Southport
Inquiry

The **Southport** Inquiry Report

Volume 2

13 April 2026

HC 1768-II

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This report is presented in two volumes.

Volume 1 focuses on the events and consequences of the attack.
Volume 2 examines the roles and actions of the agencies involved.

Both volumes should be read together for a complete understanding of the issues addressed.

Chapter 7

Policing

Introduction

1. The immediate policing response to the attack has already been examined in Chapter 4: The attack and is therefore not repeated here. This chapter focuses instead on the earlier policing response when AR came to the attention of either Lancashire Constabulary (the policing area in which AR lived and which contained The Acorns School) or Merseyside Police (the relevant policing area for both Range High School and Presfield High School). It sets out, in chronological order, the police actions and decision-making across seven key areas:
    a. The response to AR's contact with Childline and his possession of knives at Range High School in October 2019;
    b. The response to concerns raised by The Acorns School in December 2019;
    c. The response to the attack at Range High School on 11 December 2019;
    d. The response to incidents at 10 Old School Close in November 2021;
    e. The response to AR carrying a knife on a bus on 17 March 2022;
    f. The response to further calls to 10 Old School Close in May 2022; and
    g. The response to Presfield High School's request for a welfare check in March 2023.

The police response to AR's report to Childline and AR taking knives into Range High School

2. On 4 October 2019, AR contacted Childline.[1] He asked them: *"[w]hat should I do if I want to kill somebody?"* After an appropriate reply from Childline on 5 October, AR contacted Childline again on 7 October 2019, stating the issue was bullying and *"I want to kill somebody"*.[2,3] In this online chat, AR told Childline that there was somebody at school who he hated and that he wanted to kill them. He had taken a knife to school and stated he would *"only"* use it if this individual *"really annoyed me in the moment"*. However, he added that when he saw the other boy *"I want to kill him and I just get more angry when he pushes and just touches me"*.

1 MERP000176.
2 MERP000176.
3 MERP001171.

3. Following these revelations, given the risk to life, Childline entirely appropriately made a prompt referral to the National Crime Agency, who in turn alerted Lancashire Constabulary.[4] In light of the risk that AR might harm someone imminently, the Force Control Room correctly identified this as a matter which had to be dealt with prior to the next school day. Given that urgency, Police Constable Alexander McNamee and Police Constable Alex Wood, both response officers, visited AR at home on the same evening.[5]

4. PC McNamee and PC Wood noted that AR's parents were concerned about the revelations.[6] Laetitia M (AR's mother) had already taken a knife from AR and had secured the other knives in the house by locking them away.[7]

5. On being questioned, AR admitted taking a knife into school on about 10 occasions as a reaction, he suggested, to bullying.[8] He said that he would have used the knife to kill *"if things got to a certain point with the bully"*.[9] It is undoubtedly significant that AR did not, certainly initially, appreciate the seriousness of his actions. Instead, he was *"flippant and dismissive"* about what he had done.[10] AR's suggestion that he had been bullied by a particular pupil was seemingly accepted by his parents. However, AR said that he had carried a knife because he intended to hurt someone with it, depending on what happened. This was not, therefore, simply a misguided case of self-defence. This was said in the presence of his mother and possibly his father, Alphonse R. On this basis, one of the considerations at the time for PC McNamee was that AR had both the means and the intention of committing a murder.[11]

6. By the end of the discussion, AR had *"recanted somewhat"*, in the sense that he indicated he would not take a knife into school again (*"he became tearful but he still had this feeling that he was being bullied and he was a victim of that injustice at school"*).[12] This slight change of stance by AR only occurred after PC McNamee and PC Wood explained the consequences to him of being arrested.

7. PC McNamee concluded that AR did not fully understand the implications of what he had been proposing to do, both for himself and for others. He was fixated on his belief that he had been bullied, a state of affairs that he considered had not been addressed.[13] As to the honesty of AR's explanation for his actions, there may have been several factors in play. AR's autism is likely to have contributed to him being disproportionately sensitive to perceived slights,

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4 LANC000065; LANC000144.

5 LANC000041.

6 T/S: 17/131/8-13.

7 Witness Statement of PC McNamee LANC000269/§14.

8 Witness Statement of PC McNamee LANC000269/§12.

9 T/S: 17/147/1-6.

10 T/S: 17/132/7-9.

11 T/S: 17/133/14-20.

12 T/S: 17/136/2-11.

13 T/S: 17/135/17-136/1.

to view disagreements as bullying and to hold a fixed sense of perceived injustice. However, one of the defining hallmarks of AR's personality from 2019 was also that he was deeply manipulative and routinely untruthful. In Chapter 11: Education, I have concluded that while I cannot rule out that AR may have had difficulties with some other boys at Range High School, to the extent that such problems may have existed, they did not amount to a systemic course of bullying. AR's skewed perception of events and propensity towards exaggeration means that any such difficulties are likely to have been more a case of mutual dislike and name calling between pupils than targeted bullying or other more serious behaviour.

8. Taking into account his age, AR's apparent vulnerability and his potential learning difficulties, the officers did not arrest AR.[14] They were told by AR's parents that there was to be an assessment for autism.[15] Moreover, PC McNamee considered that preventative measures could be put in place by a variety of agencies and the incident, therefore, could be dealt with other than by way of a criminal justice response. In fairness to PC McNamee, I should set out his description of AR:

> *"The child I saw on the night of 7 October 2019 was a skinny, socially inept child who perceived he was being bullied and had therefore taken a knife to school for a specific reason. I believed that the police, AR's parents and school were in a position to put in place interventions that would mitigate the risk of this happening. As a result of this, I thought the immediate risk of him returning to school with a knife was low."*[16]

9. I readily understand the importance of diverting young people from the criminal justice system wherever possible. I accept that the factors I have set out above, in relation to vulnerability and age, militated against (in particular) immediate arrest or pursuit of a criminal investigation. Nonetheless, I am concerned by how quickly the decision was reached not to arrest AR or (perhaps more significantly) to deal with him otherwise than through the criminal justice system. The officers knew that AR had taken a knife into school on 10 occasions, intending potentially to use it to kill or to inflict really serious harm on another pupil. It does not seem to me that the possible need for criminal investigation – whether by arrest or otherwise – was sufficiently considered. I return below to other reasons why no criminal investigation took place, involving the later absence of a transfer to Merseyside Police. However, even on the night of 7 October 2019, it is clear that the officers regarded this primarily as a safeguarding issue. In doing so, I accept that this would have been in line with their training and the prevalent culture in policing. Assistant Chief Constable (ACC) Mark Winstanley, giving evidence on behalf of Lancashire Constabulary, accepted that policing's *"balance between risk and not criminalising children*

14 T/S: 17/134/9-17.

15 T/S: 17/130/14-24.

16 Witness Statement of PC McNamee LANC000269/§43.

needs to be re-addressed and probably re-balanced".[17] This seems to me to be an example of that lack of balance. Under government guidance issued in 2026,[18] any child knife possession offence now requires a mandatory notification to the Youth Justice Services within one working day and must result in a structured, multi-agency response. While this guidance did not exist in 2019, its requirements highlight how differently a case of repeated knife carrying should now be handled.

10. Given the way AR had acted and his admitted intent, I consider that the truly exceptional circumstances which would have justified not investigating a suspect – even one as young as AR – were absent. A proper investigation would have included some consideration of whether:

    a. AR's contention that had been bullied was true (although this would not, in any event, have afforded AR a defence); and

    b. whether his *"learning difficulties"* indicated a non-criminal justice disposal was more appropriate. A first offence of this sort, for a child of AR's age, would have been likely to result in a youth caution or youth conditional caution. Either would have caused Lancashire County Council's Child and Youth Justice Service to become involved.[19]

11. Although I accept that the officers acted with the best of intentions (and, as detailed below, did take forward other actions in response to the incident), it was an inadequate response for them simply to accept AR's explanation, without further exploration of the true circumstances of what had occurred. PCs McNamee and Wood were not in a position to assess the relevance of AR's *"learning difficulties"* following a home visit lasting approximately 20 minutes. They could not have properly evaluated whether he had been bullied, a contention about which an investigation would have discovered there was considerable doubt. The school would have credibly contested any suggestion that there had been any sustained pattern of bullying behaviour.

12. The officers made an entry on the incident log stating that AR, when asked if he was willing to use the knife, had accepted that he was *"pretty certain"* that he was.[20] PC McNamee created a non-crime 'high risk vulnerable child' investigation report.[21] Although this investigation report was submitted on 7 October 2019, there was an issue with the 'Connect' platform: a Lancashire Constabulary IT platform that acts as a single data store for the police force. This caused a significant delay in the reports being processed. As a result, this report was only returned to PC McNamee on the system on 22 November 2019, almost six weeks later. This made it difficult for the officers to update the record with any intervening information.

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17 Second Witness Statement of ACC Winstanley LANC000433/§35.

18 Government guidance for child knife possession offences available at: www.gov.uk/government/publications/child-knife-possession-offences

19 Also known as the Youth Offending Team (YOT).

20 LANC000041/6.

21 LANC000248.

However, PC McNamee suggested that this was a temporary technical problem which was resolved.[22] ACC Winstanley indicated that Connect is now greatly improved in terms of accessibility and speed of response.[23]

13. On 7 October 2019, the officer's report was automatically forwarded to the Multi-Agency Safeguarding Hub (MASH), in the form of a Protecting Vulnerable Persons (PVP) form[24] (now known as a Vulnerable Child Report). MASH is a now common national model that is intended to allow those with responsibility for the safety of vulnerable people to work together, share information and co-ordinate activities. In Lancashire, the MASH is a body within Lancashire County Council which assesses safeguarding referrals and passes them on to the relevant agencies. PC McNamee also produced a risk assessment, shared with the MASH, which noted the need for an intervention around carrying knives.[25] The referral recorded that AR believed he may use the knife in a bullying situation (*"if things escalated"*), rather than that he was *"pretty certain"* to use it. It was anticipated that this would lead to intervention by social services.[26]

14. The report also created an automatic Operation Encompass referral, which would go directly to any school within Lancashire, so that the school knew of police involvement with a child before the next school day.[27] Because Range High School was in Merseyside not Lancashire, PC McNamee was not confident that this referral would go directly to the school. He was right to be cautious: in such cases, the referral goes to Lancashire County Council, who are then responsible for passing it on to the out-of-area school. I address this in the recommendations at the end of this chapter.

15. PC McNamee understandably wanted to ensure that the school were aware of this incident before the next school day. For that reason, he alerted Range High School by sending a form via its website.[28] He advised the school of what had occurred and suggested that, ideally, they should search AR and take additional safeguarding measures. He and PC Wood also arranged for a sergeant to contact Range High School the following morning.[29] The only other step that ought to have been taken as regards immediate risk was to alert AR's intended victim, or his parents, of the risk that AR posed. ACC Winstanley accepted that this did not happen, but ought to have done.[30]

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22 T/S: 17/152/17-153/13.

23 T/S: 20/35/16-21, T/S: 20/41/2-7.

24 LANC000066.

25 LANC000067/4.

26 T/S: 17/147/15-19.

27 LANC000126. An Operation Encompass referral involved the direct transfer of information about a child from the police to their school. Full detail on Operation Encompass is set out in the Witness Statement of DI Marston LANC000407.

28 LANC000018.

29 T/S: 17/145/1-13.

30 Second Witness Statement of ACC Winstanley LANC000433/§§21-25; T/S: 20/36/14-22.

16. While the proactive measures taken to ensure the school were alerted quickly were good practice, it is of note that PC McNamee failed to alert either Range High School or the MASH that AR had admitted that he intended to use the knife. It was critical that this manifestly important piece of information was included in the police reports. This is an example of the dilution of risk information through the process of information sharing. The information held by Lancashire Constabulary about AR's intentions should have been shared accurately to ensure that the true import of what had occurred was passed to others. (I should however note that in this case, AR did state his willingness to use the knife when spoken to by staff at Range High School the following morning, and this was then conveyed to the MASH by Range High School).[31] This is one of the themes of this report, as one of the systemic failings that the Inquiry has identified. I address this in the recommendations for this chapter but the importance of the accurate passage of information is not limited to the police.

17. The next day, 8 October 2019, PC McNamee spoke with Mr David Cregeen, the designated safeguarding lead from Range High School. Mr Cregeen told PC McNamee that when AR arrived at school that morning, he was searched and no weapons were found. However, AR admitted having previously brought a knife to school and said that he would have used it to stab someone. Mr Cregeen described to PC McNamee that when AR was placed in detention during the previous week he had said *"this is why teachers get murdered"*.[32] It did not appear that AR was demonstrating any level of contrition. PC McNamee added this information to the police investigation report but did not circulate it to the MASH for sharing with other agencies. He accepted that he should have done so, though it is fair to note that Mr Cregeen also provided this information to the MASH directly. I deal with the adequacy of the response of the MASH and Lancashire County Council to this referral in Chapter 9: Social care.

18. PC McNamee's evidence was that he had, at some point, advised Mr Cregeen to report this matter to Merseyside Police directly. Range High School was within Merseyside Police's area and so they would ordinarily have responsibility for investigating offences committed there. PC McNamee thought that he might have advised Mr Cregeen in the telephone call on 8 October 2019, although it was not recorded in his note of that call in the police investigation log.[33] Certainly, by 27 November 2019, PC McNamee believed that he had given this advice to Range High School because he referred to having done so in an email to Merseyside Police.[34] Mr Cregeen had no recollection of receiving this advice. I consider that Mr Cregeen would most likely have followed the advice, if it had been given by PC McNamee on 8 October 2019.[35] It is more likely that,

31 T/S: 26/228/18-229/6.

32 T/S: 26/231/20-232/1.

33 T/S: 17/156/24-157/11.

34 LANC000070; T/S: 17/166/4-16.

35 T/S: 26/233/4-234/19.

even as early as 27 November 2019, PC McNamee was mistaken about giving that advice in October 2019. That would also be consistent with his decision, on the night he attended AR's home, to treat this as a safeguarding issue rather than a criminal justice issue. I address below whether this advice was given at the later stage of December 2019.

19. On 28 October 2019, Alphonse R wrote an email to PC McNamee asking for his assistance at the meeting of the Governing Board at Range High School on 5 November 2019.[36] The Governing Board was to consider whether to uphold or reverse AR's exclusion for repeatedly carrying a knife in school. Alphonse R suggested the school was *"relaxed"* about fighting and intimidation, and that there was a gang culture among the students. He contended that AR, as the *"victim"*, was being punished and that expulsion was a *"shortcut option"*. He criticised Childline for not providing *"follow-up"*.

20. PC McNamee replied on the same day, correctly declining to assist.[37] He highlighted that AR had committed a criminal offence multiple times by taking a knife to school and that he had admitted several times that *"he would have used it on the male in question due to 'bullying'"*. PC McNamee explained that while he understood the pressure that can be caused by bullying, AR's reaction presented *"a risk of horrific escalation"* and that while AR admitted to carrying the knife *"he did not seem to fully understand the possible repercussions, nor show any remorse"*.

21. The fact that Alphonse R had made this request showed that Alphonse R, alongside AR, did not seem to understand the gravity of AR's conduct. PC McNamee rightly identified this but it was not recorded on the police investigation log (I note that the log would not have been returned to PC McNamee on the Connect system by this point).[38] ACC Winstanley's view was that this occurrence should have been recorded for the benefit of other officers.[39] I agree.

22. On 24 November 2019, PC McNamee requested permission to close the vulnerable child investigation. He was aware that AR had been permanently excluded and had been transferred to a more appropriate school. It is not clear how PC McNamee became aware of this, which suggests that there may have been some further contact between him and Range High School. PC McNamee believed AR was receiving input from Lancashire County Council. A sergeant, however, directed him to ensure that the offending had been reported to Merseyside Police and to add Merseyside Police's reference numbers to the log so it could be closed.

36 LANC000069/2.

37 LANC000069/1.

38 T/S: 17/161/23-162/1.

39 T/S: 20/38/22-41/1.

23. As I set out above, I do not consider that PC McNamee had previously advised Range High School to report the incident to Merseyside Police, although he genuinely believed that he had done so. He duly sent an email to Merseyside Police on 27 November 2019, in which he described how AR had taken a knife onto school premises and asking if a crime report had been submitted by the school. He confirmed in the email that AR had admitted the offence.[40] Merseyside Police responded the same day, indicating that a crime report had not been received. PC McNamee had some recollection of a further conversation with Mr Cregeen in early December, which is supported by Mr Cregeen's details appearing in his pocket notebook for 5 December 2019.[41] Mr Cregeen could not remember a further telephone call. I consider that there was such a call, and it was the occasion when PC McNamee delivered the advice to Range High School to report the matter to Merseyside Police. That is because PC McNamee had been told to ensure that the report had been made, he had taken steps to follow through by emailing Merseyside Police, and his pocket notebook supports his partial recollection. I will address Mr Cregeen's position in Chapter 11: Education, but I note in the current context that it is likely that Mr Cregeen would have regarded such a report to Merseyside Police as less urgent in December 2019, almost two months after the incident had happened and well after AR had been excluded, compared to the position in October 2019. It is likely that this advice then became overtaken by the events of 11 December 2019.

24. The final result was that these offences were never 'formally' reported to Merseyside Police for them to open an investigation. Meanwhile, the Lancashire Constabulary vulnerable child investigation was closed on 9 December 2019 without Merseyside Police log reference numbers being added to the Lancashire records. PC McNamee accepted unhesitatingly and candidly that he ought to have reported the case to Merseyside Police, either when it occurred or, at the latest, following the direction from a sergeant on 24 November 2019. He would have been able either to email the relevant information to Merseyside Police, or to create a crime report on Lancashire systems and then have it transferred to Merseyside.[42] ACC Winstanley accepted equally unhesitatingly both that PC McNamee should have made the report to Merseyside Police, and that the Lancashire Constabulary vulnerable child investigation should have been kept open until it had been confirmed that Merseyside Police were going to deal with these offences. As such, this was a failure not solely by PC McNamee, but *"a failure of the system to ensure that that action took place to make sure that Merseyside had that information on their systems"*.[43] I address this systemic failure in the recommendations.

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40 LANC000070.

41 LANC000050.

42 T/S: 17/166/21-167/23.

43 T/S: 20/35/8-10.

The police response to concerns raised by The Acorns School in December 2019

25. Following AR beginning at The Acorns School after his permanent exclusion from Range High School, staff at The Acorns School recorded behaviour from AR over a short timeframe that led them to be extremely concerned. I have set out the detail in Chapter 11: Education. It culminated in AR, on 3 December 2019, making reference to not being allowed to look at guns on the internet, asking for a picture of a severed head and making graphic comments about how a broken drill bit could kill someone.

26. Mrs Joanne Hodson, deputy headteacher at The Acorns School, contacted PC McNamee on the same day, setting out her safeguarding concerns.[44] PC McNamee responded both in an email reply and then speaking to Mrs Hodson by telephone.[45,46] He agreed that AR's behaviour was quite concerning. He expressed the view that the school was *"doing everything possible"* by *"wanding"* and searching AR, and that they should immediately ring 999 if they continued to feel unsafe.

27. Although this information about AR's behaviour was undoubtedly worrying, it is right to emphasise that no further criminal offences had been revealed. Furthermore, PC McNamee was aware from his emails with Mrs Hodson that AR had a Lancashire County Council social care Early Help worker, Ms Lucy Parkinson, who had been informed about these incidents. He had also previously referred AR to the MASH. PC McNamee's view was that primary responsibility for handling what had occurred rested with Ms Parkinson and with the school.[47] He did not, however, update the enquiry log on the Lancashire Constabulary vulnerable child investigation. This step should have occurred for this information to form part of the official record, rather than forming part of a reservoir of undifferentiated email exchanges. PC McNamee agreed that this should have been [done].[48]

44 LANC000058/2.

45 LANC000059/2-3.

46 LANC000058.

47 I note that under the February 2026 guidance police involvement in child knife-related risk should not now be devolved to schools or Early Help (i.e. CFWS) alone. A mandatory, structured intervention plan would now be required from the Youth Justice Service even if no new offence had been committed.

48 T/S: 17/175/22-25.

28. PC McNamee and ACC Winstanley agreed that PC McNamee should have alerted the Lancashire Constabulary Community Safety team about AR's case.[49] It is of note that the Community Safety team were already aware of the essential elements of what had occurred via another route, discussed below. PC McNamee did not consider, on the information he had received, that a referral to Prevent was justified.[50] He considered that although AR's actions were dangerous, they were not terror-related, and they did not suggest a vulnerability to being drawn into terrorism or extremism. On the approach and the understanding prevalent at the time, this was a sustainable conclusion for PC McNamee to have reached. I have focused on whether that approach and understanding was correct in detail in Chapter 8: Prevent and Counter Terrorism Policing.

29. On 4 December 2019, Mrs Hodson emailed PC McNamee indicating that she had re-referred AR to Alder Hey Child and Adolescent Mental Health Services (CAMHS) but was not *"holding out much hope"*.[51] She then set out *"[i]s there anything else we should be doing? I [am] really worried that with a West Lancs address and a Sefton GP,* ***he is going to fall between the cracks****. We are concerned there is potential for a serious incident, if we can't access the right support"* (emphasis added). As to the ability of the police to act in circumstances such as these, PC McNamee observed in his evidence:

> *"[…] that it often feels as though other agencies think the police can have more influence in certain areas than we can. For example, when Joanne Hodson was explaining that she felt that AR was falling through the cracks with regards CAMHS. To the best of my knowledge, even now, there is no mechanism by which I or the police more widely can influence whether a certain health agency takes responsibility for a person, and it is down to their own policies and procedures."*[52]

30. I wish to emphasise that, viewed overall and in the context of a response officer, PC McNamee responded to the events largely competently and proactively. He recognised that AR's behaviour was concerning and indicative of a significant risk to others. There were some missteps and misjudgements on his part, and areas where he could have made better records, as I have set out above. However, I consider that PC McNamee's actions were broadly speaking diligent and reflected an appropriate concern for the risk posed by AR.

31. Additionally, on 4 December 2019, PC Paul Harrison from the Lancashire Constabulary Community Safety team – also known as the Early Action Team – wrote an email to The Acorns School indicating that he had been alerted to Ms Parkinson's concerns about AR, and he requested that they were

49 T/S: 17/177/7-23, T/S: 20/41/8-15.

50 T/S: 17/180/1-182/14.

51 LANC000059/1.

52 Witness Statement of PC McNamee LANC000269/§74; T/S: 17/173/15-25, T/S: 17/182/18-183/4.

referred to the MASH.[53] Mrs Janet Lewis from The Acorns School replied to PC Harrison's email the following day, indicating that she had been trying to make a MASH referral but she had not received a response to her email. She requested PC Harrison's advice.[54] PC Harrison forwarded the emails from The Acorns School to a MASH Early Help Worker who indicated they had been passed to the MASH education team. I briefly address this further in Chapter 9: Social care.

32. An emergency, multi-agency review meeting was, however, then arranged for 5 December 2019. PC Harrison did not attend, following advice from Police Sergeant Andrew Bramhall, as it was considered that the risk was at an inappropriately high level for the Community Safety team.[55] Present at the meeting were Alphonse R, AR (for part of it), representatives from Lancashire County Council's Early Help and Children and Family Wellbeing Service (Ms Anne Cookson) and representatives from The Acorns School (Mrs Jane Eccleston, the headteacher, and Mrs Hodson).[56] I deal with the details of the meeting in Chapter 9: Social care and Chapter 12: AR's family, but it was agreed by those present that AR should be referred to Prevent and back to the Police Early Action Team.[57] A multi-agency Team Around the Family (TAF) meeting was arranged for 13 December 2019.

33. Notwithstanding his decision not to attend the multi-agency meeting, PC Harrison helpfully remained involved with discussions about AR and was planning to attend the TAF meeting.[58]

The policing response to the attack on a pupil at Range High School

34. I have described the key facts concerning AR's attack on a pupil at Range High School on 11 December 2019 in Chapter 11: Education. It is relevant to recall that AR's attack was premeditated; he had booked a taxi the day before. AR was armed with a hockey stick, which he had adapted, which is what he used in the assault, but he also had a knife with him in his bag. It is also relevant to recall that when AR was unable to get to his intended target (the perceived bully), he instead attacked another pupil seemingly at random, even though he had never had any issues with the boy he attacked.

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53 LANC000060.

54 LANC000097.

55 T/S: 18/21/23-24/20.

56 LCC001346/67; LCC002311/6-7 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

57 LCC002311/7 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

58 LANC000099; LANC000100; T/S: 18/29/2-30/5.

35. While waiting for police to attend in the headteacher's office, AR was very calm and insisted that his actions had not been *"wrong"*. He stated that he had attended the school to look for another boy to attack.[59]

36. There is no issue concerning the immediate response of the Merseyside Police to this attack. Merseyside Police attended the school. AR was, appropriately, arrested by PC Liam Dodd along with PC John Clarke.[60,61] AR was searched and it was then that the kitchen knife was found in his backpack. He was taken into custody at the St Anne Street Custody Suite, Liverpool.

37. PC Harrison, who (as set out above) had been involved as a member of Lancashire Constabulary's Community Safety team, became aware of what had happened with AR at Range High School on the morning it occurred.[62] He helpfully and constructively provided information to Merseyside Police, as well as to Prevent, including ensuring that they were aware that AR had been excluded from Range High School for possession of a knife. He also informed them that The Acorns School, to which AR had moved, had recently referred him to social services because he had been accessing websites at school to research mass shootings; he had a fixation with beheadings and guns; and he had a dislike for his teachers.[63]

38. Ms Stephanie Hallaron was a Band 6 Mental Health Practitioner working for the Criminal Justice Liaison and Diversion Team at Mersey Care NHS Foundation Trust.[64] She interviewed AR in custody to assess his wellbeing and mental health.[65] AR suggested that his intended victim had previously assaulted him. He said that he had wanted to kill him for revenge and would have done so if he had found him. He told Ms Hallaron *"I did want to kill him but I don't think I would. Ideally, I wish I did it"*, but he did not think this would have happened because his visit coincided with school assembly. He showed no remorse for what he had done or what he had intended to do. When asked afterwards why he hit someone other than the pupil who he wanted to attack for revenge, he explained that he realised he was being chased by two teachers and he was not *"going to get taken to the Police Station for nothing so I thought I would hit him"*. Ms Hallaron assessed him as posing a medium risk of causing harm to others.

39. Later that day, Merseyside Police officer Detective Constable Paula Murphy was allocated as the officer responsible for the investigation into what had occurred, she was in other words the Officer in the Case (OIC). The relevant information

59 MERP002902/1.

60 Witness Statement of PC Dodd MERP007527.

61 Witness Statement of PC Clarke MERP008138.

62 PC Harrison was not able to give evidence to the Inquiry but relevant information was set out in the Witness Statement of ACC Winstanley LANC000292/§§170-173, and PC Harrison's emails were available.

63 LANC000101; LANC000102; LANC000103; LANC000104; LANC000105.

64 Witness Statement of Ms Hallaron MERC000026/§§2-3.

65 MERP002881.

was entered onto a crime report which functioned as a log of the investigation.[66] This was available on a local system called 'Niche', which is Merseyside Police's equivalent to Lancashire Constabulary's local system Connect. The two forces do not have access to the information on each other's local systems.

40. As a result of the information from PC Harrison, a team of Merseyside officers (including PCs Dodd and Clarke) searched 10 Old School Close and a number of electronic devices were seized: a desktop tower, a USB stick, an external hard drive, two portable hard drives, two laptops, and a PlayStation 4. In addition, a black iPhone was seized from AR in custody. The following day, Officer B[67] from Prevent – who was at this point reviewing AR's first Prevent referral – asked Detective Sergeant Christopher Smith, DC Murphy's supervisor, to pass his details to DC Murphy *"in relation to the computer/mobile seizures"*.[68]

41. Over the next few months, save for the iPhone (because PIN decryption would have taken 68 years) and the PlayStation 4 (which did not retain data), the seized devices were subjected to examination and were found *"to be negative for any data relevant to the investigation"*.[69,70] But the search parameters set by Merseyside Police were focused on the names of the witnesses to the offences for which AR was under investigation, as well as *"beheading"* and *"shooting"*.[71] They did not even include the name of AR's intended target as opposed to the boy he had, in the end, randomly attacked in the corridor. There is no evidence that any agency other than Merseyside Police was aware of either the search terms that were used, or the nil return on the searches that were conducted.

42. In those circumstances, although there had been initial effective co-ordination between Lancashire Constabulary, Merseyside Police and Prevent which led to the devices being seized, I do not consider that this continued when it came to examining the contents of the devices. Not only were the search terms extremely limited, but the information about the results was not shared as it should have been. DC Murphy should have done more:

    a. To seek input from Prevent so that the search terms to be applied reflected Prevent's potential concerns and interest;

    b. To ensure that Prevent were made aware of the two search keywords that had been used; and

    c. To ensure that Prevent were made aware of the results of the examination.

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66 MERP002919.

67 Officer B, a Counter Terrorism police officer, was one of the witnesses granted anonymity by the Inquiry. As further explained in Chapter 8: Prevent and Counter Terrorism Policing, Officer B was the Fixed Intelligence Management Unit (FIMU) officer for AR's First Referral to Prevent.

68 CTPNW000373/4.

69 MERP008359/116.

70 MERP002919/10.

71 MERP008359/115.

43. Similarly, the Prevent team should have done more to ensure that they communicated what they needed and expected to Merseyside Police. As I address in more detail in Chapter 8: Prevent and Counter Terrorism Policing, they should also have chased to find out the results.

44. The downloaded material was not retained beyond March 2020, and the devices were returned in May 2020.[72] DC Murphy accepted that she should have considered issuing a notice under section 49 of the Regulation of Investigatory Powers Act 2000 compelling AR to provide his iPhone PIN number.[73] However, this would be likely to have been disproportionate in the context of the investigation for which she was responsible.

45. Returning to the investigation, on 11 December 2019, due to the additional time needed for the searches, AR was bailed to his home address overnight.

46. On 12 December 2019 DC Murphy then interviewed AR under caution, with legal representation and his mother present as an appropriate adult.[74] He provided a prepared written statement in which he denied having any intention of using the knife.[75] This conflicted starkly with what he had told Ms Hallaron and was clearly untrue. In interview, he refused to answer questions, save that he denied accessing inappropriate material on the school computers, another significant lie. His behaviour was notably inappropriate during the interview, in that he openly laughed at some of the questions. His mother failed to challenge AR over his discordant attitude.[76]

47. Following AR's interview under caution, he was again released on police bail. The same day, DS Smith, DC Murphy's supervisor, sent an email by way of an update on the investigation to a wide group which included Ms Parkinson of the Child and Family Wellbeing Service, Officer B in Counter Terrorism Policing, PC Harrison in Lancashire Constabulary, and DC Murphy as the investigating officer.[77] In my view, the information-sharing about AR's arrest and the early stages of the investigation was well-handled by both Merseyside Police and Lancashire Constabulary (the latter primarily through PC Harrison). Both forces were aware of the need to share information with each other, and with other involved agencies such as Counter Terrorism Policing North West and Lancashire County Council and did so effectively and rapidly. The caveat to that is that PC Harrison's efforts were not recorded centrally (for example, via a vulnerable child investigation on Connect). This would have ensured that the information gathered would have been available centrally for other officers considering the details of AR's case, including a reference to the Prevent referral. No such record was created in the present case, notwithstanding the fact that it was established practice to do so. It is unclear why PC Harrison did

72 MERP002919/11.
73 T/S: 18/96/15-97/5.
74 MERP002882/8.
75 MERP000186/17.
76 T/S: 18/78/21-79/9.
77 MERP002566/18.

not follow this course, which meant that the events of December 2019 were not recorded in any real way on Lancashire Constabulary's local systems.[78] That had an impact subsequently, when there was confusion in March 2022 as to whether the incidents in October and December 2019 were the same or different.[79]

48. ACC Winstanley agreed that important knowledge held by PC Harrison should have been recorded on Lancashire Constabulary's systems.[80] This was a similar issue as arose with PC McNamee (save that, in this case, PC Harrison did not open a vulnerable child investigation log; PC McNamee did open one but then did not record all relevant information on it). Accordingly, I have addressed this in my recommendations. I make clear that while I have reached my conclusions on the evidence available, PC Harrison was too unwell to give evidence to the Inquiry, and is understood by the Inquiry to have been too unwell to engage in the statutory process under Rule 13 of the Inquiry Rules 2006, so that he has neither been able to provide evidence nor to respond to areas of potential criticism. It is important to note that PC Harrison may therefore have had insight on these matters which, through no fault of his own, has not been available to the Inquiry.

49. On Friday 13 December 2019, PC Harrison went to 10 Old School Close, to discuss safeguarding with AR's family. Critically, he spoke with Laetitia M about *"supervising AR at all times"* and ringing the police should he disappear. He formed the view that AR's parents were *"playing down"* the *"situation"* and AR's behaviour.[81] He helpfully shared the results of this meeting with Ms Anna Jameson of Lancashire County Council's Children's Social Care, though like his other work on the case, he did not make any centralised or formal record of it beyond what he said in his email.[82]

50. On 16 December 2019, the mother of AR's victim contacted DC Murphy to report that she had heard AR had a *"hit list"* of three potential victims, including his intended victim on 11 December 2019.[83] DC Murphy told her that she had not seen any such list. It appeared to be a rumour circulating around children and parents at Range High School. The rumour was also referred to by the headteacher at Range High School, Mr Michael McGarry, who had heard about it but never seen such a list.[84] DC Murphy confirmed to the Inquiry that she never saw such a list or any evidence that it actually existed.[85] She said that as far as she was concerned, it was never anything more than local rumour. Unfortunately, due to a misunderstanding in the post-July 2024 criminal

78 T/S: 18/33/19-35/19.
79 T/S: 18/138/1-17.
80 T/S: 20/47/18-48/9.
81 LANC000149/2.
82 LANC000107.
83 MERP002919/6; T/S: 18/81/22-82/2.
84 T/S: 26/204/2-9.
85 T/S: 18/80/12-82/4.

investigation, Merseyside Police were under the impression that this information came from Laetitia M when AR was interviewed under caution (in other words, that it had come from AR's mother, not from the mother of AR's victim).[86] This was then repeated in the Prevent learning review.[87] I am sure that this information was only the result of rumour circulating in the community at Range High School and did not come from AR or his family.

51. On 16 December 2019, PC Harrison contacted Inspector Helen Dixon (who line managed his team) to inform her of *"a rather concerning young individual"* he said he had been *"sort of"* dealing with.[88] He described that AR had been accessing information about mass school shootings online at school, he had an unhealthy obsession with guns, he drew disturbing pictures, and he talked about beheadings. Furthermore, he had been excluded from Range High School. He indicated that following consultation, this information had been forwarded to Prevent, as AR appeared to present a more serious risk than was appropriate for the Community Safety team. Their role, as it appeared to PC Harrison, was to be involved only to the extent requested by Prevent. He was of the view, therefore, that overall control needed to sit with Prevent. His views appeared to have been confirmed on the morning of 17 December 2019 when at 07:07 he received an email from Police Sergeant Carmen Thompson at Counter Terrorism Policing North West which simply stated, *"I will be attending a strategy meeting at 10 am this morning and (AR) will be coming to Prevent.*[89] *PS Bramhall and PC Harrison thereafter assumed that Prevent was the lead agency, and that, in PS Bramhall's words,"* had there been some work for us to do, they would have asked us and we would have helped where we could".[90]

52. Notwithstanding this, ACC Winstanley accepted that there was potentially still a role for the Community Safety team, not least because the individual may not be taken on by Prevent.[91] I agree with ACC Winstanley, both in general terms and because, as I describe below, in this particular case it was far from clear that PS Thompson's email was the last word on the topic.

53. The strategy meeting held on 17 December 2019 was led by Children's Social Care.[92] I focus here on the input from Lancashire Constabulary and Merseyside Police only but will return to this meeting in other chapters. In attendance were PS Thompson from Prevent; representatives from the mental health services (Mr Skott Morgan from CAMHS and Ms Hallaron), DC Murphy (the OIC from Merseyside Police), PS Bramhall and PC Harrison, representing Lancashire

86 MERP001432/49.

87 DFE000200/11; Home Office and Counter Terrorism Policing (2025), 'Prevent learning review: AR'. Available at: www.gov.uk/government/publications/prevent-learning-review-southport-attack

88 LANC000110.

89 LANC000109.

90 T/S: 18/24/13-16.

91 T/S: 20/44/9-45/12.

92 LCC000234.

Constabulary Community Safety team, a representative from The Acorns School (Mrs Hodson), a representative from Range High School (Mr Cregeen) and others. PS Thompson indicated that Prevent would be completing an assessment regarding AR and considering if a referral to the Channel programme was appropriate for him. It was agreed that Prevent would commence an initial assessment. Although the minutes do not stipulate that Prevent was the lead agency, PS Thompson's email of earlier that morning would have left PS Bramhall with the impression that Prevent were *"taking ownership"*.[93] Although I do not doubt that this was PS Bramhall's genuine impression, I consider that this reflected an inadequate engagement with the issues in this case. It should have been clear from the meeting that Prevent's involvement was subject to assessment, and that there was a potential continued role for the Community Safety team. I consider that PS Bramhall and PC Harrison prematurely closed their minds to the possibility of a role for the Community Safety team.

54. DC Murphy provided the meeting with an update on the criminal investigation, and on AR's bail conditions.[94] PS Thompson's own notes of the meeting supplement the minutes with the fact that this update included that PC Dodd had reported that AR had said *"he had taken the hockey stick to hit the victim with and that he was going to use the knife to finish him off and that he was not bothered about the prison sentence"*.[95] That is consistent with the comments AR was making to Ms Hallaron.

55. Although there was a recognition of a risk of reoffending by AR, the meeting concluded that:

> *"There is no evidence at this time that either child is at risk of significant harm. There is an acknowledged need for multi agency support and assessment on various areas of need and a level of risk based on [AR]'s offending and a need to get accounts from Dion alone and from [AR]'s parents. As such a follow up strategy meeting will take place to consider the risks to the children and further plan the assessment."*[96]

56. PS Bramhall's evidence was that the risk posed by AR had been *"covered"*.[97] However, the approach just quoted from the multi-agency strategy meeting was emblematic of the tendency on the part of many who were involved with AR, throughout the entire period leading up to 29 July 2024, to focus on the potential risk of harm to him as opposed to the risks that he posed to others. It is clearly crucial that the authorities should have a focus on the risk of harm to the young person in question, and in many cases this will often be the central or the only real issue. However, when the material demonstrates

93 T/S: 18/39/21-40/6.
94 LCC000234/2.
95 CTPNW000157/10.
96 LCC000234/4.
97 T/S: 18/47/25-48/4.

that the young person poses a significant threat to others, this should be treated with at least equal seriousness. The pervasive failure to act on AR's dangerousness (with some notable exceptions) was fundamental in this case. Indeed, PS Bramhall accepted that the Community Safety team *"really ought to have had a role in these circumstances"*.[98] He agreed that preventative policing was normally for the force where the relevant individual lived. But notwithstanding this, following this meeting, there were no actions to be undertaken by Lancashire Constabulary, and they were informed by Ms Jameson that they did not need to attend the next meeting (*"[…] there's no further role for your agency"*).[99] I note, however, that PC Harrison helpfully continued to put relevant individuals in touch with each other and provided updates on the criminal investigation.[100]

57. PS Bramhall did not want to *"step on another agency's toes"*, although he accepted that the Community Safety team could have asked to adopt a watching brief, given there was someone in their force area who was displaying high-risk behaviour.[101] On 6 January 2020, Prevent decided not to accept the case. This was not reported to Lancashire Constabulary, because they were no longer involved in the multi-agency process. That is an example of the information-sharing process falling short, and the pitfalls of the force local to AR not having any continuing role in the multi-agency management of his risk.

58. While PS Bramhall's view was that Prevent held the responsibility for assessing the risk that AR posed to others, DC Murphy, on the other hand, when asked which agency was responsible for assessing and addressing the risk AR posed, said *"I think we all had a responsibility in addressing it. I don't think any one agency had the overall control of it"*.[102,103]

59. That understanding on the part of DC Murphy was widely shared by key individuals in the various agencies who were involved with AR. I consider it represented a significant failure in what is otherwise a generally sensible *"multi-agency approach"*. In the absence of a single organisation – indeed, ultimately a senior accountable individual – with responsibility for assessing the risk and leading, co-ordinating and monitoring the response, the danger of nothing meaningful happening, apart from the sharing of information and passing referrals between agencies, is far too great. Discussions and providing updates, without more, is simply inadequate in situations such as the present.

98 T/S: 18/49/15-17.

99 LCC001695/1.

100 For example, at LANC000113 and LANC000114, when he obtained an update on the criminal investigation to pass to The Acorns School in February 2020.

