ms Hodson explained that the issue was not ignored. The third referral had caused a breakdown in the relationship with the family and had not led to action. Instead it was agreed with CAMHS that Ms Allred would work with AR on the views he was expressing. Ms Hodson agreed with the Chair that if there had been a more collegiate working relationship with Prevent then the information would have been shared[27]. LCC submits that Acorns acted reasonably in the circumstances.

20. Generally LCC submits that Acorns should be given credit for their approach to making the Prevent referrals. Whilst the Inquiry has been able to find pieces of information that could have been shared or added to the referral it should be born in mind that staff were running a PRU at a challenging time. Had Prevent engaged with Acorns as they accept they ought then one might reasonably have expected more detailed information to have been sought by Prevent through that process. As Prevent did not accept the referrals the criticisms of Acorns did not make a difference.

CYJS

[22] Evidence JL, day 27 pg. 63, line 1 on

[23] The nunchucks search was on 22-11-19 before the first Prevent referral LCC001345_7 and LCC001580. AR's internet access was blocked on 04-12-19 although he did make attempts to override this LCC001346_66. It was put to Janet Lewis that the nunchucks search should have been included in referral 1 (evidence of JL, day 27, pg. 61 line 24 on)

[24] Evidence JH, day 27, pg. 179 line 1-16

[25] LCC001772_42/158-161

[26] Evidence of JH, day 27, pg. 189 line 24 – pg. 189 line 2

[27] Evidence of JH, day 27, pg.193 line 12 on

21. CYJS is a creature of statute established pursuant to s. 39(10) of the Crime and Disorder Act 1998. Its statutory functions and responsibilities are summarised in the first witness statement of Sarah Callon[28]. It is a multi-agency service coordinated by LCC and overseen by the Youth Justice Board. As Ms Callon summarises[29]:

"The service works with children aged 8-18 who have either committed an offence or identified as being at risk of doing so. The service has embedded a child-first, restorative and trauma informed ethos into its work and strives to reduce the impact on victims and communities of crime by supporting children to maintain positive, healthy, pro-social futures.

22. The service has three functions[30]:

a. Prevention: There are a number of routes of referral into this service including from police, CSC and CFW[31].

b. Diversion: referrals can be made by the police following a criminal offence, when the police decide to issue a Community Resolution outcome and referral. The service also works with children considered for an Out of Court Resolution and, again, referrals come from the police. CYJS use the YJB Prevention and Diversion Assessment Tool.

c. Operations: this team works with children who have been sentenced to Statutory Court Orders. The duration of the involvement is set by the length of the court order.

23. AR was referred to CYJS by a Referral Order made on 19 February 2020[32]. The expectations on CYJS are summarised in the witness statement[33] and based on the YJB National Standards at the time. CYJS risk assessment is carried out in accordance with the AssetPlus Guidance[34]. The process of assessment is set out[35], starting with gathering information from other agencies. That information should be analysed to inform "judgements about likely future behaviours, risks and concerns regarding a young person's safety and well-being". "The assessment and plan should be shared with a young person, their parents/carers, and where necessary with staff in the organisation and partner organisations or agencies". Assessments are to be reviewed six monthly, or more frequently if there is a significant change in circumstances. In terms of "transferring information", "one of the primary audiences for assessments and plans are staff in other organisations, in particular where they subsequently

[28] LCC001712_3
[29] LCC001712_10/32
[30] LCC0001712_10
[31] LCC0001712_17/59
[32] LCC000025
[33] LCC0001712_16
[34] LCC001732
[35] LCC001721_7/1.2

take responsibility for managing the case. The assessment has to be stand alone and be meaningful for any subsequent reader." AssetPlus recognises professional discretion[36].

24. The AssetPlus tool generates a Youth Offender Group Reconviction Scale (YOGRS) outcome. It estimates the probability that the offender will be resanctioned for a recordable offence within two years of sentence[37]. 0-43% is a low risk, 44 to 76% is medium and 77-100% is high. The calculation factors and algorithm are set out in the Guidance[38]. These include age, offence type, conviction type, previous offending, number of previous substantive outcomes, years between first and current outcome, Copas score (volume / speed of offending) and number of offence free months. The Guidance provides "practitioners will then use their professional judgement to take account of the dynamic factors, to determine whether the rating is appropriate". The practitioner is expected to provide their own rating and explain the rationale where it differs from the indicative likelihood of offending. YOGRS is described as "an aid to practitioner judgement and not a substitute for that judgement[39]. The initial AssetPlus assessment was conducted in April 2020[40]. It generated a LoR of 48%, medium. This was only just in the medium bracket.

25. The Inquiry did not obtain statements from the two CYJS social workers who worked with AR: Ms Croll and Mr Fitzpatrick. Instead, questions were put to the corporate witness, Ms Callon and the absence of direct evidence made it difficult for Ms Callon to express a view at times. This was apparent when Ms Callon was questioned about whether the assessment of risk by Ms Croll in March 2020 was correct. The questioning was done with reference to Ms Croll's Referral Order Initial Panel Report dated 24 March 2020[41] rather than the AssetPlus Assessment. It was suggested that Ms Croll had overlooked two factors of significance – the number of times AR had previously carried knives and his stated intention to use the knife. Ms Callon referred to the relevance of the social worker's professional judgment and opinion at the time[42] and the fact that she would have expected her "to be using the Youth Justice Board guidance in terms of risk of re-offending levels that we discussed earlier. It's very difficult for me to comment based on her professional judgment in making that risk level". She was questioned about premeditation and asked "without that information, this was an

[36] LCC001732_22/2.3.1
[37] LCC001732_222
[38] LCC001732_224.
[39] LCC001732_226
[40] LCC000447
[41] LCC000452
[42] Evidence of SC, day, 28 pg.200 line 15; pg.202 line 3 and line 10; pg.203 line 10

underestimate of the risk of re-offending would you agree?". She again responded referencing professional judgment but was pressed as "a senior manager who's here in a corporate capacity, so help us"[43]. She then cited the range of factors that would be taken into account in the AssetPlus risk assessment[44] and again made reference to balancing "all the factors… for example, from school, that we've discussed", but having been asked again accepted that the seriousness and pre-planning should have led to an assessment of high level of risk[45].

26. Ms Callon was also questioned on Ms Croll's understanding of AR's parents, and specifically section 5 of the Panel Report where she referred to "supportive parents who provides prosocial values"[46]. The AssetPlus document contains Ms Croll's more detailed analysis of concerns around the parents[47]: "…There are concerns from some professionals that Alphonse does not fully recognise the impact of AR's actions and the consequences"; it was noted that AR and his father could clash[48] and that his father was starting a parenting course[49]; under "attitudes to offence(s)"[50] it said "AR's parents understand how serious AR's offence was to an extent however, do try and mitigate his actions by stating that he was angry at being sent to the Acorns and that they bullying hadn't been dealt with"; and under "resilience and goals"[51] it was noted that AR could be confrontational with his parents.

