

## SOUTHPORT INQUIRY: PHASE 1

### CLOSING SUBMISSIONS ON BEHALF OF SEFTON COUNCIL (“SEFTON”)

1. These Submissions address two discrete issues:
  - Issues relating to taxi licensing.
  - Learning that might be taken in regards to children’s social care.

#### *Taxi Licensing*

2. The Inquiry heard from Mark Toohey on Day 13, 25 September 2025<sup>1</sup>. He confirmed the truth of his Statement dated 12 August 2025.<sup>2</sup>
3. He is employed by Sefton and manages the daily operation of the taxi licensing functions of the Council. He looks after both the taxi licensing and licensing team. In addition to taxi licensing enforcement, he deals with consultations and policy changes. In that regard, he liaises with the Sefton Licensing and Regulatory Committee in the operation of policy changes.
4. He informed the Inquiry that taxi driver licenses are renewed every 3 years and vehicle licenses are renewed annually. On each occasion of the renewal of a drivers licence Sefton considers the continued suitability, or otherwise of a driver continuing to be licensed.<sup>3</sup>

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<sup>1</sup> Transcript day 13, pp 100 et seq.

<sup>2</sup> SEF 000170.

<sup>3</sup> SEF000165, SEF000166

5. Sefton considers that compliance with the material terms in its taxi Licensing Handbook<sup>4</sup> constitute a condition of the grant of the licence.
6. However, Sefton are considering whether, and if so how to make this clearer.
7. Sefton are considering the practicability of imposing as a condition of the grant of a drivers or operator's licence a requirement to share, in certain circumstances, information about a taxi journey. However, this is a matter which, in Mr Toohey's opinion, would require consultation on a wider scale.<sup>5</sup>
8. In addition, Sefton would consider consultation about whether a failure to report criminality might result in an investigation/as to whether a driver remained "fit and proper" to hold a taxi driver's licence.
9. Consideration will also be given to/including:
  - (a) An express provision requiring drivers seeking renewal of their taxi driver's licence confirmation by them that they have read the Handbook and agree to be bound by its contents.
  - (b) Safeguarding; making a training course to test their knowledge of the Handbook, including the safeguarding section, a mandatory requirement that such drivers attend.
10. As to Mr Toohey's expectations of what he would have expected Mr Gary Poland to have done, he said:

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<sup>4</sup> See SCF 000165.

<sup>5</sup> See Transcript pp111 – 112..

(a) Mr Poland should have called 999 to report what he had seen/heard of the incident immediately after he was satisfied it was safe to do so.

(b) it was contrary to the terms of the Handbook to fail to make a 999 call until 50 minutes later.

11. In consequence, an investigation was warranted into whether the actions were those of a “*fit and proper*” licensed taxi driver.

***Sefton’s plans for further improvement***

12. Mr Toohey advised that the new training programme would be mandatory for all new and existing drivers and would include consideration within it the need to report criminality.

13. Also, as a condition of the grant of a taxi drivers licence, a mandatory requirement on each driver to attend periodic refresher training regarding safeguarding and any changes to legislation and/or council policies.

14. The Inquiry have been provided with an update on the progress of these matters, in the letter from Chris Moister, Chief Legal and Democratic Office dated 20 November 2025.

***Sefton’s broad overview and consideration of the evidence***

15. Sefton express no views on the presence or absence of fault on the part of any specific agency.

16. However, it was clear from the admissions of different agencies during the Inquiry that there was a lack of professional curiosity relating to risk of harm towards AR, the risk he posed to others and his parents ability to manage that risk demonstrated during interactions with AR.

17. It may be that agencies involved lacked professional curiosity in relation to risk, the parents ability to manage that risk, to keep AR safe from himself and harm to others and procedures that insured key information was provided on handover.
18. A repeated comment or observation was that individuals dealt with the matters that were in front of them and didn't have a wider awareness of information, nor clarity concerning the conduct of other agencies.
19. There was no self-challenge to make sure that agencies held all necessary information from their own sources or files, let alone proactively sought information from others.
20. Witnesses agreed that failings to review case files fully, or have complete handovers meant they did not make fully informed decisions or recommendations.
21. Individuals within multi agency working groups did not hold each other to account, and did not challenge or even seek to clarify each other's actions. Assumptions were made based on individuals' views that someone else would take action, that these agencies would have been in possession of all the information they held, without actually clarifying whether this was the case. This arguably led to a circle of inaction or inadequate action. By focusing only on their own part, the whole picture was not put together.
22. What was required was a "heads up approach", driven by professional curiosity in relation to risk and the parents ability to manage that risk and a focus not solely on an individual's role but also considering the extent to which a wider multi-disciplinary agency approach was required.