101 T/S: 18/52/2-20.

102 T/S: 18/58/1-8.

103 T/S: 18/98/5-12.

As DC Murphy accepted, if they were all responsible for assessing the risk, there was a danger that no organisation would take responsibility for carrying out that assessment.[104]

60. Following the meeting on 17 December 2019, PS Bramhall sent an email to PC McNamee, which included the following paragraph:

> *"On another matter I went to a multi-agency meeting this morning where you had attended an address and recognised some serious concerns for a young man, [AR], in Banks. You did exactly the right thing by inputting a PVP ["Protecting Vulnerable People", i.e. the vulnerable child investigation report] on Connect that was then shared with other agencies. [AR] has since gone to his old school in Southport and committed a serious offence. Due to your timely PVP the finger of blame will not be pointed in your direction."*[105]

61. PS Bramhall accepted that the final sentence was poorly written, but he had wanted to reassure an officer who was new in the service, that he had *"done well"* and to keep him updated. It was not the responsibility of the response officer who was *"rushing from job to job"* to try to take long-term responsibility in a situation such as the present.[106] I accept this explanation. Nevertheless, PS Bramhall acknowledged that it was concerning that the risks that had been identified in October 2019 had actually come to pass two months later. Therefore, any interventions that had occurred had been ineffective. However, at this stage PS Bramhall understood that the case had been accepted by Prevent.[107]

62. Before leaving the evidence of PS Bramhall, I note that he considered that Lancashire Constabulary had a sufficient number of officers with appropriate experience and commitment working in the Community Safety team.[108] However, from early 2020 the COVID-19 pandemic severely reduced the opportunities to undertake preventative policing. It is notable, and surprising, that Lancashire Constabulary's Community Safety team had no further contact with AR after 17 December 2019.

104 T/S: 18/98/20-25.
105 LANC000194.
106 T/S: 18/54/2-55/7.
107 T/S: 18/55/8-21.
108 T/S: 18/56/18-21.

63. On 6 January 2020, the second strategy meeting took place.[109] As set out above, there was no attendance from Lancashire Constabulary. DS Jo Haffenden (one of DC Murphy's supervisors in Merseyside Police) attended and provided an update on the criminal investigation, even though there were no 'actions' arising for the attention of Merseyside Police.[110] It was notable that there appears to have been some confusion at that meeting about the status of the device searches and the internet search history. PS Thompson's notes of the meeting state *"The devices are being examined, the school internet history is also being looked at by Merseyside Police, they will update accordingly with any concerns found"*.[111] DC Murphy accepted that it was incorrect that Merseyside Police were looking at the school internet history, and that it would have been good practice to inform Counter Terrorism Policing of the outcome of the device examinations even though there was nothing of interest found.[112]

64. On 4 February 2020, AR was charged with assault occasioning actual bodily harm, possession of an offensive weapon in a public place (the hockey stick, erroneously referred to as a baseball bat in the charging documents) and possession of a bladed article on school premises (the knife).[113] He pleaded guilty to these offences on 19 February 2020 on his first appearance at the youth court. The court imposed a referral order of 10 months.[114] This was the only sentence realistically available to the court.[115] This outcome is intended to address the young person's offending behaviour through a contract with a referral order panel. I address the adequacy of the interventions under the referral order in Chapter 9: Social care, but it is relevant to note in the current context that neither Merseyside Police nor Lancashire Constabulary had, or would typically have, any involvement in managing or administering an individual who is subject to a referral order.

65. The third multi-agency meeting occurred on 4 March 2020.[116] It was not attended by Merseyside Police or Lancashire Constabulary. There was then no contact between AR and any police force until November 2021.

109 LCC000023.
110 T/S: 18/89/11-23.
111 CTPNW000009.
112 T/S: 18/90/16-91/10, T/S: 18/97/21-98/4.
113 T/S: 18/93/24-94/12.
114 T/S: 18/94/18-95/9.
115 T/S: 32/10/2-14.
116 LCC001346/58.

The policing response to calls to 10 Old School Close in November 2021

66. On two occasions in November 2021, the police were called to 10 Old School Close following 999 calls by AR's parents.

67. On the first occasion, Lancashire Constabulary were notified at 14:33 on 5 November 2021 following a 999 call transferred from Merseyside Police.[117] Laetitia M reported that AR had been smashing the house up and throwing items around and at people, that he was 15 years old, and had autism. Initially, she requested police attendance, but during that initial call changed her mind and said she did not want police attendance. The Lancashire Constabulary's Force Control Room called Laetitia M back at 17:08; she said that AR had now calmed down, that no damage had been caused, and that they had called a psychologist. She did not now need police to attend, and they had various agencies supporting them already. At 17:30, Police Constable Simon Williams, a Lancashire Constabulary officer, telephoned AR's mother, who provided some further details. AR had been on the sofa at home when a stranger knocked on the front door. This had made him agitated, and he had thrown things at the wall and made a mess. He had calmed down on hearing that police had been called. Other agencies – Lancashire County Council's Early Help and CAMHS – had already been notified.

68. In the circumstances, I am satisfied it was reasonable for the police not to attend the address in person on 5 November 2021. PC Williams made a medium-risk safeguarding referral to the MASH, and this was passed to the Children and Family Wellbeing Service team working with AR.[118] I deal with their response to it in Chapter 9: Social care. There was also an Operation Encompass referral.

69. On 30 November 2021, there was another 999 call by AR's parents. This was again received by Merseyside Police and the incident log transferred to Lancashire Constabulary's Force Control Room at 18:47.[119] AR had become angry at the food his parents had cooked him for tea. He had again thrown food around, but he had also thrown a plate of food at a rental car parked in the driveway, damaging it. During a call back by Lancashire Constabulary's Force Control Room at 20:29, the recipient of the call reported being scared of AR, and that they were having trouble with him on a daily basis.[120] This was not properly recorded on the incident log.[121]

117 Witness Statement of DC Connaughton LANC000408/§7; LANC000024.

118 LANC000076.

119 Witness Statement of PS Ward LANC000294/§11; LANC000025; LANC000079.

120 LANC000025/6.

121 T/S: 19/186/2-187/20.

70. Police officers attended at 23:39. As well as the damage to the car, Alphonse R disclosed that AR had kicked him, causing no injury. Alphonse R made clear that he did not support a criminal investigation. The officers who attended decided not to arrest AR. This was on the basis of Alphonse R's lack of support for action to be taken, the fact AR was now calm, his age, his autism, and the fact that arresting him at that point would mean detaining a child overnight. On this occasion, I accept that this was an appropriate decision. The assault and criminal damage offences were recorded but promptly closed as *"suspect suffers with autism and it is not in [the] public interest to prosecute and victim (father) does not want to make any complaint"*.[122] The review of this closure rationale by a sergeant in Lancashire Constabulary was inadequate: it involved a copy-and-paste justification that bore no resemblance to the facts of the case.[123] That has been addressed with the sergeant concerned, and ACC Winstanley's evidence was that Lancashire Constabulary have introduced a new investigation management policy that *"sets out very clear directions for what is expected of sergeants when they are conducting a review of an investigation"*.[124]

71. Again, a safeguarding referral to the MASH was made and passed to the Children and Family Wellbeing Service working with AR.[125] There was also an Operation Encompass referral to The Acorns School.[126]

72. On both occasions, I consider that Lancashire Constabulary responded appropriately to the calls. I do however note three common features which resonate with how AR was handled on other occasions. First, on each occasion, AR's autism was treated as a factor in how they dealt with the incident, without any real consideration or understanding of what that might mean for his criminal responsibility or risk. Second, on each occasion the response officers who attended had a limited understanding of AR's forensic history.[127] Third, despite a number of calls about the same child and the same address, a referral to the MASH on each occasion was seen as sufficient for policing to have completed its obligations, without wider consideration of, for example, a referral to the Community Safety team or Violence Reduction Network.[128] All three of these factors become significant when considering the next and more significant police contact with AR on 17 March 2022.

122 LANC000079/1.
123 T/S: 20/63/14-64/1.
124 T/S: 20/64/4-9.
125 LANC000080.
126 LANC000119.
127 T/S: 20/62/4-12.
128 T/S: 20/59/1-12, T/S: 20/62/13-63/9.

The policing response to AR carrying a knife on a bus on 17 March 2022

73. On 17 March 2022 at 11:14, Alphonse R reported to Lancashire Constabulary that AR was missing from home.[129] Police Constable David Fairclough volunteered to respond.[130] He went to the home address in order to gather any necessary information and to assess the risk of the person who had gone missing. There he met Laetitia M, who had come back from work. He learnt that AR had no friends or extended family. There was a reference to attention deficit hyperactivity disorder (ADHD) and autism, and the fact that he had been prescribed sertraline.[131] Laetitia M told the officer that she believed AR had taken a small kitchen knife which was missing from the kitchen. PC Fairclough was told that AR was supposed to be meeting the teachers at Presfield High School and having a tour of the new school he was to attend.[132] PC Fairclough conducted the kind of cursory search (lasting 15 to 20 minutes) for relevant information that would have been normal in such a case, looking for any suicide note, an indication of any medication AR had taken and whether he had packed a bag. Within the limitations of this search, there was nothing of significance, either in relation to AR's absence or the later attack on 29 July 2024.[133]

74. Given the events of 29 July 2024, it is of particular significance that Laetitia M informed PC Fairclough of AR's expulsion from Range High School, and they discussed the attack on a student at Range High School on 11 December 2019. She did so only when PC Fairclough prompted her about what had happened at Range High School, which he was aware of from the incident log.[134] While gathering information from Laetitia M, PC Fairclough generated a Missing From Home report on his Samsung portable device.[135]

75. When back in his car, PC Fairclough carried out a Police National Computer check on his Samsung device which provided details of the offences of assault and possession of an offensive weapon, but without the full circumstances of the offending.[136] Because the detailed material relating to the December 2019 offending was held by Merseyside Police, not Lancashire Constabulary, ascertaining the full circumstances of those offences would have required a Police National Database check which would have taken a significant period of time. The result of that is that information, such as Ms Hallaron's assessment following the attack at Range High School in December 2019, was not within

129 LANC000045.
130 LANC000419.
131 LANC000028.
132 LANC000030; T/S: 18/130/13-23.
133 T/S: 18/122/14-127/8.
134 T/S: 18/113/3-19.
135 LANC000009.
136 T/S: 18/132/13-134/10.

the records available to PC Fairclough.[137] I have recommended that the utility of the systems providing electronic material to response officers is the subject of careful review and evaluation. However, PC Fairclough had access to the Lancashire Connect intelligence records on his mobile device, which set out details of the Lancashire Constabulary vulnerable child investigation in October 2019 following the Childline report. PC Fairclough was under the mistaken impression that the conviction for offences in December 2019 and the report on Connect relating to the October 2019 incident were the same event.[138] PC Fairclough was *"fairly confident"* he was also aware of the two incidents which had been reported to Lancashire Constabulary in November 2021, although he considered that they were not out of the ordinary for a child such as AR.[139] I accept that he made himself aware of at least the outline of those recent incidents.

76. PC Fairclough accepted that it would potentially have altered his assessment of risk if he had appreciated that AR had carried a knife into school on 10 occasions in October 2019, followed by a separate attack in December 2019. However, ascertaining this would have involved a significant amount of research on a handheld device, which he would not have been able to undertake at the speed necessary at the scene.[140] He was unaware that AR had been referred to and not accepted by Prevent on three occasions, because that information was not recorded on Lancashire Constabulary systems.[141] He considered this would have been useful information and would have indicated that the high risk AR posed in 2019 had not changed.[142] Because of the limits of the information available on mobile devices, PC Fairclough was also unaware of some of the material that would have been available on Lancashire Constabulary systems on a more thorough review, such as that AR had searched for information about school shootings. I referred above to the failure by Lancashire Constabulary Community Safety team to record information from December 2019 in particular, on Lancashire Constabulary systems. The fact that limited information was available to PC Fairclough was significantly contributed to by that earlier failure.

77. PC Fairclough recorded in the Missing From Home report that:

> *"Parents believe he has gone missing as he does not wish to attend a meeting with his new school teachers. Parents believe he could be in possession of a small knife which is missing from the kitchen. He has never threatened or attempted self harm."*[143]

137 T/S: 18/134/12-136/16.

138 T/S: 18/138/1-139/24.

139 T/S: 18/142/14-143/21.

140 T/S: 18/139/3-140/24.

141 There was a very limited reference to the First Referral to Prevent on an intelligence report held by Lancashire Constabulary (LANC000064), but this would not have been available to PC Fairclough as a frontline officer.

142 T/S: 18/145/1-23.

143 LANC000009/3.

78. For reasons set out in Chapter 12: AR's family, I do not accept the honesty of that indication by AR's parents. On the contrary, I am sure they were principally fearful that he had left home with a knife to carry out another attack. One of Alphonse R's first telephone calls on discovering AR had gone missing was to Range High School, even though AR had not been a pupil there for over two years. The only reason for this must have been that he was concerned that AR had gone to carry out another attack there.[144]

79. PC Fairclough consulted the on-duty response sergeant, Police Sergeant Daniel Clarke, over the radio. Having done so, he recorded the risk level as 'medium'. In making that assessment, PC Fairclough was focusing solely on the risk to AR. He accepted the likely explanation that AR did not want to meet his new teachers and he took into account the fact that the offending in 2019 had occurred over two years earlier. Additionally, the electronic form PC Fairclough was completing did not direct his attention to the risk the missing person might pose to others. The form was tailored instead to address the position of the person who had gone missing. PC Fairclough now appreciates that attention should be paid to the wider risk to other members of the public.[145]

80. PC Fairclough contacted the Ormskirk CCTV operators to look for AR, and local Police Community Support Officers (PCSOs) began an area search.[146] He contacted Range High School and informed a member of staff there that AR was missing and was potentially in possession of a knife, given that Range High School had been the target in December 2019.[147] He made a check with One Call Taxis, as a significant local taxi company, and was told AR had not made a booking.[148]

81. Overall, I consider that PC Fairclough handled the initial report that AR had gone missing entirely appropriately; he was seeking to be diligent and pro-active.

82. AR was found by the police in the early afternoon. At 14:40 the Force Control Room was contacted by a coach driver who reported that a young black man got onto the bus and *"began to get stroppy"*.[149] The connection to the missing person incident was made by PS Clarke, and PC Fairclough and Police Constable Eve Rhodes separately attended at the scene.[150] AR was sitting at the back of the bus. He was calm and compliant. AR got off the bus when asked to do so. PC Fairclough had a clear recollection of asking AR if he was in possession of something he should not have with him.[151] AR then calmly produced a kitchen knife with a short, non-serrated blade.

144 T/S: 33/190/4-191/20.
145 T/S: 18/117/16-120/11; LANC000083.
146 T/S: 18/119/12-18.
147 LANC000031; T/S: 18/127/19-128/5.
148 LANC000029; T/S: 18/128/14-130/4.
149 LANC000046/3.
150 T/S: 19/116/10-118/1.
151 T/S: 19/8/3-9/21, T/S: 19/72/22-73/21.

AR was searched and nothing further was found. I am sure that PC Rhodes' later account in an operational competence submission that the knife was found during a search, rather than surrendered voluntarily, was inadvertently inaccurate.[152] PC Fairclough spoke with the bus driver. The driver confirmed that AR had not been violent or threatening, but had refused to pay his fare, and had refused to leave the bus when asked to do.[153]

83. PC Fairclough spoke to PS Clarke via the radio (though for reasons which were unclear, he used PC Rhodes' radio to do so). PS Clarke advised PC Fairclough to make a high-risk PVP referral (now a Vulnerable Child Referral), rather than utilise any power of arrest or detention under section 136 Mental Health Act 1983.[154] This was, in effect, a decision to treat this as a safeguarding issue. I repeat the concerns expressed above in respect of the speed with which an individual, despite being a child, was diverted away from a criminal justice outcome. In this case, he was armed with a weapon and had a history of violent offending, which made this outcome even less appropriate than in October 2019.

84. PC Fairclough did not tell PS Clarke about AR's previous convictions. PC Fairclough accepted that this was important information that should have been shared with PS Clarke, as it potentially had an impact on the correct disposal and whether it could be dealt as a 'one-off' incident involving a youth with mental health problems who needed support. In his evidence to the Inquiry, PC Fairclough readily and candidly accepted this had been a significant error on his part.[155] In turn, PS Clarke accepted that he, as the supervisor, should have asked PC Fairclough about whether AR had any previous convictions. If he had done so, it would have markedly increased the risk.[156]

85. PC Fairclough set out the reasons for the approach he adopted as follows:

> *"There were several factors which I considered. First and foremost, he was a child. I appreciate he wasn't a young child, he was 15 at that time. However, he was presenting younger than that. I was aware of his neurodiverse condition and the reason he had gone missing that day was he didn't like change. I didn't think custody would be appropriate. I still wasn't sure at that time whether he was going through a mental health episode, I hadn't negated that fully. He had been fully compliant at all times. He had handed the knife over at the first opportunity. There had been no resistance. We had confirmed there was no further offences threats or affray, anything like that. I wanted long-term support and I thought – I agreed with PS Clarke in terms of the PVP, to get other agencies involved or to update them that we are already involved in what was happening and also,*

152 LANC000246/2; T/S: 19/82/18-83/20.

153 T/S: 19/9/22-10/14, T/S: 19/11/8-12/17.

154 T/S: 19/12/20-13/11.

155 T/S: 19/13/12-14/19.

156 T/S: 19/111/2-112/6.

at that time, I felt he came from a responsible home, I thought he had a place of safety, other than custody, and all them decisions together helped me make the final decision of not making the arrest."[157]

86. PC Fairclough considered he was unable to rely on section 136 of the Mental Health Act 1983, which permits a constable to take an individual to a place of safety if they appear to be suffering from a mental disorder and are in need immediate need of care or control. PC Fairclough did not assess that AR was in need of *"immediate"* care or control so as to come within this power. He accepted, additionally, that an autism diagnosis may not have constituted a mental disorder of sufficient severity as to justify reliance on section 136. At the time, he was unable to call the mental health access line because he was not considering relying on the powers under section 136. There is now a mental health car, with a mental health practitioner who has access to the full NHS records, along with the police records.[158] PC Fairclough accepted that excessive focus was placed on AR's neurodiverse condition rather than *"what was right in front of me"*. He accepted that the approach for officers tended to be framed as a stark choice between a mental health or criminal justice resolution, excluding the analysis that this may have been criminal behaviour by someone for whom there had been a mental health diagnosis.[159] I agree that detention under section 136 would not have been appropriate given AR's level of compliance, but there ought to have been considerably more nuanced consideration of the impact of AR's autism diagnosis. Instead, it was in effect treated as a defence to the criminal offence of possession of an offensive weapon.

87. PC Fairclough accepted that, even on the information he had at that stage, he should have arrested AR, particularly given his previous convictions.[160] PC Rhodes accepted that if she had been in possession of the relevant background facts, she would have considered arresting AR for possession of the knife.[161] ACC Winstanley said in his oral evidence, and subsequently in his second witness statement, that he would have arrested AR when he was found with a knife on the bus, although he suggested that not arresting AR but taking him home to his parents was *"within the range of reasonable options"*.[162] I agree that AR should have been arrested at this point. If PS Clarke had been given the information about AR's previous convictions, he probably would have been supportive of that course of action. I do not agree that it was within the range of reasonable options to take an individual, with a conviction for a previous violent offence and for possession of a knife, found in possession of a knife in public, home to his parents. I acknowledge AR's co-operation and demeanour, and the information that PCs Fairclough and Rhodes had about

157 T/S: 19/15/8-16/3.

158 T/S: 19/17/10-20/14.

159 T/S: 19/30/25-33/2.

160 T/S: 19/17/2-9.

161 T/S: 19/82/12-16.

162 T/S: 20/69/15-72/2; Second Witness Statement of ACC Mark Winstanley LANC000433/§§30-32.

AR's autism. But as set out above, I consider that they wrongly allowed these factors to divert them down a non-criminal justice route. PS Clarke, as their supervisor on the day, accepted that he should have done more to guide these two probationary officers away from this approach.[163]

88. I readily acknowledge that PC Fairclough and PC Rhodes did many things right when responding to this incident. They were obviously trying to do their very best. They were also operating within a policing culture, as described by ACC Winstanley, that regarded custody as a last resort for children.[164] That is an important aim, and in the great majority of cases it is right that children should be dealt with in ways that do not involve either criminalising them or exposing them to the custody environment, because that is in the child's best interests which must be treated as a primary consideration. The Chief Executive of the Youth Justice Board, Ms Stephanie Roberts-Bibby, provided compelling evidence that this approach is considerably more beneficial for children in the long run.[165]

89. However, there are cases – and in my view this was one – where the level of risk to others must be seen as outweighing the importance of diverting children to non-criminal justice outcomes. PC Fairclough expressed the view that it was *"extremely difficult to get a child into custody"*.[166] He had extensive experience of cases where a child had used violence but nonetheless detention had not been authorised by a custody officer. I found that evidence concerning. It suggests that the balance may have tilted too far, in a way which is preventing police officers from taking practical or effective decisions to manage even obvious risks. In a helpful annex to its closing statement, Lancashire Constabulary set out a range of guidance and case law which shapes how the duty to act in a child's best interests is put into operational practice.[167] I return to this in my recommendations.

90. AR was given a lift home by PCs Fairclough and Rhodes. En route, they tried to elicit more information by talking to AR. On being asked about the knife, AR smiled and told them that he wanted to stab someone. He was calm and did not seem to be remorseful. He then gave a *"rather bizarre account"* of his reason for wanting to stab someone which was to the effect that he had been told by his psychiatrist or psychologist that the best way for his mobile phone to be seized by police was for him to commit a serious offence. He wanted his mobile phone to be seized because there were embarrassing videos on his social media accounts (TikTok/Instagram accounts) which he could

163 T/S: 19/130/13-17.

164 T/S: 20/73/2-19.

165 T/S: 32/20/5-15; Witness Statement of Ms Roberts-Bibby YJB000076/§§91-93.

166 T/S: 19/31/9-12.

167 Closing Statement on behalf of the Chief Constable of Lancashire Constabulary LANC000435/20-24.

not *"get rid of"* and he wanted the accounts deleted. PC Fairclough did not consider that AR understood the seriousness of what he was suggesting. This appeared to be a fixation on the part of AR.[168]

91. AR additionally made reference to poisoning people, again while smiling. PC Fairclough's evidence was that he recalled this being forward-looking, as a reference to something AR had thought about doing in future. However, I have no doubt on the evidence that he indicated he had already tried to make poison for this purpose: that is what both PC Fairclough and PC Rhodes recorded in contemporaneous documentation, the former on the incident log and the latter on the investigation log.[169] I do not consider it likely that they would both have been mistaken about this detail so close to the event, and the suggestion that PC Rhodes' account was simply reflecting what PC Fairclough had already entered on the log is not consistent with the fact that her entry on the investigation log is in significantly different terms than PC Fairclough's entry on the incident log. It is also consistent with AR's purchase of ricin precursors and chemical equipment in January 2022: he was not merely considering making poison in the future but had two months earlier taken active steps towards making it.

92. PC Fairclough accepted these were extremely concerning comments. He also acknowledged that he should have arrested AR as a result, a view which ACC Winstanley endorsed.[170,171] PC Rhodes accepted that she should have revisited the decision not to seek a criminal justice outcome in the light of AR's comments.[172] In my view, AR's comments about the purpose for which he had the knife, and still more those in relation to poison, added very significant further weight to the already strong case for arresting AR rather than solely seeking to safeguard him.

93. PC Fairclough accepted that if he had had the full picture as to AR's background, arresting him at this point would have been a very easy decision.[173]

94. Both PC Fairclough and PC Rhodes accepted that they should have drawn what AR said in the back of the police car to PS Clarke's attention, but that they did not do so.[174]

95. If they had done so, I accept PS Clarke's evidence that he would have been much more likely to advise them to arrest AR.[175] That was particularly due to AR's comments about poison. I accept that PS Clarke would have notified superiors and sought specialist advice from elsewhere in the force.

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168 T/S: 19/21/16-23/14.

169 LANC000046/4; LANC000088.

170 T/S: 19/29/9-30/17.

171 T/S: 20/73/20-74/25.

172 T/S: 19/90/4-14.

173 T/S: 19/33/19-34/8.

174 T/S: 19/33/8-18, T/S: 19/90/18-92/15.

175 T/S: 19/125/22-126/21.

Had AR been arrested, given the revelation about the potential use or manufacture of poison, 10 Old School Close would have been searched. The police would have discovered the equipment and seeds that had been bought as part of the attempt to produce ricin. AR's devices would have been seized which included the downloads of the Al-Qaeda manual. The investigation would then have been progressed by Counter Terrorism Police. It would be speculative to predict the exact outcome, but AR may very well have faced a custodial sentence, notwithstanding his youth. He would certainly have been the subject of intense focus by Counter Terrorism Policing, Children's Social Care (including Child and Youth Justice Services) and Forensic Child and Adolescent Mental Health Services.

96. I do not overlook that this was over two years prior to the 29 July 2024 attack. Nevertheless, I consider that if AR had been arrested on 17 March 2022, the attack on 29 July 2024 would probably not have occurred. It is, however, extremely important that this conclusion is not viewed in isolation, nor as a conclusion that relates only to PCs Fairclough and Rhodes, or for that matter PS Clarke. The judgements that these officers had to make were adversely affected by both the earlier failures to manage the risk that AR posed to others, and the inadequate information systems that meant that they did not have the full picture regarding his risk. Equally, I have concluded that there were further missed opportunities nearer the date of the attack. I return to this issue later in this report.

97. Even if AR was simply dealt with for the possession of the knife, and no search was conducted of his home address, given his age, his previous convictions and use of violence, he would have been likely to have been charged with the offence. Because this would not have been his first appearance before the youth court, he would likely have been given a Youth Rehabilitation Order lasting for at least 18 months. This would have led to considerably more intrusive support and rehabilitation than AR had previously received, as well as potentially more serious consequences if it were breached.[176]

98. Even if, exceptionally, a decision was taken not to charge AR, an opportunity for referring AR to the Violence Reduction Network was missed at this stage (the eligibility age having been reduced by this time).[177] Similarly, AR could have been referred to the Divert programme within Child and Youth Justice Services. ACC Winstanley accepted that knowledge of these kinds of diversion outcomes *"isn't necessarily prevalent across all our officers"* and that this has previously been a gap in Lancashire Constabulary's officer training.[178] It is though inevitably speculative as to the extent to which these options would have led to a different outcome in the event that the ricin and the Al-Qaeda manual were not found.

176 T/S: 32/37/4-22.

177 T/S: 20/11/7-12/7, T/S: 20/79/8-80/8.

178 T/S: 20/15/7-16/2.

99. When PC Fairclough and PC Rhodes arrived with AR back at 10 Old School Close, his parents appeared stressed. Laetitia M indicated she had been crying out for extra support, but her pleas had fallen on deaf ears. They were concerned that AR had indicated he wanted to stab someone.[179] PC Fairclough believed the parents were trying to act responsibly in relation to AR.[180] They advised Laetitia M to lock the knives away. While PC Fairclough recalled the small knife being placed in a *"knife block"* in the kitchen, I accept that this would not have been the case, and that the knife had been (ineffectively) hidden before AR took it, rather than left in a knife block.[181] The evidence of AR's father to this effect was corroborated by Dion R's (AR's brother) evidence and, as I set out in Chapter 12: AR's family, I found Dion R to be a credible witness. I consider that PC Fairclough was mistaken about this point of detail.[182,183]

100. PC Fairclough recalled taking Laetitia M aside to tell her about AR's comments about poison. He did so because AR had indicated that he got on better with his mother than his father. PC Fairclough considered that Laetitia M was shockingly unconcerned by AR's comments. PC Fairclough's evidence was that she indicated that AR had already mentioned poison to her previously. As set out in Chapter 12: AR's family, Laetitia M's evidence was that this did not happen: PC Fairclough did not speak to her about poison, and AR had never mentioned poison to her. Although PC Fairclough did not make a contemporaneous record of having spoken to Laetitia M about poison, it would be unthinkable for a conscientious officer who was obviously concerned about the risk posed by AR, and to AR, not to have relayed his concern to AR's parents. This was not a point of fine detail, but one of substance and of considerable significance. It was not something that is likely to be a mistaken recollection. Moreover, PC Fairclough first mentioned this conversation in passing in his initial witness statement after the attack in July 2024 and had to be asked to expand on it in a second witness statement.[184,185] That is inconsistent with any suggestion of post-attack fabrication. I add that I found PC Fairclough throughout to have been doing his very best to assist the Inquiry; he was a patently honest and credible witness. While I find PC Fairclough was mistaken about the existence of a knife block in the kitchen, the detail first appeared in PC Fairclough's witness statement for the Inquiry in 2025, not in his statements given to Merseyside Police in 2024. It is also the sort of relatively inconsequential detail about which I readily accept a witness trying to help the Inquiry, who has been asked about events on a number of occasions,

179 T/S: 19/39/12-40/5.
180 T/S: 19/40/6-15.
181 T/S: 19/41/8-20.
182 T/S: 34/21/12-22/5.
183 T/S: 33/33/5-7.
184 LANC000019/4.
185 LANC000023.

could come to be honestly mistaken. I do not consider that PC Fairclough's recollection of discussing AR's interest in poison with Laetitia M is comparable in this regard.

101. On the other hand, Laetitia M's general recollection of her contact with the police of 17 March 2022 is extremely poor. She did not, for example, remember PC Fairclough attending the home address in the morning, or PC Fairclough and PC Rhodes saying anything about AR having taken the knife in order to stab someone when they brought AR back to the home address, even though this was corroborated by Dion R and Alphonse R.[186] Her inability to recall several significant aspects of the day substantially weakens the reliability of her denial regarding the poison discussion, and I do not discount the possibility that genuine memory lapses contributed to the discrepancy. I am satisfied that PC Fairclough did tell Laetitia M about AR's comments regarding poison, and that she did indicate AR had spoken to her in similar terms previously. I am also satisfied that it is more likely than not that the substance of what PC Fairclough said would have been shared with Alphonse R afterwards. However, I accept that its significance may not have been fully appreciated at the time, and that the connection to items later found in AR's bedroom on 22 July 2024 may not have been understood. But on the balance of probabilities, I am satisfied that Laetitia M and Alphonse R did have some prior knowledge of AR's interest in poison even if that awareness was neither explored nor discussed further between them.[187]

102. PC Fairclough advised the parents to take AR to hospital for a mental health assessment. They agreed to do so, although did not in the event follow through on this. The officers were at the home for approximately 20 minutes.

103. A crime report was opened in relation to the possession of a bladed article offence but swiftly closed on PC Fairclough's recommendation. Part of the rationale for closing it was that AR lacked capacity and prosecution was inappropriate.[188]

104. A High-Risk Vulnerable Child Referral was completed by PC Rhodes and sent to the MASH.[189] I deal with how that was handled in Chapter 9: Social care. In that referral, PC Rhodes set out:

> *"[AR] suffers with ADHD and autism and is being moved to a school that specialises for this and it is possible that this is why he has had a bad [mental health] episode today as he was due to meet his teachers."*

186 T/S: 34/150/20-151/19.

187 T/S: 33/195/5-197/16.

188 LANC000089/3.

189 LANC000088; LCC000157.

105. In a similar vein, in the Lancashire Constabulary crime report in respect of the offence of possession of a bladed article, opened on 17 March 2022 and finalised on 25 March 2022, it was set out that:

> *"[AR] was reported missing earlier in the day by his parents. They described this as out of character and thought it may be in relation to [AR] attending a new school in April, he was due to meet his new teachers on the day on the incident. [AR] is highly autistic and his new school is to support those with extra needs as mainstream education could not provide the best care for him.*
>
> *[AR] was found on a bus a few hours after going missing, his parents had suggested he may have taken a knife from the home kitchen. When located, [AR] told officers he had this knife. He told officers he thought if he committed a serious crime, the police could help get his social media blocked. Despite a long conversation with [AR], he could not understand the consequences of this.*
>
> *[AR] was returned home and parents are taking him to hospital.*
>
> *A high-risk VC [vulnerable child] was submitted for support.*
>
> *[AR] does not have capacity and prosecution is not appropriate in this instance."*[190]

106. These decisions reflected the approach I have identified above in relation to AR's autism. PC Fairclough rightly acknowledged that this was based on assumptions that should not have been made.[191] ACC Winstanley accepted that the Lancashire Constabulary training for its officers could lead to a risk that children who perpetrate offences are placed in a mental health 'box' rather than a criminal justice 'box', when *"there is no reason both these issues couldn't be engaged in the course of an investigation"*.[192] That can be a particular issue in relation to autism spectrum disorder and neurodivergence, and it also overlaps with a poor understanding of the concept of mental capacity. ACC Winstanley accepted that Lancashire Constabulary's training could be more explicit about these issues.[193]

107. Indeed, in August 2025 a letter was circulated within Lancashire Constabulary which included the following guidance from Police Sergeant Andrew McGinty, the Force Mental Health and Dementia Coordinator:

> *"We therefore should not close investigations citing a 'lack of capacity' without this being confirmed by a suitably qualified person, and even in cases where it is suspected/believed/known that the suspect did 'lack capacity' and lacked control over their actions,*

190 LANC000089/2-3.

191 T/S: 19/52/23-53/25.

192 T/S: 20/18/3-11.

193 T/S: 20/68/23-69/14.

it may still be necessary to pursue matters through the criminal justice system, depending on the severity – and potentially the frequency – of the offending."[194]

108. That letter is an example of the more nuanced approach that I have identified was needed in this case. I return to this issue in my recommendations below.

109. Before concluding this section of my report, I wish to make it clear that although there is no doubt that PC Fairclough and PC Rhodes made a central, consequential and erroneous decision not to arrest AR, they were young officers, both still in their probationary periods. Given the general and understandable approach taken to avoiding children and young people entering the criminal justice system unless it is absolutely necessary, along with a widespread misunderstanding of the impact of autism on criminal capacity, it is highly likely that many other police officers would have acted in the same way. I considered both officers to have been entirely honest, and they clearly deeply regretted their missteps on 17 March 2022 (as PC Fairclough vividly expressed).[195] I do not doubt their professionalism or commitment to the police service. This was an error of significance that would likely have been made by many others, and it should not be taken as demonstrating incompetence on their part. The causes of this mistake were essentially systemic rather than being the responsibility of these two response officers.

110. Finally, although I have concluded that it is likely that the attack would not have occurred if AR had been arrested as he should have been, this should not be taken as an indication that this decision was the sole or main reason why the attack occurred. Any event has a multitude of causes. By 17 March 2022, as his purchase of the ricin precursor, his download of the Al-Qaeda manual, and his attempts to purchase weapons reveal, AR was already on the path to his offending in July 2024. After 17 March 2022, there were further missed opportunities for the risk he posed to be identified and acted upon. It would be wrong to focus solely or excessively on the conduct of these officers when considering how the attack was able to happen. It must also be borne in mind that the officers could not have known, even when AR made comments relating to making poison, and even if they had had full information about his previous behaviour, that AR was seeking to manufacture a biological weapon and that he would, in due course, carry out so tragic an assault on a class of young girls. Such events are thankfully rare. While I will in my recommendations address the potential imbalance between the welfare of children and steps required to address risk, there is a balance that is required. It would be wrong for police officers to act in all situations based on the potential very 'worst-case scenario'.

194 LANC000276.

195 T/S: 19/60/15-61/2.

The policing response to the call to 10 Old School Close on 14 May 2022

111. Two months later, Lancashire Constabulary were called back to 10 Old School Close following two further 999 calls by AR's parents in the early hours of 14 May 2022. They were both dropped calls, leading to an emergency police response.[196] The attending officers had little knowledge of AR's background, although this was at least partly and understandably because this was an emergency response.[197]

112. On arrival, the officers ascertained that AR had woken in the middle of the night and demanded access to a laptop. When this was refused, he responded by again throwing foodstuffs around the house. He then locked himself in a bathroom and flooded the bath, causing the electricity to short circuit. One of the officers went to speak to AR, but he would not speak to, or even look at, the officer. AR had however calmed down. The officers did not consider any offences had been disclosed.[198] They made a high-risk safeguarding referral to the MASH, noting that AR had been refusing to take his medication, and that Alphonse R had said that AR was getting older and stronger and they were struggling to cope with him.[199] Alphonse R also said that he was going to contact CAMHS and his GP. There was also an Operation Encompass referral to Presfield High School, and a vulnerable child investigation.[200,201] As previously, I deal with the response to these referrals by the receiving agencies in the relevant chapters.

113. As with the incidents in November 2021, I consider that the officers on the ground acted appropriately. However, I note the same themes of placing significant weight on autism, and of not having a full picture of previous events involving AR.

114. Finally, this was now the fourth call to AR's address in just over six months. On each occasion, the involvement of Lancashire Constabulary concluded when a safeguarding referral was made to the MASH. That is an example of a referral to another agency or forum being treated as sufficient to address any risk that was present. But Lancashire Constabulary did not receive feedback from the MASH as to how those cases were being taken forward. The number of repeat incidents should have been identified as a sign that the risk was not being addressed. There was, however, no mechanism in place, other than the MASH, to identify this kind of risk, which was more evident from the cumulative effect of a number of callouts than each callout

196 T/S: 19/188/23-189/17.
197 T/S: 20/86/8-16.
198 Witness Statement of PC Andrews LANC000272/§19.
199 LANC000094/2.
200 LANC000124.
201 LANC000093.

seen in isolation. ACC Winstanley rightly accepted that there needed to be a greater emphasis on dealing with the cumulative risk, not simply focusing on individual incidents.[202]

Presfield High School's request for a welfare check in March 2023

115. On 21 March 2023, Presfield High School called Lancashire Constabulary's Force Control Room to ask officers to conduct a welfare check on AR, whom they had not seen since May 2022, and whom no professional had seen since a CAMHS visit in January 2023.[203] Their attempts to gain access to the address had been rebuffed by AR's parents.[204]

116. Applying what is known as a Right Care, Right Person (RCRP) policy – a national-level initiative in England and Wales, introduced by Lancashire Constabulary in January 2022 – a call handler within the Force Control Room, Mr Robert Correy, determined that this was not an appropriate call for the police to attend.[205] He concluded that no crime had been or was being committed, and there was no immediate risk to life.[206] Based on the policy that was in place at the time, I agree that this was not an appropriate case for police officers to be deployed to the home address as a result of AR's non-attendance at school.

117. However, Mr Correy did not take AR's name or age, or any other identifying details.[207] He could not therefore carry out any sort of research into previous incidents involving AR or make a fully informed assessment of whether this was in fact an appropriate case for police deployment. While he reached the right conclusion, that did not reflect a careful and properly informed exercise of professional judgement. Mr Correy could and should have gathered more information before reaching that conclusion. While Lancashire Constabulary identified this after the attack, Mr Correy was initially resistant to feedback on the approach taken under the RCRP policy.[208] It was only in his evidence to the Inquiry that Mr Correy accepted that he ought to have approached the call differently.[209] That was in part due to the fact that discrepancies between

202 T/S: 20/81/13-18.
203 LANC000095.
204 T/S: 27/217/15-218/8, T/S: 27/240/7-24.
205 LANC000162.
206 T/S: 19/158/9-159/14.
207 T/S: 19/165/1-6.
208 T/S: 19/176/15-178/10.
209 T/S: 19/178/19-179/10.

the RCRP policy and the material within the script which call handlers have to follow in the Force Control Room were brought to light in the course of the Inquiry.

118. Lancashire Constabulary have conducted audit and quality assurance work on other calls from 21-22 March 2023 where control room staff applied RCRP.[210] That work indicates that information such as names and dates of birth was routinely obtained, appropriate checks took place, and signposting to relevant other services carried out. I also note that from 6 October 2025 the Lancashire Constabulary RCRP question set which call handlers follow was changed, so that the first question was to obtain the person's name and date of birth. In the light of this work, I accept that Mr Correy's handling of the call about AR on 21 March 2023 was not representative of how RCRP is typically operated by Lancashire Constabulary. I am, however, mindful that RCRP is a policy which, if not carefully and properly implemented, risks police failing to attend incidents which they ought to attend. While Mr Correy reached the correct outcome in this case despite the failings in how the call was handled, that would not necessarily be so in other similar cases. Although I am reassured by the evidence of how Lancashire Constabulary more typically handles RCRP calls, this incident should be a reminder to the Constabulary, and to other forces adopting RCRP, that it is an approach which requires high levels of care in design and policy drafting, thorough and effective training, and a high degree of supervision if it is to be relied upon.

Recommendations

Immediate recommendations

119. I make the following recommendations for immediate action.

> **Recommendation 25:** Lancashire Constabulary should consider extending Operation Encompass to share automatically relevant information with schools in bordering areas. The Department for Education should consider national implementation. This is because children will not necessarily attend school in the same police force area as they live.

120. There was a persistent issue of 'dilution' of information as it went through multiple referrals from the police.

210 Witness Statement of Temporary Superintendent Storey LANC000444.

Recommendation 26: Lancashire Constabulary, and the College of Policing nationally, should ensure that forms and training emphasise the importance of recording, as precisely as possible, the words and behaviour of individuals who may pose a significant risk to others.

121. I am concerned that the system of reporting cross-border offences between forces has the appearance of being somewhat 'hit and miss'. Passing information to another force by email does not seem to reflect a clear and established procedure which ensures that the information will be handled appropriately on receipt.