27. In her "Explanations and Conclusions" Ms Croll words "Motivations for Behaviour" in respect of the bullying carefully, framing this in terms of AR's feelings and perceptions[52] rather than as fact. She explains why she considers the parents to be "supportive parents who provide pro social models"[53]: them wanting the best for AR, their proactivity and support. She again refers to AR carrying knives into school on ten occasions. How the information that fed into the assessment is then used to formulate the conclusion is set out in some detail[54],. She appears to have generally considered AR a "medium" risk, with his risk of reoffending reduced to "low" due to being out of education, which was the most likely place for offending.

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[43] Evidence of SC, day 28, pg.203 line 11
[44] Evidence of SC, day 28, pg.203 line 23 on
[45] Evidence of SC, day 28, pg.204 line 22
[46] Evidence of SC, day 28, pg200, line 4 on
[47] LCC000447_0010
[48] LCC000447_11
[49] LCC000447_15
[50] LCC000447_20
[51] LCC000447_24
[52] LCC000447_34
[53] LCC000447_35
[54] LCC000447_37 to 40

A fair reading of the assessment is that with "imminence" that risk would have been medium. Her overall conclusion is of a medium risk. It is countersigned by a manager.

28. LCC submits that Ms Callon's initial reluctance to agree that AR should have been assessed as high risk was appropriate. Consideration of the AssetPlus document[55] demonstrates that premeditation was included in the assessment[56], the detail of the October incident was also noted[57], as were concerns around the parents. It was also noted that AR had previously stated that he wanted to cause serious harm to his intended victim[58]. The analysis of the level of risk took into account the relevant issues and the assessment fell within the reasonable range of conclusions it was open to the social worker to reach.

29. LCC has made concessions in Ms Callon's statement and in its written Opening Statement[59] about other aspects of CYJS involvement and it stands by those reflections.

CSC

30. This section addresses in brief the law and guidance in this area. It is provided to assist the Inquiry to understand thresholds for intervention by CSC and also the legal and evidential tests to be met for a child to be removed from the care of his parents. This is a complex area and the following is not exhaustive. If the Inquiry is considering a recommendation that children such as AR be managed within the child protection system then the Inquiry may wish to obtain more detailed expert evidence during phase 2.

The purpose of the child protection legislation

31. The Children Act 1989 came into force in 1991. Its priority is to promote the wellbeing of children and keep them safe from harm. There has been no substantive amendment to ss. 31 and 38 since then. The legal framework focuses on risks of harm to the child. It is, therefore, a framework that is not well equipped to deal with a child such as AR.

32. This interpretation is reinforced by earlier and current guidance:

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[55] LCC000447
[56] LCC000447_20: "This does appear to have been planned the night before when AR ordered a taxi"
[57] LCC000447_22: "During the assessment process the YOT have been informed of concerning behaviour by AR that was not criminalised. AR made childline aware in October 2019 that he had been taking a knife into school and this had happened in excess of 10 time..."
[58] LCC000447_23
[59] P14/21

a. Working Together to Safeguard Children 2018[60] contains no references to risks posed by children to others.

b. Whilst WTSC 2018 introduced a section on contextual safeguarding[61] the focus was on criminal exploitation, online abuse, sexual exploitation and extremism leading to radicalisation creating risks *to* the child.

c. WTSC 2018 provides that when assessing a child for Channel, local authorities and their partners should consider how to align these with Children Act 1989 assessments[62]:

"Whatever legislation the child is assessed under, the purpose of the assessment is always:
- to gather important information about a child and family
- to analyse their needs and/or the nature and level of any risk and harm being suffered by the child
- to decide whether the child is a child in need (section 17) or is suffering or likely to suffer significant harm (section 47)
- to provide support to address those needs to improve the child's outcomes and welfare and where necessary to make them safe"

d. WTSC 2018 sets out "the principles and parameters of a good assessment"[63], including:

"Assessment should be a dynamic process, which analyses and responds to the changing nature and level of need and/or risk faced by the child from within and outside their family. It is important that the impact of what is happening to a child is clearly identified and that information is gathered, recorded and checked systematically, and discussed with the child and their parents/carers where appropriate.
…
"Good assessments support practitioners to understand whether a child has needs relating to their care or a disability and/or is suffering or likely to suffer significant harm…
"The local authority should act decisively to protect children from abuse and neglect including initiating care proceedings where existing interventions are insufficient…
…
"High quality assessments:
- Are child centred…
- Are focused on action and outcomes for children
- Are holistic in approach, addressing the child's needs within their family and any risks the child faces from within the wider community
- Ensure equality of opportunity
- Involve children, ensuring that their voice is heard…
- Involve families
- Identify risks to the safety and welfare of children
- Build on strengths as well as identifying difficulties
- Are integrated in approach
- Are multi-agency and multi-disciplinary

[60] LCC001899
[61] LCC001899_0024
[62] LCC001899_0025
[63] LCC001899_0026

- Are a continuing process, not an event
- Lead to action, including the provision of services
- Review services provided on an ongoing basis
- Are transparent and open to challenge"

e. WTSC 2018 has an Assessment Framework pictorial. At the centre is "CHILD Safeguarding & promoting welfare"[64]. The assessment "should be focused on outcomes, deciding which services and support to provide to deliver improved welfare ..."[65]

f. WTSC 2018 contains a series of flowcharts of action that ought to be taken depending on what assessment is made of the response that is needed in response to the referral.

g. The Children's Social Care National Framework 2023[66] describes the "Purpose of children's social care" thus:

"Children's social care exists to support children, young people and families, to protect them by intervening decisively when they are at risk of harm and to provide care for those who need it so that they grow up and thrive with safety, stability and love".

h. The "Principles of children's social care" are that children's welfare is paramount; their wishes and feelings should be sought, heard and responded to; CSC works in partnership with whole families, children are raised by their families, with their family networks, or in family environments wherever possible; that the local authority should work with other agencies to effectively identify and meet the needs of children, young people and families; and that local authorities should consider the economic and social circumstances that impact them.

i. Working Together to Safeguard Children 2023[67] provides:

"Safeguarding and promoting the welfare of children is defined for the purposes of this guidance as:

- Providing help and support to meet the neds of children as soon as problems emerge
- Protecting children from maltreatment, whether that is within or outside the home, including online
- Preventing impairment of children's mental and physical health and development
- Ensuring children grow up in circumstances consistent with the provision of safe and effective care
- Promoting the upbringing of children with their birth parents… wherever possible and where this is in the best interests of the children
- Taking action to enable al children to have the best outcomes in line with the outcomes set out in the Children's Social Care National Framework

"Child protection is part of safeguarding and promoting the welfare of children and is defined for the purpose of this guidance as activity that is undertaken to protect specific

[64] LCC001899_30
[65] LCC001899_32/70
[66] LCC001898_13
[67] LCC001899_123

children who are suspected to be suffering, or likely to suffer, significant harm. This includes harm that occurs inside or outside the home including online."

j. WTSC 2023 emphasises that "a child-centred approach is fundamental to safeguarding and promoting the welfare of every child".