23. In the 2023 Statutory Guidance “*Working Together to Safeguard Children*”<sup>6</sup>, supporting children at risk of, or experiencing harm outside the home, paragraph 195 provides:

*“195. Where there are concerns that a child is experiencing extra-familial harm, practitioners should consider all the needs and vulnerabilities of the child. Some children will have vulnerabilities that can be exploited by others and will require support appropriate to their needs to minimise the potential for exploitation. All children, including those who may be causing harm to others, should receive a safeguarding response first\* and practitioners should work with them to understand their experiences and what will reduce the likelihood of harm to themselves and others.”*

*\*Emphasis added.*

24. In the *Working Together to Safeguard Children 2018*<sup>7</sup>, relevant to the time of the 2019 referral, paragraph 40 provides: “Assessment of risk outside the home”

***“Assessment of risk outside the home***

*40. As well as threats to the welfare of children from within their families, children may be vulnerable to abuse or exploitation from outside their families. These extra-familial threats might arise at school and other educational establishments, from within peer groups, or more widely from within the wider community and/or online. These threats can take a variety of different forms and children can be vulnerable to multiple threats, including: exploitation by criminal gangs and organised crime groups such as county lines; trafficking; online abuse; teenage relationship abuse;*

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<sup>6</sup> Working together to safeguard children 2023: statutory guidance.

<sup>7</sup> Working Together to Safeguard Children 2018.

*sexual exploitation and the influences of extremism leading to radicalisation. Extremist groups make use of the internet to radicalise and recruit and to promote extremist materials. Any potential harmful effects to individuals identified as vulnerable to extremist ideologies or being drawn into terrorism should also be considered.<sup>8</sup>*

25. Section 31 of the Children Act 1989 provides;

***Matters relating to children's social care***

Care and supervision

*“31. On the application of any local authority or authorised person, the court may make an order—*

*placing the child with respect to whom the application is made in the care of a designated local authority; or*

*putting him under the supervision of a designated local authority . . .*

*A court may only make a care order or supervision order if it is satisfied—*

*that the child concerned is suffering, or is likely to suffer, significant harm; and that the harm, or likelihood of harm, is attributable to—*

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

*or*

*the child's being beyond parental control.”*

26. Under Section 47 of the Children Act 1989, the threshold of “*likelihood*” of significant harm is reached when there is reasonable cause to suspect that a child is:

(a) Suffering or

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<sup>8</sup> Under the Counter-Terrorism and Security Act 2015.

(b) Likely to suffer significant harm.

27. If found to have happened, following the assault by AR's father on AR the threshold for a Section 47 intervention was met.
28. The Inquiry will, respectfully want to consider whether AR should have been dealt with as part of a safeguarding process, not via Early help. Was the focus of relevant agencies on the support to be provided to AR and the parents willing to give consent to engage in that support, rather than on the actual or potential risks to/posed by him?
29. The referral to prevent appears to have been a response to escalating risk. However, the Inquiry will need to consider whether this should/could have been a referral to children's social care as the first step in triggering and intervention. This may then have led to a child protection referral i.e. a Strategy Discussion, a formal multi-agency meeting to plan a response. In turn, this may have led to an Initial Child Protection Conference ("ICPC") to decide whether a Child Protection Plan was required.
30. It also seems clear that the threshold under Section 47 was clearly passed when AR attended school with a knife, on each of the occasions when he did. Again, had intervention based upon safeguarding and parental capability rather than early help been considered, those matters set out at paragraphs 27 – 29 above might have been considered.

***The steps Sefton are taking now***

31. Without waiting for the Phase 1 Inquiry Report, Sefton is proactively considering the advice it gives to those in its adult/children social case services.

- Encourage professional curiosity regarding risk of harm to children and the risk they pose to others which must consider the parents ability to manage that risk. All staff should be encouraged to ask questions and to engage fully with the work they are asked to do. Not just “their” bit but with the wider teams contributing and outcomes desired.
- Staff should be given time to ensure they fully understand their instructions and the information held by them.
- Instructions and handovers should be full and complete undertaken in a consistent way with agreed key information highlighted. Processes should be developed and implemented to reflect this.
- Line managers should foster an environment of constructive 2 way challenge.
- The professional curiosity/ challenge should be cross organisation with teams being open to asking questions of or by each other.
- All staff should consider whether a focus on retaining consent for support is overriding the statutory duty to safeguard children from the harm they may experience or pose to others and the parental ability to manage their risk.

### ***Conclusions***

32. These Closing Submissions should be read together with Sefton’s Opening Submissions.<sup>9</sup>
33. Sefton is very grateful to the Chair for the opportunity to have participated at Phase 1 of the Inquiry as a Core Participant.

**Louis Browne KC**  
**Exchange Chambers**

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<sup>9</sup> [Opening-statement-on-behalf-of-Sefton-Council.pdf](#)

**Chris Moister  
Richard Clegg  
Tom Dillon  
Sefton Council  
24 November 2025**