Recommendation 27: Lancashire Constabulary and Merseyside Police should review the effectiveness of their information-sharing systems and consider whether a more robust process is required. Findings should be shared with the National Police Chiefs' Council and College of Policing for consideration as to whether national level guidance is appropriate.

122. There were clear and important examples in this case of information being passed on to other agencies but not being recorded centrally by Lancashire Constabulary (for example, via a vulnerable child log on Connect). Such central recording is critical, to ensure that the information gathered is available for other officers who may be dealing with the disposal of the immediate event, or who may be called to deal with the person in subsequent events. I doubt that the pattern of record-keeping shortcomings evident by Lancashire Constabulary are in any way unique to that force.

Recommendation 28: Lancashire Constabulary should ensure its training and systems address the risks associated with failing to record case information on police systems so it is readily available to others. The National Police Chiefs' Council and College of Policing should consider whether further national guidance is required.

123. ACC Winstanley accepted that within Lancashire Constabulary there is no policy which specifically relates to the risk of physical violence by children against others, whether generally or as a result of a fixation on violence.[211] He nonetheless maintained that they have processes in place to identify people who are at risk of reoffending or cause a risk to communities, whether they are adults or children. He did not accept that the absence of a policy prevents Lancashire Constabulary from identifying children or young people in that category or dealing with them. Given the evidence I heard, I am unable to accept that latter contention by ACC Winstanley. On the evidence before

211 T/S: 20/14/1-20.

me, the crucial aim of ensuring that a child's best interests are a primary consideration may, in some cases, have shifted so that it is a paramount consideration that cannot meaningfully be balanced with risk to others. If that is right, it means that the risk from children to others – including other children – is not adequately being addressed. The officers dealing with AR were essentially focused on the risk of harm to him and potentially to Dion R, and they largely failed to view what had happened through the lens of the growing risk that AR posed to others. Indeed, ACC Winstanley conceded that the training of officers in this area was not necessarily comprehensive (*"that knowledge is not necessarily prevalent across all our officers"*).[212]

Recommendation 29: Lancashire Constabulary should ensure its procedures and training sufficiently addresses the risks children and young people may pose to others and the options for addressing that risk. The College of Policing, with national partners, should review legislation and guidance on how police respond to children and young people who present a risk of serious harm to others.

I note that the government guidance on child knife possession issued in February 2026 now requires immediate Youth Justice Service notification and a mandatory intervention plan, recognising possession of a knife in public by a child as a high-risk indicator necessitating robust action rather than informal diversion.

124. ACC Winstanley maintained that the force training adequately equipped response officers as to how to deal with children with autism spectrum disorder.[213] Again, I am unable to accept that evidence. The incident on 17 March 2022 revealed that two officers dealing with AR who had relatively recently completed their initial training had treated AR's autism as an explanation which negated the possibility of criminal responsibility. In fairness to ACC Winstanley, he accepted that a mental health diagnosis may lead to an increased risk to others, that officers are not qualified to judge mental capacity, and that force training may benefit from strengthening in this area.[214] I was encouraged by the August 2025 letter promulgated by Lancashire Constabulary, but effecting widescale cultural change will require more concerted effort.[215] As with other areas, I doubt these issues are confined to Lancashire Constabulary, although I note the array of training and guidance provided by the College of Policing.

212 T/S: 20/15/13-19.

213 T/S: 20/16/3-23.

214 T/S: 20/17/7-18/11.

215 LANC000276.

Recommendation 30:

1. Lancashire Constabulary should strengthen its autism spectrum disorder-related training for new officers and through continuous development.
2. National policing bodies, with input from the Department of Health and Social Care, should consider whether reforms to guidance or training are required.

125. I readily acknowledge the real assistance that has been provided by the Samsung devices and, potentially, by the laptop and tablets that are currently being trialled for response officers. However, I was concerned at the apparent difficulty in searching the records of Lancashire Constabulary for the most relevant aspects of AR's background material, especially during the incident on 17 March 2022. Efficient, user-friendly technology with information being presented in the most helpful way is clearly critical for police officers who often have only limited time to make detailed searches of the records. The ability to make the correct decision can be heavily dependent on access to the right information. That was clearly lacking in this case. I appreciate that there have been recent improvements in this regard, but the present technology provided to response officers should be rigorously assessed to ensure it is fit for purpose. The officers did not seem to have a ready view of the most pertinent information. That was exacerbated by the difficulties in extracting information that was held by different police forces.

Recommendation 31:

1. Lancashire Constabulary should ensure response officers have access to effective technology providing clear, essential case information.
2. The National Police Chiefs' Council, College of Policing and Home Office should review whether current policing information systems, particularly the limitations on cross-force access, are suitable for modern policing needs.

Observation J: The cross-border policing complexities identified in this chapter may be relevant to the government's ongoing consideration to reform of the number and organisation of police forces, albeit that issue is beyond the scope of this Inquiry.

Recommendations for matters to be further considered in Phase 2 of this Inquiry

126. I make no separate recommendations in this chapter for matters that should be considered in Phase 2. However, the features of the police evidence discussed here have informed the Phase 2 recommendations set out elsewhere in this report.

127. ACC Winstanley accepted that the absence of multi-agency meetings after January 2020 revealed a potential problem as regards the different agencies working together in order to understand their roles and responsibilities in managing AR. Whether these meetings are held is entirely dependent on the convening power of the local authority. If meetings do not happen, there is no feedback process as to what the various agencies have or have not been doing or the early identification of threat, risk, harm and appropriate early intervention. ACC Winstanley, while indicating that this lack of understanding was not necessarily the fault of the MASH, accepted it revealed a weakness in the multi-agency approach, given the absence of a clear appreciation of what the various agencies were doing because of the information that had been shared. Simply by way of example, he agreed that response officers should be able to familiarise themselves with the difficulties experienced by CAMHS and the relevant school, along with the non-attendance issues of which it would help for them to be aware.[216] ACC Winstanley's evidence supports the need for a clear delineation of a single agency, and a single person (a Senior Responsible Officer) within that agency, with responsibility for ensuring proper coordination between the agencies. It also supports the need for a common risk assessment across agencies, enabled by effective information sharing and coordination. This is entirely consistent, from the perspective of policing, with my overarching recommendations in Chapter 1: Fundamental problems.

128. ACC Winstanley indicated his support for consideration of a safer knife replacement scheme in Lancashire (as detailed on the College of Policing website).[217] This scheme was piloted in Kent and now involves other police forces. In Chapter 5: Weapons and poisons I have recommended consideration in Phase 2 of restricting or ceasing the sale of knives with sharp points.

129. ACC Winstanley expressed the view that it is inappropriate for the police to intervene in cases of persistent school non-attendance. He agreed that someone should have responsibility for investigation and review when this occurs.[218] I return to this is Chapter 11: Education.

216 T/S: 20/22/19-28/2.
217 T/S: 20/115/7-22.
218 T/S: 20/88/24-91/11.

Chapter 8

Prevent and Counter Terrorism Policing

Introduction

1. This chapter addresses the handling of the three referrals to Prevent concerning AR which were made by The Acorns School. The dates of the three referrals were: 5 December 2019, 1 February 2021 and 22 April 2021. The three referrals were assessed and closed by officers of Counter Terrorism Policing North West (CTPNW).

The policy and process of a Prevent referral

2. The government's counter-terrorism strategy (CONTEST) has four strands: Prevent, Pursue, Protect and Prepare. The strategic objectives of Prevent at the relevant time were to *"[t]ackle the causes of radicalisation and respond to the ideological challenge of terrorism"*. The Prevent strand of CONTEST is the most relevant to AR. However, by way of context: the Pursue strand aims to stop terrorist attacks happening in this country, including by counter-terrorism investigations and criminal prosecutions; the Protect strand aims to strengthen the UK's protection against a terrorist attack and the Prepare strand essentially aims to minimise the impact of an attack if one does happen.[219]
3. Anybody can raise a concern into Prevent if they are worried a member of the public is at risk or there is a concern about radicalisation.[220] Under the Prevent duty, specified authorities, including schools, are under a duty to have due regard to the need to prevent people from being drawn into terrorism in the exercise of their functions (section 26 of the Counter Terrorism and Security Act 2015 (CTSA 2015)).
4. The Home Office is responsible for the broad policy, the oversight and the overall delivery of the Prevent programme.[221] The operational responsibility for individual case referrals rests, in the first instance, with one of the nine regional units within the Counter Terrorism Policing network, and then with Channel panels which are chaired by local authorities.[222] Counter Terrorism Policing Headquarters (CTPHQ), which provides strategic support and co-ordination for the Counter Terrorism Policing network, is responsible for the operational policy and foundation course training for CTP officers.[223]

219 T/S: 22/5/2-24.
220 T/S: 22/13/10-13.
221 T/S: 22/8/19-22.
222 T/S: 22/8/8-18.
223 T/S: 22/9/5-10.

The stages of a Prevent referral

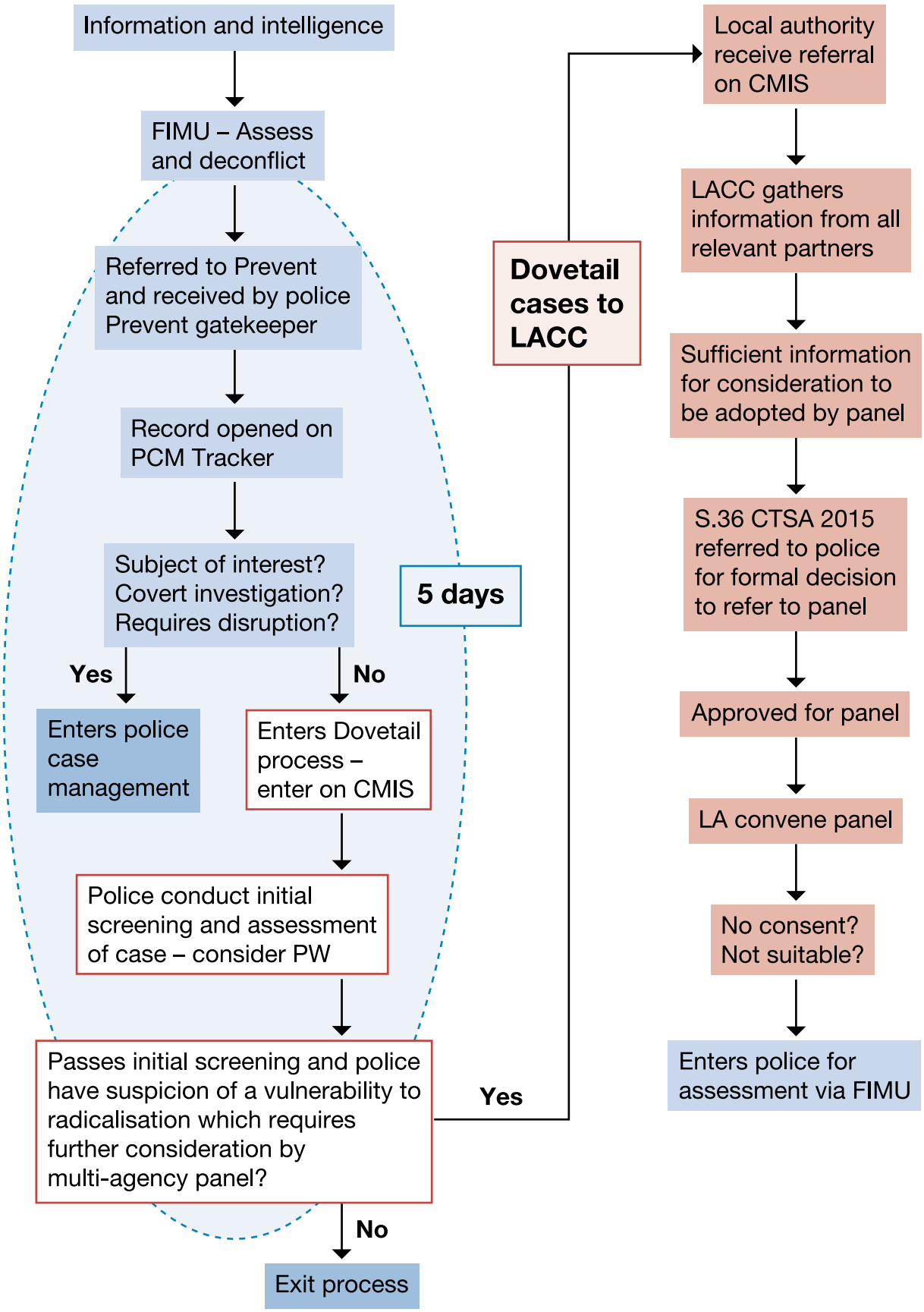
5. When a Prevent referral is accepted, it is adopted by what is called a 'Channel panel'. A Channel panel seeks to support individuals vulnerable to being drawn into terrorism. A Channel panel is chaired by the local authority, and its members include local police and anyone else the local authority considers appropriate (e.g. schools and youth offending services). Channel panels offer a tailored package of support to the person who has been referred to help them move away from harmful activity. For example, this could include the use of theological mentoring. Prevent is not a punishment and participation with the package of support is voluntary.

6. A referral to Prevent initiates a series of steps to assess the referral and decide whether it should be referred to a Channel panel and, in turn, whether the Channel panel should accept the referral. The process has a significant number of stages and decision points.[224] At the outset of a referral, the Prevent Case Management Tracker (PCMT) is opened. This is a database used to record information about Prevent referrals and to monitor their progress from initial submission through to conclusion.

7. At the time of AR's three Prevent referrals, the 'Dovetail' pilot was in place in the North West of England. Dovetail transferred case management responsibilities from the police to local authorities. A simplified version of the steps that must be taken for a referral to be accepted by a Channel panel in a Dovetail area is set out below:[225]

224 In her written statement, Ms Ellsmore referred to six key Prevent decision-making points, or thresholds, where a person's suitability for Prevent support is considered (First Witness Statement of Ms Ellsmore, HOM000078/§§30-31). However, the diagram below shows that there are numerous intermediate steps.

225 CTPHQ000045/8.



The acronyms not already addressed are as follows: CMIS – Channel Management Information System used to record detail of cases referred to Channel; FIMU – Fixed Intelligence Management Unit; LA – local authority; LACC – Local Authority Channel Coordinator; PCM Tracker – Prevent Case Manager Tracker – a database used to record details of Prevent referrals.

8. The actions in the left-hand column of the diagram are carried out by Counter Terrorism Police (CTP). In the case of AR, the relevant CTP unit was CTPNW. If CTP consider that there are reasonable grounds to suspect that a person is susceptible to becoming a terrorist or supporting terrorism then, in a Dovetail area, the case is referred to the Local Authority Channel Coordinator and goes through the actions in the right-hand column. The Local Authority Channel Coordinator carries out information gathering and then refers the case back to CTP for the formal decision to refer the case to the Channel panel, under section 36 of the CTSA 2015. The test for a section 36 decision is whether there is *"a reasonable belief that the person is vulnerable to being drawn into terrorism"*. The Channel panel then consider the referral and decide whether to accept it.

9. With one caveat, AR's referrals did not go beyond the initial screening stage and were never considered by the Local Authority Channel Coordinator or, thereafter, by the local Channel panel. Instead, the referrals followed the 'exit process' route at the bottom of the left-hand column of the above diagram. The caveat is that the First Referral was briefly run as what is referred to as a Police-Led Partnership (PLP). Director of Prevent in the Home Office, Ms Catherine Ellsmore, explained in her statement: *"CTP may choose to manage individuals in PLP where they are considered not to be suitable for Channel, either because they do not consent, the case is considered too high-risk [to] be managed within Channel, or where there are sensitivities due to the status of individuals subject to police terrorism investigations"*.[226] As I shall address in more detail below, the only reason that AR's referral was briefly handled as a PLP case was to facilitate a home visit and discussion with him.

10. For the purposes of AR, the important stages in the referral process were as follows:

    a. Counter-terrorism intelligence assessment and deconfliction by the Fixed Intelligence Management Unit (FIMU): the second and fifth boxes from the top in the left-hand column;

    b. Consideration by the Joint Assessment Team (JAT): not shown in the above diagram but carried out for some cases around the time of the 'FIMU – assess and deconflict' decision;

    c. The Police Gateway Assessment (PGA): assessment of whether there are reasonable grounds to suspect that a person is susceptible to becoming a terrorist or supporting terrorism: the penultimate box in the left-hand column; and

    d. Exit process: the final box in the left-hand column.

    I expand on each of these stages below.

226 First Witness Statement of Ms Ellsmore HOM000078/§73.

Counter-terrorism intelligence assessment and deconfliction by the Fixed Intelligence Management Unit (FIMU)

11. The initial task of conducting a counter-terrorism intelligence assessment and deconfliction check is the responsibility of the CTPNW FIMU. The purpose of this stage is to avoid duplication with, or disruption to, other investigations. The FIMU will carry out background checks and research a range of police records. If the individual referred to Prevent is already the subject of a counter-terrorism investigation, then the Prevent referral would need to be handled appropriately.[227] In addition, the FIMU will consider whether a counter-terrorism investigation should be opened.

12. Once the case has been deconflicted by the FIMU, then the referral is assigned to a Prevent Counter Terrorism Case Officer (CTCO). The FIMU officer should ensure that any relevant information related to the referral that is held on police systems is made available to the CTCO.

13. FIMU officers are trained on the national standards for Intelligence Management. Annex B of these standards relates to Prevent.[228] It states that:

> *"Whilst the police may hold key information which can help assess the risk of radicalisation and disrupt people engaged in drawing others into terrorism, it is important to remember that Prevent seeks to intervene at the earliest possible opportunity and safeguard individuals by reducing or eliminating the risk of them becoming involved in terrorism using a range of both police and multi-agency led tactical options.*
>
> *Within Prevent the term 'vulnerability' describes factors and characteristics associated with susceptibility to radicalisation which if present, may potentially make an individual more vulnerable to extremist narratives.*
>
> *…*
>
> *During IMU Assessment it is important to keep in mind the key objective of Prevent is to protect vulnerable individuals from being drawn into terrorism. Where intelligence suggests a vulnerability CT/DE [Counter Terrorism/Domestic Extremism] relevance should be considered in its widest sense including the potential for that person to be drawn into terrorism."*

14. This guidance was seeking to draw a distinction between the role of a FIMU officer and the role of a Prevent officer. The role of the FIMU includes assessing whether the person referred should be the subject of a counter-terrorism investigation within the Pursue strand of Contest. Such a judgement is made by reference to the definition of terrorism under the Terrorism Act 2000 (see below)

227 T/S: 22/109/13-110/5.

228 CTPHQ000042/2,3.

which includes a need to prove a terrorist ideology.[229] The role of a Prevent officer or CTCO is to consider vulnerability to terrorism, which incorporates wider considerations of safeguarding. I consider the respective roles of, and the relationship between, the FIMU officer and the CTCO further below.

15. Officer A and Officer B, CTP officers, were witnesses who were granted anonymity by the Inquiry: (see Ruling anonymity Officers A and B PDF.)[230] In terms of the relevant personnel, the FIMU officers were as follows:

    a. First Referral: Officer B;

    b. Second Referral: Officer A;

    c. Third Referral: Detective Constable Timothy Aspinall.

Consideration by the Joint Assessment Team (JAT)

16. In addition to the FIMU assessment, the First Referral was triaged by the Joint Assessment Team (JAT). The JAT is a triage team comprising of CTP and MI5 officers which evaluates intelligence that originates from a range of sources. In some circumstances, that intelligence can include a Prevent referral. The JAT evaluates the intelligence and considers whether further investigation or action are required to supplement the intelligence, including whether the case meets the threshold for a counter-terrorism investigation, such as an investigation under the Pursue strand.[231]

17. In terms of the relevant personnel, the CTP JAT officer for the First Referral to Prevent was Detective Constable Philip Blundell, who worked alongside an MI5 officer.

Police Gateway Assessment

18. The assessment of whether there was a *"suspicion of a vulnerability to radicalisation which requires further consideration by a [Channel] panel"* is made by the CTCO to whom the referral is allocated.[232] The CTCO makes this assessment using the Police Gateway Assessment, which is an initial screening and triage process. It requires a Prevent practitioner to consider the key factors in the case such as the individual's grievances, activities and ideology. I address some of the specific considerations, as it relates to AR, in the section below.

229 T/S: 20/177/13-24.

230 Southport Inquiry, 'Decision on the Applications by Counter Terrorism Policing North West for a Restriction Order and Special Measures on behalf of Officer A and Officer B', 2025, available at: https://southport-prod.s3.eu-west-2.amazonaws.com/2025/12/Ruling-anonymity-Officers-A-and-B-.pdf

231 T/S: 20/174/1-176/23.

232 CTPHQ000045/8.

19. The Police Gateway Assessment is part of the process of evaluation that should be completed within five days but sometimes the need to obtain information means that this stage may take longer.[233] For example, there may be a need to liaise with the person making the referral and other relevant agencies. The CTCO uses the Police Gateway Assessment to determine whether to refer the case onto the Local Authority Channel Coordinator for information gathering, mark the case for closure or to run the referral as a Police-Led Partnership. The CTCO's decision is reviewed by their Prevent supervisor.

20. There is a distinction between the decision made at this Police Gateway Assessment stage and the later decision made under section 36 of the CTSA 2015 (see the right-hand column of the diagram above). As I have described above, in a Dovetail case, after the CTCO has made the Police Gateway Assessment, then the Local Authority Channel Coordinator gathers information from all relevant parties. After that information gathering by the Local Authority Channel Coordinator, the CTCO then makes the section 36 decision. The section 36 decision has a higher threshold than the earlier decision: whether there was *"a reasonable belief that the person is vulnerable to being drawn into terrorism"*.

21. Curiously, the Police Gateway Assessment test was not explained in the Prevent and Channel Duty Guidance documents prior to 2023, albeit they were set out in the guidance issued by CTP.[234] The complexity of these multiple stages was demonstrated during the evidence of Detective Chief Superintendent Sarah Kenwright, Head of CTPNW, who appeared in her oral evidence to confuse the stages at which the Police Gateway Assessment and section 36 decisions were made: although in fairness to her, I note that she has never acted as a CTCO.[235]

22. In terms of personnel:

    a. The CTCO for all three referrals was Police Sergeant Carmen Thompson (a police constable at the relevant time);

    b. The Prevent supervisors were:

        1. First Referral: Detective Sergeant James Neale;

        2. Second and Third Referrals: Detective Sergeant Rachael Treharne.

Exit process

23. The Policy for Prevent Practitioners dated June 2018 set out that, as a matter of general application, cases should only be closed *"when the vulnerability has been addressed and any risk has been appropriately managed"*.[236]

233 T/S: 21/14/20-15/11.

234 First Witness Statement of Ms Ellsmore HOM000078/§42.

235 T/S: 22/113/25-115/3.

236 CTPHQ000116/9.

If the referral does not meet the threshold and is closed, then the CTCO should consider whether information should be provided to other relevant bodies (such as mental health services, social care or education).

The criteria for Prevent

24. A critical issue that arises in this case is whether someone who is intent on inflicting serious violence but has not demonstrated any material terrorist ideology or a vulnerability to being drawn into terrorism nonetheless can come within the ambit of the Prevent programme. Here, I set out the guidance that was in place at the time of the Prevent referrals made in respect of AR.

25. Terrorism is defined by section 1 of the Terrorism Act 2000 as *"the use or threat of action"* which is *"designed to influence the government or an international governmental organisation or to intimidate the public or a section of the public"* and is *"for the purpose of advancing a political, religious, racial or ideological cause"*.[237] The specific actions under the Act are serious violence against a person, serious damage to property, endangering a person's life creating a serious risk to the health or safety of the public or a section of the public, and action designed seriously to interfere with or seriously to interrupt an electronic system.

26. On 25 June 2019, Ms Sara Skodbo, the Director of Prevent, and Chief Superintendent Nik Adams, the National Coordinator for Prevent Counter Terrorism Policing, sent a letter to Regional Prevent Co-ordinators, Channel Panel Chairs, Local Authority Prevent Co-ordinators, Higher and Further Education Prevent Co-ordinators, Prevent Education Officers and Health Prevent Co-ordinators ('the joint letter').[238] This communication was intended to describe the authors' joint position on managing individuals with *"unclear, mixed or unstable ideologies"*. This is a significant letter, and I have set it out in its entirety at the end of to this chapter to avoid quoting lengthy passages.

27. The letter provided Prevent case examples of individuals with unclear, mixed or unstable ideologies which included those who: *"are obsessed with massacre, or extreme or mass violence, without specifically targeting a particular group (e.g. 'high school shootings')"*. Later, the joint letter asked recipients to *"consider the possibility of an individual's obsessive interest in public massacres of any kind as a possible signal of vulnerability"*.

28. For individuals with an unclear ideological motivation to be included in the Prevent programme, they needed to be at risk of *"being drawn towards an extremist ideology, group or cause"*, and in this context the letter importantly differentiates terrorism from other forms of violence. It was noted that the Terrorism Act 2000 does not define or limit what is meant by *"political, religious or racial"*. The authors observed that the individual's belief does not have to

237 Section 1 of the Terrorism Act 2000, available at: www.legislation.gov.uk/ukpga/2000/11/section/1

238 CTPHQ000134.

be long-standing or deep-rooted. There was a reference to those with an obsessive interest in public massacres, but this is described as providing a possible sign of *"vulnerability"* (which, for these purposes, is a *"vulnerability"* of being drawn into terrorism).

29. In a critical passage, it was explained that *"Some individuals seek to support or enact TACT [Terrorism Act] offences without a clear understanding of the ideology or cause they are ostensibly supporting. Therefore, individuals whose ideological motivations are unclear, mixed or unstable, but who demonstrate a connection to, or personal interest in, extremism, terrorism or massacre* ***should be given the same consideration for support*** *as those whose concerning ideological motivations are more consistent and obvious"* (emphasis in the original). Immediately following this observation, the authors stated that the letter was not intended to expand the remit of Prevent. Instead, the guidance provided by the letter was intended to ensure that individuals receive the support they need if they were vulnerable to being drawn into any form of terrorism, as described in the Act. A further key observation was as follows:

> *"When it comes to preventing people being drawn into terrorism, our responsibility is to offer interventions and support to all individuals who are at risk, irrespective of whether that risk is being driven by a true belief in an ideological cause or group, or whether an involvement to either of these is being driven by other vulnerabilities and complex needs."*

30. The Dynamic Investigation Framework was produced by CTP as guidance to assist CTCOs when assessing referrals.[239] It was in use at the time of AR's First Referral in 2019.[240]

31. The Dynamic Investigation Framework included a section on grievance narratives which included a personal grievance which could be real or perceived and could include: *"acute personal anger towards authorities over an issue… seeking personal redemption or revenge; acutely personal feelings of social, political or religious alienation, marginalisation or discrimination"*.

32. The Dynamic Investigation Framework introduced the section entitled 'Ideology' as follows:

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239 CTPHQ000040.

240 The evidence was unclear as to the stage when the Dynamic Investigation Framework was to be used. DAC Evans stated that it was to be used, and was in use, at the time of the Police Gateway Assessment: T/S: 23/61/22-64/4; Second Witness Statement of DAC Evans CTPHQ000153/§21. PS Thompson suggested that it was to be used after the Police Gateway Assessment for a Police-Led Partnership case, although she also noted an intention to merge the Police Gateway Assessment and Dynamic Investigation Framework into one process: Witness Statement of PS Thompson CTPNW000180/§13, §21. In any event, PS Thompson states that she did take the Dynamic Investigation Framework into account: Witness Statement of PS Thompson CTPNW000180/§35, §75.

> *"Consider & describe the Subject's exposure to, interest in, or fixation upon an extremist ideology or causes. Note that Subjects don't have to be 'true' or fanatical believers of such an ideology in order to be vulnerable to it."*[241]

33. Within a list of particular factors meriting consideration, the Dynamic Investigation Framework set out the following:

> *"Consider fantasies about massacres or mass-killings… A concerning fascination in the tactics (of) terrorism, mass-killings or school massacres per-se, in the absence of a unifying ideology or narrative reason for this interest,* ***may*** *also be indicative of a Subject who requires support through Prevent. The context needs to be explored around this interest, as, for example, an obsession like this combined with multiple/acute complex needs or grievances might be suggestive of a higher risk Subject. Explore and explain the circumstances."* (emphasis in the original)[242]

34. I analyse this guidance, and changes that have been made since the referrals, in the 'Overall themes and conclusions' section below.

The First Referral to Prevent

Content of the First Referral

35. On 5 December 2019, Mrs Janet Lewis, the designated safeguarding lead at The Acorns School made the First Referral regarding AR.[243] She reported a number of concerns regarding AR's behaviour. These included AR's exclusion from Range High School for carrying a knife to school on 10 occasions to *"stab someone"* (which resulted in his admission to The Acorns School on 17 October 2019) and his online searches on 15 November 2019, during an IT lesson, for school shootings in America. On 29 November 2019 AR had walked up and down in class, delivering hard punches to one of his hands. During a conversation as to how to promote a business, AR had suggested that telling others that his business was new to the area was a not a good idea because people would think he would kill them because they did not know him. He said that *"people don't trust others they don't know in case they get murdered"*. He repeatedly got out of his seat, and he walked under the highest part of the ceiling where he jumped up and delivered a very hard punch to a hanging laminate. On 3 December 2019, while working with oil pastels, colouring 'Call of Duty' images, AR commented *"[w]hy can we have these with guns but can't look at guns on the internet?"* and *"can we have a picture of a severed*

241 CTPHQ000040/5.
242 CTPHQ000040/5-6.
243 CTPNW000154.

head then". Also on 3 December 2019, AR had discussed different YouTubers and YouTube videos. It appeared to the teacher that he was discussing videos of people hurting themselves. He said that if a drill bit broke it could fly off and kill someone. On 4 December 2019, AR had referred to a political leader as a *"retard"*. It is relevant to note that this First Referral to Prevent was made before (in fact just the week before) AR's hockey stick attack at Range High School on 11 December 2019.

The school internet browsing history

36. In relation to AR's searches for school shootings, the referral stated that *"we can no longer log student web history"*. It stated that AR's father, Alphonse R, had stated that AR had only copied behaviour of another student and clicked on a hyperlink to a news story. The referral stated that *"Mrs Martindale was present during the telephone conversation and said that she would need a few days to get a copy of AR's browser history"*.

37. The school internet browsing history was disclosed to the Inquiry and analysed.[244] The Inquiry's analysis showed that AR had been searching for mainstream news articles about a school shooting, contrary to the excuse provided by his father. Moreover, it showed that AR had also been trying to view images of deeply unpleasant degloving injuries.[245]

38. There were a series of emails between Mrs J Lewis and CTPNW officers when the referral was submitted.[246] Unfortunately, the emails were retained and disclosed in a format which made it difficult to be sure: how many emails were sent by Mrs J Lewis, when those emails were sent and what was attached to them. Based on the disclosed emails alone, it is theoretically possible that Mrs J Lewis sent two emails with different attachments, and it is possible that one of those emails contained the browsing history.[247] However, based on all of the evidence, I am satisfied that The Acorns School did not send the browsing history to Prevent at the time of the referral. I have reached that conclusion for the following reasons:

    a. The attachments that are visible on the disclosed emails do not include the internet browsing history;[248]

    b. Mrs J Lewis stated that she would not have had any involvement in providing the browsing history to Prevent;[249]

244 LCC001401; ILT000022 – Both disclosed but not published due to sensitive content.

245 T/S: 27/172/1-176/18.

246 LANC000175.

247 T/S: 27/53/18-54/8.

248 T/S: 27/51/4-52/23.

249 Witness Statement of Mrs J Lewis LCC001774/§11.

c. None of the CTPNW officers who had any involvement with the First Referral (Officer A, Officer B, PS Thompson, DS Neale) stated that they had seen the browsing history;

d. Officer B recorded, on 10 December 2019, that he had re-contacted Mrs J Lewis *"as we do not have any details of the internet search history or what he was looking at Jan will be contacting the school IT provider to obtain this information if this is still available"*;[250]

e. At the strategy meeting on 17 December 2019, it was stated that The Acorns School were looking at internet searches;[251]

f. There is no record of the browsing history being sent or handed over at a later date and nor does Mrs J Lewis state that this had occurred; and

g. The Merseyside Police investigation into the hockey stick attack at Range High School also sought the browsing history but it was not provided.[252]

39. In her statement to the Inquiry, the current headteacher at The Acorns School, Mrs Joanne Hodson, stated that the school had provided the browsing history to Prevent on 5 December 2019 when the referral was made.[253] As I have set out more extensively in Chapter 11: Education, Mrs Hodson was an impressive and, I accept, wholly honest witness. I accept as accurate her recollection of seeing a printed-off hard copy of the internet browser history because she had a clear recollection of seeing the browser history in that format and thinking that the content was hard to understand (*"just as a list of gobbledygook"*).[254] While I cannot rule out the possibility that a hard copy of the internet search history was taken by The Acorns School to the strategy meeting of 17 December 2019, the factors listed in the paragraph above do not support the conclusion that it was handed over to the police or Prevent on that occasion (as Mrs Hodson – I accept genuinely – believes occurred). I am re-enforced in this conclusion by the further statements obtained from PS Thomspon and DC Murphy on this point, both of which suggest that no hard copy of the browser history was handed over.[255]

250 LANC000175/66 and see also the JAT referral form: CTPNW000146/2.

251 CTPNW000157/15.

252 DC Murphy was told that it was no longer available (T/S: 18/67/7-22), although Ms Heaton, The Acorns School ICT teacher at the time AR accessed the school shooting article, stated that she was not contacted with any request whether for a witness statement or otherwise, at that time: Witness Statement of Ms Heaton LCC002135/§7.

253 Witness Statement of Mrs Hodson LCC001773/§133.

254 T/S: 27/181/14-15.

255 Second Witness Statement of PS Carmen Thompson CTPNW000454; Second Witness Statement of DC Paula Murphy MERP008362.

40. Given that the browsing history must have been obtained by The Acorns School at some stage, there was a failure by those at The Acorns School to ensure that it was provided to Prevent. In addition, Mrs J Lewis accepted that the school ought to have told Prevent:

    a. That AR had also been looking at nunchucks during a lesson; and

    b. That he had tried to override the security settings on the computers.[256]

    While these were failures on the part of The Acorns School, it is fair to note two things in this context. First, the school was plainly doing the right thing by making the Prevent referral. Second, as addressed in Chapter 11: Education, and in other chapters of this report, otherwise and seen in the round, The Acorns School acted diligently and often impressively in how they sought to handle the risks posed by AR.

41. While The Acorns School should have ensured that it did provide the internet browser data to Prevent, the CTPNW officers should have followed this up and ensured that it was sent and considered. Officer B knew that steps were being taken to obtain the browsing history and yet he did not follow up with The Acorns School for the outcome of those steps. Similarly, PS Thompson was aware that steps were underway to obtain the browsing history but also did not follow up with The Acorns School. PS Thompson's entry on the PCM Tracker states that she: *"advised agencies to re refer to prevent should they have any more concerns in the future and also if any relevant information is found on his internet history from the school or from his devices"*.[257] However, in so far as this related to The Acorns School, I do not consider this was sufficient. It wrongly placed the onus on the school to determine whether relevant information was found on the browsing history when this was a task that CTPNW were better equipped to carry out.

42. PS Thompson accepted in her evidence that between the school, the FIMU and herself, they should have ensured that the browsing history was considered before the referral was closed. PS Thompson accepted, *"I think we needed to have had sight of that history, definitely"*.[258] She acknowledged, moreover, that the referral should not have been closed before she had followed up on this material. Ms Ellsmore stated that available opportunities to understand online activity should be taken where practicable before making the Police Gateway Assessment and certainly before closing the referral and DCS Kenwright gave consistent evidence.[259,260] The decision to close the referral was approved by DS Neale. I agree with the evidence of PS Thompson,[261] Ms Ellsmore[262] and

256 T/S: 27/61/10-63/14.
257 CTPNW000122/31.
258 T/S: 21/78/18-25.
259 T/S: 22/54/12-20.
260 T/S: 22/136/13-24.
261 T/S: 21/108/14-19.
262 T/S: 22/55/21-56/2.

DCS Kenwright[263] that this issue, as well as the other outstanding actions referred to below, should have been identified and mitigated at the supervision stage. DCS Kenwright stated that it would be helpful if the PCM Tracker had a similar structure to other police databases where there are actions which have to be formally closed.[264] Deputy Assistant Commissioner (DAC) Victoria Evans (the Senior National Coordinator for Prevent and Pursue in CTPHQ) stated that there is now a new system called the 'Prevent Case Management Tracker enhanced' which allows activities to be recorded and that a case cannot be closed unless those activities are resolved, so I do not make a recommendation in this respect.[265] No further information was sought when PS Thompson carried out six month and 12-month reviews.

43. Mrs J Lewis stated that if any of those officers had spoken to her, she would have looked into it again and provided the internet browsing history.[266] Officer B indicated that the browsing history would have had to be analysed manually.[267] Given the entries about degloving injuries appeared on the fourth page of the browsing history, and continued over three pages, and the browsing around school massacres would have been visible from a simple text search, it is my assessment that any competent analysis by CTPNW would have identified those issues.

44. PS Thompson accepted that if she had been aware of the subject matter of AR's searches, it would have raised *"the level of concern significantly"*, given it would have exposed AR's lies about how he came to be viewing the article about a school shooting and his violent interests in relation to the degloving injuries.[268] The lack of information is of particular significance because PS Thompson accepted that if she had been aware of these details she would have referred the case to Channel.[269] This knowledge, additionally, would have acted as a spur to apply far more detailed search terms to the inspection of AR's electronic devices, to which I now turn.[270]

The seizure and search of AR's electronic devices

45. On CTPNW receiving the First Referral, Officer B completed the FIMU checks on AR and on 11 December 2019 he then referred AR's case to the JAT. The JAT referral form included an update that AR had been arrested, having carried out the hockey stick attack at Range High School that morning.[271]

263 T/S: 22/140/10-141/17.
264 T/S: 22/147/13-148/2.
265 T/S: 23/96/1-97/21.
266 T/S: 27/59/22-60/2.
267 T/S: 20/146/23-147/9.
268 T/S: 21/77/9-13.
269 T/S: 21/78/4-6.
270 T/S: 21/79/1-12.
271 T/S: 20/149/22-150/5.

46. The next day, Officer B was updated by Merseyside Police about the investigation into that attack. He replied asking to be updated with the outcome and *"... pass my details to the OIC [Officer in the Case] in relation to the computer/mobile seizures"*.[272] Officer B was, therefore, aware that Merseyside Police had seized AR's electronic devices following the attack.

47. Merseyside Police ran searches on AR's seized devices which included searches for the word *"shooting"* and *"beheading"*. The searches did not return any results.[273] However, there was no contact between CTPNW and Merseyside Police about the results of the searches and the Prevent referral was closed without knowledge of the outcome. Furthermore, no CTPNW officer, including Officer B and PS Thompson, provided any input on whether other word searches could have been carried out. Officer B accepted with hindsight that it would have been helpful to have a slightly wider set of search terms run across those devices and for CTPNW to have provided further guidance to the Merseyside Police investigation.[274] PS Thompson stated that it was her understanding that Merseyside Police would update her if anything of significance arose from the searches but accepted that it would have been better practice to have made enquiries as to what had come back, as did DCS Kenwright.[275,276] Even if it was felt that the results of the searches would not be obtained within a sufficient timeframe, this should have been picked up by PS Thompson's six-month review.[277]

48. It is not known whether wider word searches would have returned any results from AR's devices at that time. It is true to say that, when searches were carried out after the attack in 2024, there was no evidence of such material being held by AR before June 2021.[278] Nevertheless, the school browsing history demonstrates that AR may have been looking at concerning material at this time that might have been captured by wider word searches and so this was a further missed opportunity.

49. I note the issues in respect of the seizure of AR's devices and also in relation to the browsing history. I have also considered concerning evidence in relation to AR's online activity (see Chapter 6: Online harms). These issues show the importance of understanding the online behaviour of a person referred to Prevent. I note that a review by CTPNW identified a number of non-compliant cases in relation to proper Internet Intelligence Investigation checks being conducted. The review states that while CTPHQ developed a standalone Internet Intelligence Investigation policy in October 2022, this was not integrated into national policy or training and CTPNW was not aware of the policy until a

272 CTPNW000373/4.

273 T/S: 18/69/4-71/7; MERP008359/115.

274 T/S: 20/151/3-154/24.

275 See the PCM Tracker entry quoted above, CTPNW000122/31.

276 T/S: 21/78/10-17, T/S: 22/137/21-25, T/S: 22/139/21-22.

277 PS Thompson was aware it could take three months: T/S: 21/62/17-20.

278 T/S: 11/25/13-26/15.

CTPHQ assurance visit in November 2024. CTPHQ, in contrast, suggests that CTPNW officers were involved in the development of the Internet Intelligence Investigation policy, that the CTPNW Regional Prevent Co-ordinator was sent that policy via email in February 2023, and that CTPHQ rely on Regional Prevent Co-ordinators to disseminate policies of this kind to the network.[279] I do not need to resolve this dispute between CTPHQ and CTPNW as to why CTPNW was not aware of the October 2022 Internet Intelligence Investigation policy for over two years. Whatever its cause, Prevent officers must fully recognise the importance of this issue.