33. It is LCC's position that the purpose of multi-agency meetings convened in relation to child protection and wellbeing concerns must be considered in the context of the above. In its written opening LCC cautioned against CSC being seen as the "lead agency by default", because they are the service dealing with children's needs day to day. This concern crept into some of the questioning of Ms Anderson when the following exchange took place[68]:

"Q: If I can put it this way, we haven't seen any evidence that there were any other multi-agency forums either engaged in this case or that were considered to be engaged in this case, putting Prevent to one side. That would suggest that the answer to the question is no, it was only Working Together to Safeguard Children, wouldn't it?
A: Agreed.
Q: That then does create the risk that I was trying to put to you earlier, that where you have a forum which is wholly set up around a Child Protection system focused on risk to the child, risk from the child ultimately doesn't receive adequate attention?"

34. As a general proposition LCC does not disagree with this last question. It was not clear whether the question was intended to acknowledge a gap in multi-agency working, or whether it was a criticism of how CSC was operating within the realm of child protection. If it was the former, LCC would agree that the child protection system is not the place for adequate attention to be given to risks posed by children to others and, if it is the only multi-agency forum available, it should not be. If it was the latter, LCC would disagree that the way it operates its child protection system is inadequate for this reason.

The structure of social care provision to children in Lancashire

35. As the Inquiry is aware, children's social care is undergoing reform nationally[69]. In November 2024 the DfE published the policy statement "Keeping children safe, helping families thrive"[70] setting out the government's proposals. The "Families First Partnership Programme Guide" March 2025[71] ("FFPP") launched in the spring this year. This is pertinent because it provides the backdrop to the reforms to CSC and CFW in LCC[72]. It was put to Katherine Ashworth that changes currently being implemented were because it was

[68] Evidence of LA, day 31, pg. 121 line 19 on
[69] DFE000256_48/81 on
[70] DFE 000086
[71] DFE000171
[72] LCC002309_002/3

recognised that the previous arrangements (Family Safeguarding) had been a retrograde step. In fact, as she explains in her second statement, it is in response to national reform.

36. At the time this case is concerned with social care was structured so that children who met the statutory criteria for intervention (s. 17 or s. 47 of the Children Act 1989) had a social worker, but children who did not but who had needs greater than those suitable for universal services were supported by CFW. The effect of the change being brought about by FFPP is that children requiring targeted early help and children in need will all sit within Family Help, but that there will now be some social worker capability within that service. LCC has prepared a "Proposal for Implementing the "Keeping Children Safe, Helping Families Thrive" Policy"[73]. Of relevance to this Inquiry, this includes a "seamless Family Help System" merging early help and s. 17 into a single offer of support and implementing multi-agency child protections teams ("MACPT"). A new threshold document was published in October 2025[74]. The focus of FFPP remains on safeguarding children from harm:

"We envision a transformed system, where practitioners from social work, police, health, education, and beyond work together to promote the wellbeing of children and keep them safe from harm…"

CSC contact with AR

37. Turning to CSC's contact with AR:

Key corporate evidence

a. Ms Anderson accepted that there was evidence of dilution of information through the evolution of the case.[75]

b. She also agreed there should be a concise chronology that outlines risk factors so that when someone picks up the child they are able to see clearly. A user friendly system was not in place at the time but is in the process of being implemented[76].

c. When asked about the primary focus of social work being on risks to the child Ms Anderson said that additional responsibility to assess and take action in relation to the risk of harm a child presents to others would present a difficulty to the sector[77].

[73] LCC002305
[74] LCC002307
[75] Evidence of LA, day 31, pg.126 line 18 on
[76] Evidence of LA, day 31, pg.127 line 17 on
[77] Evidence of LA, day 31, pg. 167 line 4 on

d. Ms Anderson agreed with the Chair that it would only be in the very rarest of cases that children would be removed from the home and placed into care as a result of an assessment that they posed a high risk of harm to others[78].

e. In terms of the future it was Ms Anderson's evidence that assessment and management of risk of criminal action by a child should be led by professions with specialism in this. CSC accepts it should be a key part of the team around the child, offering support and interventions, where appropriate guided by the expertise of other agencies[79].

f. It was put to Ms Anderson that at various points CSC or CFW were in practice the lead agency and there were no other multi- agency forums to consider risk. LA accepted this but noted that the contribution from multi-agency partners into that process should ensure the risk to others is considered[80].

g. Ms Anderson was asked whether the effect of the statutory scheme in which CSC has to operate is that AR had serious unaddressed needs recognised by the agencies involved but with no way to address them. She replied[81]:

> "Yes, I think that there is a real question for us around how we help children with special educational needs and autism, who struggle to access the community to have the right services and interventions that reintegrate them into our communities. I think you've talked about the role of CAMHS in helping us with a formulation that will help us help those children reintegrate into communities, and I think we do need a system that enables us to meet that need and I also think we need to find a way to be able to monitor the risk that might be happening in private in a home in a bedroom and those will be questions for the State."

The chronology

h. It is accepted that in October 2019 the MASH could have held the referral of AR's case at level 3, although the assessment of level 2 was understandable.

i. The MASH should not have refused the referral in December 2019, although the case was swiftly stepped up to CSC anyway.

j. It is LCC's position that the case did not meet the threshold for s. 47 in December 2019. There was no evidence that AR was at risk of significant harm and no basis on which he could be removed from the family home.

k. Ms Jameson and Ms Anderson accepted that there were shortcomings in Ms Jameson's records: a failure to record some contacts with the family, the multiagency meeting on

[78] Evidence of LA, day 31, pg. 168 line 3 on
[79] Evidence of LA, day 31, pg. 168 line 10 on
[80] Evidence of LA. day 31, pg. 121 line 19 on
[81] Evidence of LA, day 31, pg. 164 line 14 on

4 March 2020 and events that she did not record in her February 2020 assessment[82]. Ms Anderson, explained improvements that have been made to record keeping[83].

l. It is LCC's position that the step across to CFW in March 2020 was reasonable.

m. In September 2021 the social worker was carrying out a carer's assessment that was not about risk of harm, but "if you see risk of harm then you should do something about it". In terms of the report of violence in August 2021, Ms Anderson said that from a social worker's perspective incidents of violent outbursts for children with SEND needs / autism are faced by many parents with a higher frequency and greater severity. "Child and parent violence is huge in this country now and, in Lancashire, we now have a programme for parents that is all about child and parent violence and how to manage that." Taking that together this would not necessarily have triggered a social worker to think she needed "to do something like a Section 47"[84]. There was an opportunity to consider a s. 47 assessment, and to recognise that AR was a CiN; however issues of isolation and not accessing the community were common. Ms Anderson said that numbers of children not in school are huge, with 140,000 children affected[85].

n. It is accepted that at this time a short-term piece of work was not likely to be adequate to meet need and CSC should have been clearer that AR required longer term input when he was stepped across to CFW in September 2021. That work could have been delivered by TYS and if CAMHS had worked with the youth worker as they would now, the team around the child could have worked well[86].

o. LCC has accepted that there were errors in respect of the bus incident in 2022. The missing from home interview was inadequate and a missed opportunity to explore AR's comment about wanting to harm someone and his interest in knives. Had a connection been made between the incidents in 2019 and in 2022 this could have led to greater curiosity about AR's access to knives and his use of the internet.