The Joint Assessment Team referral

50. As I have indicated, Officer B completed the FIMU checks on AR and then on 11 December 2019 referred AR's case to the JAT. He provided the JAT with the Prevent referral form itself, the JAT referral form and a FIMU intelligence report concerning AR taking a knife into school and researching school shootings.[280]

51. Within the JAT, DC Blundell reviewed the referral alongside an MI5 officer. DC Blundell stated in his evidence to the Inquiry that he considered it was *"quite possible"* that AR had a fascination with US school shootings.[281] In addition, he stated that AR: *"not only had a fascination with weapons, he had actually gone into the real world with a weapon to settle a score or act upon his grievance"*.[282]

52. The conclusion recorded by DC Blundell was: *"[t]he intelligence and relevant research at present does not meet any Lead or Police threshold for investigation under CT / DE [Counter Terrorism / Domestic Extremism] banner. However, consideration now that there is a Local Authority MASH led intervention following arrest and previous history at both schools that preference would be for continuance and recommend Dovetail team and Channel Panel are sighted with regards safe-guarding and AR vulnerabilities going forward"*.[283]

53. DC Blundell explained that he felt it was necessary for the Dovetail team and for MASH to be sighted on the documents and that social services should be sighted on the referral form. He stated that it was his hope that the Prevent officer would refer the case onto Dovetail or Channel, or at least share the information.[284] He accepted that, in making this suggestion, he was stepping on the toes of the CTCO, but that he felt that this was appropriate because the intelligence was concerning.[285]

279 T/S: 23/73/9-75/21; although also noting the further detail in DAC Evans's supplemental statement: Second Witness Statement of DAC Evans CTPHQ000153/§§22-27.

280 T/S: 20/148/16-22.

281 T/S: 20/193/17-23.

282 T/S: 20/194/6-14.

283 CTPNW000146/4

284 T/S: 20/198/1-19.

285 T/S: 20/200/11-21.

54. Within the FIMU, Officer B then sought to convey the outcome from the JAT to the CTCO, PS Thompson. By an email dated 16 December 2019, Officer B stated: *"This has been returned from the JAT for a prevent referral to be inputted onto the pcm tracker and referral to channel/dovetail"*.[286] PS Thompson therefore ostensibly received a direction from the FIMU to make a referral to Channel/Dovetail.

55. It is informative that DC Blundell was sufficiently concerned about AR's referral that he felt that Dovetail/Channel should, at the very least, be sighted on his case. In addition, the words of DC Blundell and Officer B include several demonstrations of, at the very least, loose use of language which tended to blur the different assessments being undertaken by the FIMU and Prevent officers.

56. A further example of this was Officer B tasking PS Thompson to carry out a visit of AR *"to establish ideology and consideration for Channel/dovetail"*.[287] Officer B stated that he was unaware of the joint letter about ideology at this time.[288] Officer B's direction was potentially inconsistent with the wording of that letter because it directed PS Thompson to establish whether there was an ideology, whereas the letter required a consideration of the risk of *"being drawn towards an extremist ideology, group or cause"*. I address in paragraphs 58 to 62 below a further example of this confusing language in relation to the First Referral.

Prevent assessment and closure of the First Referral

57. PS Thompson was aware of the referral before it had been reviewed by the FIMU and the JAT because she had contact with Police Constable Paul Harrison of the Lancashire Constabulary Community Safety team. On 11 December 2019, PC Harrison emailed PS Thompson about the hockey stick attack at Range High School, forwarding his earlier email to the Merseyside Police custody sergeant. PC Harrison raised among other things that AR wanted to talk about *"guns and beheading"* and that he seemed to have a *"[certain] hatred of teachers in particular"*.[289] The email stated that AR had gone into Range High School *"with the sole intention of killing a particular pupil with the hockey stick and if that didn't work he would use the knife but the pupil in question was thankfully not in school today.!!"* In the forwarding email to PS Thompson, PC Harrison added that AR had planned and prepared the attack by ordering a taxi the day before.

286 CTPNW000373/7.
287 LANC000175/152.
288 T/S: 20/158/15-159/8.
289 LANC000175/77.

58. The following week, following the FIMU assessment, PS Thompson then attended the strategy meeting held on 17 December 2019.[290] That morning, PS Thompson sent PC Harrison an email which was undoubtedly misleading: *"Good morning, I will be attending a strategy meeting at 10 am this morning and [AR] will be coming to Prevent. Thanks Carmen"*.[291] PS Thompson accepted that the natural interpretation of this email would have been that a decision had been taken to accept AR's Prevent referral. PS Thompson's evidence was that what she had intended to convey was that she would be attending the meeting with a view to carrying out an assessment *"as to whether we would consider referring [AR] to Channel"*. PS Thompson acknowledged this email should have been worded with greater clarity.[292] It is important to note, however, that the 'actions' agreed at the conclusion of the meeting set out that the Prevent team was to commence its initial assessment, which was a clear indication that the referral had not been accepted by Prevent.[293] Furthermore, PS Thompson could not recall any expressions of confusion at the meeting as to the Prevent processes. I therefore do not draw any conclusions from the email sent to PC Harrison.

59. At the meeting, there was a discussion of AR's recent behaviour, in particular the hockey stick attack at Range High School. Detective Constable Paula Murphy, the investigating officer at Merseyside Police, stated that AR had been arrested and bailed and that he had given a prepared statement which stated that he had no intention to use the knife during the attack.[294] However, PS Thompson recorded that AR had said to a police officer from Merseyside Police that he had taken the hockey stick to hit the victim and that he intended to use the knife to *"finish him off"*.[295] AR had said that he was not bothered if he was imprisoned as a result. AR had also told Ms Stephanie Hallaron, Criminal Justice Liaison and Diversion Practitioner, that he had intended to kill the alleged bully and would have done so if he had found him.[296] PS Thompson was aware, therefore, that AR had lied during the police interview to diminish the significance of his actions.[297] She noted that AR had assaulted someone other than the intended victim because he was being chased by teachers and *"didn't want to get into trouble for nothing"*.[298] AR had shown no remorse or empathy for what he had done. PS Thompson also noted that someone at the meeting had said: *"stated boys picking on him, this was not the case they were trying to engage, made comments about the staff saying they are evil,*

290 For further discussion of this meeting, see Chapter 7: Policing, Chapter 9: Social care, Chapter 10: AR's healthcare and Chapter 11: Education.

291 LANC000109.

292 T/S: 21/59/5-61/2.

293 LANC000004/7.

294 LANC000004/3-4.

295 CTPNW000132/2.

296 LANC000004/4.

297 T/S: 21/62/1-64/2, T/S: 21/66/7-20.

298 CTPNW000157/9.

bizarre behaviour".[299] PS Thompson was also made aware that AR considered that the Manchester Arena attack had been a *"good battle"* from the point of view of the attacker.[300]

60. PS Thompson's understanding was that the many inappropriate things AR had said were the result of his autism and the frustrations caused by his belief that he had been bullied. Consequently, she did not view AR's violent actions as *"extreme violence"* for the purposes of referral to Channel. She did not detect that AR had been trying to promote a grievance or an ideology of any kind.[301] Nonetheless, she accepted there was a *"wealth of highly concerning information."*[302]

61. PS Thompson recognised that the referral contained concerning elements, which led her (following a discussion with her supervisor) to conclude that additional information was required, including by way of speaking with AR. She wanted to establish *"what was going on, what his thought process was, what his behaviour was like, how he presented himself"*.[303] The PCM Tracker for 20 December 2019 reflected this in the following entry:

> *"There is very little information about this case, a prevent visit to be conducted to carry out a risk assessment and determine the appropriate course of action when further information is obtained."*[304]

62. PS Thompson accepted that this latter entry, along with a similar one completed by the FIMU officer, failed to reflect the extent of the information provided in the original referral and the strategy meeting. She explained in evidence that what she had meant was that more information was needed to complete the assessment as to whether the case met the threshold for a referral to Channel, particularly as to whether AR displayed any extreme behaviour or ideology. She accepted, however, that AR did not need to have an *"underlying fixed ideology"* for a referral to Channel.[305]

63. On 20 December 2019, the PCM Tracker was updated by PS Thompson, confirming that the referral had moved from initial assessment to a PLP.[306] This was done following a discussion between PS Thompson and her supervisor in order to allow for the visit to AR.[307] It was not in fact necessary to move the referral to a PLP to carry out the visit.

299 CTPNW000157/13.
300 CTPNW000157/14.
301 T/S: 21/70/10-71/16.
302 T/S: 21/74/19-75/1.
303 T/S: 21/57/9-16.
304 CTPNW000122/32.
305 T/S: 21/81/9-83/17.
306 CTPNW000122/32.
307 T/S: 21/76/1-4.

PS Thompson was not able to explain why it became a PLP and DCS Kenwright acknowledged that it may have been due to a misinterpretation of the policy as it stood at the time.[308,309]

64. On 23 December 2019, PS Thompson completed a police case management plan.[310] The police case management plan was an onward plan for the case where managed under a PLP.[311] In the police case management plan, PS Thompson recorded that she intended to seek advice on AR's case from the Vulnerability Support Hub, which is now the Clinical Consultancy Service.[312] The Vulnerability Support Hub included clinicians such as mental health nurses, psychologists and psychiatrists, who provide advice to CTCOs on mental health issues. This would include how to manage the individual's needs and appropriate support. For reasons she was unable to explain, PS Thompson failed to make a Vulnerability Support Hub referral for AR. PS Thompson candidly acknowledged this was an error. In mitigation, she noted that the Child and Adolescent Mental Health Services (CAMHS) had been involved with AR, providing support in relation to his autism. However, she acknowledged that AR was awaiting a mental health diagnosis and that the *"triggers"* for his behaviour were unclear. Moreover, she accepted that the Vulnerability Support Hub could have helped her to understand how AR's autism was affecting his behaviour and risk.[313]

65. In my assessment, PS Thompson was right at the time to mark AR's case as one that required input from the Vulnerability Support Hub. Had she taken forward that input (as she clearly originally intended to do), it would have assisted and better informed her assessment of whether AR met the Police Gateway Assessment threshold. For example, PS Thompson accepted that the Vulnerability Support Hub could have assisted her consideration of AR's autism in relation to her assessment following the 17 December 2019 strategy meeting where she had concluded that the inappropriate things said by AR, for example that he wished to kill the alleged bully, were a result of his autism.[314] The Inquiry's expert psychiatrist, Dr Tina Irani, considered that AR's autism increased, rather than reduced, his level of risk to others.[315] PS Thompson stated that she took this into consideration.[316] However, that is not clear from the contemporaneous records and input from the Vulnerability Support Hub

308 T/S: 21/80/3-9.

309 T/S: 22/148/14-149/6.

310 CTPNW000122/24-25.

311 Prompts for the police case management plan were set out in the DIF: CTPHQ000040/3.

312 23 December 2019 entry, *"A referral to the vulnerability hub to be submitted by prevent."* CTPNW000122/24.

313 T/S: 21/86/16-88/21.

314 T/S: 21/73/9-21.

315 DRI000001/33/§4.4.7.

316 T/S: 21/100/2-11.

could have assisted PS Thompson to understand that AR's autism was not a mitigation for his concerning comments, rather something that exacerbated the risk apparent from those comments.

66. Ms Ellsmore noted that this misconception is a common issue in the handling of Prevent referrals.[317] I stress the evidence that autism is case-specific and certainly does not exacerbate risk in all cases. I note that training in relation to autism has been put in place for Channel panels and intervention providers.[318] I note also that practitioners have the Clinical Consultancy Service (formerly the Vulnerability Support Hub) to provide guidance. I appreciate that guidance and training to CTCOs is under review but, nevertheless, the need for improved training for CTP officers is addressed in my recommendations at the end of this chapter.[319]

67. PS Thompson accepted that the police case management plan, when analysing AR's grievances, should have made reference to the allegation of bullying and the issues AR was reporting at school. She stated that further guidance would have assisted at the time.[320]

68. PS Thompson's police case management plan concluded that there should be a visit to AR to determine if the case was suitable for a referral to Dovetail. PS Thompson indicated that the visiting officers were to determine if there was any counter-terrorism or domestic extremism (CT/DE) ideology and risk assess any vulnerabilities and safeguarding and put the appropriate support in place. The visit was risk assessed, and AR's risk was assessed to be medium to high based on his recent arrest and use of weapons. As a result, PS Thompson was to attend AR's home accompanied by another CTP officer, full personal protective equipment was to be worn and for their own personal safety they were to notify the communications staff in advance that they were to conduct the visit.[321]

69. In order to take forward the police case management plan, on 31 December 2019 PS Thompson accompanied by Police Constable Christopher Lawrence sought to visit AR at home. That visit was effectively aborted because Alphonse R told the officers that he was working nights as a taxi driver and requested that they return on 3 January 2020.[322] Therefore, on 3 January 2020 PS Thompson again accompanied by PC Lawrence re-attended AR's home to conduct the interview.[323]

317 T/S: 22/43/3-44/10.

318 T/S: 22/46/10-47/5.

319 Second Witness Statement of Ms Ellsmore HOM000223/§13(c), §§22-28.

320 T/S: 21/88/22-91/7.

321 Witness Statement of PS Thompson CTPNW000180/§32.

322 CTPNW000122/28.

323 CTPNW000135.

70. During the course of this visit, AR suggested to the CTP officers that the school had *"taken things out of context"* in relation to his behaviour and online activity. When he was asked about researching the internet for school shootings, he stated that he had seen a news article on Yahoo and out of interest he had *"clicked through"* to it. He maintained – falsely – that he had not actively searched for school shootings. He had looked on the internet for nunchucks, in the context of research for a lesson on *"building things"*. He claimed his teachers wrote about him in order to get him into trouble, and he felt they were picking on him. As to his recent arrest, he suggested his actions were because a pupil had been bullying him for a number of months, but his teachers had not intervened.[324] He maintained, and PS Thompson appears to have accepted, that he had carried knives into school because he had been bullied. AR showed no remorse and did not seem to understand the consequences of his actions. He did not demonstrate any empathy for the individual he had assaulted, who was not his intended victim. Nonetheless, PS Thompson accepted his statement that he would not carry knives again, as he understood that this is wrong.[325] Given the terms of Mrs J Lewis's referral and the accumulation of highly worrying information, this involved an unjustified acceptance of the version of events by AR, who had been demonstrated to lie on critical and relevant issues.

71. AR also told the officers that he did not like Dion R, who he suggested was faking his disability (an inability to walk). He said he was angry with Dion R because he had to move schools at the same time as his brother and he had consequently lost all his friends.[326]

72. PS Thompson recorded her assessment that AR displayed traits of autism, as he failed to make eye contact, he continuously fidgeted, he seemingly struggled to understand his emotions and he was unable to empathise with the victim of the recent assault.[327] PS Thompson recorded that AR's *"extreme emotions"* were likely to be the result of his autism. It is important to note in this context that AR had not received a formal diagnosis of autism spectrum disorder at this stage, as PS Thompson correctly recorded in her note of the visit.[328] While PS Thompson was astute to observe the indications of autism, her judgement that AR's extreme emotions could be attributed to autism (at least insofar as this was seen as a mitigation of risk) was less sound and serves to emphasise the importance of obtaining advice from the Vulnerability Support Hub.

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324 CTPNW000135/1.

325 T/S: 21/99/1-9.

326 CTPNW000135/1.

327 PS Thompson attended with PC Lawrence who, no doubt, would have fed into the assessment. However, as the CTCO, it was for PS Thompson to reach the conclusions.

328 CTPNW000135/2.

73. The note of the visit recorded that AR had not displayed any extremist views, or counter-terrorism or domestic extremism ideology during the conversation. He failed to demonstrate any interest in politics or religion, and he had not revealed grievances against particular groups.[329]

74. At that time AR was without access to the internet since his devices had been seized and he was not given online access at school. He claimed he usually played games such as Fortnite but he was then unable to do so.[330] PS Thompson explained in her evidence to the Inquiry that it appeared that a significant element of the material AR researched on the internet related to current news.[331]

75. By reference to AR's personal circumstances, PS Thompson's action result document of the visit set out the conclusion that AR was vulnerable on account of the possibility that he was autistic. Dion R's disability had caused a significant change, resulting in the family moving home and AR moving school. AR resented his brother, feeling pushed out by the attention Dion R was receiving. AR was friendless, isolated, had been bullied and he *"required a diagnosis in relation to his Autism so that the right support can be put into place"*.[332]

76. There was a further strategy meeting on 6 January 2020.[333] It is sufficient to indicate that PS Thompson was present and the meeting was informed that following the home visit, the Prevent referral was to be closed. It was simply recorded under the heading 'Prevent' that:

> *"AR has been seen by the team and it is not felt that he has any issues regarding the Channel/Prevent programme. There were no concerns that he was being led into criminality or radicalised. It was noted that he showed no remorse for the incident. Assessment to be shared."*[334]

77. The strategy meeting minutes concluded, in relation to suggested outcomes, with boxes being ticked for 'Police investigation' (a reference to the police and CPS action following the hockey stick attack at Range High School) and 'No Further Action'. The reasons for this outcome were described as follows:

> *"Professionals agreed there was no ongoing evidence that [AR] or [Dion R] were at risk of significant harm however it was accepted there is a risk to [AR] of further criminality and now on (sic) his needs being*

329 CTPNW000135/2.

330 CTPNW000135/2.

331 T/S: 21/97/4-14.

332 CTPNW000135/2.

333 For further discussion of this meeting, see Chapter 7: Policing, Chapter 9: Social care, Chapter 10: AR's healthcare and Chapter 11: Education.

334 LCC000023/2.

> *neglected through a lack of education provision and there being a perceived gap in the support his underlying health needs require and the support currently available to him."*[335]

78. The action result document compiled by PS Thompson for CTPNW following this strategy meeting contained the following:

> *"The school feel that pupils and teachers would be at risk if the subject was to return to school due to comments he made previously about wanting to get teachers murdered, the subject has been displaying extreme emotions of dislike and hatred which are believed to be traits of Autism.*
>
> *"The investigation in relation to the recent assault is still ongoing with Merseyside Police and awaiting a CPS decision. The devices are being examined, the school internet history is also being looked at by Merseyside Police, they will update accordingly with any concerns found."*[336]

79. In addition to the action result document following the strategy meeting, on 7 January 2020, PS Thompson also updated a separate 'action report'. She recorded, apparently for the attention of the FIMU Officer B, that she had: *"[visited] the subject on the 03/01/20 there is no CT/DE ideology…;"* that she had *"… attended the [strategy] meeting on the 06/01/20…"* and she asked, *"Please can you advise if this can now be closed to prevent."*[337] The next day, 8 January 2020, PS Thompson entered onto the PCM Tracker: *"FIMU have assessed that the case can now be closed to prevent there are no CT/DE concerns present at this stage; the relevant agencies are supporting the subject, all agencies are aware that if any new concerns are identified they can re refer to prevent."*[338] Officer B responded to the action report on 9 January 2020 stating, *"the above has now been reviewed [and] can now be closed in relation to the incidents at school this is being dealt with by merseyside police who have taken the matter to cps the subject is excluded from school and is open to social services."*[339]

80. A plain reading of those communications suggests that PS Thompson was asking Officer B to approve the closure of the Prevent referral, and that Officer B was providing such approval. It was not Officer B's role to make such a decision, nor was he trained to do so. Both Officer B and PS Thompson maintained that, despite the wording, this was not the case, and that they both understood that the communication was instead about whether the action could be closed on the CTP platform in question.[340]

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335 LCC000023/2.

336 CTPNW000009.

337 CTPHQ000087/1.

338 CTPNW000122/30.

339 CTPHQ000087/1.

340 T/S: 20/165/18-169/22, 21/104/11-106/10.

Officer B's responses appear to go beyond the answer to such a question and, in my view, demonstrate a level of confusion about the respective roles, although that may have been due to his relative inexperience at the time and a lack of training in issues of Prevent. He would not have needed to include information about the wider context of the case if he was simply approving the closure of a limited action. However, I am certain that PS Thompson understood her role and that the Police Gateway Assessment was her decision to make. I do consider, however, that her emphasis on a lack of ideology being apparent from the home visit of 3 January 2020 is telling and I come back to this question below.

81. PS Thompson made a further entry on the PCM Tracker on 15 January 2020 which reflected the pending closure of the Prevent referral.[341] The entry set out the steps that PS Thompson had taken and summarised the information that had been gathered. It set out AR's comments that the school had taken things out of context in relation to AR's behaviour and online activity and stated that he had not actively searched for the news article about school shootings. It referred to the hockey stick attack at Range High School and stated that AR said he had done this because he was being bullied. PS Thompson concluded:

> *"I do not feel that there are any CT/DE concerns at this stage, however the subject is extremely vulnerable and needs support from other agencies that are already in place, I have advised agencies to re refer to prevent should they have any more concerns in the future and also if any relevant information is found on his internet history from the school or from his devices. This information has been assessed by FIMU as suitable for closure at this stage."*[342]

82. On 31 January 2020, DS Neale (the relevant supervising sergeant) reviewed PS Thompson's decision and closed the referral. He stated: *"as detailed in the PCM the concerns relayed to Prevent have been explored and do not appear to be linked to an Ideology or a vulnerability to radicalisation. There are vulnerabilities and needs which are being met by mainstream safeguarding and this case can be closed to Prevent"*.[343]

Lack of verification of AR's account of events and explanations

83. What was crucially missing from PS Thompson's assessment was any attempt to verify the account that AR had given. A clear warning that AR was being untruthful had already been provided. The information obtained at the 17 December 2019 strategy meeting showed that AR may lie and contradicted some of the information provided at the visit on 3 January 2020. While PS Thompson stated that she was aware of the risk of disguised

341 CTPNW000122/31.
342 CTPNW000122/31.
343 CTPNW000122/31.

compliance, she nevertheless accepted AR's assertion that he had been bullied, that he had accidentally stumbled across details of school shootings on the internet and that his behaviour was a reflection of his *"vulnerability"*.[344,345]

84. It is easy to be wise after the event, and it is important to guard against hindsight bias. It should be recognised that PS Thompson had to take a proportionate approach to assessing the referral and balance a demanding workload.[346] Part of the approach may, again, link to her understanding of AR's autism, which was not supplemented with clinical input from the Vulnerability Support Hub.[347] However, some elementary enquiries with AR's present and previous schools would have confirmed that AR had lied to them during this interview on critical issues. This would have revealed that, contrary to AR's account, he had carried out intentional and disturbing internet searches, that there were reasons to doubt AR's account of the extent of any bullying at Range High School and strong evidence to doubt any suggestion of bullying at The Acorns School. In relation to the latter, Mrs J Lewis's response to the suggestion that AR had been bullied at The Acorns School was that this was *"complete rubbish"*.[348] However, after she visited AR, PS Thompson never verified his account with Mrs J Lewis or anyone else at The Acorns School. As a result, she did not hear Mrs J Lewis give such a strong denial (nor did she determine whether the internet search history had been obtained).

85. I agree with the evidence of Mrs Hodson, the then deputy headteacher of The Acorns School, who stated:

> *"What I'm really surprised about with the First Referral is that there was no triangulation. So we sent in what we thought was happening, all our concerns, all the risks and what he had been searching for, and all of those sorts of things. They then went to meet AR and Dad who said, basically, that the teachers are picking on him and that he just clicked on a link but nobody ever then came back to us to check that or ask for any more information or check with anybody else even. They accepted that at face value."*[349]

86. A consistent failing identified during the Inquiry has been the lack of curiosity shown by multiple officials who had dealings with AR throughout the relevant period. The extent of PS Thompson's notes and record keeping suggests that she sought to be (and I accept that she was) a diligent officer. But PS Thompson was right to accept candidly in her evidence that she should have *"probed things a bit more"*.[350] Given what was known about AR by 3 January 2020, PS Thompson should have shown more professional curiosity

344 T/S: 21/101/4-13.
345 T/S: 21/95/15-96/1.
346 T/S: 21/10/14-11/2.
347 T/S: 22/158/19-159/3.
348 T/S: 27/64/19-65/7.
349 T/S: 27/182/4-13.
350 T/S: 21/98/4-24.

about the veracity of AR's account and she should have been considerably more cautious before accepting his explanations. A careful assessment by DS Neale, as supervisor, in considering whether the referral was suitable to be closed, ought also to have recognised this. It is an obvious thing to state that simply because something is said by a child or a young person does not mean that it is necessarily true, as the present case vividly demonstrates. It is critical that children and young people are able to *"find their voice"* and that those who are listening to them do so with care, but it is equally critical that what they say is not accepted without adequate professional reflection and evaluation. AR's account was significantly at odds with the extensive other available evidence, save for what was unrealistically asserted by his father.

Analysis of the decision to close the First Referral

87. PS Thompson knew information about AR that suggested that he may have a fascination with extreme violence and or be vulnerable to being drawn into a school massacre interest and ideology:

    a. AR had researched school shootings during class;

    b. He had made comments about teachers getting murdered;

    c. He had been told by PC Harrison that AR had a *"[certain] hatred of teachers in particular"*;

    d. He had taken knives into school;

    e. AR stated that he hated his school, that he was bullied and felt the teachers were picking on him;

    f. AR had returned to his school, despite his exclusion, with a knife and adapted hockey stick and struck a pupil – not the alleged bully – with the hockey stick. AR had pre-meditated the attack, taken weapons to his school, intended to kill, and instead attacked an innocent bystander. His actions could have been viewed as an unsophisticated school attack;

    g. AR had said that he would have used the knife; and

    h. This was linked to an apparent interest in violence. For example, AR asking for a picture of a severed head in class and apparently watching videos of people hurting themselves.

88. PS Thompson accepted that if she had been aware of AR's internet history (e.g. the repeated searches for 'degloving' injuries) before closing the First Referral, she would have referred him to Channel. She acknowledged, furthermore, that she made other errors, such as the failure to feed into the searches of AR's devices by the Merseyside Police investigation, the omission to follow through on her intention to refer AR to the Vulnerability Support Hub, and her failure to treat AR's account on 3 January 2020 with greater scepticism.

Given the known information about AR summarised above, those steps should all have been taken. If those steps had been taken, they would have further fortified the need to continue the referral.

89. DAC Evans' view was that the First Referral should have proceeded to the Channel information gathering stage. Ms Ellsmore believed that the case should have been in Channel, taking into account what was known and what should have been known.[351] I agree that the First Referral should have proceeded to the Channel information gathering stage. The reasons given above show that there were reasonable grounds to suspect that AR was a person susceptible to becoming a terrorist or supporting terrorism. If the Local Authority Channel Coordinator had concluded information gathering, in my view the case should have been referred to the Channel panel, following a section 36 decision by PS Thompson. The section 36 decision was a higher threshold than the Police Gateway Assessment: *"a reasonable belief that the person is vulnerable to being drawn into terrorism"*. I consider that the circumstances of AR's case, set out above, met that test. I have analysed what would have happened thereafter in the 'Overall themes and conclusions' section below.

90. In the closing statement on behalf of CTPNW, it was submitted that:

> *"[w]hilst acknowledging that further steps should have been taken by PC Thompson before the decision to close the referrals was made (as discussed above), CTPNW does not consider on information presented that at the time of the referrals there were reasonable grounds to suspect that AR was vulnerable to being drawn into terrorism."*[352]

They also cite the evidence of DCS Kenwright in support. I do not accept this for the reasons I have given in the paragraphs above. In particular, as I have explained, I consider that any competent analysis of the browsing history would have identified the concerning searches for degloving injuries, as well as the fact that AR had given a false explanation for how he came to be viewing the news article about the school shooting. Moreover, CTPNW's position contradicts the evidence of their own CTCO, PS Thompson, who clearly would have viewed AR's searching for degloving injuries as a matter of concern that merited a referral to the Channel panel.[353] Additionally, the position adopted by CTPNW does not, in my assessment, sufficiently allow for the proper extent of the concerns that should have been aroused by the nature of AR's attack at Range High School, which I have addressed above.

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351 T/S: 22/57/2-11. It was also the view of a number of independent reviews carried out after the attack: the Prevent Learning Review CTPHQ000055/16, available at: www.gov.uk/government/publications/prevent-learning-review-southport-attack, Lord Anderson's 'Lessons for Prevent' report CTPNW000114/65, available at: www.gov.uk/government/publications/lessons-for-prevent and the Dignate Report CTPHQ000028/7 although I have of course carried out my own independent analysis of the evidence.

352 Closing Statement on behalf of Counter Terrorism Policing North West CTPNW000451/28/§89.

353 In contrast to the position adopted in §§90-91 of the Closing Statement on behalf of Counter Terrorism Policing North West, CTPNW000451/28.

CTPNW's position, as articulated in their closing statement, has the hallmarks of a perhaps somewhat defensive rear-guard action to justify the closure of the First Referral. With the important provisions below, my conclusion is that PS Thompson was wrong to advise the closure of the First Referral and DS Neale was wrong to endorse her recommendation.

91. I accept that PS Thompson was aware of the requirements of her role and she had paid particular attention to the training which had been provided. As I have already indicated, she was – I find – a diligent officer. That was reflected in many aspects of her work on the First Referral. She attended the two strategy meetings; she visited AR and she kept extremely thorough notes. I am grateful to PS Thompson for her candour during her evidence and I stress that I do not doubt that she was seeking to act with professionalism and that she acted with the best of intentions. I also consider, as set out above, that this issue ought to have been identified when PS Thompson's supervisor, DS Neale, reviewed her decision.

92. Moreover, I consider that her missteps need to be viewed in the context of the analysis set out below. There was a lack of clarity as to whether or in what circumstances someone who was intent on inflicting serious violence but had not demonstrated any material terrorist ideology or a vulnerability to being drawn into terrorism could nonetheless come within the ambit of the Prevent programme. I am confident that this underlying uncertainty as to whether someone in AR's position met the criteria for a Channel referral would have been a significant contextual factor which contributed to PS Thompson's decision not to refer AR. As Matthew Butt KC has underlined in his Closing Statement on behalf of CTPHQ, PS Thompson was aware of the letter of 25 June 2019 and the Dynamic Investigation Framework. However, she stated that she felt that the concepts could have been explained in more detail and through more formal training.[354] I shall therefore return to this issue in the recommendations set out at the conclusion of this chapter.

Communication of the decision to close the First Referral

93. The decision to close the Prevent referral was communicated to almost all of the relevant parties at the 6 January 2020 strategy meeting. However, Lancashire Constabulary were not invited to that meeting. PS Thompson accepted that she should have emailed Lancashire Constabulary about the outcome of the referral.[355] Given the extent of the risks that remained as regards AR, there should have been an established and reliable procedure to ensure that all those concerned were kept up to date with the significant milestones in the handling of this evidently dangerous teenager. AR's situation was potentially of particular relevance to Lancashire Constabulary's Community Safety team (also known as the Early Action team), who had been involved with AR from

354 T/S: 21/30/23-31/5.

355 T/S: 21/110/3-8.

early December 2019 and attended the first strategy meeting. There was no obvious means by which they could be informed of this result on the relevant police and CTP systems. Simply sending an email to an officer within the Lancashire Constabulary or to a representative of any other relevant agency, if that had occurred, is unlikely to have been a satisfactory means of ensuring that an enduring record was available for other officers or officials seeking information on AR. I shall therefore return to this issue in the recommendations set out at the conclusion of this chapter.

The Second Referral to Prevent

94. The Second Referral, on 1 February 2021, was again made by Mrs J Lewis.[356] She highlighted two items posted on AR's Instagram account. These had been forwarded to her by Mr David Cregeen, designated safeguarding lead at Range High School. Mr Cregeen had become aware of the posts because AR remained in contact with some pupils from Range High School. As Mr Cregeen observed, there was nothing strikingly dangerous when considering the posts in isolation. They contained details regarding Colonel Gaddafi, which he suggested might raise some potential radicalisation concerns, particularly if AR had been posting or discussing other similar material. The posts, which were screenshots taken from the newsshopper.co.uk website (uploaded in November 2011), were in the following terms:

> *"He [in context Colonel Gaddafi] fought for the poor women in Libya and he fought for the rights of the continent of Africa against the Western imperialism. Gaddafi succeeded by creating a modern direct democracy. Gaddafi really had little power, as he was just a leader by name. The people were the ones who were directly involved in every decision which was made, like a true democracy! This no doubt angered many Western nations who could not stand the thought that a third-world country could possibly have a more democratic political system than their own! In our so called 'democratic nation' it is the politicians and banks who have all the power rather than us, the people. It seems that it is our Western nations which are much closer to dictatorships as we have no say in day-to-day political matters."*

And:

> *"I also found out that Gaddafi supported the great leader Nelson Mandela in his fight for freedom against apartheid which the Western nations were also supporting. If it weren't for Gaddafi's help South Africa may never have won its own freedom from apartheid, and Mandela himself has thanked Gaddafi personally many times!"*

356 CTPNW000126.

95. Although it may be thought that at least one of the assumptions posted by AR (the suggested democratic functioning of the government in Libya under Colonel Gaddafi) was plainly wrong, there was nothing about these extracts, taken in isolation, to raise concerns that AR was vulnerable to being drawn into terrorism. But, as Mr Cregeen correctly suggested, when considered alongside other material, a different picture, one of concern, might have been detected.[357]

96. Officer A, the FIMU officer for this Second Referral, considered the referral and provided the following assessment on 1 February 2021:

> *"Subject has been previously referred to Prevent. The outcome of that referral (for which the intelligence was far more concerning) was that he did not have any CT/DE ideology or vulnerable to radicalisation. I have reviewed this new referral which refers to 2 posts he has made on his Instagram page which relate to Gaddafi and discusses whether he was that bad. I have searched for and unable to find any Instagram page associated to him. Likewise, I have found no Social Media accounts in his name. The Instagram posts he has made are screenshots from website:*
>
> *www.newsshopper.co.uk/youngreporter/9394709.was-gaddafi-really-that-bad*
>
> *and is from November 2011.*
>
> *It does not appear that the subject was the author of this report. As such I do not believe this new intelligence is worthy of a new Prevent referral as I do not assess it would meet the thresholds for adoption at Chanel [sic] and the content does not suggest he holds any extremist ideology but rather an opposing opinion on Gaddafi's Libyan regime, questioning the US and EU motivation for removing […]."*[358]

97. It was not Officer A's role to determine whether the intelligence was worthy of a new Prevent referral and for adoption at Channel. As a FIMU officer, Officer A was not trained to make such an assessment. I appreciate that FIMU officers should not be discouraged from providing an analysis of the intelligence and, as above, PS Thompson understood her role so there was no evidence that these comments led her into error. Nevertheless, this type of language from the FIMU was misplaced and could have led to confusion or overly influenced the decision of a CTCO.[359]

98. PS Thompson carried out a Police Gateway Assessment on 15 February 2021 which included a description of the relevant background facts. PS Thompson recorded that she had: *"checked police systems and there are no updates to report since the last referral was closed. The school have been contacted*

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357 CTPNW000126/4.

358 CTPNW000124/18.

359 Notwithstanding the explanation given by Officer A in his First Witness Statement CTPNW000179/§56-58.

and they do not have any additional concerns other than the information reported from his previous school".[360] She did not carry out checks with any other agencies, such as CAMHS or social services.[361] Her briefly-stated conclusion was that:

> *"This referral does not highlight any new concerns and can be closed to prevent, school are aware to re refer if there are any concerns in the future."*[362]

99. PS Thompson did not consider that the information provided any relevant new information and that the *"behaviours"* were the same as those rehearsed in the First Referral.[363] The assessment made following the First Referral, in her view, was unchanged. I consider that this was a reasonable conclusion for PS Thompson to have reached based on the content of the Second Referral alone and the lack of a suggestion that there had been any other material changes. However, this should have been an appropriate moment to review the entirety of the material from both referrals and to address the earlier shortcomings.[364] As stated by Ms Ellsmore, the Second Referral should have led to this holistic re-assessment of the cumulative risk picture because the question for PS Thompson remained whether AR was vulnerable to being drawn into terrorism.[365] A further example is that PS Thompson suggested in her Inquiry Witness Statement that appropriate measures and safeguarding were in place to manage AR's risk factors through the school and other agencies. However, without further enquiries, PS Thompson was unaware of whether the position had changed since early 2020.[366] There was no suggestion from PS Thompson that she was unaware of the exercise that she was required to undertake for a repeat assessment, although I do note that re-assessments were not specifically addressed by policy at the time and that a policy for repeat referrals has now been put in place to ensure that CTCOs understand the nature of the exercise.[367]

100. PS Thompson's contact with The Acorns School was via email. After email contact with PS Thompson, further emails were exchanged between Mrs J Lewis and Mrs Maggie Allred, to which PS Thompson was not copied in. Mrs Allred, the High Support Teacher at The Acorns School, had expressed the concern that although AR might not pose an immediate risk, he could *"easily be radicalised"*, which would present a *"huge risk"* of harm to others. Mrs J Lewis replied that PS Thompson would be looking into it and that they could only

360 CTPNW000124/18.
361 T/S: 21/119/2-18.
362 CTPNW000124/18.
363 T/S: 21/116/16-23.
364 T/S: 21/121/2-22.
365 T/S: 22/29/10-17. See also the evidence of DCS Kenwright: T/S: 22/168/9-169/17.
366 Witness Statement of PS Thompson CTPNW000180/§49.
367 HOM000049, HOM000095.

refer what they saw.[368] Mrs J Lewis accepted in her evidence that Mrs Allred's assessment should have been passed onto Prevent and I shall return to this in Chapter 11: Education.[369] PS Thompson was never made aware of this and would have explored this issue if it had been brought to her attention.[370]

101. PS Thompson's assessment was reviewed by DS Treharne on 17 February 2021, who noted:

> *"I have reviewed this case and note there is a lack of information in all areas. I am satisfied that the OIC has made sufficient enquiries with the original referrer and linked in with FIMU. The concerns in this case were around posts online which were not deemed CT/DE relevant. There does not appear to be any further safeguarding that is currently required. I am unable to see any previous referral into Prevent on the PCMT [Prevent Case Management Tracker], although as that has been closed and this case does not contain any CT/DE concerns then I am satisfied this can be closed immediately."*[371]

102. DS Treharne was unable to see the First Referral.[372] She had some IT issues at one stage during her time with Prevent but could have asked a colleague to allow her access.[373] She observed in evidence, *"the substance of the First Referral [was within the] record there, and summarised within the body of the information provided by the CTCO in the course of the Second Referral"* and she discussed the matter with PS Thompson.[374] However, DS Treharne accepted that the summary of the previous referral was incomplete. For example, while it stated that AR had gone back to Range High School with a hockey stick, it did not set out that an attack had actually occurred, that the attack was on an innocent bystander, or that AR had said that he intended to use the knife and to kill. DS Treharne accepted that this further information was very concerning and it was information she needed to be aware of if she was approve the closure properly.[375] In addition, she was unaware of the outstanding information from the First Referral, including the searches of AR's devices and the provision of the school browsing history and was unable to say why she did not address the referral to the Vulnerability Support Hub.[376,377] As a result, DS Treharne accepted that the level of supervision could have been better.[378] In mitigation, she was relatively new in her role as a Prevent supervisor

368 LCC001526/1.
369 T/S: 27/72/7-22.
370 T/S: 21/118/19-119/1.
371 CTPNW000124/18.
372 T/S: 21/164/1-23.
373 T/S: 21/161/2-24, T/S: 21/163/7-10.
374 T/S: 21/166/1-17.
375 T/S: 21/167/5-168/18.
376 T/S: 21/170/1-12.
377 T/S: 21/173/19-174/2.
378 T/S: 21/175/14-20.

and stated that she had not been trained or inducted when she had been promoted from a CTCO to a Prevent supervisor.[379] I return to this issue in the recommendations set out at the conclusion of this chapter.

103. It would appear that The Acorns School was not informed of the decision to close the Second Referral.[380] PS Thompson thought she would have provided this update but accepted that she could not recall which, if any, steps she had taken.[381] While The Acorns School had PS Thompson's details and might have asked her for further detail, the evidence shows that they were unclear about the progress of AR's Prevent referrals and whether any interventions had been provided.[382] Again, I shall return to this issue in the recommendations set out at the conclusion of this chapter.

The Third Referral to Prevent

104. The Third Referral, once again from The Acorns School, was made on 22 April 2021.[383] The Prevent referral form was as follows:

> *"[AR] was using the computer to look at his English work (BBC bitesize). As Mrs Allred came closer to the screen and she noticed 2 other web pages were open with the words 'London Bridge'. At no point had Mrs Allred seen him look at these pages. [AR] quickly closed them before anything else could be seen. Mrs Allred asked what [AR] had been looking at. He said he was reading the news about the recent bomb that had been planted on London Bridge and he was reading the news. Mrs Allred asked [AR] what he knew about it and [AR] spoke in detail about the IRA, how it began and the 'occupation' of Northern Ireland in the 1600's by the British and that is what started the conflict in Northern Ireland. Mrs Allred said she is pleased he is interested in history and global politics as long as he is looking at reliable websites as there are a lot of sites that say inaccurate things and he needs to get a balanced view. [AR] said he understood, and he said he reads the Guardian. [AR] then went onto to talk in great detail about the conflict between Israel and Palestine and his views on this and that some reasons for the conflict are justified in his opinion. He said that the MI5 have been asked to kill people in the IRA and Mrs Allred said it is unlikely and [AR] clarified the news said that the MI5 had been asked to 'take them out' which Mrs Allred clarified is different.*

379 T/S: 21/146/17-147/16. I also note that this was raised as an issue in the CTPNW Prevent Process and Policy Adherence Review: CTPNW000453/13.

380 T/S: 27/74/1-4.

381 T/S: 21/123/2-21.

382 LCC001526.

383 CTPNW000137.

[AR] said there are always two sides to a story. Mrs Allred said that it is important that [AR] isn't being influenced by anyone to believe an ideal and asked if he understood about radicalisation. Mrs Allred said if he is ever speaking to someone who says they have all the answers and to not trust anybody but them then that is not safe. Mrs Allred reminded [AR] to make safe choices and not do anything that promotes violence in any way as he knows what the consequences of that are. [AR] made no comment but nodded as though he understood. Mrs Allred asked would he be interested in a job as a journalist and [AR] said no.

It was clear by [AR]'s conversation he had read a lot about the history and current politics of these conflicts and had formed strong opinions about what was right. His conversation was animated and passionate as though these topics are of great interest to him."

105. On the same day as the Third Referral was made, DC Aspinall, the FIMU officer, set out the following history as regards the First Referral:

"[AR] is a current pupil at the Acorn School in ORMSKIRK, prior to this he was excluded from The Range in Merseyside for bringing a knife into school and speaking about school massacre/shooting, it transpires that [AR] had phoned childline to report bullying prior to bringing a knife into school. This was managed under PCM31490 and closed in 2020 as no CT DE after a visit by Prevent officers, who were satisfied that his vulnerabilities lied [sic] elsewhere in a potential ASD diagnosis.[384]

Although I recognise that a summary rather than a full rehearsal of all the details is preferable in these documents this was a notably diluted account of AR's actions and intentions, missing out entirely his attack on a pupil at Range High School (namely, the assault on someone other than the person he intended to harm) and AR's preparedness to use the knife. Mrs J Lewis had provided a very full and helpfully detailed account of the principal concerns in the First Referral (at paragraph 35, above).

106. Thereafter, having set out a brief and not entirely accurate summary of the matters raised in the Second Referral, DC Aspinall turned to the circumstances of the Third Referral.[385] He observed that AR had viewed news items concerning the London Bridge attacks and a conversation with his teacher which involved Israel, Palestine, MI5 and the IRA. DC Aspinall suggested that the advice given to The Acorns School that they could refer AR to Prevent if they *"feel that he shows any vulnerabilities going forward"* can lead to *"kneejerk referrals"*, although he did go on to say that the referral had been done with the best of intentions as a result of the initial issues when AR was at

384 CTPNW000143/1-2.

385 CTPNW000143/2.

Range High School.[386,387] DC Aspinall considered the comments made by AR failed to indicate that he held extremist views. Indeed, he noted AR's comment that there are *"always two sides to a story"* and that AR had a clear interest in current affairs. AR's autism spectrum disorder (ASD) diagnosis was viewed as a potential contributing factor.

107. DC Aspinall concluded that the referral did not raise any *"CT/DE vulnerability"*, and instead it merely demonstrated AR's interest in world news and current affairs (which, it was maintained, is a trait of ASD).[388] He concluded that AR's educational needs were being met and future concerns could be reported. In the covering email to his assessment, DC Aspinall also referred, inappropriately in my view, to AR's *"minor behavioural concerns"*.[389]

108. PS Thompson said that she did not endorse the reference by DC Aspinall to *"kneejerk referrals"*,[390] and nor did DS Treharne.[391] PS Thompson accepted that the matters raised in the Third Referral were not irrelevant and could be material to whether AR had a fascination with violence. They were potentially relevant to the risk posed by AR. In her view the school had acted correctly in making this referral.[392] DS Treharne noted that these issues ought to have been analysed in PS Thompson's Police Gateway Assessment.[393]

109. On 7 May 2021, PS Thompson wrote a conclusion in the PCM Tracker stating that there were *"… no CT/DE concerns at this stage. He is currently waiting for an EHCP [Education, Health and Care Plan] and is awaiting a specialist educational placement which I believe will help and support him through his ongoing education"*.[394] DS Treharne accepted that the education, health and care plan and specialist educational placement were not matters that CTPNW were able to assess (although the Vulnerability Support Hub could, in theory, have provided input).[395]

110. On 7 May 2021, DS Treharne, the supervising sergeant, reviewed the case. She indicated that AR demonstrated critical thinking skills regarding different viewpoints. DS Treharne concluded AR was not at risk of radicalisation and that no further safeguarding steps were required as he had sufficient support in place.[396] On 10 May 2021 the referral was closed. Again, although the PCM

386 CTPNW000143/2.
387 CTPNW000143/3.
388 CTPNW000143/3.
389 CTPNW000143/1.
390 T/S: 21/128/22-129/17, T/S: 21/131/12-15.
391 T/S: 21/181/9-13.
392 T/S: 21/129/4-131/15.
393 T/S: 21/182/20-184/2.
394 CTPNW000125/19.
395 T/S: 21/182/20-183/17.
396 CTPNW000125/19, entries for 7 and 10 May 2021.

Tracker stated that the referrer had been contacted and offered advice and support and was aware of reporting any future concerns, it is not clear that The Acorns School were in fact told of the closure.[397,398]

111. As with the Second Referral, it does not seem to me that the contents of the Third Referral, on its own, was enough to justify a referral to the Channel panel. However, as with the Second Referral, PS Thompson accepted that repeat referrals, such as occurred in the present case, should lead to a re-assessment of the entirety of the information from the past referrals, along with the new material, in order to reach a fully informed conclusion as to the merits.[399] Moreover, the fact that this was a Third Referral from the same source should, in and of itself, have raised concerns.[400] That did not happen in relation to the Second and Third Referrals. Such an exercise should then have led to a referral to the Channel panel, particularly given the guidance that was in place at the time of those referrals in the CTCO Case Officers Guide, published in 2020.[401]

Potential further Prevent referrals

112. I have set out in Chapter 9: Social care, my concerns over the information available to Lancashire County Council's children's services in October 2021, which did not, but should have, led to a further Prevent referral.

113. In addition, there is an issue about further comments that AR made while still at The Acorns School in January 2022. On this occasion, AR made comments about the Holocaust and compared it with other genocides, saying that they should be *"advertised equally"*.[402] Mrs J Lewis accepted that in hindsight these comments met the threshold to make a Prevent referral.[403] However, she felt at the time, that after no action had been taken in relation to the three previous referrals, that Prevent may not take any further action.[404] It is also likely that the deterioration in the relationship between the school, AR, and Alphonse R – after Alphonse R provided AR with the Third Referral – was a contributing factor.[405] However, I consider that if The Acorns School had been provided with fuller feedback on their earlier referrals and the reasoning for their closure, they may well have been more likely to have made a fourth referral arising from AR's further comments in January 2022.

397 CTPNW000125/18-19.
398 T/S: 27/77/2-4.
399 T/S: 21/131/16-22.
400 This was accepted by Ms Ellsmore: T/S: 22/55/15-20.
401 CTPHQ000034/23-26; T/S: 23/53/6-56/18.
402 LCC001346/12.
403 T/S: 27/77/11-80/4.
404 T/S: 27/80/5-16.
405 T/S: 27/76/4-77/1.

114. There was then the incident with AR carrying the knife on the bus on 17 March 2022. PS Thompson agreed that if the events of that day had been brought to her attention by a further Prevent referral, it was likely that the case would have been referred to Channel.[406] This is of considerable relevance to the issue of the information that should be available to frontline officers when dealing with incidents. If the officers dealing with the 17 March 2022 incident had been aware of the three Prevent referrals, it is highly likely that AR would have been referred for a fourth time to Prevent, resulting in at least a referral to the Channel panel.

115. The evidence therefore shows that AR should have been subject to three further Prevent referrals. Had further Prevent referrals been made, they ought to have led to Channel referrals because:

    a. They should have been further opportunities to identify the shortcomings in the assessment of the First Referral;

    b. The cumulative effect of the further referrals should have been a significant concern; and

    c. In the case of the bus incident (in which poison had been mentioned), the seriousness of that incident in isolation would have justified that outcome.

116. I have addressed the lack of further Prevent referrals made by Lancashire County Council (LCC) (October 2021), The Acorns School (January 2022) and LCC and Lancashire Constabulary (March 2022) in the respective chapters. However, I have a concern that those agencies that might make referrals considered that a firm ideology was required for a Prevent referral and I return to this issue in the recommendations at the end of this chapter.

Overall themes and conclusions

The respective roles of the FIMU officer and the CTCO

117. The respective roles of, and the relationship between, the FIMU officer and the CTCO was considered in some detail during the evidence. It was reasonable for FIMU officers to provide observations about the case: indeed the CTCO Case Officers Guide (August 2020) required them to do so whenever possible and practicable.[407] However, at the time of the three referrals in this case, the observations written by the FIMU officer for consideration by the CTCO sometimes read as if they were directions as to whether the referral should be accepted or closed by the CTCO. DS Treharne, one of the Prevent supervisors, said that she felt that there was some confusion about the separation of roles

406 T/S: 21/133/16-18.

407 CTPHQ000034/33.

and responsibilities between the FIMU and CTCOs. She had raised concerns in 2021 that a FIMU officer, certainly on occasion, appeared to be subverting the role of the CTCO in this way.[408] I consider that, on the evidence given to the Inquiry, this complaint was entirely justified. While DS Treharne emphasised that she had a good working relationship with the FIMU officers, there were numerous examples of wholly inappropriate, directive language being used by officers within the FIMU.[409] In my view, DCS Kenwright failed, in her evidence in this regard, to make an appropriately critical analysis of the relevant records and what they reveal.[410]

118. Given the difference in roles between FIMU and Prevent officers, critical analysis of the use of directive language by FIMU officers is not mere semantics. As set out above, the role of the FIMU includes assessing whether a person referred should be the subject of a counter-terrorism investigation. Any criminal prosecution would need to prove a terrorist ideology.[411] The role of a Prevent officer is to consider vulnerability to being drawn into terrorism, which incorporates wider considerations.

Observation K: Clear guidance and training are essential to ensure that the distinct functions of FIMU officers and Prevent officers are not conflated, and that the independent decision-making role of Counter-Terrorism Coordinators is not undermined by FIMU input.

However, I note that there is now a new referral form, revised national standards for Intelligence Management guidance on the language that should be used and how FIMU officers should be working with Prevent officers, which will be reflected in training.[412] I also note that terminology has changed to the use of Pursue or counter terrorism relevance and Prevent relevance.[413] As a result, I do not make a recommendation in this area.

408 T/S: 21/149/1-150/4. She could not remember who in the FIMU she spoke to and there is no evidence that it was any of the officers that handled AR's referrals, although, later in her evidence, she stated it was opinions such as those made by Officer A that she took exception to: T/S 21/153/22-25.

409 T/S: 21/150/16-18.

410 T/S: 22/129/23-135/10.

411 T/S: 20/177/21-24.

412 T/S: 22/174/1-13.

413 T/S: 23/46/7-25.

The decisions to close the referrals

119. In conclusion, the failure to send the First Referral to the Local Authority Channel Coordinator for information gathering was the critical error in the context of this chapter. The Second and Third Referrals did not contain the same depth or extent of worrying material relating to AR as the First Referral. Instead, they provided what were, in essence, supplementary details. Indeed, the Second and Third Referrals, standing alone, would probably not have justified a referral to Prevent. However, they should have prompted a re-evaluation of the entirety of the information which had been sent to Prevent, and that process would equally have led to the Second and Third Referrals being sent to the Channel panel.

120. Dr Sakthi Karunanithi, the LCC Director corporately responsible for Prevent since October 2024, stated that if AR had been referred onto Channel, then it was his expectation that it would have passed the section 36 decision threshold and progressed through to the Channel panel.[414] I agree with that evidence as I have explained above.[415] Ms Ellsmore stated that, had AR been taken on, *"there would have been a forum in which the local authority, mental health providers, education would be working together with the police under the auspices of Prevent, to look at mitigating the risk of AR being drawn into extreme violence"*. This could have included an intervention provider to work one-to-one, including in relation to AR's online activity, and other diversionary activities such as working with community partners.[416] This may have had an impact on AR's violent future and, in addition, assisted the Channel panel's understanding of AR's mindset and risk.

121. AR would have had to consent to participation in any package put forward by the Channel panel and, as he was a child, such consent would have been provided by his parents. If they had not consented, the referral would have been managed as a PLP, which would have included an element of risk management.[417,418] I recognise that either AR or his parents may have refused to engage meaningfully, or indeed at all, in this process.[419] As a result, I do not draw firm conclusions on the outcome if AR had been referred to the Channel panel.[420] Nonetheless, I have focused below in detail on what, in my view, was the wholesale uncertainty as to which agency, if any, had responsibility for assessing and addressing AR's known potential for inflicting serious harm on

414 Witness Statement of Dr Karunanithi LCC001928/§49.

415 Notwithstanding the Closing Statement on behalf of Counter Terrorism Policing North West CTPNW000451/31/§101, I have no good reason to doubt Dr Karunanithi's account and his evidence is consistent with that of Ms Ellsmore: T/S: 22/57/2-11.

416 T/S: 22/24/9-25/7.

417 T/S: 22/57/19-58/17.

418 T/S: 22/173/7-13.

419 T/S: 33/181/22-182/13.

420 This is consistent with the evidence of Ms Ellsmore: T/S: 22/58/18-59/2.

another or others. In addition, I have focused on the inability on the part of the courts to impose limits on the activities of individuals such as AR, in order to protect the public.

The closure of referrals

122. DAC Evans accepted that there are elements of the research undertaken and the conclusions reached by Prevent in cases that are closed which could properly be shared with frontline police officers.[421] Although material may have been discussed at strategy meetings, that did not necessarily mean that it would 'filter down' into the records available for frontline police officers. DAC Evans agreed that CTPHQ could consider this potential ability to share information concerning closed Prevent referrals more widely, to help inform later decisions.[422] Although I understand the difficulties that can be associated with the dissemination of information of this kind, I address this in my recommendations at the end of this chapter.

The agency holding the risk

123. PS Thompson stated that in her view no agency had, or considered they had, responsibility for AR throughout the entirety of the period of the three referrals. Moreover, she considered there was a linked failure in the sharing of information between the agencies as to whether the police, the schools or other agencies had 'lead' responsibility for assessing and addressing the risks posed by AR. In my view, this lack of a structure for ensuring – to the extent feasible – that a single agency had responsibility for co-ordinating the response to the risks posed by a dangerous individual such as AR is one of the major flaws exposed by the evidence in this Inquiry.[423] I have addressed this in Chapter 1: Fundamental problems (Recommendation 1).

The management of violence fixated individuals by Prevent

124. As I have already stated, a critical issue for the purpose of the Inquiry is whether someone who is intent on inflicting serious violence but has not demonstrated any material terrorist ideology or a vulnerability to being drawn into terrorism nonetheless can come within the ambit of the Prevent programme. In this context, I have particularly taken into account Ms Ellsmore's statement in which she set out:

> *"Whilst the current and previous policy position, underpinned by guidance, communications, training and assessment tools, has permitted sufficient flexibility for those with a fascination with extreme*

421 T/S: 23/37/18-39/20.
422 T/S: 23/39/21-43/3.
423 T/S: 21/134/4-24.

> *violence to be referred and considered for Prevent support, I consider that it is clearer now than it was at the time of AR's referrals that, for Prevent purposes, an individual showing fascination with extreme violence apparently without an ideological driver could be considered for Prevent support."*[424]

125. It goes without saying that I entirely accept the genuine intention behind this assertion. However, the difficulty it poses for a case such as AR's was revealed by Ms Ellsmore during her evidence when she said:

> *" […] we took Sir William Shawcross' advice to delineate (the) mixed, unclear or unstable category and to look at that more closely but we still made clear in all of the guidance and training that was done at the time that ideology was, of course, an important consideration but it was by no means the only consideration, and that there are a range of susceptibilities and vulnerabilities and behaviours* ***that could show that somebody was on a pathway to radicalisation****."*
> (emphasis added)[425]

126. The underlying and enduring focus has been whether the individual's *"fascination with extreme violence"* has, additionally, led to the conclusion that they are, at least potentially, on a *"pathway to radicalisation"*. Mr Butt KC on behalf of CTPHQ has accepted candidly in his closing statement that:

> *"[…] CTPHQ considers that Prevent remains the appropriate framework for anyone at risk of susceptibility to being drawn into terrorism. This will, in the majority of cases, include individuals fixated with mass casualty attacks. We recognise, however, that many Violently Fixated Individuals [VFIs] may have an interest in committing crimes that, however appalling, do not constitute acts of "terrorism"; and therefore to include them within Prevent and wider Counter Terrorism systems may be detrimental to those referred individuals and to the system's ability to tackle the core threats it is intended to address. There must be a whole-system approach by the Government to tackle the risks posed by VFIs."*[426]

127. This is a complex and difficult issue for those responsible for public safety, not least because of the risk to the Prevent programme of being overwhelmed with referrals which relate to individuals who have not demonstrated a terrorist susceptibility. The attempt to capture this latter group, at least to an extent, while simultaneously avoiding a change to the remit of the Prevent programme has resulted in a description of the relevant criteria which, in my view, remains ambiguous, unsatisfactory and hard for ground level CTP officers to implement consistently. Although this lack of clarity has been long-standing, the dilemma is undoubtedly significant: the wider the scope of intended appropriate subjects

424 First Witness Statement of Ms Ellsmore HOM000078/§98.

425 T/S: 22/60/8-17.

426 Closing Statement on behalf of Counter Terrorism Policing Headquarters, CTPHQ000154/13/§46.

of Prevent, the more difficult it will be to avoid excessive referrals which itself will risk the most dangerous cases not receiving adequate focus. Ms Ellsmore candidly accepted a tension in relation to the approach of CTCOs to ideology and that the role of Prevent as part of the *"broader safeguarding and violence protection system"* is very *"challenging"*.[427] In that context, it is also relevant that the threat, or perception of threat, from violence fixated individuals has changed and evolved in recent years, albeit that, as dealt with in detail below, both the Home Office and CTP recognised this as far back as mid-2019.[428]

128. Two letters and some of the relevant guidance reveal the extent of this uncertainty.

129. The first is the joint letter of 25 June 2019 from Ms Sara Skodbo, the Director of Prevent, and Chief Superintendent Nik Adams, the National Coordinator for Prevent Counter Terrorism Policing, to which I have already referred and appears at the end of this chapter.[429] This communication was intended to describe the authors' joint position on managing *"individuals with unclear, mixed or unstable ideologies"*. For ease of reference, I repeat here some of the key passages from this letter to which I have averted earlier in this chapter:

    a. For individuals with an unclear ideological motivation to be included in the Prevent programme, they needed to be at risk of *"being drawn towards an extremist ideology, group or cause"*, and in this context the letter importantly differentiates terrorism from other forms of violence. It was noted that the Terrorism Act 2000 does not define or limit what is meant by *"political, religious or racial"*. The authors observed that the individual's belief does not have to be long-standing or deep-rooted. There was a reference to those with an obsessive interest in public massacres, but this is described as providing a possible sign of *"vulnerability"* (which, for these purposes, is a *"vulnerability"* of being drawn into terrorism);

    b. In a critical passage, it was explained that *"Some individuals seek to support or enact TACT [Terrorism Act] offences without a clear understanding of the ideology or cause they are ostensibly supporting. Therefore, individuals whose ideological motivations are unclear, mixed or unstable, but who demonstrate a connection to, or personal interest in, extremism, terrorism or massacre* ***should be given the same consideration for support*** *as those whose concerning ideological motivations are more consistent and obvious"* (emphasis in the original). Immediately following this observation, the authors stated that the letter was not intended to expand the remit of Prevent. Instead, the guidance provided by the letter was

427 T/S: 22/61/11-62/5, T/S: 22/72/16-74/3, as did DAC Evans: T/S: 23/88/5-21.

428 First Witness Statement of Cathryn Ellsmore, HOM000078/§§100-107; T/S: 22/33/5-16, T/S: 22/37/12-38/21, T/S: 23/103/12-104/2.

429 CTPHQ000134.

intended to ensure that individuals receive the support they need if they were vulnerable to being drawn into any form of terrorism, as described in the Act;

c. A further key observation was that: *"When it comes to preventing people being drawn into terrorism, our responsibility is to offer interventions and support to all individuals who are at risk, irrespective of whether that risk is being driven by a true belief in an ideological cause or group, or whether an involvement to either of these is being driven by other vulnerabilities and complex needs"*.

130. I emphasise, therefore, that although this letter encouraged a less rigid approach to assessing an individual's potential susceptibility to being drawn into terrorism, it did not extend the parameters of Prevent so to include those who pose a risk or high risk of inflicting serious harm on others when there were no indications of a vulnerability to be drawn into terrorism.[430]

131. This is fundamental in AR's case. For the reasons that I have given above, at the material time, there were reasonable grounds to suspect (and believe) that AR was vulnerable to being drawn into terrorism. However, with the benefit of hindsight, and in particular the insight gained post-attack through analysis of AR's electronic devices, there is no credible evidence that AR had demonstrated a commitment to any specific terrorist ideology. Instead, his persistent preoccupation was directed at inflicting serious harm on another or others, as revealed by his violent actions, the weapons he acquired and his interest in beheadings, pictures of guns and school killings. The examples which might be taken to suggest a terrorist ideology, for example the single seemingly approving reference to the Manchester Arena bomber and downloading the research document which contained the Al-Qaeda training manual, were insufficient for reaching this conclusion when set alongside everything else.

132. While DS Treharne, the Prevent supervisor, had no memory of receiving a copy of the joint letter, she was aware that there had been a communication concerning mixed and unclear ideologies.[431] PS Thompson was aware of its contents and had been trained in the concepts it covered.[432]

133. The Dynamic Investigation Framework produced by CTP, in place at the time of the First Referral in 2019, introduced the section entitled 'Ideology' as follows:

430 Such a change could not, of course, be done via a letter anyway because the test of vulnerability to being drawn into terrorism is set out in statute at section 36 of the CTSA 2015, available at: www.legislation.gov.uk/ukpga/2015/6/section/36

431 T/S: 21/141/19-142/11.

432 T/S: 21/24/4-17.

> *"Consider & describe the Subject's exposure to, interest in, or fixation upon an extremist ideology or causes. Note that Subjects don't have to be 'true' or fanatical believers of such an ideology in order to be vulnerable to it."*[433]

134. Within a list of particular factors meriting consideration, the following was set out:

> *"A concerning fascination in the tactics (of) terrorism, mass-killings or school massacres per-se, in the absence of a unifying ideology or narrative reason for this interest,* ***may*** *also be indicative of a Subject who requires support through Prevent. The context needs to be explored around this interest, as, for example, an obsession like this combined with multiple/acute complex needs or grievances might be suggestive of a higher risk Subject. Explore and explain the circumstances."* (emphasis in the original)

135. It follows that although this particular 'Dynamic Investigation Framework consideration' raised the issue of a *"concerning fascination"* with *"mass-killings or school massacres"* even when there is an absence of a *"unifying ideology or narrative reason for this interest"*, nonetheless for such a *"fascination"* to result in inclusion in the Prevent Programme, the Dynamic Investigation Framework guided practitioners towards considering whether there were additional contextual features such as other *"multiple/acute complex needs or grievances which indicate a higher risk Subject"*. There was no clear statement that such a fascination could be sufficient in and of itself. That is consistent with the lack of clarity within the 2019 letter on this issue.

136. But applying this criterion to AR's case, for the reasons I have given above, I have no doubt that the result of the First Referral should have been a referral to, and adoption by, the Channel panel. The system in place at the time had sufficient flexibility and scope for AR to have met the relevant thresholds in respect of susceptibility to being drawn into terrorism. However, I recognise that a requirement for a *"concerning fascination"* with mass killings or school massacres was theoretically a high threshold to meet (although one might question, rhetorically, whether there could be a normal or healthy interest in mass killings and school massacres). In any event, as I have stated above, it is very important that the shortcomings (as I have found them to be) of

433 CTPHQ000040/5.

PS Thompson and DS Neale in the closure of the First Referral are seen in the context of what I have found to be a lack of clarity in the policies that they had to apply.[434]

137. Turning to the second letter, on 13 March 2025 Ms Ellsmore wrote to Channel/Prevent multi-agency panel chairs, deputy chairs and Channel panel members, Prevent Leads and Co-ordinators, CTCOs, Regional Prevent Co-ordinators, Department for Education Regional Co-ordinators/Prevent Education Officers and DHSC Regional Safeguarding Leads following the conviction of AR.[435] This letter, as with the one above, is set out in its entirety at the end of this chapter. It was expressly stated to be a response to the Home Secretary's concern, expressed in Parliament, as to whether Prevent is *"currently able to effectively manage the rapidly evolving risks presented by the cohort of young people who are fascinated by violence, but without a clear terrorist ideology"*. Ms Ellsmore sought to clarify the policy position and *"strengthen assurance"* regarding repeat referrals and referrals categorised as *"fascination with extreme violence or mass casualty attacks"*.

138. I observe in passing that I am satisfied that the position as regards repeat referrals has significantly improved. Most particularly that on each referral the overall picture, including the full background based on the earlier referrals, will be reviewed and there is a presumption that multiple referral cases will not be closed at the Police Gateway Assessment stage.[436] There is now greater oversight from senior CTP officers for multiple referral cases.[437]

139. As with the 2019 joint letter, the commitment in this second letter is that referrals *"should proceed"* in cases where the precise ideological driver is unclear ***"…if there is a concern that someone may be susceptible to radicalisation"*** (emphasis added). Again, in passing, I note that sensibly it is stressed that Prevent concerns should not be dismissed because of the individual's mental ill-health.

140. The second letter is consistent with the approach in the 2019 joint letter that a *"fascination with extreme violence or mass casualty attacks"* may lead to the adoption of the case by the Channel panel in *"appropriate"* cases, of which the sole example provided is that *"the person may be on a pathway that could lead to terrorism"*.

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434 Ms Ellsmore accepted that policy and guidance is now clearer: T/S: 22/33/13-16, T/S: 22/37/12-38/21; and inconsistent practice and approach in dealing with mixed, unstable and unclear cases was revealed in Home Office analysis: Closing Statement on behalf of the Secretary of State for the Home Department HOM000212/5/§14. DAC Evans also acknowledged that she understood the point that there was a risk that the 2019 letter was *"trying to ride two horses"* though explained the reasons why it might appear to do so: T/S: 23/60/19-61/21. She also acknowledged that *"people's understanding of what they categorised as mixed, unclear or unstable [ideology] could be differently interpreted and confused"*, which is why that terminology has been superseded: T/S: 23/88/5-21.

435 HOM000100.

436 CTPNW000067.

437 T/S: 22/65/4-66/22, T/S: 23/94/18-95/24.

141. There are two further updates to consider in addition to the letter of 13 March 2025:

    a. Ms Ellsmore stated that the new Prevent assessment framework includes a number of indicators of concern that a CTCO should consider when assessing a referral. AR would have met a substantial number of those indicators and Ms Ellsmore felt that, as a result, AR's case would have made it to Channel;[438]

    b. The CTPHQ Fascination with Extreme Violence and Mass-Casualty Attacks Interim Referrals Policy V2.0 - February 2025 notes that *"recent Prevent Learning and Dignate reviews have highlighted an inconsistent awareness of risks within Prevent Subjects where CT ideology is either not present, or not clear"*.[439] It notes that: *"[a]n interest in mass-casualty attacks or acts of extreme or graphic violence can indicate a heightened risk of escalation to committing similar violence themselves, despite the absence of a CT ideology. From the date of this policy, Prevent officers must treat these referrals with the same level of diligence and risk management as referrals where there are clear concerns with terrorist ideologies… The cases within this category are Prevent Relevant and therefore decisions on risk and the management of these cases should be treated accordingly. This has been the CTP-Prevent position since 2019, and remains as such to date"*. In addition, a more senior officer must approve any closure of a referral if the reason for the referral is fascination with extreme violence.[440] In addition, I note that it:

        1. Requires CTCOs to refer cases to the Vulnerability Support Hub's successor (Clinical Consultancy Service) if they reasonably suspect that the referral Subject may have a mental health problem – be it any form of mental ill health or neurodiversity issue; and

        2. Highlights the risk of disguised compliance.

142. However, as confirmation of how these two letters have been interpreted by practitioners, in answer to the question *"what would get them over the line against a background of not having a clear ideology?"*, PS Thompson said during her evidence that she would be looking to see if there was anything that she felt was making them at risk of being drawn into terrorism or of being at risk of radicalisation.[441] I recognise that PS Thompson is no longer a CTCO and the position is improved by the changes that have been made but, nevertheless, I am concerned by this tension. DCS Kenwright stated that there were some individuals within the violence fixated individuals cohort that are

438 T/S: 22/63/4-19. I also note that a series of relevant factors were set out in the CTCO Case Officers Guide CTPHQ000034 published in 2020: T/S: 23/53/6-56/18.

439 CTPNW000016/5.

440 T/S: 22/64/20-65/3.

441 T/S: 21/31/12-22.

susceptible to being drawn into terrorism but others that are not.[442] The Home Office Thresholds Review concluded in June 2025 found that there is clear inconsistency around the application of Prevent thresholds where referrals and cases do not have a clear ideology.[443] Ms Ellsmore accepted that: *"there is still a problem here in the fact that a clear ideology is not required for Prevent still not being fully understood and recognised"* and accepted that *"there is a lot more to do"*.[444] I have grave concerns that there are persons who pose a real risk of inflicting serious harm on others and are fixated on violence, but who have no vulnerability to being drawn into terrorism. In its current form, Prevent is unlikely to accept them.[445]

143. I entirely accept that the recommendations made in this report must be proportionate and achievable. Far too great a number of young people carry knives for each of them to be accepted into the Prevent programme. Similarly, numerous individuals have a known or suspected susceptibility to act violently, but they cannot individually be made the subject of this kind of intervention. What distinguishes the present case is that AR, by his own admission and by his repeated actions over a number of years, revealed that he had an enduring intention to inflict really serious harm on another or others and was prone to fixation on such violence and the grievances he held. Put simply, this was a clearly signposted disaster waiting to happen, yet there was no effective mechanism to prevent it. In my judgement, the events of 29 July 2024 have exposed a significant gap in the mechanisms by which the public are provided protection, including by way of adoption by the Prevent programme. As a consequence, I advance recommendations in Chapter 1: Fundamental problems that I consider require wider scrutiny and consideration in Phase 2 of this Inquiry.

442 T/S: 22/178/7-10.

443 HOM000090.

444 T/S: 22/76/2-8, T/S: 22/77/11-18.

445 In this respect, I will be interested to consider the full evaluation findings of the Prevent Below Threshold Pilot Panels: Second Witness Statement of Ms Ellsmore: HOM000223/§36-41.

Recommendations

Immediate action

144. I make the following recommendations for immediate action.

> **Recommendation 32:** While training for Counter Terrorism Policing, staff involved in Prevent currently cover the importance of understanding a referred individual's online activity and the practical steps required to assess it, the Home Office and Counter Terrorism Policing Headquarters should review and strengthen this training to ensure that officers fully understand both the importance of investigating online activity and that where online behaviour is a factor in a referral, cases should not ordinarily be closed until proportionate steps have been taken to access and assess the individual's online activity. Counter Terrorism Policing Headquarters should ensure that this remains a consistent priority across all regions. Counter Terrorism Policing North West should review its own processes in this regard.

145. I note the ongoing work being undertaken jointly by the Home Office and CTPHQ, including legal review, policy development and the upgrade of national tools.

> **Recommendation 33:** Counter Terrorism Policing's capability to access and analyse data relating to a referred person's online activity should be reviewed in the context of Prevent referrals, to determine whether staff have the technical tools required to undertake this assessment. The Home Office and Counter Terrorism Policing Headquarters should ensure this review is conducted.

146. I note that training on neurodiversity and on the Clinical Consultancy Service is now a mandatory element of Prevent training.

Recommendation 34: Counter Terrorism Policing Headquarters should review its neurodiversity training for Prevent practitioners (including, where appropriate, drawing in wider healthcare advice) to ensure that they sufficiently equip practitioners with a proper understanding of:

1. How autism may influence risk in the context of a Prevent referral.
2. The importance of timely referrals to the Clinical Consultancy Service to obtain advice on how neurodiversity, including autism, may affect the risks in any individual case.

Counter Terrorism Policing Headquarters should ensure that this remains a consistent priority across regions. Counter Terrorism Policing North West should review its own processes in this regard.

Recommendation 35: Counter Terrorism Policing Headquarters should review and where necessary strengthen the training that Counter Terrorism Policing officers involved in Prevent already receive to ensure that they understand the importance of balancing concern for an individual's vulnerability with appropriate professional curiosity and awareness of disguised compliance. The training should:

1. Address cases involving children or individuals with mental health conditions or neurodivergence, where concern for vulnerability may obscure the potential for dangerousness;
2. Equip officers to test and verify accounts, including probing explanations when necessary and comparing accounts with other available evidence, including that provided by the referrer.

Counter Terrorism Policing North West should review its own processes in this regard.

Recommendation 36: Counter Terrorism Policing Headquarters and the Home Office should assess and issue clear guidance on best practice for sharing appropriate information about closed Prevent referrals. This guidance should ensure that relevant professional agencies outside Counter Terrorism Policing, including local police and referring bodies, are notified of a closure and provided with relevant feedback, unless strong legal or other case specific risk grounds justify non-disclosure.

Recommendation 37: Prevent Supervisors should receive improved role specific training, including training on supervising decisions to close Prevent referrals and ensuring that all outstanding actions have been completed. This may be achieved by work currently underway but the effectiveness of new training in this area should be audited.

Recommendation 38: Building on the Key Principles of Prevent issued on 23 February 2026, the Home Office should ensure that accessible information and appropriate training materials should be made available to organisations which are likely to make Prevent referrals (particularly those subject to the Prevent Duty) to strengthen understanding that a fixed ideology is not required for a referral to be made or accepted. The development of a Prevent practitioner portal should be prioritised.

Recommendations for matters to be further considered in Phase 2 of this Inquiry

147. I have made recommendations in Chapter 1: Fundamental problems of this report in relation to the need for Phase 2 to consider the identification of a single lead agency, and the development of a shared risk assessment tool in relation to children and young people who pose a risk of harm to others. I am certain that that consideration will need to include whether such a single lead agency would be separate from, or incorporated into, the Prevent Strategy. The latter model of incorporation into Prevent might involve explicitly expanding the statutory remit of Prevent to include those who present a high risk of serious harm to another or others and/or who appear fixated with violence, irrespective of whether they are vulnerable to being drawn into terrorism.

148. I have also recommended, in Chapter 1: Fundamental problems, that consideration be given in Phase 2 to whether there should be an ability to restrict or monitor access to the internet on the part of children and young people where a significant threshold of risk is passed in relation to the harm they pose to others. As I have set out in Chapter 1, I will wish to examine how such an ability might, where necessary, be supported by a court-imposed order, including how any such order could relate to individuals within the Prevent programme. I recognise that this is not a straightforward question: much of Prevent's effectiveness depends on it being consensual and not perceived as a coercive tool. At the same time, where such a risk has been identified, it cannot be right that an individual who poses that risk can simply refuse to engage with those seeking to address it. This is a difficult issue that will need to be confronted in Phase 2.

149. Otherwise, given the centrality of Prevent to those two overarching recommendations, I make no specific recommendations in respect of Prevent for matters to be further considered in Phase 2.

The joint letter of 25 June 2019[446]

Sara Skodbo
Director Prevent, RICU and JEXU
OSCT, Home Office

Chief Superintendent Nik Adams
National Coordinator for Prevent
Counter Terrorism Policing Headquarters

Dear Police RPCs, Channel Panel Chairs, Local Authority Prevent Coordinators, Higher & Further Education Prevent Coordinators, Prevent Education Officers, and Health Prevent Coordinators,

We write to you to set out our joint position on managing individuals with unclear, mixed or unstable ideologies, as the National Coordinator of Prevent for CT Policing and Director of Prevent in OSCT.

The changing terrorist threat to the UK is well documented. The shift in scale has been accompanied by a diversification in the nature of the threat, with an increased threat of attacks using less complex methods by small groups or individuals. This has led to a number of stakeholders asking how they should manage individuals with unclear ideological motivations.

In some cases, the ideology is obvious, well embedded and appears to be the primary factor that is drawing an individual towards supporting or engaging in Terrorism Act (TACT) offences. In these circumstances identifying and challenging that ideology is likely to be an essential part of how you would seek to reduce that individual's vulnerability, and the risk posed to themselves and to the public.

However, for an increasing number of individuals being referred to Prevent, ideological drivers can appear mixed, unclear or unstable (from about 700 referrals in 2016-17 to almost 2,000 in 2017-18). Anecdotal evidence suggests that this group commonly present with multiple and complex vulnerabilities (such as criminality, substance misuse, social isolation and poor mental or emotional health, and so on). In such cases it often appears that people are being drawn towards an extremist ideology, group or cause because it seems to provide them with a 'solution' to the other problems in their lives, or an outlet to express problematic and dangerous behaviours that they may have developed.

We have seen many similar and often overlapping Prevent case examples, including individuals who:

- demonstrate an interest in multiple extremist ideologies in parallel, such as Salafist militant jihadism and *"white supremacy"*;
- switch from one ideology to another over time;

446 CTPHQ000134.

- target a 'perceived other' of some kind (perhaps based upon gender or another protected characteristic), but do not otherwise identify with one particular terrorist ideology or cause;
- are obsessed with massacre, or extreme or mass violence, without specifically targeting a particular group (e.g. 'high school shootings'); and/or
- may be vulnerable to being drawn into terrorism out of a sense of duty, or a desire for belonging, rather than out of any strongly held beliefs.

It may be helpful to recap what differentiates terrorism from other forms of violence.

The Terrorism Act 2000 defines terrorism as:

1. ... the use or threat of action where:
    a. the action falls within subsection (2),
    b. the use or threat is designed to influence the government [or an international governmental organisation] or to intimidate the public or a section of the public and
    c. the use or threat is made for the purpose of advancing a political, religious, racial or ideological cause.
2. Action falls within this subsection if it:
    a. involves serious violence against a person,
    b. involves serious damage to property,
    c. endangers a person's life, other than that of the person committing the action,
    d. creates a serious risk to the health or safety of the public or a section of the public or
    e. is designed seriously to interfere with or seriously to disrupt an electronic system.
3. The use or threat of action falling within subsection (2) which involves the use of firearms or explosives is terrorism whether or not subsection (1)(b) is satisfied.

Note that the Act does not define or limit what is meant by *"political, religious, racial or ideological cause"*, nor does it restrict *"ideological cause"* to being political, religious or racial, or to being solely those ideologies held or promoted by proscribed organisations. The Act certainly does not stipulate that a perpetrator has to have a long-standing and deep-seated belief in the ideology or cause that he or she is ostensibly supporting by committing a TACT offence.

Also, it's worth noting that the ***"threat"*** of relevant *"action"* is technically enough to complete a TACT offence, and that where this *"action"* involves the *"use or threat"* of firearms or explosives, there need be no specific intention on the perpetrator's part to *"influence"* (or intimidate) the government or public.

Some individuals seek to support or enact TACT offences without a clear understanding of the ideology or cause they are ostensibly supporting. Therefore individuals whose ideological motivations are unclear, mixed or unstable, but who demonstrate a connection to, or personal interest in, extremism, terrorism or massacre, **should be given the same consideration for support** as those whose concerning ideological motivations are more consistent and obvious.

This letter may raise the question of whether we are seeking to expand the remit of Prevent. We are not.

We are providing clarification of our responsibilities in relation to the Terrorism Act, and seeking to ensure that everyone who needs support receives it, and of course to protect the public from the risk of **all** vulnerable people who are being groomed, coerced or self-propelled towards TACT offences.

In 2017-18, 8% individuals referred to Prevent due to concerns around Islamist extremism or right-wing extremism ultimately received support via Channel. The corresponding figure for individuals referred due to concerns about 'mixed, unstable or unclear' ideologies was less than 1%. While there are likely to be many reasons for this, as we have seen in recent tragic attacks, the motivations of the terrorists responsible sometimes remain unclear even after the event, so we need to pay due regard to this complex issue in order to better protect the public.

We have received a number of questions from across the country about how to manage such individuals. Our guidance in response to these questions is to ensure that people receive the support they need if they are vulnerable to being drawn into any form of terrorism described within the Act.

When it comes to preventing people being drawn into terrorism, our responsibility is to offer interventions and support to all individuals who are at risk, irrespective of whether that risk is being driven by a true belief in an ideological cause or group, or whether an involvement to either of these is being driven by other vulnerabilities and complex needs.

The power of Prevent lies in tackling vulnerability early to prevent future harm. Oversimplifying the assessment of risk to offer support only to those with a very clear or embedded extremist ideology risks missing opportunities to support those with perhaps less obvious, but no less relevant or urgent, vulnerabilities.