p. There was a failure by the MASH to consider the referrals in relation to the bus incident properly[87]. The police referral should have triggered a s. 47 strategy discussion[88]. The police have conceded that AR should have been arrested and dealt with in the criminal justice system, which would have superseded this process; however, had this not

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[82] Evidence of AJ, day 29, pg.102 line 21 to p106 line 9; p124 line 23 on
[83] Evidence of LA, day 31, pg.123 to 127
[84] Evidence of LA, day 31, page 145, line 6 on
[85] Evidence of LA, day 31, page 147, line 10
[86] Evidence of LA, day 31, page 147, line 18 to page 149 line 19
[87] Evidence of LA, day 31, page 152, line 13
[88] Evidence of LA, day 31, page 153, line 12

occurred, there was an opportunity for CSC and the police to do a joint investigation involving a home visit[89]. Acorns and Presfield and CAHMS would have also been engaged in the s. 47 strategy meeting.

q. In terms of opportunities to intervene between May 2022 and March 2023 Ms Anderson explained the limitations of LCC's statutory powers[90]. The only way to gain access to the home without consent would have been via the police and they would need a higher threshold to be met. "Parents and families have the right not to have State intervention… and we have to have evidence of experiencing significant harm or likely to experience significant harm to force parents to let us in… Not seeing a child for this amount of time…, for a child of this age, doesn't give us significant harm".

r. In addition, during this period, because of AR's age CSC would not have been able to force him to work with them[91].

What difference could alternate action by CSC have made?

38. This section considers the legal framework and a hypothetical analysis of what possible avenues of action might have been open to LCC should the Inquiry consider CSC should have decided that AR might meet either statutory threshold at any given point[92].

Child in Need

39. S. 17 of the Children Act 1989 places a duty on LAs to provide services for CiN.

a. "Child in need" is defined in s. 17(10) of the Act.

b. There is no obligation on the parents or the child, if of appropriate age, to accept s. 17 services. They depend entirely on the consent of the parents or, where relevant, of a child who has the capacity to provide consent.

40. Social workers allocated to CiN have no power, absent consent, to enter the home, search a child's room or interrogate their electronic devices. Services and interventions offered pursuant to s. 17 depend for success on genuine motivation and engagement from the parents to produce positive improvement in the child's circumstances. Whilst having a social worker oversee a CIN plan would have brought certain benefits – arguably greater ability to hold other agencies to account - in reality the position of the social worker would not have been

[89] Evidence of LA, day 31, page 154, line 10
[90] Evidence of LA, day 31, page 158, line 20 to p160, line 10
[91] Evidence of LA, day 31, page 163, line 11 on
[92] LCC reminds the Inquiry of its submissions in §35 above

different to that of the FSW. There is no reason to think that AR would have been any more engaged (and potentially would have been less so). The social worker would not have any significantly different interventions to offer and had no powers of compulsion. LCC submits that this would have been unlikely to reveal the extent to which AR was becoming dangerous due to his parents' determination to conceal the truth.

Section 47 enquiries

41. Some of the family CPs have suggested AR should have been removed from his parents. The only route to removing AR would have been via public law care proceedings, starting with a s. 47 enquiry. It is important that this process is understood.

42. S. 47 establishes the duty on local authorities to make such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.
    a. The duty would have been established if LCC had reasonable cause to suspect AR was suffering or likely to suffer significant harm (s. 47(1)(b)).
    b. The threshold for s. 47(1)(b) is deliberately lower than s. 31(2) and s. 38, but the focus is still the same: the care given to the child and the harm or likelihood of harm to *them,* not the risk posed by the child to others.
    c. S. 47 enquiries can result in the following outcomes:
        a. Concern not substantiated and, therefore, no further action.
        b. Social work assessment required to evaluate whether the concern is substantiated and then to decide what further action is warranted.
        c. Concern substantiated and the local authority proceeds to an Initial Child Protection Conference.

43. If a concern is substantiated and the identified harm or likely harm is acute and obvious and immediate safeguarding action has not been taken or has been ineffective care or supervision proceedings are issued forthwith. To assess the likelihood of such proceedings being successful it is necessary to consider the approach of the Family Court.

Proceedings brought for a care or supervision order – essential legal principles

44. No child may be removed from the care of their parents by a local authority without a court order authorising the same[93] or parental consent pursuant to s. 20 CA 1989. Bearing in mind the evidence given by the parents, it was highly unlikely that they would have consented to AR being removed from their care. LCC would have been required to apply for a care order had it considered that AR should no longer be in the care of his parents.

45. To obtain an *interim care order* authorising AR's immediate removal from home LCC would have had to satisfy the Family Court of the following:

    a. That there were reasonable grounds to believe that the threshold criteria in s. 31(2) were made out; and

    b. The local authority had provided the court with sufficient reason to establish the test for interim removal. Establishment of the interim threshold criteria does not equate to justification for removal[94].

46. By the date of a *final hearing*, the test in s. 31(2) would have had to be established before the Court could have made a final care or supervision order i.e. that AR was or was likely to suffer significant harm attributable to the care given to him by his parents or that he was beyond parental control. The burden of establishing the threshold criteria is on the local authority. The parents do not have to disprove anything alleged against them or prove a contrary fact. The standard of proof is the civil standard.

47. In *Re A (A Child)* [2015] EWFC 11 Sir James Munby P gave detailed guidance in relation to establishing the threshold criteria and the need to specify in the case of each allegation how and why it would, if true, give rise to a risk of significant harm to the child.

48. In *Re J (A Child)* [2015] EWCA Civ 222 Aikens LJ suggested that the *Re A* principles could be summarised as follows:

> "i) In an adoption case, it is for the local authority to prove, on a balance of probabilities, the facts on which it relies and, if adoption is to be ordered, to demonstrate that "nothing else will do", when having regard to the overriding requirements of the child's welfare.
>
> ii) If the local authority's case on a factual issue is challenged, the local authority must adduce proper evidence to establish the fact it seeks to prove. If a local authority asserts that a parent "does not admit, recognise or acknowledge" that a matter of concern to the authority is the

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[93] *R (G) v Nottingham City Council* [2008] 1FLR 1660

[94] For example *Re A (Children) (Interim Care Order)* [2001] 3 FCR 402

case, then if that matter of concern is put in issue, it is for the local authority to prove it and, furthermore, that the matter of concern has the significance attributed to it by the local authority.

iii) Hearsay evidence about issues that appear in reports produced on behalf of the local authority, although admissible, has strict limitations if a parent challenges that hearsay evidence by giving contrary oral evidence at a hearing. If the local authority is unwilling or unable to produce a witness who can speak to the relevant matter by first hand evidence, it may find itself in "great, or indeed insuperable" difficulties in proving the fact or matter alleged by the local authority but which is challenged.

iv) The formulation of "Threshold" issues and proposed findings of fact must be done with the utmost care and precision. The distinction between a fact and evidence alleged to prove a fact is fundamental and must be recognised. The document must identify the relevant facts which are sought to be proved. It can be cross-referenced to evidence relied on to prove the facts asserted but should not contain mere allegations ("he appears to have lied" etc.)

v) It is for the local authority to prove that there is the necessary link between the facts upon which it relies and its case on Threshold. The local authority must demonstrate why certain facts, if proved, "justify the conclusion that the child has suffered or is at the risk of suffering significant harm" of the type asserted by the local authority. "The local authority's evidence and submissions must set out the arguments and explain explicitly why it is said that, in the particular case, the conclusion [that the child has suffered or is at the risk of suffering significant harm] indeed follows from the facts [proved]".

vi) It is vital that local authorities, and judges, bear in mind that nearly all parents will be imperfect. The State will not take away the children of "those who commit crimes, abuse alcohol or drugs or suffer from physical or mental illness or disability, or who espouse antisocial, political or religious beliefs" simply because those facts are established. It must be demonstrated by the local authority that by reason of one or more of those facts, the child has suffered or is at risk of suffering significant harm. Even if that is demonstrated, adoption will not be ordered unless it is demonstrated by the local authority that "nothing else will do" when having regard to the overriding requirements of the child's welfare. The court must guard against "social engineering"
vii) When a judge considers the evidence, he must take all of it into account and consider each piece of evidence in the context of all the other evidence, and, to use a metaphor, examine the canvas overall."

49. Establishing the threshold criteria involves a rigorous, evidence-based approach. In the context of the first limb a clear link must be established between the harm alleged and the care given to the child by the parents.

50. In the context of "beyond parental control", the local authority must prove that the state of being beyond control has led to or is likely to lead to the child suffering significant harm; however, the local authority need not prove any fault on the part of the parents for the fact that the child is beyond control. Simply having a child who does not do what the parents are asking does not satisfy the criteria.

51. In the case of an interim care order ("ICO"), separation is only to be ordered if the child's safety demands immediate separation. "Safety" is to be defined in the broadest sense and includes psychological safety[95]. In **Re C (A Child) (Interim Separation) [2019] EWCA Civ 1998** Peter Jackson LJ distilled the following propositions from the prior case law:

(a) An interim order is made when the evidence is incomplete. It should only be made where it is necessary to regulate matters that cannot await the final hearing.

(b) The removal of a child from their parents is an interference with their AR right to respect for family life. Removal at an interim stage is a particularly sharp interference.

(c) Accordingly, removal will only be authorised where it is necessary and proportionate. The lower threshold for an interim care order is not an invitation to make an order that does not meet these exacting criteria.

(d) A plan for immediate removal will only be authorised where the child's physical, emotional or psychological welfare demands it and where the length and likely consequences are proportionate to the risks.

(e) The high standard of justification for separation that must be shown by the local authority requires it to inform the court of all available resources that might remove the need for separation.

Application of the legal principles to the case of AR

52. There are two points in the chronology of LCC's involvement with AR at which LCC anticipates the Inquiry may be invited to consider that the commencement of care or supervision proceedings should have been considered: December 2019, after the Range High School attack, and 17 March 2022 when AR went missing from home.

53. LCC submits that in December 2019 the first limb of the s. 38 interim threshold criteria would have been difficult to establish notwithstanding the seriousness of the attack:

a. There was no evidence that the parents had encouraged, enabled or provided an environment which led AR to do what he had done.

b. The parents were apparently caring and supportive of AR.

c. There was no "social" evidence against the parents in terms of substance misuse, domestic abuse or criminality which might have provided the link between deficits in their care of AR and him deciding to offend.

d. There were no concerns about the parents' care of DR.

[95] *Re B (Care Proceedings: ICO)* [2010] 1 FLR 2010

e. The first Prevent referral had been closed with no further action.

54. The interim test for AR being beyond parental control might have been able to be established, but not necessarily given the limited period over which he had become involved in carrying a knife and the RHS attack. The parents would have had a reasonable argument that an insufficient pattern of conduct had been established, particularly in the context of suspected but as yet undiagnosed ASD, to lead the Court to conclude that reasonable grounds existed.

55. If the s. 38 threshold had been satisfied it is unlikely that the Court would have made an ICO and approved him being removed:

a. The "no order" principle applies (section 1(5) CA 1989).

b. AR's behaviour would have been likely to have been viewed through the prism of undiagnosed ASD, a disability that was not well understood where risk was concerned.

c. AR's parents were apparently co-operating with the local authority.

d. AR was likely to have a youth justice social worker under the referral order if he did not receive a term of imprisonment. He, therefore, would have social work oversight and intervention but also involvement from other specialist agencies.

e. AR's wishes and feelings would have been highly likely to have been against removal. His parents' stance would likely have been the same.

f. It would have been likely to have been argued that the making of an interim care or supervision order was, in the circumstances, neither necessary nor proportionate in the context of the index incidents.

g. The fact that no interim order is made does not mean that no final order may be made. However, unless there had been a serious further incident(s) during the proceedings we submit that achieving a final order in these circumstances would be highly unlikely.

56. In March 2022[96] the local authority might have been able to establish the interim threshold criteria by relying on AR's history culminating in the incident when he went missing from home in possession of a knife, which he said he had intended to use, and reporting that he had tried to make poison. The establishment of the threshold by the local authority would however have been a complex exercise and there would have been no guarantee that it would have

[96] Based on what was actually known and not on what could have been known if the police had arrested AR and searched the property. Had this occurred there would probably have been significant discoveries, but the appropriate way forward would likely have been via the criminal justice system

been established at a final hearing. Some legal advisers may have held a reasonable view that the local authority would be unlikely to establish the threshold criteria on the evidence available and would have advised accordingly. If proceeded with, LCC would have had to rely on the Court finding that deficits in the parents' care of AR in terms of establishing and maintaining appropriate behavioural and moral boundaries had exposed AR to the risk that he would be adversely affected by a probable descent into serious criminality. However, the contrary argument would likely have been[97]:

a. The police were taking no further action and had put the matter down as a mental health episode on the part of AR. Words of advice had been given to the parents.

b. The Prevent referrals had occurred eleven months earlier. What the closed down Prevent referrals would add to the evidential picture would have been likely to have been argued as limited.

c. There was no evidence that AR had tried to make poison. The commencement of his online purchasing of weapons and other dangerous items was unknown due to AR's deceit and that of his parents. There is no power in the Family Court, under either the Civil Procedure Rules or the Family Procedure Rules 2010 (as amended), to authorise the confiscation of electronic devices for expert interrogation save with the consent of the owners. As a child with capacity to withhold consent, it is very likely that, if asked, AR would have withheld the same. His parents were equally unlikely to decide to override their son's consent given their misplaced priorities. The only sanction left is that the Court may be invited to draw adverse inferences from the refusal of consent. Where so much was being concealed by the parents about AR's behaviour and circumstances generally, it is difficult to conceive what, if any, inferences the Court might have been invited by the local authority properly to draw.

d. The use of violence by AR was, by then, over two years earlier and, whilst there had been subsequent incidents in the home in the previous year, they were not as serious and would have likely been viewed in the context of AR's autism.