Experience has demonstrated that preventing people being drawn into terrorism can be very challenging, often involving complex individual needs that have no simple or single-service answer. We therefore recommend that the content of this letter is discussed within your local Contest and/or Prevent Boards and within your Channel Panel meetings. We ask you to consider carefully the following:

- Draw on the professional judgement and experience of your colleagues, and ensure those making decisions understand their specialist area in the context of CT risk. This is to ensure individual interventions are considered in the context of their impact on the overall risk;
- do not restrict your preventative work only to individuals associated with the ideologies of formally proscribed organisations;
- consider those individuals who appear to have an interest in multiple, concurrent, and even contradictory extremist ideologies or causes, or who seem to shift from one extremist ideology/cause to another;
- do not necessarily rely on vulnerable individuals to be able to identify, understand or describe with coherence their own ideological motivations as a measure of the risk of being vulnerable to being drawn into terrorism; and,
- consider the possibility of an individual's obsessive interest in public massacres of any kind as a possible signal of vulnerability.

Our teams within CTPHQ and OSCT are happy to discuss any cases where further guidance is required, and we thank you for your continued support and determination to protect vulnerable people and keep our communities safe from terrorism.

Yours sincerely,

Sara Skodbo, OSCT

Nik Adams, CTPHQ

Cathryn Ellsmore's letter of 13 March 2025[447]

Dear Channel/Prevent Practitioners

Channel/PMAP chairs, deputy chairs and Channel panel members
Cc: Prevent Leads and Coordinators, Counter Terrorism Case Officers, Regional Prevent Coordinators, DfE Regional Coordinators/PEOs, DHSC Regional Safeguarding Leads

Prevent/Channel policy clarification and assurance measures

On the 21 January 2025, following the conviction of Axel Rudakubana for the Southport attack, the Home Secretary gave a statement in Parliament where she outlined a number of next steps. This included determining whether Prevent is currently able to effectively manage the rapidly evolving risks presented by the cohort of young people who are fascinated by violence, but without a clear terrorist ideology.

Whilst longer term improvements are considered, measures are being introduced to clarify the policy position and strengthen assurance on two significant issues: **repeat referrals** and **referrals categorised as 'fascination with extreme violence or mass casualty attacks**.' This work has been jointly developed and agreed by the Home Office and CTPHQ in response to the changing profile of those requiring support, and the need to increase consistency in the assessment and progression of Prevent referrals.

Cohorts categorised as 'fascination with extreme violence or mass casualty attacks' have been relevant for Prevent since 2019, although analysis has shown there to be significant inconsistency with how such referrals are progressed through the system. The ideology list, shared with the network in early May 2024, provides a clear definition and is attached again for ease of reference. There should be one consistent and proportionate threshold applied to Prevent activity across the full range of radicalisation concerns. While there may be times when the precise ideological driver is not clear, referrals should proceed if there is a concern that someone may be susceptible to radicalisation.

In your decision-making it is important to consider both the harm to the person, as well as the potential wider societal harm committed by the person. Where Prevent concerns are present, these must not be dismissed or accounted for based on a person's mental ill-health. If other support mechanisms are simultaneously required or being considered, these should proceed unless there is a good reason not to do so. It must also be remembered that other services, such as safeguarding, do not have a remit to assess a person's CT risk.

447 HOM000100.

CTP are introducing interim operational policy changes that will come into effect immediately, to strengthen decision-making and assurance at the assessment stage. All repeat referrals will be progressed for information gathering and will be subject to additional senior sign-off and assurance checks before exit. This will support CTP decision-making, as well as reflect the cumulative risk of repeat referrals, and build in greater assurance.

A summary of the revised measures is provided below with separate communications issued across the CTP network by CTPHQ:

- Clearer definitions of repeat referrals and referrals categorised as 'fascination with extreme violence or mass casualty attacks' within the interim policy.
- Increased Inspector oversight to review risks and agree an action plan with the CTCO and their supervisor.
- These types of cases should go through the PGA. A decision to close at PGA should be the exception requiring endorsement by a RPC or appointed deputy.
- Full information gathering and additional checks must take place.
- A contact visit is required prior to closure (to exhaust all investigative routes to understand risk factors) for referrals not meeting the S36 threshold which are to be closed at `Information Gathering'.
- Referral closure prior to Channel is to be endorsed by the RPC.
- All other ideologies should continue to be handled as they have been previously.
- The interim policy will be subject to review in 3 months.

Where repeat referrals, or those categorised under `fascination with extreme violence or mass casualty attacks' are referred to Channel panels for consideration, we endorse the adoption of these cases where appropriate (such is if there are concerns that the person may be on a pathway that could lead to terrorism). In instances where the Channel panel decide **not to adopt a case, but residual vulnerabilities remain**, an interim policy addendum is attached outlining updated signposting arrangements. and steps to be taken which strengthen existing exit pathway requirements detailed in paragraphs 81-85 of the Channel Duty Guidance. Channel panels may begin to see these Prevent referrals progressed more routinely for Channel consideration following this policy clarification.

We recognise that the pace and scale of improvements across Prevent is significant. Your support in delivering Prevent at the local level remains vital as we further shape our policy and operational approach. We fully appreciate the hard work and dedication of practitioners in delivering this important work and would like to take this opportunity to thank you for the continuing professionalism and dedication that you and your panel show in the delivery of Channel and Prevent.

We will continue to keep you abreast of developments as they occur and communicate any advice promptly as it relates to your Channel practice. In the meantime, if you have any questions, please do reach out to us at Channelhomeoffice.gov.uk or contact your Channel Quality Assurance leads or Prevent Advisers for further advice.

Yours,

Cathryn Ellsmore
Deputy Director, Prevent
Homeland Security Group

Chapter 9

Social care

Introduction

1. As AR lived in Banks, Lancashire, the overwhelming majority of relevant local authority involvement with AR was by Lancashire County Council (LCC).
2. I will address LCC's involvement as the local education authority separately in Chapter 11: Education. This chapter addresses LCC's involvement in social care for AR, particularly but not only through its children's services. LCC is the fourth largest local authority in England, with over 350,000 children and young people living there.[448] I have at all times borne in mind the scale and extent of the work that LCC must undertake in this field.
3. There is a level of complexity to the social care arrangements, including the structures and teams that were in place and the legal framework in which they operated. It is necessary to understand these in order to assess fairly how these teams (and LCC overall) dealt with AR in the more detailed chronology to which I shall turn later in this chapter.

The legal framework

4. There is a complex legal framework in respect of social care for both children and adults. As regards children, the key statutes include the Children Act 1989 and the Children Act 2004.
5. The Children Act 1989 sets out a range of important powers and duties on local authorities and others aimed at protecting children from harm. Key sections include:
    a. Section 17, which imposes a general duty on local authorities to safeguard and promote the welfare of children within their area who are in need and, so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs;
    b. Section 25, which provides a power to utilise secure accommodation for any 'looked after child' who either has a history of absconding, is likely to abscond from non-secure accommodation, and is likely to suffer significant harm if they do so; or who if kept in non-secure accommodation is likely to injure themselves or other persons. Such accommodation is only used in relatively extreme circumstances that I do not consider were ever close to being engaged in this case;
    c. Section 31, which provides for a court to make a care or supervision order on the application of a local authority, where it is satisfied that the child under the age of 17 is suffering, or is likely to suffer, significant harm, and that the harm (or the likelihood of harm) is attributable to the care being given to the child not being what it would

448 LCC001999/7.

be reasonable to expect a parent to give them, or the child being beyond parental control. 'Harm' means ill-treatment (which need not be physical ill-treatment) or the impairment of health (including mental health) or of physical, intellectual, emotional, social or behavioural development. By section 38 of the Act, a court can make an interim order once an application under section 31 has been made;

d. Section 47 imposes a duty on a local authority to make enquiries to enable them to decide whether they should take any action to safeguard or promote a child's welfare. It applies, in particular, where a local authority has reasonable cause to suspect that a child who lives in their area is suffering or is likely to suffer significant harm. I observe that 'reasonable cause to suspect' is a low threshold.

6. Within the Children Act 2004, section 11 imposes a duty on various public authorities, including local authorities and youth offending teams, to *"make arrangements for ensuring that their functions are discharged having regard to the need to safeguard and promote the welfare of children"*.[449] Practically speaking, this has two significant impacts. First, it requires those public authorities to treat the best interests of a child as the primary (but not paramount) consideration. Second, it provides the statutory underpinning for the Working Together to Safeguard Children guidance, issued by the Department for Education, that sits at the heart of multi-agency child safeguarding. For most of the time with which the Inquiry is concerned, the relevant version of Working Together to Safeguard Children was the July 2018 edition.[450]

7. Under Working Together to Safeguard Children, there is a clear escalation framework when concerns are raised about a child's welfare. This involves, at various stages, multi-agency meetings between relevant professionals, initially in the form of a 'strategy meeting'. This is often the gateway to a section 47 enquiry commencing. If the enquiry does not allay concerns, this can end up in a child being placed on a child protection plan, which may in due course lead to an application to the Family Court under section 31 of the Children Act 1989.

8. It is right to observe that this framework is heavily focused on the risk of a child suffering significant harm. It is possible to conceptualise a child carrying out criminal offences and/or being drawn into the criminal justice system as something which risks causing them significant harm, which might take the form of physical harm (for example, from someone responding to violence by a child with lawful self-defence) or developmental harm (as a result, for example, of the impact of custody).[451] Moreover, as a common sense observation, where a child is at risk of causing harm to others, it will often be other children to whom the risk exists.[452] I accept, however, that this kind of analysis was not

449 Children Act 2004 section 11(2). Available at: www.legislation.gov.uk/ukpga/2004/31/section/11

450 LCC001769.

451 T/S: 31/10/4-9, T/S: 31/113/8-15.

452 T/S: 31/114/24-116/3.

an embedded part of the culture or thinking of children's services nationally in the period with which the Inquiry is concerned. Even the 2023 edition of Working Together to Safeguard Children, which placed greater emphasis on the concept of 'contextual safeguarding' (meaning the risks to the child arising from factors outside the family or the home, such as criminal exploitation, online abuse, sexual exploitation and radicalisation risks), does not clearly identify the risk a child may pose to others as a major factor for consideration by those responsible for child protection.[453] Nor does the Children's Services National Framework introduced by the Department for Education in December 2023.[454] I regard this as something of a blind spot within the system, which had an impact on individual decisions about how to engage with or respond to AR. I will identify below specific occasions where I find this occurred and return to the wider issue in my conclusions.

9. In respect of adults, the Care Act 2014 is the key statute. I will deal with any relevant provisions when considering the limited involvement that LCC's Adult Social Care had with AR.

The Continuum of Need

10. The legal framework in respect of children is translated by LCC into a Continuum of Need (CON), indicating different levels of need and the associated support.

11. Within LCC from (at least) 2017 to 2021, there were essentially four levels of the CON:

    a. Level 1 was 'universal' needs, in other words the same needs as every child has;

    b. Level 2 was 'Early Help' that might involve either single agency or multi-agency work on a consensual basis;

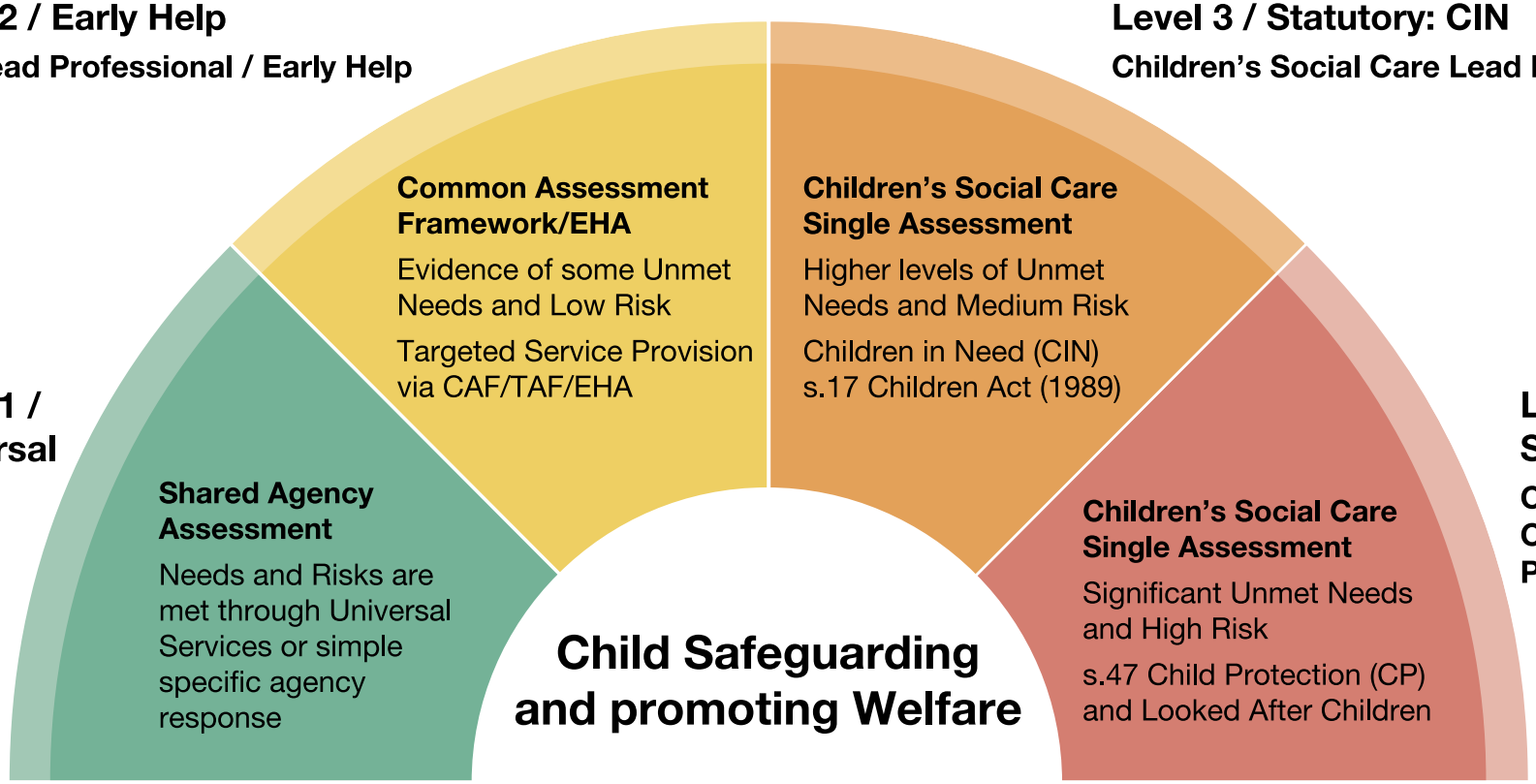
    c. Level 3 was for cases that fell within section 17 of the Children Act 1989 definition of a child in need;

    d. Level 4 was for when there were significant unmet needs and high risk, such that a section 47 enquiry or steps beyond that – such as an application for a care order – were potentially required.[455]

    Within LCC, cases at level 3 or 4 would have a lead professional from Children's Social Care (see below). Cases at level 2 would have a lead professional from Early Help (i.e. the Child and Family Wellbeing Service) again, see below. The following graphic from LCC depicted its CON up to 2021:[456]

453 LCC001944.
454 LCC001898; T/S: 31/119/20-24.
455 LCC001768.
456 LCC001768.

Pan – Lancashire Continuum of Need



Information Sharing

Go straight to Level 4 as soon as risk of significant harm is suspected

If in doubt, consult with agency safeguarding leads, or the Duty Social Worker in your area:

Lancashire: DPA Blackpool: DPA Blackburn with Darwen: DPA

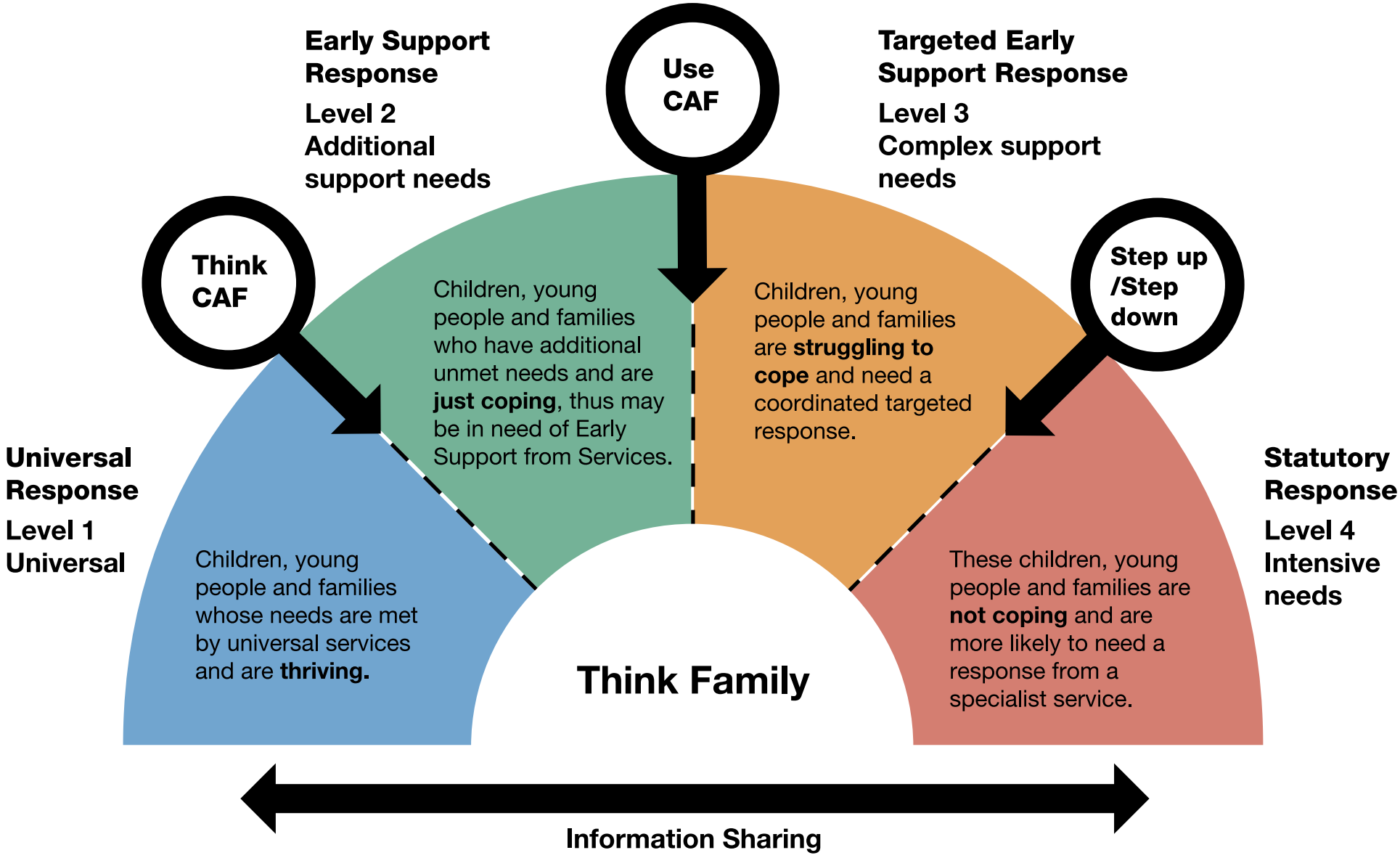
Blackpool Local Safeguarding Children Board, Lancashire Safeguarding Children Board, Blackburn with Darwen Safeguarding Children Board

12. From a point in 2021 onwards, the numbering of the levels in the CON changed.[457] Level 1 remained 'universal' needs. Level 2 became focused on 'additional support needs'. In practice, this appears to have been used for cases where there was a single agency response to an unmet need, such as mental health support through child and adolescent mental health services (CAMHS) or educational support through a school. The new level 3 was approximately equivalent to the former level 2, where there was multi-agency working, on a consensual basis, to address any 'complex support needs'. Level 4 became split into level 4a, which equated to the former level 3 that addressed children who met the definition of 'child in need' within section 17 of the Children Act 1989, and levels 4b and 4c, which equated to the former level 4 and related to children who were in need of a child protection plan. The following graphic from LCC depicted its CON after the 2021 change:[458]

457 LCC001926/10-19.

458 LCC001926/10.

Diagram of Lancashire Continuum of Need



13. LCC's guidance on applying the pre-2021 CON stated that children who engaged in *"challenging/disruptive behaviour putting self/others in danger"* or who were *"assessed as high risk either to themselves or others as a result of their offending behaviour"* should be treated as level 4, requiring a child protection and safeguarding response through Children's Social Care.[459] Similarly, LCC's guidance on the post-2021 CON made clear that if *"you suspect a child is [...] at high or very high risk of harm to others, follow child protection procedures"*, which entails treating it as at least a level 4b case.[460] In other words, despite the question of risks of harm to others not being embedded in LCC's thinking around child safeguarding, treating those risks as a child protection matter was formally a part of LCC's policy at all material times. Ms Louise Anderson, giving evidence on behalf of LCC's Children's Social Care, accepted that risk of harm to others was *"clearly a factor that Children's Social Care needed to have in mind when thinking about how to assess a child and the level of risk around a child"*.[461] Again, I return to this difficult issue below.

The structure of the teams involved with AR

14. There were two key teams within social care that were involved with AR and his family, the Child and Family Wellbeing Service and Children's Social Care.

The Child and Family Wellbeing Service

15. The Child and Family Wellbeing Service (CFWS/CFW) provided assistance at what was originally CON level 2 and then became CON level 3. CFWS required consent from the family to work with them. This assistance was provided by family support workers working as part of what was known as Family Intensive Support. The key family support workers within Family Intensive Support were:

    a. Ms Lucy Parkinson, from October to December 2019;[462]

    b. Ms Andrea Fontaine (now Fontaine-Smith), from March 2020 to February 2021;

    c. Ms Louise Lewis, from September 2021 to March 2022;

    d. Ms Ashleigh Williams, from April to September 2023.

459 LCC001900/35.

460 LCC001926/16.

461 T/S: 31/108/7-111/19.

462 Due to her ill health, it was not possible to obtain evidence from Ms Parkinson.

Ms Anne Cookson, a senior family support worker supervised Ms Parkinson. The other family support workers were all supervised by Ms Sharon Barrett, a senior family support worker.[463] Among the witnesses for LCC, Ms Katherine Ashworth, Head of the Children and Family Wellbeing Service from 2020 onwards, gave corporate evidence for the service on LCC's behalf.

16. Support from Family Intensive Support was at least until 2021 a 'time-limited' service, which, as relevant to AR, later moved from being a 12-week to a 20-week service, although these periods could be extended to attempt to address needs that had not been met. Ms Barrett explained that the service has now abolished these time restrictions.

17. When a case was open to Family Intensive Support at level 2 (or later, level 3), the family support worker would typically lead a multi-agency group called the Team Around the Family (TAF). As well as any agencies involved with the family, such as the relevant school and/or CAMHS, this would also generally include the parents and sometimes the child. TAF meetings typically occurred monthly when the case was open to CFWS. It was intended to be a collaborative approach where professionals and the family meet to identify the strengths and needs of the child and the family.

18. As well as Family Intensive Support, CFWS was also responsible for Targeted Youth Support, a service that provided direct support for young people through youth workers and the running of youth clubs. Mr Carl Coughlan of Targeted Youth Support worked with AR between November 2021 and March 2022, and then briefly in June and July 2023.

19. It is right to set out clearly that family support workers and senior family support workers within CFWS are not qualified as social workers. Their role is typically to deal with relatively straightforward cases, carrying out preventative work that is intended to prevent concerns from becoming more entrenched or more serious. Without in any way intending any disrespect to their important role, they are not well-placed to deal with more complex cases. AR's case was undoubtedly, as set out below, a complex case that engaged difficult issues which were, in truth, inevitably far beyond the capacity of CFWS to manage. While I have set out criticisms of a number of the individual family support workers and senior family support workers below, all these criticisms should be read in the light of the broader critical conclusions relating to LCC generally, and to the criticisms I have made of the national framework. All of the family support workers and their supervisors at senior family support worker level identified in this chapter of the report were working within that deficient framework.

463 Ms Barrett was unable to engage in the Rule 13 process for health reasons. While LCC have addressed relevant issues concerning Ms Barrett, it should be noted she has not been able to provide an individual response.

Children's Social Care

20. The second key team was Children's Social Care which dealt with cases at CON levels 3 and 4 (later CON level 4a or higher), namely cases where a child has been identified as a 'child in need' or as suitable for a child protection plan. It is only at level 4 (and in particular at the graver end of cases at level 4, levels 4b and 4c in the post-2021 CON) that Children's Social Care would consider whether applications to the Family Court under the Children Act might be appropriate. Children's Social Care was typically staffed by social workers, although sometimes with support workers working alongside them. The key individuals within Children's Social Care in this case were Ms Anna Jameson, a social worker (December 2019 to March 2020), Ms Julie Hamill, a support worker working with Ms Jameson, and Ms Stacey Haydock, a social worker (June to September 2021). Ms Louise Anderson, Director of Children's Social Care since November 2022, gave corporate evidence relating to Children's Social Care.

21. Children's Social Care was also responsible for three other services:

    a. The Multi-Agency Safeguarding Hub;

    b. The Child and Youth Justice Service department;

    c. The Missing from Home team.

22. The Multi-Agency Safeguarding Hub (MASH) operates as the 'front door' to social services. It is run by LCC. It is the access route to social services. Cases are assessed at the MASH and then potentially allocated to an appropriate team. Ms Anderson gave the following description:

    > *"It is where all contacts come into the local authority from other partners, from other organisations, from members of the public, with regards to children who might be at risk of harm. Its a multi-agency hub: it has within it police, probation, education and health. It has Early Help and social work staff there and they essentially triage those contacts that come in and make decisions as to where in our system they should go, if they should go anywhere at all."*[464]

23. Sometimes cases are closed by the MASH without a referral out to another service. This would typically be the case if there was no parental consent and the threshold for a referral to Children's Social Care was not met. Alternatively, cases can be referred out to other teams within LCC such as CFWS or Children's Social Care, or to other agencies. One unsatisfactory feature of the LCC MASH is that it does not provide any feedback on what has been done with the referral to the original referrer, even where that is another professional agency.[465] This appears inconsistent with Working Together to Safeguard Children.[466]

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464 T/S: 31/104/8-17.

465 Witness Statement of DI Kelly LANC000395/§179.

466 LCC001769/17/§22; LCC001944/58/§151.

24. If a case is passed out from the MASH to Children's Social Care, the Children's Social Care Duty and Assessment Team undertake an assessment to understand the child's level of need, for instance whether they should remain open to Children's Social Care, and if so at what level (for example, whether they are a child in need or should be on a child protection plan), or whether they can be 'stepped down' to CFWS. In Lancashire, this team also undertakes eligibility assessments for support for children with special educational needs and disabilities (SEND). Where strategy meetings under Working Together to Safeguard Children are required, these are typically convened by the Duty and Assessment Team. Each of Ms Jameson, Ms Hamill, and Ms Haydock worked within Children's Social Care's Duty and Assessment Team.

25. The Child and Youth Justice Service (CYJS) was involved with AR from February 2020 to late January 2021 during his referral order. The CYJS was also known as the Youth Offending Team (YOT) and these were used interchangeably. CYJS was a multi-agency service and sat as a department within Children's Social Care. It was the CYJS Operations team that had contact with AR. The Operations team is predominantly staffed by social workers but also with a small number of support workers and probation officer secondees.[467] In this case, the relevant social workers were Ms Anna Croll (from February to June 2020) and Mr John Fitzpatrick (from June 2020 to February 2021). Ms Sarah Callon, the Service Director for CYJS, gave corporate evidence on behalf of CYJS, although she was not in post at the relevant time.

26. As well as the Operations team, CYJS also has Prevention and Diversion teams which can receive referrals from other agencies such as the police, Children's Social Care and CFWS and then conduct intervention work with a child who is at risk of being drawn into the criminal justice system. This work would typically be consent-based, although it might also follow some out-of-court disposals such as a Youth Conditional Caution. AR was never referred to CYJS via the Prevention and Diversion teams; CYJS' only involvement was in the Operations teams managing AR's referral order.[468]

27. Third, Children's Social Care was responsible for the Missing from Home team, which employed support workers to conduct interviews with children who had been reported missing but then returned home. I heard evidence from Ms Amanda Chapman, who conducted such an interview with AR following the 17 March 2022 bus incident.

28. There were other internal bodies and teams involved with AR's case, with a range of responsibilities, as considered later in this section of the report. As Counsel to the Inquiry indicated during their opening statement, an issue I have needed to consider is whether the number and complexity of the structures within LCC may have acted as a barrier for those seeking assistance, as well as hampering the ability of LCC to respond to the risk posed by AR when that was forcefully and clearly reported.

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467 T/S: 28/179/6-10.

468 T/S: 28/177/16-179/1.

29. The structure above was introduced from approximately 2019 to 2021.[469,470] The early parts of LCC's social care engagement with AR therefore overlapped with a period of significant organisational change for the Council. I return to the impact of this in my conclusions.

Chronology of social care involvement

30. Against this background, I turn in this section to address the detail of the involvement of LCC's social care teams with AR. I do so under the following headings:

    a. 8 October to 11 December 2019: the first CFWS episode;

    b. 11 December 2019 to 4 March 2020: the first Children's Social Care assessment;

    c. 19 February 2020 to 2 February 2021: the role of CYJS and AR's referral order;

    d. 4 March 2020 to 1 February 2021: the second and third CFWS episodes;

    e. June to September 2021: the second Children's Social Care assessment;

    f. September 2021 to 14 March 2022: the fourth CFWS episode;

    g. 17 to 24 March 2022: Children's Social Care's response to the knife on the bus incident – and events in May 2022;

    h. April to September 2023: the fifth CFWS episode.

    These sections are broadly chronological, but it should be noted that CYJS's involvement overlapped with the first Children's Social Care assessment, and with the second and third CFWS episodes.

8 October to 11 December 2019: the first CFWS episode

31. As I have addressed in Chapter 7: Policing, on 7 October 2019 Police Constable Alexander McNamee from Lancashire Constabulary made a high-risk safeguarding referral to the MASH after learning that AR had been carrying a knife to school following his contact with Childline.[471]

32. PC McNamee's report of what had occurred was automatically forwarded to the MASH and was received on 8 October 2019. He noted relevantly as follows:

469 T/S: 31/25/1-27/16.

470 First Witness Statement of Katherine Ashworth LCC001998/§15.

471 LCC000003.

"A referral came from ChildLine regarding [AR], who had made concerning comments to them. [AR] has been bullied by a male called [name redacted] and [AR] has become highly agitated and frustrated regarding this. As a result [AR] has taken a knife from his kitchen to school on several occasions.

[AR] was spoken to by police and admitted to taking the knife to school previously. He seemed honest throughout and ***told us that if things escalated with [name redacted] then he believes he may use the knife*** (emphasis added*).*

[AR] was informed of the severity of the offence of simply carrying a knife. He seemed to understand this and became somewhat upset but did seem genuinely frustrated about the bullying. Though the school have taken some safeguarding steps it appears they haven't fully tackled the issues.

The school he attends is Range School, Formby, who have been emailed to appraise them of this. The log has also been deferred for the attention of the AM Sergeant to call the school regarding it so that they can take further action.

[AR]'s mother is supportive of police investigation and had noticed her knife was missing, though she got it back from [AR] as soon as she realised and has now hidden them all.

There was some suggestion from [AR]'s mother that he may suffer from Autism however this is not diagnosed nor confirmed. His brother, Dion R, is quite severely disabled and is in a wheelchair. There is additional risk in case [AR]'s behaviour deteriorates to the point where negative behaviour is also developed at home.

[AR] and his mother Laetitia both consented to their details being shared.

[…]

Referred to CSC as [AR] has been the victim of bullying at b (sic) school has resorted to taking a knife into school as the matter has not been resolved. [AR] action's place both himself and other at risk of harm.

Shared with CSC, Education and Health

Risk Assessment

Vulnerable Child Risk Assessment

Risk Rating: High

Reason For Starting: [AR] has been bullied at school and has taken a knife to school. Though he hasn't used it or got it out of his bag this shows potential for huge escalation.

> *Whilst [AR] did appear to understand the severity of the offence and potential repercussions* ***the risk is high that he could again take a knife to school*** (emphasis added).
>
> *The school are being made aware and are in Merseyside and [AR]'s mother has taken appropriate action with regards the knives.*
>
> *[AR] definitely needs support around the bullying issue but also intervention around carrying knives. He does have friends but I believe feels isolated and targeted as the bully only goes for him.*
>
> ***The fact that he has told ChildLine and police that he believes he may use the knife in a bullying situation is obviously cause for serious concern.*** *[…]"* (emphasis added).

33. I consider this to be a critical document in the context of what occurred on 29 July 2024. It means that from the beginning of October 2019, LCC were on clear notice of the high level of danger posed by AR: he had repeatedly taken a knife into school which, depending on the circumstances, he intended to use (*"he may use the knife in a bullying situation"*). There was, furthermore, an unequivocal warning that there was a real risk of escalation. One of the issues I have addressed in this report is the continuing strong focus on the welfare of AR, a focus which was insufficiently matched by measures taken to protect others from the considerable risk he posed. It is noteworthy, therefore, that whereas this high-risk safeguarding referral from PC McNamee to the MASH was acknowledging and warning about the high risk to others, this risk to others was to a large extent left unaddressed, while the focus was on the needs of and risks to AR himself. I address the difficult question of the role child safeguarding arrangements should play in managing risk to others in the conclusions and recommendations of this chapter and in Chapter 1: Fundamental problems.

34. Despite LCC being put well on notice of this risk, I am concerned that as early as 8 October 2019 it was considered that the case merited being dealt with at 'level 2' and it was immediately stepped down to CFWS to *"follow up with mother and offer appropriate support/signposting"*. Given the seriousness of AR's actions and intentions, I consider this was wholly inappropriate, particularly given Mr David Cregeen, designated safeguarding lead from Range High School reported later on 8 October that AR had recently commented, when given detention, *"that's why teachers get murdered"*. He also reported that, when AR had been challenged at Range High School about carrying knives into school, he said he would have used it to stab someone if he had to. Mr Cregeen identified this as level 4 on the CON and expressed grave concerns over the risk AR posed to himself and to others.[472] Ms Anderson accepted he was not wrong to form that opinion, but she was nonetheless of the view that the case could legitimately have been placed at either level 2 or level 3 on the CON as it then stood.[473] I consider that this view

472 RAN000005; T/S: 26/234/20-236/23.

473 T/S: 31/128/22-130/17.

illustrates the blind spot within Children's Social Care in respect of risk of harm to others. It is impossible to see why AR did not, as at 8 October 2019, pose a high or very high risk of harm to others that should have led to him being subject to child protection procedures under LCC's own policies. It should also have led to a referral to CYJS for consideration of Prevention and Diversion intervention.[474]

35. Because it was stepped down to Level 2, AR's case was referred to the CFWS. On 8 October 2019, AR's case was allocated to Ms Parkinson, a family support worker.

36. On 14 October 2019, Mr Cregeen from Range High School contacted the MASH with further information, indicating that on 20 September 2019 AR punched another student who had tapped him on the head. He set out:

> *"[AR's] reactions seem to be out of proportion, he was tapped on the head so punched another pupil. When asked why he brought in the knife, very calm saying he would stab him, no remorse, was not to scare him off, and said it was to stab him. He was fed up of [the other boy] pushing him around. School feel this is out of proportion, no threats to life were made to [AR] or family and [AR] stated he was ready to stab [the boy]."*[475]

37. This did not lead to any reconsideration of the appropriate response to the risk AR posed to others.

38. Ms Cookson of CFWS, Ms Parkinson's supervisor, made contact with the family by telephone on 16 October 2019 concerning the MASH referral, and obtained Alphonse R's consent to CFWS providing support. A home visit was to be organised.[476]

39. On 29 and 30 October 2019, Ms Parkinson tried to contact the family to arrange a visit but could not reach them.[477] Ms Ashworth agreed that by present standards there had been an excessive delay in making contact. It did, however, reflect the process that was in place at the time, where following receipt of information from the MASH a senior family support worker would review the case before allocation.[478]

40. Ultimately, there was a delay of a month before the first home visit by Ms Cookson and Ms Parkinson occurred on 6 November 2019. Consent was given by Alphonse R for support from CFWS and for them to gather

474 T/S: 28/180/3-181/8.

475 LCC001894.

476 LCC002311/1-2 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

477 LCC002311/2 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

478 T/S: 31/11/11-12/14.

information. The CFWS staff did not see AR.[479] Ms Anderson expressed her concern at the length of time it took CFWS to start working with the family. She said, *"I don't think that the slow start was solely the fault of the family, on reading this file"*.[480] The fact that there was a *"slow start"* to this case is another indicator that the high risk posed by AR was not properly appreciated within LCC.

41. Under LCC's current procedures, they have now instituted 'seven-day visits' and engage quickly with families following a referral.[481]

42. Following the initial visit on 6 November 2019, AR's parents ceased to respond to CFWS, not answering phone calls or responding to a letter.[482]

43. By 29 November 2019, as a result of information received from The Acorns School, CFWS were aware that AR had been looking at inappropriate news headlines and imagery of potential relevance to the knife incident.[483] On 3 December 2019, The Acorns School shared further information with CFWS on developments concerning conversations during an art class around guns and decapitation, which led to discussions about AR's understanding of what was and was not appropriate.[484] The Acorns School also made a further referral to the MASH about this information.

44. On 5 December 2019 there was a meeting between Alphonse R, CFWS (Ms Cookson) and The Acorns School (Mrs Jane Eccleston, headteacher, and Mrs Joanne Hodson, deputy headteacher). AR was present for part of the time.[485] As Ms Ashworth described the position, Alphonse R and AR appeared to be in denial about The Acorns School's valid concerns.[486] She agreed that they played down the significance of AR's behaviour and they did not have a full understanding of its consequences. AR accused the school of lying, including the relevant class teacher. Alphonse R suggested The Acorns School was like a prison. It is highly likely that Alphonse R lied in his assertion that he had not received any calls or communication from CFWS. I accept without difficulty the contemporaneous evidence that Ms Parkinson had been attempting repeatedly to make contact with the family to continue with the implementation

479 LCC002311/3 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

480 T/S: 31/133/15-24.

481 T/S: 31/133/17-19, T/S: 31/48/24-49/3.

482 LCC002311/4-5 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

483 LCC002311/5-6 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

484 LCC002311/6 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

485 LCC002311/6-7 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document); LCC001346/67; LCC000024/5.

486 T/S: 31/16/9-20/1.

of the agreed support. The First Referral to Prevent was made the same day by Mrs Janet Lewis, designated safeguarding lead and Pupil Support Manager from The Acorns School. A TAF meeting was set up for 13 December 2019.

45. It is characteristic of the attitude of Alphonse R that on the following day, 6 December 2019, he telephoned Mrs Eccleston to suggest that the school staff were inappropriately blaming AR, who he said was a *"good boy"*.[487]

46. Also on 6 December 2019, Ms Jenny Ashton of the MASH responded to The Acorns School's referral, saying that:

> *"the concerns do not present as Level 4. The concerns regarding [AR] searching on the internet for violent images, can be managed with level 2 support such as Police Community Safety Officer and Emotional Wellbeing Services/CANW [Child Action Northwest]. Children with autism (which [AR] may have) often develop obsessions around death, violence and crime. This is due to their neurodevelopment and I wasn't sure whether [AR] was being assessed for Autism by the Community Paediatrician? I hope this advice is of help."*[488]

47. Ms Ashworth asserted in her witness statement that:

> *"It would not have been possible for statutory services to get involved at that time as the risk factors identified would not have made [the] threshold for a referral to children's safeguarding."*[489]

48. In similar vein, Ms Anderson gave evidence that this was an appropriate assessment by the MASH at this stage, although she acknowledged that there was no apparent recognition that an autism spectrum disorder (ASD), combined with a fixation on violence, death and crime can in some cases become extraordinarily high risk.[490] That reflected the lack of understanding of this across the whole system at the time.[491]

49. This evidence is concerning. AR had created a real and serious risk to others by carrying a knife on multiple occasions to school. He had said that he intended to use the knife to stab another boy. He had shown no credible remorse for these actions. He had engaged in deeply troubling use of the internet at his new school, by way of researching shootings, guns and discussing beheadings. There had been limited engagement from his family, and when it occurred his father undermined the school and appeared to be in denial about the seriousness of events: he had defended his son and underplayed his behaviour. In those circumstances, the case, in my view, undoubtedly should have been 'stepped up' to level 4 on the CON, on the basis that statutory or specialist services were required. The criteria in section 47 of the Children Act 1989 were

487 LCC000024/6.

488 LCC000024/6.

489 First Witness Statement of Ms Ashworth LCC001998/§49.

490 T/S: 31/131/4-22.

491 T/S: 31/132/4-133/4.

met, namely that LCC, on this material, had reasonable cause to suspect that a child who lived in their area was suffering, or was likely to suffer, significant harm.[492] Put shortly, if AR had used a knife to stab another child at school, the harm he would have caused to himself would have been dire. Whether by a custodial sentence or a care order, consideration would have been given to whether AR needed to be forcibly removed from his home when already in a vulnerable and anxious state. If that occurred, the disruption to his life, given his circumstances, would have been likely to cause him serious harm.