e. Much would likely have been made of the fact that the incident occurred when AR was transferring schools, likely to have been argued as challenging for him due to ASD.

f. Could it have been established that there were reasonable grounds to believe that AR was beyond parental control in March 2022? Possibly, but not necessarily. AR did not fit the typical picture of a child beyond parental control. He rarely left the house. He

[97] LCC is not endorsing these arguments, but illustrating the complexities of cases in the Family Court

was not involved with external third-party bad influences. His parents were, apparently, generally adequate parents leading conventional lives. The incidents involving AR were punctuated by periods where he was apparently doing nothing wrong. His disability would also have been taken into account to a significant extent.

g. If the interim threshold criteria could have been established, the prospect of the local authority obtaining an interim care order with an approved plan of removal would have been unlikely given the statutory framework and accompanying case law. Even less likely would the prospect be of the local authority proving the threshold criteria and obtaining a final care order with a plan of permanent removal from home unless something serious had occurred whilst a final hearing is pending.

h. AR's interests in any proceedings would have been represented by a Children's Guardian (section 5 CA 1989). He would have had his own legal team and would have been a party to the proceedings. Should his views came into conflict with those of his Children's Guardian, provided he had capacity to instruct a solicitor directly, he would have been appointed his own solicitor. It is reasonable to assume that AR's case would have been strongly resistant to any plan to remove him from home. The position of his parents would have been highly likely to have been the same. Accordingly, the local authority would have been likely to have faced extreme opposition to an application for a care order and it would have been placed at strict proof of the threshold criteria.

Other legal remedies and their limits

57. It has been suggested that there was scope to manage AR securely through the child protection process. Secure accommodation orders pursuant to section 25 CA 1989 can only be made where the child is looked after by the local authority i.e. they are the subject of a care order or are accommodated by the local authority. This would not have been the case for the reasons given above. SAO's are time limited, in the first instance to three months and, thereafter, for six months at a time. The statutory criteria pursuant to section 25(1) must be satisfied each time the Court considers whether to make an order.

58. The High Court may exercise its inherent jurisdiction to authorise deprivation of a child's liberty where it is necessary and proportionate to safeguard and promote the child's welfare. It is not possible for a local authority to apply for deprivation of liberty orders where the child is still living at home. Therefore, AR would have had to have been removed from the care of

his parents for this remedy to be available. Authorisation of deprivation of liberty is time limited and kept under the careful scrutiny by the Court due to the child's A 5 rights.

59. A care order cannot be made in respect of a child aged 17 or over (s. 31(3) CA 1989).

60. It can be seen from the above that it is unlikely that CSC would have been able to take steps successfully to remove AR from the home. Had CSC done so it is difficult to see how this would have mitigated the risk. Had AR been removed from home it would have been very difficult to find a suitable placement for him given his history. Further, research shows that children who are removed into care experience far poorer outcomes in life than those who are not. Had AR been removed it may well have been the case that the risks he posed would have increased and it is unlikely that the circumstances of his removal would have enabled any significant measures to be put in place to manage that risk. Again, if the Inquiry is considering this scenario, further evidence in phase 2 is likely to be of assistance.

CFW

The purpose and role of CFW

61. CFW is an early help service. The development of the EH service in Lancashire has followed national guidance, in particular for the relevant period, WTSC 2018[98]. Chapter 1 of WTSC 2018 sets out the purpose of early help, how families in need of help should be identified and assessed and the sorts of services that should be provided[99]:

62. In terms of the nature of the assessment WTSC 2018 specifies that "early help assessments should be evidence-based, be clear about the action to be taken and services to be provided and identify what help the child and family require to prevent needs escalating to a point where intervention would be needed through a statutory assessment under the Children Act 1989"[100]. The focus therefore is on identifying a particular service or piece of work that a family might require to be delivered by CFW to help with a particular need.

63. This interpretation is supported by the following[101]:

"In addition to high quality support in universal services, specific local early help services will typically include family and parenting programmes, assistance with health issues,

[98] DFE000100
[99] LCC001899_13
[100] LCC001899_15
[101] LCC001899_16

including mental health, responses to emerging thematic concerns in extra-familial contexts, and help for emerging problems relating to domestic abuse, drug or alcohol misuse by and adult or a child. Services may focus on improving family function and building the family's own capability to solve problems. This should be done within a structured, evidence-based framework involving regular review to ensure that real progress is being made. Some of these services may be delivered to parents but should always be evaluated to demonstrate the impact they are having on the outcomes for the child."

64. At the start of the chronology of this case CFW was a relatively new service. The Inquiry has heard how it has developed over time. This progression is demonstrated by the various iterations of the CFW "Service offer"[102]. Early versions show time limitations on the service. What is evident from the "service offer" documents is that the support provided is practical and targeted towards particular, identified needs.

65. The purpose of the service is not to simply remain "open" to a family generally. Instead it should assess need, provide targeted interventions to meet those needs and then benchmark progress at the end of that intervention. This is in accordance with WTSC 2018 and 2023. FFPP proposes a different approach to the delivery of early help services, with workers that remain with families throughout their journeys with social care. The fact that this approach is part of a reform of children's social care nationally demonstrates that LCC's approach was standard at the time and, insofar as the Inquiry might question it, any potential criticism would sit with the system and not the approach and attitude of the workers themselves.

General observations about the circumstances of EH provision

66. CFW became involved in a substantive way in the spring of 2020 when AR was stepped across to the service. LCC makes two important points about this.

67. The first is that by this stage the multiagency response to AR had already failed:
    a. AR had been referred to Prevent and it is accepted that Prevent did not handle the referrals as they should have done. AR ought to have had support ftom Prevent working with his complex needs around his fascination with violence and the risk he posed.
    b. The police had been involved with AR in October 2019 and December 2019 but, apart from investigating and charging the offence at the Range High School, had dropped away. They did not retain any oversight of what had happened to the Prevent referral or whether AR posed risks that needed addressing once Prevent decided not to progress.

[102] LCC001921

c. FCAMHS had been consulted and did not provide a service that accorded with the role described by Dr Irani. Her evidence was stark about the extent of the service that FCAMHS should have offered. AR should have been the subject of a detailed risk assessment, FCAMHS should then have advised on what interventions were needed to support AR and how they should be targeted by the services delivering them to address the risk he posed. FCAMHS accept that the work of Mr Hicklin fell short of this.

d. So far as LCC understood things, CAMHS were to work with AR to address the risk he posed to others. In fact, due to issues within that service, they fell away entirely in the spring of 2020 without making LCC aware.

68. The second important point is that CFW became involved at the point that the Covid19 lockdown commenced. This caused unavoidable alterations to the service[103].

69. For a child to be open to CFW, a decision had already been made by a social worker (usually within the MASH) about the level of the child's need on the Continuum of Need and that the child was suitable for their service (i.e. not requiring statutory intervention)[104]. As a result their focus was not on assessing the risk to the child in the way a social worker would or the risk posed by the child, but on identifying and meeting need. CFW workers were required to escalate any concerns they might develop that the level of need had reached the point where an assessment by CSC was indicated, but their role was distinct from the role of a social worker and should not be confused with it.

70. In addition to CFW being a targeted service that is engaged to provide specific interventions, it is a consensual service. WTSC 2018 says that for an early help assessment to be effective "it should be undertaken with the agreement of the child and their parents or carers, involving the child and family as well as all the practitioners who are working with them. It should take account of the child's wishes and feelings wherever possible, their age, family circumstances and the wider community context in which they are living"[105]. The child centred and collaborative approach described by the witnesses and, in respect of which their evidence was at times challenged, was consistent with national and local guidance.

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[103] LCC001921_5

[104] Although it is accepted that CFW work with children presenting a range of needs, including those showing signs of being drawn into criminality and around carrying knives

[105] LCC001899_15

71. The questioning of CFW witnesses at times did not place weight on this guidance and these characteristics of the service. This led to questioning of CFW workers about what they should have appreciated of the complex risk posed by AR when they were not properly informed; and about how they should have viewed and dealt with the parents; when these challenges were not in accordance with the purpose and method of working of their service.

72. LCC accepts that during the early periods of the CFW service resource pressures and time-limited intervention models were present. Parenting programmes and direct work sessions tended to be delivered in blocks of between 6 and 12 weeks. These models aimed at and enabled short-term change but did not always allow for long term transformation. Although this time limited model was common nationally in around 2019, LCC acknowledges that the effect of this was that the system prioritised throughput over long-term relational work. Criticism of this approach sits with LCC and any impact of it on the quality of the work done by CFW is due to the model they were working within rather than individual FSW.

73. LCC considers that the Inquiry might form the view that the limitations of the statutory child protection scheme and its focus on thresholds for statutory intervention impacts CFW services. There were times when it has been accepted that CFW workers probably ought to have consulted with CSC about AR, but it is also LCC's position that had they done so CSC probably would not have accepted him into their service because he did not meet the statutory threshold for intervention. The issue is not unique to LCC but the Inquiry should be astute not to place individual blame on FSW for the limitations of the system they worked within.

74. Finally, there are times when FSW were criticised for not escalating concerns to CSC raised by other agencies. Not only is CFW not the only agency who can refer to CSC, but the statutory safeguarding partners (e.g. CAMHS) are obliged to make their own referrals into CSC if they have concerns about the safety and welfare of a child[106].

AR's contact with CFW

75. LCC acknowledges the following:

    a. When AR was referred to CFW after his exclusion from the Range in Oct 2019 they did not achieve meaningful interaction with the family prior to the attack at the Range.

[106] See WTSC and KCSIE

b. Andrea Fontaine-Smith was challenged on her decision to close AR to CFW during the summer of 2020[107]. LCC submits that at the time she was working within a time limited service that was tasked with delivering specific interventions. As a result of the covid lockdown she could not deliver them and decided CFW should start work with AR when lockdown was lifted. This was not an unreasonable decision for the FSW, although the Inquiry may form a view about the scope of the service (see para 72). As it happens AR engaged with Acorns once lockdown was lifted in any event.

c. Ms Fontaine-Smith was also asked about the contents of her assessment and records, in particular that she had not recorded that AR had recently presented as posing a high risk[108]. She was also criticised that there was an overly narrow focus on risks to AR, rather than risks he posed to others[109]. LCC submits that should the Inquiry accept these criticisms, they relate to the scope of the role of a FSW rather than Ms Fontaine-Smith's practice.

d. Ms Fontaine-Smith was challenged about her response to AR's father refusing consent to share her assessment with CYJS[110]. Ms Fontaine-Smith did not have any particular insight into the complexities of the family and gave evidence that families could be reluctant to share information. She explained that her approach was to try and gain consent, which is in fact what occurred. It was put to her that she should have reported to CYJS that the father had been initially reluctant to share information. LCC submits that there was no reason for Ms Fontaine-Smith to read into this exchange the significance placed on it by the Inquiry. Her decision to deal with the issue collaboratively was in line with her training. It is accepted however that informing CYJS about the father's request would have been good practice.

e. Ms Fontaine-Smith and Ms Barrett were also asked about the dilution of risk information in CFW documentation and it was suggested that this led to a significant failure in the analysis of risk both in late 2020 and following the altercation with AR's father in January 2021[111]. Ms Anderson gave important evidence summarised above about the context in which violent incidents involving parents and SEND children should be understood in children's social care. The incidents were not overlooked and the altercation with AR's father was investigated. Absent the FSW understanding that

[107] Evidence of AFS, day 30 pg. 184 line 23 on
[108] Evidence of AFS, day 30, pg. 171 line 12 on
[109] Evidence of AFS, day 30 pg. 210 line 9 on
[110] Evidence of AFS, day 30 pg. 198 line 21 on
[111] Evidence of SB, day 30 pg. 54 line 13 on and pg. 90 line 23 on

there were reasons to be particularly concerned about AR, one can perhaps why she did not place the significance on them that they are now known potentially to have.

f. It was put to Louise Lewis and Sharon Barrett that a Prevent referral should have been made following what was recorded about AR's comments on 4 October 2021[112]. It is accepted by LCC that a referral could have been made but, based on the comments recorded alone which do not present with any particular ideology and were concerned generally with questions of global politics (admittedly controversial ones) the Inquiry may form the view that making a referral was desirable but not mandatory.

g. It is accepted that the incidents in the home in November 2021 that were reported to the police should have been discussed within the TAF and should have been raised at the Family Discussion meeting with CSC.

h. It is also accepted (and was accepted in the opening statement) that AR could have remained open to CFW during his transition to Presfield. From the perspective of the FSW they were working in a system that LCC accepts prioritised throughput at the time, so this issue sits with LCC rather than the individuals concerned.

i. It is accepted that the TYS worker Mr Coughlan should have reviewed AR's records. There is no evidence to suggest that AR revealed anything to Mr Coughlan of significance that he would have acted in relation to had he known AR's history.

j. Although LCC considers that the primary failure in respect of the missing on the bus incident sits CSC, it was accepted by the FSW that they could have made more effort to establish the circumstances of what had happened. They were not the gateway to the case re-opening however. The appropriate agency to respond was CSC and it would have been inappropriate for CFW to deal with it, bearing in mind how serious it was.

k. Between April 2022 and September 2023 CFW workers tried to engage with AR and his family. This was a period when the parents were lying to those workers about what was happening in the home. Although the work of the police and this Inquiry has uncovered the extent of those lies, from the perspective of the CFW workers the parents were cooperative and mostly plausible. They believed that they were dealing with someone who was socially isolated and school avoidant in the context of ASD. At this time, post pandemic, this was not an uncommon issue. Whilst they could have sought advice from CSC about AR, it is unlikely this would have led to a different action because AR did not meet a threshold for intervention. He was also 17 and capacitous, which impacted on what any of the social care agencies could achieve with him.