50. As set out above, I accept that this kind of analysis was not embedded in child protection in 2019, although it was consistent with LCC's own policies in respect of children posing a high risk of harm to others.[493] In fairness to Ms Ashworth, she accepted that, on these facts, better practice in 2019 would have meant that it should have met the threshold for intervention by Children's Social Care.[494]

51. Ms Anderson, in contrast, maintained that it was only with the benefit of hindsight that AR could be seen as being high risk, and that the case could appropriately be held at this point by staff who were not qualified as social workers.[495] I do not accept this. In my judgement, AR met the criteria for statutory intervention by Children's Social Care on 5 December 2019. I consider that Ms Ashworth's concession was a sensible one. Ms Anderson's view is again reflective of the blind spot within Children's Social Care in relation to risk to others. That does not mean that it was solely for Children's Social Care to address that risk, but it was important that those within Children's Social Care, including in the MASH, were alert to identifying it.

52. Notwithstanding the steps which had previously been instituted for AR's benefit after the October 2019 Childline report, he nonetheless carried out the hockey stick attack on a student at Range High School on 11 December 2019 and was arrested by Merseyside Police.

11 December 2019 to 4 March 2020: the first Children's Social Care assessment

53. The 11 December 2019 hockey stick attack at Range High School and AR's arrest led to a number of reports to LCC. CFWS were informed of what had occurred on the same day by Police Constable Paul Harrison of the

492 Level 4a 'Intensive needs' in the later post 2021 changes included cases where it was suspected that the child was at high or very high risk of harm to others, with indicators including: challenging/disruptive behaviour putting others in danger; parental refusal to engage over concerns, and school exclusion with other risk factors; LCC001926/16-17.

493 LCC001900/35.

494 T/S: 31/20/2-22/23.

495 T/S: 31/133/25-134/19.

Lancashire Constabulary Community Safety team.[496] The immediate response was a decision to await further information, rather than to seek an immediate step-up to Children's Social Care or input from CYJS.

54. The Emergency Duty Team was also notified of the incident by Merseyside Police on the same day, in part because they needed an assessment as to whether AR could safely return home overnight on bail.[497] This also does not appear to have prompted a decision to step the case up.

55. Ms Stephanie Hallaron, a mental health professional working in the Criminal Justice Liaison and Diversion Team (CJLDT) had assessed AR in police custody.[498] She tried to refer AR into the LCC MASH but *"they would not accept the case at level 4 and that it was open to CFW"*.[499] Ms Anderson rightly accepted this was a wholly unreasonable decision by the MASH as *"I would obviously expect the MASH to take and accept referral when someone has just committed a crime"*.[500]

56. Ms Hallaron then made contact with CFWS to share the serious concerns that she had about AR's risk. She also ensured that LCC had a copy of her assessment report which set those concerns out in detail. Following Ms Hallaron making contact with Ms Parkinson in CFWS, Ms Parkinson and Ms Cookson approached the MASH again on 12 December 2019. The duty social worker took the view that the case could be stepped up to level 3, which would mean a transfer from CFWS to Children's Social Care. Notably, it was not at that time stepped up to level 4 – although I consider that would have been entirely appropriate on the available information.[501]

57. Finally, the LCC MASH received a safeguarding referral at level 4 from Merseyside Police (via Lancashire Constabulary) on 12 December 2019.[502] The case was finally stepped up to level 4, and responsibility transferred from CFWS to Children's Social Care, on 13 December 2019.[503] I consider that the reluctance on the part of the MASH to step the case up to level 4 despite AR having been arrested for serious violent offences is symptomatic of its attitude generally: that risk to others was not a matter for Children's Social Care. As should by now be clear, that attitude was wrong on LCC's

496 LCC002311/8 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

497 LCC002310/2 (the Transcript refers to LCC002301 but LCC002310 is a better version of the same document).

498 MERP002881.

499 LCC002311/11 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

500 T/S: 31/134/20-136/11.

501 LCC002311/9-10 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

502 LCC000231; LANC000128; LANC000129.

503 LCC000273.

own policies even in 2019. This was a serious failing within LCC properly to appreciate its role in addressing the risk that AR posed both to himself and to others (including to other children).

58. The decision to step up the case to Children's Social Care led to its allocation to Ms Anna Jameson, a social worker within the Children's Social Care Duty and Assessment Team, who began to carry out an assessment and also made arrangements for a multi-agency strategy meeting.[504]

59. On 16 December 2019, Ms Jameson and Ms Julie Hamill, a community support worker, visited AR's family home.[505] Ms Jameson candidly and rightly accepted that adequate notes were not made of this visit.[506] As reported to the strategy meeting on 17 December 2019, the family *"engaged"* with the visit, but it was apparent that AR was *"quite a force in the household, appearing to dominate discussion and at times shout down his parents who did not appear keen to challenge his opinions"*.[507] It was considered that this behaviour would *"require further exploration"*, including separate conversations with AR's parents and Dion R. AR lied to Ms Jameson and Ms Hamill as to his intentions on 11 December 2019 in that he suggested he had taken the knife to Range High School for his protection. That was not consistent with what he had said to Ms Hallaron or (as LCC would later find out) to the officer who arrested him. In my view, this deception on AR's part, along with the reports of his behaviour within the home, should have heightened LCC's concerns.

60. Ms Jameson and Ms Hamill expressed the view that AR *"presented with traits of ASD [autism spectrum disorder] to a 'high level'"*. They observed that AR's parents struggled with *"boundaries"* and that they potentially failed to *"understand his additional needs and how to best parent him"*. They were not concerned, however, that AR was being neglected or that his parents posed a risk to AR or that he posed a risk to Dion R.

61. What is entirely missing from the report of this visit on 16 December 2019 is any assessment or apparent recognition of the risk presented by AR to others apart from Dion R. The focus was entirely on AR and his needs, particularly as regards parenting. While I stress that I accept without reservation that AR's circumstances and his welfare required careful consideration, I found this limited approach which omitted the welfare of others to be profoundly concerning. Ms Jameson explained that those working in child protection were looking at the risk of significant harm to the child. The risk of harm to others was, in her view, a question for other agencies, primarily the police, the CYJS and CAMHS.[508] There was, however, no attempt to seek input from CYJS by, for example, inviting them to the strategy meeting or making a referral to them,

504 Witness Statement of Ms Jameson LCC001767/§§19-23.

505 LCC002310/8 (the Transcript refers to LCC002301 but LCC002310 is a better version of the same document).

506 T/S: 29/61/6-20, T/S: 29/84/24-85/3.

507 LCC000234/3.

508 T/S: 29/63/4-65/7.

despite Ms Hallaron specifically suggesting it to Ms Jameson.[509] This is a further example of the blind spot within Children's Social Care in respect of how risk to others should be managed.

62. Ms Jameson organised and attended the multi-agency strategy meeting which took place the following day (17 December 2019), chaired by her manager Mr Matthew Rowe.[510] That was a routine and appropriate first step as contemplated under Working Together to Safeguard Children following Children's Social Care opening a case. It could have led to a decision to initiate a section 47 enquiry, given one was not already underway.[511] In terms of who to invite, she consulted with Ms Hallaron and with PC Harrison, which enabled links to be made with CAMHS, Forensic Child and Adolescent Mental Health Service (FCAMHS) (to whom Ms Hallaron had made a referral, although they were ultimately unable to attend this meeting), Prevent, Merseyside Police and the relevant schools, including Range High School.[512] CFWS were also represented. Overall, this was an impressively rapid co-ordination of a wide range of agencies and provided an excellent opportunity for information sharing and multi-agency decision-making about a difficult and concerning case.

63. Unfortunately, I consider that this opportunity was largely missed. There were two reasons for this.

64. First, the quality of Ms Jameson's record-keeping about the information that was shared was poor. Ms Jameson accepted that this was the case.[513] Two examples underline the point. First, Mr Cregeen from Range High School shared at the meeting that AR had previously referred to the Manchester Arena bombing, from the perspective of the bomber, as having been a *"good battle"*. This was recorded in the notes of Police Sergeant Carmen Thompson from Prevent.[514] It did not feature anywhere in the LCC minutes of the meeting. Ms Jameson rightly agreed that this was a significant piece of information in the context of this meeting, and that the effect of it not being recorded in the minutes was that it was lost to LCC's corporate knowledge thereafter.[515] Second, Detective Constable Paula Murphy from Merseyside Police shared with the meeting that AR had told Police Constable Liam Dodd, who had arrested him at Range High School, that AR had said he *"had taken the hockey stick to hit the victim with and that he was going to use the knife to finish him off and that he was not bothered about the prison sentence."* Again, this does not feature in Ms Jameson's minutes of the meeting, although it was significant information about AR's intent and the risk he posed to others that

509 T/S: 29/68/16-69/5.

510 LCC000234; LCC001346/63; CTPNW000132; LANC000054; LCC000019; LANC000135.

511 T/S: 29/67/5-13.

512 MERC000018; MERC000024; T/S: 29/67/14-70/9.

513 T/S: 29/75/14-76/10, TS: 29/121/19-122/9.

514 CTPNW000023/14.

515 T/S: 29/75/14-76/10.

corroborated the information Ms Hallaron provided to the meeting. It is fair to note that Mr Rowe, as Ms Jameson's practice manager and the meeting chair, would have reviewed and approved her minutes of this meeting.

65. The second – and more fundamental – reason that this opportunity was largely missed was that there was no collective appreciation of the importance of addressing the risk that AR posed to others. The meeting agreed that AR did pose such a risk, with Ms Jameson's notes recording that *"concerns summarised and discussion held regarding risk of significant harm. It was agreed that there is a risk of re-offending from [AR] however at this point based on the interactions so far there is no evidence that the children are presently at risk of serious harm"*.[516] The plan to address this was for further inquiries such as a Prevent assessment, an initial CAMHS appointment, further assessment by Children's Social Care and a follow-up strategy meeting on 6 January 2020. Ms Jameson's view was that this was appropriate because there was insufficient information about *"the risk to him, which is what we were there to discuss"*.[517] I accept that a follow-up meeting after further investigations and assessments from various different agencies was appropriate, but Ms Jameson's view of the purpose of the meeting was, in my view, too narrow. There was clear and sufficient information about the risk AR posed to others which needed to be addressed. I repeat that this does not mean it was necessarily for Children's Social Care to take on this task itself or alone, but that risk ought to have received greater attention than it did.

66. Ms Ashworth accepted at the conclusion of her evidence that at this point consideration could have been given to AR being removed from home and taken into care (*"I could envisage that"*), following a level 4 discussion concerning what had occurred.[518] To give this option at least consideration would, in my view, have been a proportionate response at that time. It was known that on 11 December 2019 AR, who had previously carried a knife or knives into school on 10 occasions with a stated intent to use it, had intended to use a knife if necessary on another pupil and had travelled to Range High School in order to do so, having booked a taxi the day before. AR was only prevented from attacking his intended victim because he was absent from school that day; and even after he was recognised by a teaching assistant and escorted to school assembly, he ran off and aggressively attacked another student with the modified hockey stick. This was all in the context of AR's deeply concerning behaviour at The Acorns School, both online and towards other pupils and teachers, as well as an already readily apparent tendency on the part of AR's parents and AR himself to deny or downplay any wrongdoing. In my view, at the least, a section 47 enquiry should have been initiated at this stage.

516 LCC000234/3.

517 T/S: 29/80/3-5.

518 T/S: 31/98/5-100/11.

67. I repeat that this does not necessarily mean it was for Children's Social Care to 'own' or manage the risk that AR posed to others. But it is not sufficient for Children's Social Care simply to say that this was not their focus. Ms Jameson's approach– which I should say I consider, based on Ms Anderson's evidence, to have been entirely in keeping with what was expected of her by her employer – demonstrates that the issue of risk to others was simply not a prominent factor in her thinking. I have referred already to the lack of any invitation to CYJS to the strategy meeting. Following the first strategy meeting, Ms Jameson also decided not to invite Lancashire Constabulary's Community Safety team to the follow-up strategy meeting as *"there's no further role for your agency"*.[519] Had there been proper thought given to the risk AR posed to others, it would have been an obvious course of action to invite the team responsible for preventative policing for the area in which AR lived to the follow-up strategy meeting, as well as ensure that CYJS in their preventative and diversionary function were involved. I accept that Ms Jameson's email was consistent with the Community Safety team's own view and indeed she may have been influenced by that team's view that they had no further role. However, I have covered in Chapter 7: Policing why it was wrong for Lancashire Constabulary simply to step away at this point. In my view, Ms Jameson ought to have challenged, rather than gone along with, the position of the Community Safety team.

68. Following the strategy meeting on 17 December 2019, Ms Jameson and Ms Hamill conducted a further home visit on 23 December.[520] There is no adequate note of that meeting, which Ms Jameson again accepted was a failing on her part.[521] In the course of that visit, it appears likely that Dion R was spoken to separately, and indicated that AR had *"extreme views"*.[522] I accept Ms Jameson's explanation that this referred to AR's views being extreme *"in terms of that he doesn't just not like something, he hates it. It is the extreme that way"*, rather than being *"extremist"* in a terrorism sense.[523] At this stage, the assessment by Prevent remained outstanding. Had Dion R been referring in any way to extremism in a terrorism sense, I accept that Ms Jameson would have reported any such concerns raised by Dion R about AR to Prevent. Moreover, from the totality of his evidence, I also accept that Dion R did not hold the view that his brother was an extremist in the terrorism sense.

69. The follow-up strategy meeting took place on 6 January 2020.[524] It was attended by Children's Social Care including Mr Rowe (in the chair) and Ms Jameson, PS Thompson from Prevent, Mr Skott Morgan from CAMHS,

519 LCC001695.

520 LCC002310/10 (the Transcript refers to LCC002301 but LCC002310 is a better version of the same document).

521 T/S: 29/84/21-85/3.

522 LCC000031/1.

523 T/S: 29/85/10-24.

524 LCC000235; LCC001346/60-61; CTPNW000009.

Ms Hallaron, Mrs J Lewis from The Acorns School, Detective Sergeant Jo Haffenden from Merseyside Police and others. Children's Social Care are recorded as having contributed the following to the meeting:

> *"Home visits have taken place to see [AR] and Dion. Both children engaged well and the discussions with parents were positive. There is no evidence from a safeguarding point of view of continued risk of harm to the children however there are clearly some outstanding support needs which need to be addressed following assessment and actions from all agencies."*

70. PS Thompson informed the meeting that following the Prevent assessment, AR would not be taken into the Channel or Prevent programmes as *"there were no concerns that he was being led into criminality or radicalised"*. Ms Jameson accepted that this was not a determination that AR posed no risk to others.[525] However, there was outstanding work from CAMHS and FCAMHS, with a meeting due on 21 January 2020 *"which will focus on his potential risks"*.[526]

71. As to 'Suggested Outcomes' after the follow-up strategy meeting, two boxes were ticked, namely 'Police Investigations' and 'No Further Action' with the reasons recorded as being:

> *"Professionals agreed there was no ongoing evidence that [AR] or Dion R were at risk of significant harm however it was accepted there is a risk to [AR] of further criminality and now on his needs being neglected through a lack of education provision and there being a perceived gap in the support his underlying health needs require and the support currently available to him."*[527]

72. Despite the 'No Further Action' box being ticked, under 'Reason(s) for decision(s)' it was explained that *"[t]his is not in fact no further action"* as there was an ongoing assessment by Children's Social Care, to which there was contribution by other relevant agencies, along with the ongoing criminal investigation into AR. The 'No Further Action' indication therefore appears to reflect the decision not to refer the case for a section 47 enquiry.[528] As far as risk to others was concerned, there was an outstanding action for *"a risk assessment needing to be completed prior to [AR's] re-introduction to school"*, anticipated input from FCAMHS, and Children's Social Care's own assessment was described as one which *"will comment on the risk he poses and the risks he is subject to"*. In the light of those contemporaneous minutes, it would be wrong to conclude that the attendees at this meeting were oblivious to the risk that AR posed to others. Unfortunately, however, the lack of appropriate multi-agency structures or systems for recording and managing that risk,

525 LCC000235/2; T/S: 29/88/2-14.

526 LCC000235/2.

527 LCC000235/2.

528 T/S: 29/89/13-90/13.

combined with the lack of insight among those present into the need to take positive action to address the risk that they had identified, meant that it was again not properly or effectively addressed.

73. On 21 January 2020 a meeting was organised by FCAMHS, at which Mr John Hicklin (a clinical nurse specialist, FCAMHS), Ms Sarah Loughrin and Ms Hallaron (CJLDT), Ms Jameson and Ms Hamill (LCC), and Mrs Hodson (the deputy headteacher from The Acorns School) were present. Ms Jameson was hoping to get clarity around any assessment or interventions that FCAMHS might be able to offer around the risk AR might pose to others.[529] Again, Ms Jameson did not take her own note of this meeting and accepted that she should have done.[530] However, there is a comprehensive note from Mrs Hodson.[531]

74. Mr Hicklin explained that FCAMHS' role was to consider *"higher risk and offending behaviour"* and that he would decide whether their service would be able to *"offer anything"* and whether it would be necessary to meet with AR and his family.[532] He made remarks which Ms Jameson took as indicating *"none of us could say what the future held and what was going to happen"*, which she did not consider particularly helpful in terms of risk assessment.[533] I deal with the appropriateness of those remarks and Mr Hicklin's approach to this case in Chapter 10: AR's healthcare.

75. Mrs Hodson, in the presence of Ms Jameson and Ms Hamill, described AR's admissions meeting when she had asked him why he had brought a knife on multiple occasions to Range High School. He had replied *"[t]o use it"*, indicating to Mrs Hodson that his thinking was very literal.[534] She described the school's frustration of trying to engage with other agencies before the incident in December. Mr Hicklin repeated his view as to the uncertainty as to what might happen next. He suggested that AR clearly needed some sort of specialist provision with ongoing therapy and social stories, adding (addressing Mrs Hodson) *"[b]ut unfortunately, you've been left holding the baby!"*[535]

76. I would stress that as a result of this discussion, Ms Jameson and Ms Hamill could have been left with no doubt as to Mrs Hodson's profound apprehension as to the risk that AR posed. She is recorded as stating as follows:

> *"[…] she had other students and staff to consider. [AR] was bright and articulate and all his actions on that day had been pre-meditated, even to the extent of contacting (the intended victim's) sister and booking the taxi the day before. Mum had agreed to hide all the*

529 T/S: 29/90/18-91/6.
530 T/S: 29/91/7-13.
531 LCC000020.
532 LCC000020/1.
533 T/S: 29/93/20-94/4.
534 LCC000020/2.
535 LCC000020/2.

> *knives from him at home after the first incident at The Range, yet he had still managed to obtain one and take it with him in December, along with a modified hockey stick. It hadn't been a spur of the moment, impulse decision."*[536]

77. The meeting discussed a range of other issues, including the approach to the request for statutory assessment (the first step towards an education, health and care plan (EHCP)), AR's pathway to an autism diagnosis, and who was to conduct a risk assessment as regards AR returning to school. Mrs Hodson and Ms Hallaron expressed their concerns that, with that range of issues outstanding and only limited interventions planned, AR *"could be left high and dry with no services supporting him"*.[537] Those concerns were well-placed. They do, however, illustrate that the meeting with FCAMHS had to some degree ceased to focus on assessing the risk that AR might pose to others, and become something akin to a third strategy meeting with a wide scope of multi-agency concerns being discussed.

78. Despite that, this meeting finished without a plan in place to carry out a suitably comprehensive assessment of the risk that AR posed to others and, furthermore, without any solution being advanced to address the prospect of him being left *"high and dry"* with no agency holding responsibility for his dangerous potential. I consider that all those who formed part of this multi-agency approach should have ensured this state of affairs was urgently rectified. That includes Children's Social Care.

79. I note that when Mr Hicklin wrote to Ms Hallaron (as the original referrer to FCAMHS) with the outcome of the referral on 11 February 2020, he provided no clear risk assessment, but recommended psychologically informed interventions focused on emotional recognition and regulation, improving AR's ability to think consequentially, improving his capacity for an empathetic response, and developing alternative strategies to anger, and strategies to manage stressors in his life.[538] The intention was for CAMHS to deliver (or at least co-ordinate delivering) these interventions. Ms Jameson was provided with that letter as part of completing her Child and Family Assessment.[539]

80. Ms Jameson also received input into the Child and Family Assessment from a number of other agencies, as had been anticipated on 6 January 2020. That included confirmation from Prevent that they had closed AR's case, with advice to re-refer to Prevent should there be more concerns in future.[540] It also included a letter to Ms Jameson from Mr Morgan of CAMHS dated 14 February 2020, who did not indicate that any interventions were planned as *"I feel with time [AR] will learn to understand his emotions and regulate them*

536 LCC000020/3.

537 LCC000020/3.

538 MERC000014.

539 T/S: 29/98/8-100/9.

540 LCC002310/14 (the Transcript refers to LCC002301 but LCC002310 is a better version of the same document); T/S: 29/108/7-109/6.

within situational contexts".[541] Ms Jameson's position was that having gone to FCAMHS and CAMHS in the hope of risk assessment and intervention, she regarded them as the experts in this field and had to look to them for their professional recommendations.[542] That is no doubt correct, but it ought to have been apparent that neither FCAMHS nor CAMHS had in fact provided any assessment of the risk posed to others by AR, and that there was now no plan for any interventions.

81. On 20 February 2020, Ms Jameson finalised the Child and Family Assessment for AR.[543] (I note that it is not wholly clear whether she had received the input from CAMHS at this point: the assessment itself indicates not, but Mr Morgan's letter is dated 14 February 2020, and there is no dispute that Ms Jameson received it at some point). That coincided – intentionally – with the point at which AR was dealt with in the Youth Court for the offences arising out of 11 December 2019.[544] To produce the assessment, Ms Jameson had a number of conversations with AR. She agreed that in some of his answers AR may have been attempting to manipulate her, in particular in relation to the degree of remorse he felt about the attack and his intentions in carrying out the attack. She considered that she was probably thinking at the time that it was important not to take what AR said at face value, but her documentation did not reflect that.[545] I am afraid I do not agree that this was only a case of poorly phrased documentation. I consider that Ms Jameson was too prepared to take what AR said in relation to his offending at face value at the time. Her focus was on assessing risk to him, rather than risk to others. Moreover, even if that is wrong, the effect of recording it in that way meant that anyone coming to this Child and Family Assessment later would have no indication that AR's narrative was not necessarily to be accepted wholesale.

82. Ms Jameson recorded that AR's parents responded appropriately to the concerns of the local authority and that they implemented appropriate boundaries, although AR could be defiant and challenging. When asked about this in her oral evidence to the Inquiry, Ms Jameson agreed that her analysis of the dynamic between AR and his parents, and his parents' ability to set and enforce boundaries, was a generous one. Ms Jameson also agreed that her Child and Family Assessment did not appear to take into account the concerns that she, and other agencies, had raised about those issues since 11 December 2019.[546]

83. The outcome of the Child and Family Assessment was that AR was placed at level 3 on the CON, as he was a 'child in need' as defined in section 17 of the Children Act 1989. That meant a child in need plan was required,

541 AHCH000095/6.
542 T/S: 29/101/8-20.
543 LCC000027.
544 T/S: 29/101/22-102/5, T/S: 29/117/19-24.
545 T/S: 29/104/1-105/18.
546 T/S: 29/102/12-103/25.

and Ms Jameson duly produced one.[547] It identified needs around risk to others which were to be dealt with through the referral order and the intervention of the CYJS; around education, to be dealt with through LCC's Education team; and around AR's ASD. That was described as being dealt with by CAMHS and FCAMHS. As set out above, neither CAMHS nor FCAMHS in fact considered that they had an ongoing role and Ms Jameson was, or should have been, aware of this from their correspondence. Challenged on this in her oral evidence to the Inquiry, Ms Jameson could not say why the child in need plan was inconsistent with the position they had set out.[548]

84. This is an important point. The closing statement on behalf of LCC includes the suggestion that *"from late 2019/early 2020 onwards, multiagency working had mostly failed"*. I agree. But they also submitted that *"[s]o 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"*.[549] I do not accept that this is an accurate portrayal of the situation. It should have been apparent from the information provided by CAMHS (and FCAMHS) that they did not intend to take further steps (I deal with whether they were right to do so in Chapter 10: AR's healthcare). It is right that the communications from CAMHS and FCAMHS were not always clear, and that the absence of anyone from CAMHS at the meetings on 21 January and 4 March 2020, as well Mr Morgan's abrupt departure from CAMHS in February 2020 (which LCC does not appear to have been informed of), did not help matters.[550] But the remedy for this was to press CAMHS for clarity and engagement, not simply to make assumptions as to the work they would do. This misapprehension on the part of Ms Jameson led to actions being assigned to CAMHS, and potentially also to FCAMHS, on the child in need plan in February 2020 that they were not intending to carry out. LCC cannot simply point to failures by other agencies to explain why multiagency working failed. To its credit, LCC did accept in its opening statement for this phase of the Inquiry that there were failures by it in respect of making, holding and monitoring the multi-agency plan at this point in time. For the reasons set out above, I agree.

85. Ms Anderson agreed that at this stage *"a more robust multi-agency plan with clear monitoring arrangements should have been developed"*.[551] She suggested that it was not necessarily one that she would have expected a social worker to produce in 2019, but that it is what she would expect a social worker to do now in 2025. I do not accept that this is a realistic distinction. It ought to have been clear at the time (including to Ms Jameson and those supervising her) that a more robust multi-agency plan was required.

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547 LCC000236.

548 T/S: 29/107/18-108/6.

549 Closing Statement on behalf of Lancashire County Council LCC002314/3/§7(e), 30/§67(d).

550 T/S: 24/179/17-180/2.

551 First Witness Statement of Ms Anderson LCC001855/§188; T/S: 31/140/8-141/14.

86. Instead, on 4 March 2020, Ms Jameson hosted a child in need meeting. Once again, she made no proper note of the meeting but fortunately there is a record from Mrs Hodson.[552,553] Prior to the meeting, Alphonse R had sent an email to Ms Jameson expressing his serious criticisms of The Acorns School, minimising AR's offending behaviour, and portraying AR as a victim of bullying.[554] Ms Jameson accepted that this was *"potentially"* a further sign that AR's parents were not putting appropriate boundaries or guidance in place for AR: I consider that it was a clear sign to that effect.[555]

87. The meeting was attended by Ms Jameson and Ms Hamill from Children's Social Care, Mr Cregeen from Range High School, Ms Hallaron from the Criminal Justice Liaison and Diversion Team, Mr Hicklin from FCAMHS, Ms Croll from CYJS, a team leader from CFWS, Mrs Eccleston and Mrs Hodson from The Acorns School and Ms Pita Oates from LCC's team for alternative education provision.. In the course of the meeting, The Acorns School responded to Alphonse R's email, firmly disputing its contents. The meeting noted CAMHS had not identified any further mental health issues (so Mr Morgan's letter to Ms Jameson must have been received by this point, given CAMHS were not in attendance). There was an important discussion concerning the assessment of risk in relation to AR, in particular in connection with his return to school. Children's Social Care indicated they did not have the capacity to carry out an assessment but equally those involved in AR's education stated they were unable to provide a comprehensive risk management plan because the risks *"have yet to be established"*. Ms Croll, AR's newly assigned social worker from CYJS, stated that the indicator for future risk was AR's past behaviour and the risk, accordingly, was medium to high. Those involved in education made it clear that AR could not enter school premises or at any alternative venue until *"all professionals"* had completed a multi-agency risk assessment in line with Working Together to Safeguard Children.

88. Against this background, Ms Jameson told the meeting that AR was to be *"stepped down"* from being open to Children's Social Care, returning to the voluntary support provided through CFWS under TAF. The impression given by the notes is that this was a unilateral decision by Children's Social Care, although Ms Jameson maintained that it would have been a collective decision rather than an inevitability.[556] This step down – which involved moving AR from level 3 to level 2 on the CON – duly occurred on 24 March 2020. I note that the CYJS were also working with AR on account of the referral order, which was of course mandatory. Ms Jameson accepted in evidence

552 LCC002310/22 (the Transcript refers to LCC002301 but LCC002310 is a better version of the same document); T/S: 29/113/12-114/8.

553 LCC001346/58.

554 LCC002310/21 (the Transcript refers to LCC002301 but LCC002310 is a better version of the same document).

555 T/S: 29/113/7-11.

556 T/S: 29/116/10-117/15.

that there should have been a *"much more robust"* multi-agency plan in place, with Children's Social Care having responsibility for co-ordinating this approach.[557]

89. Ms Jameson agreed that, at this meeting, there was a sense that matters were not really moving forward, and it was the same issues time and time again not being resolved.[558] In my view, that was accurate. It reflects the fact that there was an obvious outstanding risk to others, which was most acutely felt by The Acorns School, where the risk was perhaps most likely to crystallise. As I have addressed in Chapter 10: AR's healthcare, the most appropriate and detailed means of assessing the level of risk was the Structured Assessment of Violence Risk in Youth (SAVRY) tool, and this had not been taken forward by FCAMHS. Moreover, there was no, or no effective, multi-agency process or structure capable of managing the risk. Ms Jameson agreed that when it came to assessment of the risk to others, it was at the very least difficult to find any single agency that was prepared to or capable of taking that on.[559] Ms Anderson resisted intensely any suggestion that it was for Children's Social Care to manage that kind of risk within the Working Together to Safeguard Children framework.[560] I do not agree: LCC's own policies on thresholds reflected that where a child was assessed as posing a high risk of harm to others, child protection procedures should be followed.[561] However, I do agree with Ms Anderson that the wider statutory and policy framework is not well suited to organisations like Children's Social Care addressing risks of this nature, because of their intense focus on the welfare of the individual child. As I have said elsewhere in this report, in many cases that will be the crucial factor to focus on. But where there is a high risk to others, that factor must be properly taken into account and addressed. The difficult question of how to balance those factors when both are present – more accurately, how a system for balancing those factors can be developed – is a topic I have addressed in my recommendations below and in Chapter 1: Fundamental problems.

19 February 2020 to 2 February 2021: the role of CYJS and AR's referral order

90. It is convenient here to address the work of LCC's CYJS with AR. This team was also sometimes known as the Youth Offending Team (YOT). The CYJS team were engaged with AR from the point of his conviction and sentence on 19 February 2020 to early February 2021. They therefore overlapped with the end of the work of the Children's Social Care (described above) and with the second and third episodes of CFWS engagement (also described below).

557 T/S: 29/124/23-125/14.
558 T/S: 29/114/25-115/3.
559 T/S: 29/122/10-25.
560 T/S: 31/140/5-143/16.
561 LCC001900/35 for the pre-2021 position.

However, it is convenient to deal with CYJS separately. Throughout their engagement with AR, it is relevant to bear in mind that by section 37(1) of the Crime and Disorder Act 1998 the principal aim of the youth justice system is to prevent offending by children and young persons. Section 37(2) imposes a duty on all persons and bodies carrying out functions in relation to the youth justice system to have regard to that aim.

91. The CYJS team had not received any referral relating to AR prior to his sentencing. It would have been open to other agencies to refer AR into the Prevention and Diversion teams arising from AR's admission to Childline in October 2019 that he had repeatedly carried knives to school, or in the aftermath of the 11 December 2019 attack prior to AR being sentenced.

92. In the event, as I have indicated, CYJS' only involvement was through their operations teams under the referral order. On 19 February 2020, following AR's guilty pleas, he was sentenced to a 10-month referral order for the offences of assault occasioning actual bodily harm, possession of an offensive weapon in a public place (the hockey stick) and possession of a bladed article in a public place (the knife).

93. When a child receives their first conviction, a referral order is the only available sentencing option, save for a custodial sentence or a discharge. The length of the referral order is decided by the court, in the range between 3 and 12 months. The requirements of the order are set afterwards by a referral order panel or a youth offender panel, made up of volunteers. They produce a referral order contract setting out what the offender is required to do during the life of the order. If an appropriate assessment is not already available, the CYJS will assess the child using the Youth Justice Board assessment toolkit, AssetPlus.[562] The AssetPlus looks, among other things, at the risk of serious harm to others, defined as death or injury, either physical or psychological, which is life threatening and/or traumatic and from which recovery is expected to be difficult, incomplete or impossible. The risk of such harm is banded as between 'low' and 'very high'.[563]

94. In AR's case, LCC's CYJS has been unable to locate AR's referral order contract. I accept that this was as a result of a data transfer in 2023. This would self-evidently not have affected how AR was dealt with in 2020 to 2021, when the contract would have been available. But it does mean that the precise requirements which were imposed are now unknown, although their broad outline can be discerned from other documents which are available.[564]

95. Ms Croll was the CYJS social worker to whom AR's case was first allocated.

96. Before the main impact of the COVID-19 pandemic was felt, there were instances where the initial handling of AR's case did not meet good practice:

562 First Witness Statement of Ms Callon LCC001712/§52.

563 T/S: 28/172/21-174/3; LCC001738/5.

564 T/S: 28/195/21-197/4.

a. At the outset of their involvement, CYJS were provided with a set of documents from the Crown Prosecution Service which were quite limited, amounting in effect to just the initial details of the prosecution's case. While receiving limited information in this way may not have been unusual, Ms Callon accepted that it would have been good practice to obtain the full Crown Prosecution Service pack, but she could not see any evidence that this had happened, nor could she explain why this had not occurred in this particular case (as noted above, Ms Callon was not in post at the time and so could not comment on whether the level of information provided was typical).[565] The fact that this was a Merseyside Police investigation while AR was under the supervision of CYJS based in Lancashire may well have made obtaining further information more challenging. However, this should not have been an insurmountable hurdle to obtaining fuller information;

b. On 26 February 2020, Ms Croll conducted an assessment meeting at AR's family home, but the record of the meeting contained no meaningful detail beyond the fact that it was held.[566] Ms Callon readily accepted that the record was of poor quality, with no indication of what information had been collated;[567]

c. Representing CYJS, Ms Croll attended the multi-agency strategy meeting that was held on 4 March 2020, to which I have already referred at paragraph 86. Ms Callon's view was that the CYJS record of this meeting *"…doesn't tell us very much"*. She would have expected a fuller contact record when a multi-agency meeting has taken place. The contrast in level of detail recorded in the thin CYJS note and the far more extensive note of the same meeting by Mrs Hodson of The Acorns School is striking, as Ms Callon again accepted.[568]

In light of the above, Ms Callon accepted the proposition that if risk assessments are only as good as the information that is obtained, CYJS's early involvement with AR "was not a very good start".[569]

97. It is right to record that the information sharing from other agencies to the CYJS should have been better. However, the records also suggest the CYJS did not do enough to pull in as much information as possible about AR at the start of the referral order. The combined effect was that, from the outset, the risks that AR posed to others was inadequately understood by CYJS. This was reflected

565 T/S: 28/182/6-183/24; LCC000021.

566 LCC000488/31.

567 T/S: 28/184/6-185/1.

568 T/S: 28/185/2-24; Compare LCC000488/31 (CYJS record) with The Acorns School record LCC001346/58.

569 T/S: 28/185/17-20.

in the initial referral order panel report for the meeting on 24 March 2020.[570] The report did include reference to the earlier occasions in October 2019 when AR had taken a knife to school. But the report reflected a fundamental understatement of the real level of risk in noting that AR has said that he had not planned to use the knife in the December 2019 attack. In fact, as I have set out in other chapters of this report, AR had admitted to thinking about killing the perceived bully when carrying knives into school in October 2019 and in the 11 December 2019 attack.[571] Ms Callon observed that this information was not reflected in the CYJS contacts. She accepted that this information was fundamental. While accepting this was suggestive of a weakness in CYJS not pulling in sufficient information, Ms Callon also emphasised the multi-agency nature of the youth justice teams, and the expectation that relevant information would be shared. Ultimately, however, fundamental information had not been reflected adequately or appropriately in this early assessment by CYJS.[572] Ms Callon observed that *"…there is clear parts of information which haven't made it through, haven't been researched, haven't been gained from the work at the time and then haven't gone through to the assessment, to the report and been shared in terms of the intervention plan"*.[573] Moreover, important aspects of the missing information were known by LCC's own CFWS and Children's Social Care teams, so it was not just agencies external to LCC who had failed to share information. The result was that the risk AR posed to others and his risk of re-offending were materially underestimated at this early stage in the referral order.

98. By the time of the first panel meeting on 24 March 2020, the pandemic was obviously imposing restrictions on normal methods of working and the meeting was by telephone rather than in person.[574] I accept that lockdown, and the COVID-19 restrictions more generally, made meaningful interventions very challenging in the early months of the referral order.[575] Against the uncertainty created by the later data transfer loss causing the referral order contract to be lost, the aims of the referral order work appear to have been around seeking to tackle AR's isolation, understanding the consequences of his actions, addressing anger management / his poor coping mechanisms in reacting to perceived bullying, and a degree of education around knife crime risks. Ms Callon noted that at the time, referral orders nationally were generic and lacked detail, as appeared to be the case here. She emphasised that more specific aims are now set within referral order contracts.[576] Within the referral

570 LCC000452.

571 *"to use the knife to finish him off"* (CTPNW000132/2).

572 T/S: 28/188/22-195/9.

573 T/S: 28/194/16-22.

574 LCC000488/26.

575 First Witness Statement of Ms Callon LCC001712/§166.

576 LCC000488/26 (input of the referral order panel volunteer); T/S: 28/196/15-199/4; First Witness Statement of Ms Callon LCC001712/§164; Second Witness Statement of Ms Callon LCC002134/§9.

order contract, there should have been 30 hours of reparative work. Even with the mitigating circumstances of the pandemic restrictions, AR does not seem to have carried out anything under the referral order that could be considered meaningful reparative work. Ms Stephanie Roberts-Bibby of the Youth Justice Board said that objectives set by AR's referral order appear to have been *"very, very limited"*.[577] I accept and endorse that assessment.

99. During April 2020, Ms Croll conducted an initial AssetPlus assessment, the conclusions of which were countersigned by Mr Colin Clements, the CYJS practice manager on 28 April 2020.[578] This is a detailed document which was helpfully summarised in Ms Callon's written evidence.[579] On the risk of serious harm, the AssetPlus assessment judgement was 'medium risk'. The applicable definition of 'medium risk' was *"Some risk identified but the young person is unlikely to cause serious harm unless circumstances change. Relevant issues can be addressed as part of the normal supervision process"*. The definition of 'high risk' was *"Risk of serious harm identified. The potential event could happen at any time and the impact would be serious. Action should be taken in the near future and the case will need additional supervision and monitoring, e.g. supervision by middle or senior management, local registration"*.[580]

100. I have substantial reservations about the reasonableness and accuracy of CYJS' assessment that the risk of serious harm to others was only medium.

101. Within the assessment form, Ms Croll gave as her reasons for the risk of serious harm judgement as follows:

> *"When considering the risk of serious harm there is no doubt that [AR] had the potential to cause serious harm to both his intended victim and his eventual victim. [AR] has stated to other professionals he intended to cause serious harm but in reality didn't think he would or could have. When considering risk of serious harm I have also considered the imminence of any situations where [AR] may cause serious harm. [AR] has a short antecedent history therefore, the likelihood of becoming involved in offending behaviour is lowered. [AR] has been in some fights at school however these have not involved weapons or caused serious harm. [AR] is not known to have been involved in any situations in public where he could cause serious harm and this appears at the moment to be confined to a school environment. Since [AR] is not in school this also decreases the risk of serious harm.*

577 T/S: 32/27/3-7.

578 LCC000447.

579 First Witness Statement of Ms Callon LCC001712/§§93-118.

580 LCC001738/5.

> *I acknowledge that this became a 'random' attack as [AR] couldn't find his intended victim however, [AR] did not cause him serious harm. [AR] has searched for extremist footage on the internet however, there is no indication that he was planning to copy any of this behaviour or an indication that he was planning to carry out this behaviour. [AR] has been assessed by Prevent and they have ended their involvement."*[581]

102. Ms Croll had marked the likelihood of reoffending as 'medium' in the headlines on the form, yet in giving her reasons, she suggested, inconsistently, that she assessed him as a 'low risk' of re-offending:

> *"When considering risk of reoffending I have assessed [AR] as 'low' risk. I have considered that [AR] has limited antecedent history. [AR] appears to only have become involved in offending behaviour in response [to] bullying. This appears to be because [AR] couldn't appropriately manage the situation. At this moment in time [AR] is not showing indications that he is involved in offending behaviour in the community or in the family home. His offending appears to revolve around the school environment and difficult peer relationships. [AR] is not in school therefore, his opportunities to engage in negative behaviours in a school environment are limited. [AR] does appear to have appropriate boundaries and supervision which is another desistance factor."*[582]

103. I accept that there are inevitably issues of subjective judgement that need to be applied to assessments of this kind, and that it is also easy to be affected by hindsight bias. However, even fully allowing for these factors, I find that the assessment of risk within the AssetPlus form suffered from:

    a. Giving too much credence to AR's explanations and insufficient attention to the admissions he made at the time (for example, *"It is not thought that [AR] had the intention of being proactive in harming anyone and he had taken [the knife] in to defend against one particular pupil"*);[583]

    b. Giving too much weight to the supportiveness of AR's parents, although there was some recognition that AR's father did not fully recognise the impact of AR's actions (for example, *"[AR] has supportive family who want the best for him. [AR's] father has been proactive in attempting to get him back into education and seeking support for him. I have assessed this as a strong factor for desistance as if [AR] has the support he needs he may be less likely to engage in offending behaviour"*);[584]

581 LCC000447/38-39.
582 LCC000447/39.
583 LCC000447/5.
584 LCC000447/35.

c. Being too ready to downplay other indications of risk (for example, *"[AR] appears to have taken an interest in watching macabre footage such as beheadings and shootings. However, there is no indication that [AR] has made any plans to carry out these offences. [AR] appears interested in these sorts of events as shown when he told the CJLD practitioner about genocide in Rwanda. [AR] does appear to have made comments at school about teachers being killed however, this appears to have been a flippant comment said after being in trouble I have rated this as 'weak' as there does not appear to be any offence paralleling or indication that [AR] will commit acts like this"*);[585]

d. Placing too much weight on the fact that AR was not in school and therefore had limited opportunities to offend. Ms Croll is likely to have been influenced by the imminent risk being apparently reduced, when this assessment was being produced, by the fact that AR largely had to remain indoors at home because of the first lockdown. However, this had the effect of masking the actual risk he posed. To the extent that lockdown mitigated the immediate risk, the assessment should have reflected that this was a short term and (in effect) artificial reduction of the risk.