[112] Evidence of SB, day 30, pg. 107 line 4 and Evidence of LL, day 29, pg. 167 line 6

ASC

76. It is accepted by LCC that there was a serious failure by both the Adult social worker and her manager in respect of the transitions assessment of AR. It is unlikely that an adequate assessment would have revealed anything of significance bearing in mind:

    a. The dishonesty perpetuated by AR and his family at this time;

    b. The fact that no other agency was able to achieve engagement with AR;

    c. None of the agencies involved (including CAMHS) identified anything suspicious in their interactions with AR and his family at the time.

Witnesses

77. LCC will not make observations about all of its witnesses who gave evidence, but it does believe that some CFW witnesses were subject to unjustified personal criticism, with questioning that was affected by hindsight and that did not take into account: the limitations of the framework they worked within; that they were operating within a system that had entirely failed around them; they were dealing with a dishonest family and, although skilled workers, they were not qualified professionals. Insofar as the Inquiry makes criticisms about the issues put to them, LCC submits that many of them are more appropriate directed to the system rather than the individuals.

Reflections and recommendations

78. AR has been referred to as a violence fascinated individual. He was someone who wished and planned to commit a horrific act of violence. His precise characteristics have not been defined and LCC submits that it is important that thought is given to this. The evidence LCC has seen suggests AR probably was not motivated by his neurodiversity, mental health, criminal activity, radicalisation or environmental factors, although his risk may have been increased by some of these. It is the perception of LCC that there is an increase in this type of individual. It is also the perception of LCC that this type of individual remains poorly understood and it would welcome a recommendation that further research be carried out into who falls into this area of acute concern and how agencies might identify them. There needs to be some way of differentiating them from "conventional" criminality.

79. LCC would welcome research into the best interventions to provide to individuals in this category. The solution to the problem probably does not lie in tagging or removing the liberty of individuals who present these risks[113], but in quality, targeted early interventions.

80. LCC submits the Inquiry has revealed a gap in the system: an absence of a robust multi agency framework that was seized with responsibility to assess the risk that AR was identified as posing to others in 2019, to make and hold the plan for management of that risk, to hold account of and assess the implementation of the plan and its success and to take responsibility for updating and sharing that risk with other agencies[114]. Recommendations for any new or revised system requires thought so that it offers clarity and streamlining and does not add to the current complexity of multiagency working. The Inquiry might conclude that the evidence shows multiagency partners currently operating within a fragmented and overly complex national system, where professionals who need to work together are required to navigate multiple statutory frameworks simultaneously[115]. Each system has its own governance, priorities and legal requirements. This can cause duplication, gaps and confusion about roles and responsibilities. It is a theme of case reviews that professionals can lack clarity about the purpose and governance of meetings and that processes are not joined up.

81. Related to this point, the evidence suggests that the experience of a potential offender may differ depending on which agency they first come into contact with. For example the police have one suite of interventions available they might refer someone to, mental health another, CYJS and CSC / CFW have others. There needs to be streamlining and more consistency in the system. One potential avenue is to strengthen MASH.

82. LCC submits that there needs to be improvement in the quality of multiagency working. The evidence reveals that none of the agencies who had contact with AR were good at working to create a shared plan where all understood what the others would do and where there was joint benchmarking of progress and outcome. Even within the multiagency structure there is evidence of silo thinking where agencies were given individual tasks but were not clear on what others were doing and why and what impact action was intended to have on what should

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[113] Who have not committed a criminal offence, but who are recognised as presenting a risk of offending

[114] Evidence of ACC W, day 20, pg. 117 lines 1-10

[115] E.g. Looked After Child (LAC) reviews; Care, Education and Treatment Reviews (CETRs); Care Programme Approach (CPA); Section 117 Aftercare; Education, Health and Care Plans (EHCPs); Deprivation of Liberty Safeguards (DoLS); MAPPA; and Youth Justice protocols, just to name a few.

have been a joint plan for improved outcome. It is LCC's experience that there has been improvement in the quality of joint working in some of the newer initiatives it is involved in: the MACPT formed under FFPP, Prevent, the new prevention panels etc.

83. A risk assessment process is needed that should be multi-agency in nature to ensure shared ownership and consistency across services. The Inquiry is invited to consider a recommendation for a risk assessment that can be completed / contributed to by any agency and is capable of transitioning between children's and adult services to ensure consistency.

84. LCC supports national efforts to strengthen the capacity of CAMHS and FCAMHS who, like many public bodies, have suffered from constrained resources. It supports the need for all safeguarding partners to work better to consistently embed the expertise of mental health services in the multi-agency safeguarding framework and to improve accessibility, diagnostic clarity and interagency coordination. There is need for earlier specialist input, clearer referral pathways and stronger integration of services. CSC perceives that there may be an issue around mental health diagnosis and its impact on risk in children. It is the perception of LCC that mental health services can be reluctant to label and therefore potentially stigmatise children, for well-intentioned reasons. This can mean that other agencies lack clarity in their understanding of those children. The evidence also suggests that there is work to be done in understanding and educating agencies about the impact of neurodiversity and mental health problems on risk, to ensure that risks are not underestimated and concerns explained away.

85. Although legitimate questions have been asked about whether the child protection process should have operated better as a safety net to address the risk AR posed to others in the absence of any better structure, LCC submits the child protection process is not an appropriate one to lead any new multiagency process:

    a. First, there is no logical reason for the process to be dependent on whether the individual is a child or an adult. Risk is not driven by age, although age may impact what steps are taken to address it. Like MAPPA and Prevent, the system should be the same regardless of age. The agencies contributing to the process may well be different if the person presenting the risk is a child, but the process itself should be consistent. ASC has very limited compulsive powers in relation to adults and would be wholly inappropriate to be the lead agency in relation to adults.

    b. CSC does not have the expertise to lead on these issues, which primarily engage the expertise of the criminal justice system and/or forensic mental health.

c. Social care does not have the resourcing or capacity to lead, although it recognises that it will often play an important part in multiagency working, as would Education.

86. CYJS is not an appropriate agency to lead for the same reason – its role is limited to young people. It is happenstance whether a potential offender is a child or an adult. It is accepted however that in the case of children CYJS should have an important role in working within the structure to deliver interventions.

87. The Inquiry may decide to consider the question of how risk posed by children to others should be assessed in education. It seems likely that if the Inquiry makes recommendations about a multi-agency structure to consider, assess and manage the risk posed by those such as AR, that risk in the education setting would be one of the areas to be addressed.

Conclusion

88. LCC has set out above its analysis of how and why the system failed to address the risk posed by AR and instances where its services did not meet the standard that they should have done. It accepts that there were missed opportunities for the multiagency framework to intervene earlier and more decisively to address the risk AR posed and it accepts its role in that. LCC does not believe that its employees could have foreseen either the risk of what AR was going to do or indeed that he was going to act when he did.

89. Phase 1 has revealed a range of difficulties with the multiagency structure and the quality of multiagency working and LCC recognises that it has an important role in assisting the Inquiry with phase 2. Much work has already been done by LCC to improve many of the areas where it recognises there were shortcomings and it remains committed to continuing to work with the Inquiry and its multiagency partners into the future.

LAURA JOHNSON KC AND SAMANTHA BOWCOCK KC

21 November 2025