104. While it was not a reflection contained in her corporate witness statement, in her oral evidence, Ms Callon accepted that the CYJS assessment of the risk of serious harm at medium was wrong and apologised that this had not been accepted earlier.[586] Ms Callon was right and responsible to make that concession. That position was also reflected in the oral evidence of Ms Roberts-Bibby, of the Youth Justice Board, which has national responsibility for the youth justice system (although it has no involvement in individual cases).[587] She said that with a background of taking weapons into school, a known victim, intent to cause them harm and pre-planning, a high-risk assessment would be right.

105. In light of Ms Callon and Ms Roberts-Bibby's evidence, it was therefore concerning that in the closing statement on behalf of LCC, LCC submitted that *"the analysis of the level of risk [of serious harm as medium] 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"*.[588] For the reasons set out above, I reject that contention.

106. In late April and May 2020, Ms Croll was able to have some telephone calls with AR which were deemed to count towards his referral order programme. Permitting this to count as contact under the referral order was perfectly

585 LCC000447/36.

586 T/S: 28/209/16-210/19.

587 T/S: 32/31/3-14.

588 Closing Statement on behalf of Lancashire County Council LCC002314/13/§28.

reasonable given the COVID-19 restrictions. The notes made of these telephone discussions were, however, often very sparse, for example, *"[AR] was spoken to over the phone"*, although more detail was on occasion recorded.[589,590]

107. On 19 May 2020, there was a TAF meeting led by Ms Fontaine, with representatives from other agencies: Ms Croll attending for CYJS, Mrs Hodson for The Acorns School, along with Alphonse R and Ms Janet Ramsay, an educational psychologist who was involved in AR's EHCP assessment.[591] At this meeting, Ms Croll gave an update on her attempted weekly contact under the referral order and offered to share a summary of the AssetPlus assessment. She informed the attendees that, in accordance with the AssetPlus assessment that she had drafted in April that AR was a *"Medium risk of serious harm"* although *"Minimal risk at the moment because of the current restrictions"* (a reference to lockdown).[592]

108. The next day, 20 May 2020, Mrs Hodson emailed CFWS and CYJS to *"share my concerns with you following the TAF meeting yesterday"*.[593] Among a detailed list of her concerns, Mrs Hodson raised that *"neither Dad nor [AR] seem to have moved on in their thinking in the 6 months since the incident"*, that *"Dad seems to perceive that [AR] is the victim rather than the perpetrator. He excuses his behaviour..."*. She said that *"Anna [Croll] discussed that YOT considered that there was a medium risk of serious harm but because of lockdown imminence wasn't there.[594] If we do bring [AR] back in 1-1 with a specialist teacher, we then have opportunity and imminence"*. Mrs Hodson's conclusion was that *"I feel that [the risk] [AR] poses to us all as a school has increased rather than reduced. I have a duty to both staff and pupils in raising my concerns with you"*.

109. I shall return to this correspondence in dealing with the CFWS response, below. Of relevance to LCC's CYJS is that this communication from Mrs Hodson should have been a matter of real and serious concern to Ms Croll and the CYJS team. An experienced educator in a Pupil Referral Unit was expressing serious and well-argued reservations about both the risk posed by AR to other people, and about his parents' ability to contribute to managing it. Moreover, Mrs Hodson, unlike Ms Croll and Ms Fontaine, had been involved with AR since October 2019, and had attended the earlier multi-agency meetings in December 2019 to March 2020. Of the three professionals, Mrs Hodson unquestionably had the most informed perspective on AR and the risks he posed. As regards my conclusion that the risk of harm to others should have been assessed by CYJS as high, I note that far from being a conclusion that can only be reached

589 LCC000488/20 (entry for 4 May 2020).

590 E.g. LCC000488/20 (entry for 11 May 2020).

591 LCC000054; LCC000061; LCC001580/16-17.

592 LCC000054.

593 LCC000998/9.

594 Lancashire County Council's Child and Youth Justice Service (CYJS) was also known as Youth Offending Team (YOT).

with hindsight, Mrs Hodson was clearly cautioning at the time that CYJS' assessment of the risk of serious harm at medium was an understatement. LCC should have been more open to this challenge.

110. Ms Fontaine replied to Mrs Hodson on 21 May 2020.[595] I shall deal with that in more detail in dealing with the CFWS third episode below. For the reasons I have set out there, Mr Fontaine's response was entirely misjudged and did not properly engage with Mrs Hodson's concerns.

111. Regrettably, Ms Croll's own response on 22 May 2020 largely echoed and supported that of Ms Fontaine, with little sign that she had sufficiently thoughtfully considered or acted on Mrs Hodson's concerns.[596] Given that a fellow and experienced professional had raised concerns in this way, this was a significant missed opportunity which could and should have led CYJS to re-assess their own AssetPlus assessment.

112. Ms Croll proceeded in her reply to provide a summary of the assessment of risk of serious harm (medium) and risk of reoffending (now stated to be low). In this summary, Ms Croll clearly extracted the reasoning from the full AssetPlus assessment. I note that she concluded on the risk of serious harm that she was *"concerned that should [AR] feel a sense of injustice, grievance or conflict that he does not know how to respond to in a positive way that he may try to take matters into his own hands and resolve them in an inappropriate way which may harm others"*. That is precisely what had happened on 11 December 2019 and there was nothing to suggest that AR would not attempt to repeat his actions. This was not, therefore, a situation in which the risk level would only increase if the circumstances changed. Indeed, the circumstances in May 2020 were essentially identical to those in December 2019, save that for a period there was a COVID-19 order to 'stay at home'. There were grave doubts as to whether any remorse expressed by AR concerning the December 2019 attack was genuine. Furthermore, Ms Croll's own assessment was that there was now an *"increased opportunity"* for AR to commit offences or serious harm, although she did not assess this would put him into the high risk band. Ms Croll also now assessed that the risk of AR offending was low, an assessment which I consider was equally flawed. Even if there was only a medium risk of AR causing serious harm, there was no sustainable basis for suggesting that the risk of reoffending was low. Causing serious harm would almost inevitably involve AR in reoffending, and the risk, even on Ms Croll's own assessment, should therefore have been medium.

113. Rather than reconsidering the risk assessment based on Mrs Hodson's considered views, the CYJS response seems instead to have inferred that The Acorns School were being overly cautious. They suggested that the school should give AR and his father the chance to challenge the school's view of risk. Ms Croll said *"If your risk assessment concludes that [AR] can not be in a classroom or school environment it may be beneficial to discuss this*

595 LCC000998/8-9.

596 LCC000998/6-7.

with [AR] and Alphonse so they fully understand that decision ***and have the opportunity to challenge this appropriately****"* (emphasis added).[597] I do not doubt that Ms Croll was acting with anything other than the best of intentions. However, this is another example of the risks of the (usually appropriate) child-centred approach leading to an overly narrow viewpoint. As I have already indicated, Mrs Hodson had been right to press that the risk to others was higher than CYJS had assessed and CYJS should have been more open to this challenge.

114. Additionally, as Ms Callon accepted, it would have been useful for the agencies involved to have met to discuss the material parts of the AssetPlus assessment, instead of CYJS only sharing some of it by email.[598] Ms Roberts-Bibby, Chief Executive Officer of the Youth Justice Board, went further. Save for removing addresses and the like, she could see no reason why an AssetPlus assessment should not be shared in full with other professionals engaged with the child; *"…it is a professional document that can be shared"*. The Youth Justice Board would like to review the guidance in this regard.[599] The Acorns School had been pressing for a full multi-agency risk assessment to be carried out. In these circumstances, it was regrettable that CYJS were only prepared to share by email a high-level summary of their AssetPlus assessment conclusions.

115. Consistent with the policy requirement, the CYJS team reviewed the AssetPlus assessment several times within the lifespan of the referral order. The first review was completed on 19 June 2020.[600] There were only modest changes to the previous assessment, which I accept would not of itself have been unusual. Additions were made noting the extent to which Alphonse R appeared to mitigate and minimise AR's actions, and equally that AR did not see negative consequences for his victim.[601] As Ms Callon accepted, none of these factors indicated a decrease in the risk to others.[602] The revised assessment is not suggestive of the CYJS team having more substantively reconsidered their earlier approach. The risk of reoffending was still marked on the form as being 'medium' even though Ms Croll had indicated in her communications with The Acorns School that it was 'low'.[603]

116. At about the same time as this AssetPlus updated assessment, there was a change of CYJS social worker. Mr Fitzpatrick took over the work on AR's referral order from Ms Croll who was due to leave the team. Ms Croll's handover note included the fact that she had challenged Alphonse R's attempted justification for AR taking a weapon into school on the basis that *"…he was scared"*.[604]

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597 LCC000998/7.
598 T/S: 28/213/17-214/15.
599 T/S: 32/30/5-31/2.
600 LCC000448.
601 First Witness Statement of Ms Callon LCC001712/§126.
602 T/S: 29/1/14-2/24.
603 LCC000448/5, 39.
604 LCC000488/11.

While the handover note was no doubt helpful, some aspects of relevance were omitted, such as the frequency with which AR had taken the knife into school in October 2019, the concerning school internet use, and his potential intention to kill in having armed himself with a knife in the hockey stick attack at Range High School on 11 December 2019. Such issues may have been covered in a case discussion between them as they were colleagues in the same office, although it is not apparent from the records themselves that such a case discussion in fact occurred.[605] There is at least some prospect, therefore, that the risk information was somewhat diluted in the handover between case managers, although the expectation was that the case manager would read through the totality of earlier notes.

117. There was a referral order panel review on 23 June 2020.[606] Ms Callon rightly observed that the objectives being discussed were quite generic, although she stressed that they were likely to have been more stringent were it not for the pandemic.[607] While there is some uncertainly because of the paucity of the records and a degree of allowance must be made for COVID-19, I find that the expectations being set on AR as part of the management of the referral order were too low. He was being required to keep in touch with the CYJS team and to speak with teachers, but there appears – at least on the face of the records – little, if anything, of greater substance at this stage.

118. From July 2020, with national lockdown restrictions having eased, some face-to-face work was conducted with AR. AR appeared to respond better to this than to the earlier (of necessity) remote contact. Mr Fitzpatrick rightly considered that face-to-face contact with AR inside his home address was necessary and he took measures to achieve this despite the pandemic, which will not have been the case for all young people under a referral order in this period. There were 30-minute sessions on 'No Knives, Better Lives' (21 July 2020), 'Victim awareness and victim impact' (7 August 2020) and 'Emotional regulation method anger management' (20 August 2020).[608] Clearly these were appropriate interventions, but I note that they were few in number, short in duration and the totality of educational-type activity appears to have amounted in total to 1.5 hours in the whole referral order. There is no recorded challenge within the records to AR's assertions that he would not take a knife out again, despite AR's obvious tendency to be self-serving if not actively manipulative in what he said. Ms Callon said that she would have expected such challenge to have happened, although it is not recorded in the notes.[609] Ms Callon accepted that if AR had been recognised as high risk of

605 T/S: 29/4/13-7/7.
606 LCC000488/9.
607 T/S: 29/7/8-12/3.
608 LCC000488/7-8.
609 T/S: 29/13/11-17/21.

serious harm (as I find he very clearly should have been), then three 30-minute interventions of this kind would simply not have been sufficient.[610] The CYJS interventions with AR under the referral order were inadequate.

119. From early September 2020, contact with AR began to reduce, initially to once a fortnight and then to once a month as he approached the end of the referral order in January 2021. While a gradual reduction in contact might be expected towards the end of the referral order period (and in general terms was consistent with guidance), in AR's case this coincided with what I find to have been an inappropriately lenient approach to AR's attendance and engagement. On 9 September 2020, AR refused to come out of his room to see Mr Fitzpatrick. The case records show that Mr Fitzpatrick had said that he would normally issue a warning in these circumstances but would not do so as *"[AR] [h]as ASD"*.[611] This was despite the fact that AR had already had one occasion of refusing to speak to Mr Fitzpatrick which was excused (16 July 2020 when it was said, *"No enforcement due to [AR's] possible ASD"*).[612] And despite AR refusing even to speak to Mr Fitzpatrick on 9 September 2020, Mr Fitzpatrick told AR's parents that he would reduce the contacts to fortnightly. This was surprisingly (and I find inappropriately) lenient for a child convicted of a serious offence of violence who was refusing to speak to his CYJS social worker. It has been suggested that this was in line with national practice in respect of 'Child First' youth justice work and trauma-informed practice.[613] The guidance referred to on these themes both post-date 2020, and neither Ms Callon nor Ms Roberts-Bibby took the view that this decision was in fact justified. Moreover, the contemporaneous notes described above are inconsistent with any suggestion that enforcement action was not taken because AR attended re-scheduled appointments after refusing to attend the originally scheduled one. Making proper allowance for a child's needs, neurodivergence and mental health within a referral order is no doubt appropriate, however, the individual circumstances must be carefully scrutinised. In AR's case his autism did not excuse (and should not have been permitted to excuse) his failure to engage with Mr Fitzpatrick. It was poor practice to have been so lenient in the particular circumstances of AR's case.

120. Moreover, CYJS then started to accept AR's mere attendance at school as qualifying as contact time for the purposes of his referral order. Once again, Mr Fitzpatrick recorded that he was taking this approach *"Due to AR's autism"* (10 September 2020).[614] While Ms Callon explained that the CYJS does sometimes accept education contact as part of referral order work,

610 T/S: 29/18/6-25 (she caveated that there may have been interventions not recorded on the notes).

611 LCC000488/7.

612 LCC000488/9.

613 LCC002317, HM Government, 'Working definition of trauma-informed practice', (2022), available at: www.gov.uk/government/publications/working-definition-of-trauma-informed-practice; LCC002318.

614 LCC000488/7.

I cannot accept that it was appropriate in AR's case given the nature of his offence and risk profile. The reasoning again appears to have been because AR was autistic. But this replicates the theme seen elsewhere of agencies appearing to assume that autism diminishes responsibility, whereas its impact is highly variable from person to person. In AR's case, he was responsible for his own actions; AR had sufficient intelligence and understanding to know that he was in the wrong when (for example) wilfully refusing to see his CYJS worker. On 15 September 2020, AR now for the third time, outright refused to speak to Mr Fitzpatrick. However, Mr Fitzpatrick marked it off as 'agency contact' (meaning as counting towards contact time in the referral order) because, on checking, The Acorns School reported that he had been in school that week and engaging well. AR did see Mr Fitzpatrick the following week, and it was then that it was decided to reduce the appointments yet further to just once a month. This was despite the facts that:

a. The pattern of AR's engagement with Mr Fitzpatrick had been poor over the recent weeks;

b. At the 'enhanced' level supervision AR was still on at this stage, CYJS' own policy dictated a minimum contact of twice per month, as Ms Callon accepted.[615]

This was again unduly lenient, inconsistent with policy, and failed to hold AR to account properly under the referral order. I find that CYJS in this respect failed to set sufficient boundaries and expectations on AR. This is concerning for a youth justice team whose role includes holding the young offender to account and ensuring they meet their obligations under their sentence.

121. When challenged as to whether the CYJS was showing here *"a troubling pattern … of treating [AR] very generously and being very light touch"*, Ms Callon said that she would have expected *"further contacts addressing – whether it's victim awareness, anger management, offending behaviour, more generally consequences of offending, which I can't see it evident on the record"*, although she said she did not know if she *"necessarily would agree"* that it was a troubling pattern of being too light touch.[616]

122. Ms Roberts-Bibby of the Youth Justice Board was more direct on this aspect. She considered that the contacts that were done were *"very light"*, and that while there was a case for professional judgement and an element of leniency on initial refusals, after that, *"I think you are then into the realms of this is now non-compliance"*.[617]

123. Even with the risk as CYJS had assessed it, I find that the team had too little meaningful contact with AR, and were too ready to excuse his poor compliance, rather than impose the sense of relentless engagement that Ms Roberts-Bibby thought should have been the tenor of the approach.

615 T/S: 29/27/8-28/4.

616 T/S: 29/21/25-23/4.

617 T/S: 32/28/5-29/25.

I accept the evidence of Ms Roberts-Bibby that on the correct assessment of a high risk of serious harm, there should have been *"a much greater level of engagement"* and that in the face of non-compliance, there should, if anything, have been an increase not a reduction in the level of contact.[618]

124. Without detracting from these conclusions, it is right to recognise that the last couple of months of 2020 was (in relative terms) a positive period for AR in terms of his school attendance and engagement. On 31 October 2020, Mrs Maggie Allred at The Acorns School reported that *"from our point of view the risk is steadily reducing as far as we can observe"*.[619] With more positive reports from school, and AR later engaging with Mr Fitzpatrick in home visits (although now infrequent ones) on 19 November and 9 December 2020, I can understand why CYJS considered that there was improvement at the end of 2020.[620] That was reflected in the 15 December 2020 December review of the AssetPlus assessment when the judgement on risk of serious harm was reduced from medium to low.[621] Mr Fitzpatrick listed a number of changes recording aspects of progress that had been made.[622] A reduction in the assessment from high to medium may have been warranted at this stage, but for the reasons I have addressed above, the original assessment of risk of serious harm at medium was not appropriate.

125. On 19 January 2021, Mr Fitzpatrick conducted CYJS' last home visit under the referral order.[623] On that day, AR reported that his father had assaulted him. It transpired that in fact AR had been threatening to break his father's laptop, and it was AR who had first assaulted his father by kicking him *"between the legs"*, only then did Alphonse R strike AR (likely a slap around the face in seeming inappropriate retaliation). Having discussed the matter with the CYJS supervising manager (Mr Clements), Mr Fitzpatrick liaised with CFWS over the potential risks to AR and also called The Acorns School.

126. Given that AR had made an allegation of assault by his father, it is understandable that the immediate considerations were of the child protection issues. I make no criticism of the fact that this was the immediate priority. What is however of concern is that this incident appears – from the records – barely to have registered with CYJS as a concerning sign about AR's conduct and risk to others. Other than an indication that Mr Fitzpatrick spoke with AR about his behaviour and said *"that it was not ok to threaten to break his dad's laptop"*, there is no indication in the case records that AR's own behaviour in assaulting his father was addressed or assessed. This incident was referred to in the final AssetPlus assessment dated 2 March 2021, but only through the

618 T/S: 32/31/15-32/14.

619 LCC000488/5.

620 LCC000488/4.

621 LCC000449/46.

622 Summarised in First Witness Statement of Ms Callon LCC001712/§136.

623 LCC000488/3. This record shows that Mr Fitzpatrick became aware of AR's assault on his father during the visit itself which was just before the referral order ended.

lens of child protection and the risks to AR.[624] Ms Callon accepted – although with a degree of understatement – that the way this incident was addressed in the risk assessment was *"perhaps… not sufficient in terms of the analysis of that information"*.[625] The way that CYJS considered this incident as regards the risks that AR posed to others was inadequate. Having appropriately passed to CFWS any implications for child protection, they should have addressed the fact that right at the end of the referral order AR had threatened to break his father's property and had kicked him in the scrotum. In the context of AR's earlier offending, this was not a trivial incident. The AssetPlus assessment said: *"No evidence of any further offending since the original offence"*. In light of AR's assault on his father, this was not accurate. AR's assault by kicking his father was not mentioned under 'Other Behaviours of Concern'.[626] The section on 'Type of behaviour and impact on others' referred only to violence against peers and does not appear to have been updated either. Instead, it inaccurately stated, *"At review there have been no reports of any further concerning behaviour since the original offence date"*.[627] Furthermore, nothing about the implications of this assault appear to have been deliberated in Mr Fitzpatrick's case closure discussion with his supervising manager.[628]

127. Mr Fitzpatrick prepared a final referral order panel report.[629] The sections of this report completed by AR himself were answered superficially. Mr Fitzpatrick not unreasonably pointed to AR's improved school engagement. But Mr Fitzpatrick also said inaccurately that AR had not missed any appointments.[630] AR had in fact refused to see Mr Fitzpatrick on a number of occasions as detailed above. It was noted that AR had been unable to complete any restorative justice interventions *"Due to COVID-19"*.[631] While an agreed exit plan was created, its content appears somewhat rushed. The section on progress made with the referral order contract was very short, incomplete and stopped mid-sentence.[632] The exit plan was superficial. For example, the plan for parents/carers to help AR achieve his targets was *"Support [AR] in all areas of his life"*, and the help available to him was said to be: *"Parents, Acorns School"*.[633]

624 LCC000450/7-8.
625 T/S: 29/38/12-25.
626 LCC000450/22-23.
627 LCC000450/40.
628 21 January 2021, LCC000488/2.
629 LCC000089.
630 LCC000089/3.
631 LCC000089/3.
632 LCC000092/1.
633 LCC000092/2.

128. End of referral self-assessments were also completed by AR and separately by AR's parents.[634] Their answers were all extremely brief. They have the ring of AR and AR's parents telling CYJS what they thought they wanted to hear. That is consistent with Alphonse R in fact seeing CYJS as being there to punish AR, a matter to which I return at paragraph 155, below.

129. AR's case was closed to CYJS on 21 January 2021, with the end of the referral order.

130. In Chapter 6: Online harms, I have already commented that CYJS did not conduct any work with AR in relation to online behaviour or safety and that this was an example of inadequate exploration or response given that significant concerns about online harms had been identified. To the extent this reflected the absence of a relevant objective set by the referral order panel because AR's specific offending had not involved online harms, this was a symptom of poor information sharing including within LCC.

131. It is important to make allowance for the challenges of COVID-19 during the duration of this referral order. To the extent that AR engaged with adults seeking to help him, there is little doubt that he did so better in person than online or by telephone. There will have been significant challenges for the CYJS at this time in all its case load, not least AR.

132. However, even making allowance for this, for the reasons I have explored above, I find that the risk assessments conducted by CYJS, their interventions and record keeping were all relatively poor. I find that they did not do enough to challenge AR's offending behaviour and risks, although it is impossible to know whether better CYJS interventions alone would have had any effect on AR's offending trajectory.

133. My concern over this overall lack of rigour in CYJS' approach to AR is exemplified by a final example that arose post-closure. On 2 February 2021, The Acorns School contacted Mr Fitzpatrick to provide a copy of the Second Referral to Prevent that had been made by the school. This concerned the social media posts concerning Colonel Gadaffi (addressed in more detail in Chapter 8: Prevent and Counter Terrorism Policing). Mr Fitzpatrick's response, a week later, was to say simply *"Hi sorry for the late reply. [AR] closed to our service on 21.01.21"*.[635] Ms Callon candidly acknowledged that this was *"unacceptable"*, displaying an apparent lack of professional curiosity.[636] It is concerning that the further Prevent referral did not trigger any response or questions at all on the part of the CYJS.

634 LCC000090; LCC000091.

635 LCC001510/1.

636 T/S: 29/40/16-41/17.

4 March 2020 to 1 February 2021: the second and third CFWS episodes

134. Having dealt separately with the role of CYJS, the next strand to consider is the role of CFWS from March 2020 to February 2021. At this point, CFWS offered a time-limited service, with cases held open only for a 12-to-20-week period.[637] The role of CFWS that had been identified in the step-down decision was primarily around the family's social isolation and limited support in the local community. In addition, CFWS also acted as convenor for the multi-agency TAF meetings.

135. In line with the decision to step the case down from Children's Social Care taken on 4 March 2020, Ms Fontaine (now Fontaine-Smith) became AR's allocated CFWS family support worker with effect from 24 March 2020. On the *"Referral to Early Help"* it was recorded that:

> *"[AR] has assaulted another pupil in a school he used to attend. He attended the school for the purpose of assaulting a particular pupil but assaulted another with a hockey stick. When the police arrived [AR] said he had a knife in his bag. This was confirmed. [AR] was arrested. He later discussed feelings/intentions of killing the pupil he was looking for with the hockey stick or knife if the stick was not enough."*[638]

136. Ms Fontaine was supervised by Ms Barrett, an experienced senior family support worker within CFWS. As well as a telephone handover to Ms Fontaine from Ms Jameson,[639] Ms Cookson, who had been the senior family support worker for AR's case from October to December 2019, also provided useful information to Ms Barrett about AR's case by email.[640] When Ms Barrett passed this email to Ms Fontaine, she instructed her to delete it once it had been read. She said that this was so that the information it contained was not placed on AR's electronic notes as this was unnecessary.[641] I found that reasoning difficult to follow but am prepared to accept that this was not a deliberate attempt to ensure that certain information was not properly recorded or retained on LCC's systems. In the context of this case as it stood in 2020, I can see no motive for anyone, including Ms Barrett, to have taken such a step.

137. As well as the details of AR's December 2019 offending, including importantly his intent to kill, CFWS were aware of AR's history of accessing highly concerning material on the internet.[642] They were also aware of AR's possible ASD.

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637 T/S: 30/10/20-11/11.

638 LCC000238.

639 LCC002311/15-16 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

640 LCC000973/1.

641 T/S: 30/17/6-20/11.

642 LCC002311/15-16 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document); T/S: 30/22/8-15.

Ms Barrett said her understanding of the case was that AR's behaviour was linked to his *"black and white"* thinking and possible ASD, although this had not yet been formally diagnosed.[643] Ms Barrett accepted that an incorrect approach at this time was a tendency to view autism as explaining the kind of behaviour exhibited by AR rather than appreciating that the seriousness of his behaviour may be increased on account of his autism.[644]

138. Ms Fontaine filled out a Common Assessment Framework form on 9 April 2020.[645] Ms Barrett was at pains to explain that this was not in fact a Common Assessment Framework Assessment, because there was already a Child and Family Assessment in place. Instead, it was a 'non-systems Common Assessment Framework assessment' that involved *"just getting the voice of the family at that point"*.[646] I do not criticise Ms Barrett for trying to explain the precise steps her service was taking, but this is a good example of the complexity of LCC's systems and procedures making it extraordinarily difficult for anyone from the outside to gain an understanding of their decisions and actions. That promotes neither transparency nor accountability. I further note that it seems distinctly unhelpful that similar but distinct assessments within LCC children's services – the Child and Family Assessment and the Common Assessment Framework – have such similar acronyms.

139. No face-to-face work was conducted with AR between March and May 2020 due to the COVID-19 lockdown.[647] Starting on 8 April 2020 there was a series of attempts by Ms Fontaine to contact the family but usually these were unanswered. On 4 May 2020, The Acorns School indicated that their attempts to contact the family had generally been unsuccessful. CYJS had had similar difficulties in achieving contact. Ms Barrett agreed that the family were not engaging well with the relevant services, even making allowances for the challenges of lockdown.[648]

140. As set out above, on 19 May 2020, there was a TAF meeting led by Ms Fontaine, with representatives from CYJS (Ms Croll) and The Acorns School (Mrs Hodson) in attendance, along with Alphonse R and Ms Janet Ramsay, an educational psychologist who was involved in AR's EHCP assessment.[649] Familiar issues were discussed, such as AR's lack of engagement with schoolwork being sent home, the need for a risk assessment before AR could return to school premises, and Alphonse R's desire for AR to be in a mainstream school. As I have addressed in

643 T/S: 30/24/12-25/25.

644 T/S: 30/3/14-4/5.

645 LCC000283.

646 T/S: 30/28/21-29/8.

647 T/S: 30/34/7-18.

648 LCC002311/16-19 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document); T/S: 30/34/19-37/8.

649 LCC000054; LCC000061.

dealing with CYJS's involvement, Ms Croll offered to share a summary of the AssetPlus assessment, and informed the attendees that AR was a *"medium risk of serious harm"*.

141. As I have also addressed in the previous sub-section, on 20 May 2020 Mrs Hodson of The Acorns School expressed concerns to CFWS and CYJS that *"neither Dad nor [AR] seem to have moved on in their thinking in the 6 months since the incident"*, that *"Dad seems to perceive that [AR] is the victim rather than the perpetrator. He excuses his behaviour..."* and ultimately that *"I feel that [the risk] [AR] poses to us all as a school has increased rather than reduced"*.[650] I have already set out the reasons why this should have been a matter of real and serious concern for CYJS above, and the same applied to CFWS. Mrs Hodson's concerns accordingly deserved a thoughtful and careful response from Ms Fontaine. I regret that they did not receive one.

142. Instead, in her reply, Ms Fontaine acknowledged *"concern and frustration around the perceived mind-set of Alphonse and [AR]"*, which she said could be *"challenged through conversation with Alphonse"* but said that *"I don't feel that this increases the risk posed by [AR], because there is appropriate parenting in place. [...] In any case, Alphonse's view of his son's temperament and behaviour, and his expression of his preferred educational placement, does not, in my opinion, influence the risk level"*.[651] She pushed for the issues to be raised at a further TAF meeting *"to allow appropriate challenge on some of these issues. This gives Alphonse an opportunity to respond to the challenge and provides AR with an opportunity to contribute his thoughts, feelings and wishes"*.

143. Ms Croll replied the next day, broadly supporting Ms Fontaine's position and providing a summary of the AssetPlus assessment conclusions. I have set out my conclusions in respect of that response above.

144. I consider that although Ms Fontaine's response was polite and superficially professional, it was entirely misjudged. It displayed a markedly narrow and blinkered response to The Acorns School's valid concerns. It was illogical to take the view that Alphonse R's inability to accept or confront his son's offending behaviour did not increase the risk AR posed to others. It quite obviously did. It was equally inappropriate to put these concerns off to a meeting with Alphonse R and AR so that they could *"challenge"* The Acorns School's views. I add that the tone and content of the email would not have given The Acorns School any sense that they would have support from CFWS (or CYJS) in such a meeting.

145. Neither Ms Barrett nor Ms Fontaine appeared able to recognise the problems with this response when asked about it in evidence.[652] Ms Ashworth accepted that Ms Fontaine's response to the detailed concerns that were set out by the

650 LCC000998/9-10.

651 LCC000998/8-9.

652 T/S: 30/42/19-43/16, T/S: 30/176/13-182/11.

school had the appearance of something of a *"brush off"*.[653] This reflected the extent to which CFWS, in particular, is focused on consent and, as Ms Fontaine put it, on looking *"at the risk to, not the risk from"*.[654] While I find that this was an inappropriate response to The Acorns School's concerns, I accept that Ms Fontaine was not deliberately trying to downplay or minimise The Acorns School's concerns. Nevertheless, the response is symptomatic of an overly narrow mindset within CFWS in relation to multi-agency working and consideration of risk to others that I found troubling.

146. A similar pattern unfolded just under three weeks later, when on 9 June 2020, CFWS closed AR's case.[655] It was stated that *"due to COVID-19 restrictions, case to be closed until [AR] returns to school and face to face direct work sessions can be offered"*. This was at least partly as a result of a request by Alphonse R, even though Mrs Eccleston of The Acorns School had sent Ms Fontaine a lengthy email on 9 June 2020 explaining why, in their view, the family needed more support in order to persuade AR to re-engage with education, particularly in the context of the school being closed over the summer and CFWS having had more success than The Acorns School in building a relationship with AR's family.[656] She expressly sought the assistance of CFWS in this exercise.

147. This request was declined, and support was expressed as being contingent on AR returning to school. In evidence, Ms Barrett and Ms Fontaine sought to justify the temporary closure of the case (despite The Acorns School's request that it stay open) on the basis that they were a time-limited service, that they were unable to work with AR directly due to COVID-19, and because Alphonse R had, in effect, withdrawn consent. Therefore, in their view it was appropriate for the case to have been closed, although Ms Fontaine accepted that *"in an ideal world"* she would have been able to keep it open.[657] I accept that there were factors pointing towards temporary closure at the time, and that this was consistent with how CFWS then worked, but Ms Ashworth accepted that *"it's reasonable to say we could have kept [the case] open over that summer, that wouldn't have been an unreasonable thing to do"*.[658] The decision to close reflected an overly dogmatic adherence to process as opposed to genuine engagement with what the case required. It was also a further example of an attitude to the concerns of other agencies that was at risk of being cavalier. As a further demonstration of this, despite the CFWS response to the 20 May 2020 email being to suggest that matters should be aired at a future TAF meeting, the closure decision meant that no further TAF meetings took place until November 2020.[659]

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653 T/S: 31/57/12-59/3.

654 T/S: 30/180/19-21.

655 LCC000284/1.

656 LCC000998/2-3.

657 T/S: 30/43/17-51/1, T/S: 30/182/21-188/4.

658 T/S: 31/63/6-8.

659 T/S: 30/182/4-6.

148. There was accordingly no substantive engagement by CFWS with AR's case between June and September 2020. The case was reopened by CFWS on 14 September 2020 with Ms Fontaine remaining the lead family support worker and Ms Barrett still her supervisor. In light of the criticism I have made of the previous closure, it is fair to emphasise here that Ms Fontaine had proactively approached Alphonse R to ask if support was still required, which was good practice and reflected the genuinely temporary nature of the closure in June 2020.

149. Given the passage of time since the last assessment, on 28 October 2020 Ms Fontaine completed a full Common Assessment Framework assessment.[660] As an essential element of her analysis, Ms Fontaine set out:

> *"From gathering information there are no safeguarding concerns at this stage for either of the children. Their basic needs are being met by parents, and overall they have a safe, stable and happy home life.*
>
> *The family were previously open to CSC [Children's Social Care] and had a C&F [Child and Family] assessment. They have also [had] support from Parenting 2000 in Southport, which proves their ability and willingness to engage in services to the benefit of the children and family life. […]*
>
> *[AR] has involvement with the Youth Offending Team regarding incidents of carrying knives and assault. Although it is relevant to mention this incident, it is not the main focus of this assessment. [AR] has shared that he is struggling with his anxiety, and he feels that previous professional involvement has focussed on the incident of assault and carrying knives and that no one has thought about or supported him with his feelings and emotional wellbeing.*
>
> *[AR] has previously disliked attending Acorns and struggled with peer interactions. This currently is not an issue as [AR] is receiving 1:1 tuition, however it is important for his ongoing development and future education that [AR] learn to manage these social situations. […]*
>
> *There have been no violent/aggressive incidents from [AR] since last year, which was under very specific circumstances, and there are no safeguarding concerns for either child. In addition to this [AR] is now regularly attending school therefore this case sits at level 2 on the continuum of need."*

150. I accept entirely that a Common Assessment Framework assessment conducted by CFWS is aimed at gathering and analysing information about a child's circumstances and that of the family; identifying any unmet needs or risks of harm; and determining what support or services are required to safeguard the child's welfare and improve their outcomes. Such a child/young person-oriented objective is self-evidently entirely appropriate. However, in a case such as the present it should be matched with a similarly intense focus on

660 LCC000306/4.

the risk the individual poses to others, to be assessed on a multi-agency basis. Ms Fontaine accepted that in hindsight, a young person-centric approach had allowed AR to deflect any questions or exploration of the risk he posed to others.[661] I consider that this should in fact have been apparent at the time.

151. Ms Barrett accepted that exploration of the risk AR posed to others was missing in this assessment of AR, although she maintained that there was *"no role in our team"* in relation to risk to others. Instead, their 'actions' were to help AR access education.[662] She accepted, however, they did have a role in identifying risk and that the Common Assessment Framework assessment reads as though CFWS was too prepared to leave this risk to others.[663]

152. Furthermore, missing from this Common Assessment Framework assessment was any reference to AR's intent to kill, in the context of his offending, along with the persistent *"downplaying"* by the parents and by AR of the significance and seriousness of his offending. Instead, it was suggested that the parents had responded appropriately. Ms Barrett accepted that in this regard the assessment was superficial, highly incomplete and plainly wrong.[664] In addition, it appears that Ms Fontaine took at face value AR's assertions that his offending had been a response to *"ongoing"* or *"relentless"* bullying. As previously set out, that was at best simplistic, and at worst a wholly inaccurate explanation for AR's offending. Overall, the October 2020 Common Assessment Framework assessment involved a significant dilution of the risk information that was available to CFWS.[665]

153. The overall effect of this was that insufficient attention was given by CFWS to the risk AR posed to others. I accept that it was not CFWS' role to address or manage that risk, but it did have a role in identifying it. It also had a role in co-ordinating the multi-agency response to AR's needs, through the TAF process. Notably, there was no input from CAMHS into this assessment and Ms Fontaine's efforts to reach CAMHS were unsuccessful.[666] There was no CAMHS attendance at any TAF meetings during this period.[667] Ms Fontaine considered that this probably hindered her ability to assess AR's circumstances fully, which is unsurprising. Had there been proper attention to AR's risk to others, it would have been vital to ensure that there was sufficient input from CAMHS.

154. The relationship between CFWS and AR's family in relation to this Common Assessment Framework assessment was not an entirely easy one. In particular, on 2 November 2020, Alphonse R wrote to Ms Fontaine in the following terms:

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661 T/S: 30/193/19-25.

662 T/S: 30/53/2-11.

663 T/S: 30/58/14-59/18.

664 T/S: 30/55/22-57/15.

665 T/S: 30/55/1-21, T/S: 30/189/9-190/11.

666 LCC000391/1.

667 LCC000085; LCC000310; T/S: 30/195/18-196/6.

> *"Please send me the updated assessment report. Only after reading it, I can consent to sharing it with the school or any other third party. It is important that you inform me or Laetitia about information sharing beforehand.*
>
> *As you are well aware, this service is voluntary with the child and the family at the centre. When we feel comfortable, we can be inadvertently or innocently share personal information that no other family shares, not to say that there is something sinister but because it is not necessary. Therefore, we trust that you use your professional judgement not to share sensitive irrelevant information with the offending team (YOT), social services, nor the school for that matter. We treat your service like the service of a counsellor, so we expect a high degree of confidentiality and sensitivity. [AR] can trust you and say stuff as a child, but we don't expect you to record or share some information with others that can turn our family upside down. This is unbelievably important because we are not exchanging our family essence and dignity for some benefits that your organisation provides.*
>
> *Hence, it is really a sensitive field that my words cannot express. In other words, we commissioned you (the CAF) to help us (that is between you and us only) and to help [AR] receive meaningful education and that is where the school comes in. I don't get why the YOT in charge of punishing [AR] has anything to do with your assessment report. We don't want them in this matter please. They should not know more than they need to see out their enforcement work and they don't need your input. Please don't involve them anymore. Also please share with Acorns only part of the report that they need to improve [AR]'s education. […]*
>
> *With regards to [AR] communication with me and other family stuff he mentioned including his eating difficulties, that should be between us or any agency that you deem relevant only after the express family consent."* [668]

155. This communication reveals a number of concerning issues. First, Alphonse R wholly incorrectly viewed CYJS (referred to here as the YOT), whose role was to support AR on his referral order, as punishing AR. Second, AR was also attempting to limit the information shared by CFWS with The Acorns School, who needed to be aware of relevant updates about AR and his family, not just *"to improve AR's education"* but also because of the risk that AR posed to staff and other students. Third, neither CYJS nor The Acorns School were informed by CFWS of this refusal by Alphonse R to share this information, which was potentially critical to the work they were undertaking.

668 LCC002311/32 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

156. Ms Barrett accepted that this was an example of Alphonse R attempting to direct or manipulate the agencies, particularly as regards sharing information. Ms Barrett agreed that Alphonse R should have been working closely with the CYJS and that his attitude, as disclosed by this message, represented an increased risk.[669] Ms Fontaine agreed that *"looking back"* this message was an obvious attempt to drive a wedge between her and the CYJS in terms of sharing information, although this was not how she saw it at the time.[670]

157. The initial response from Ms Fontaine did not engage with these concerns. She sent Alphonse R a message stating:

> *"Hi Alphonse, thank you for your message, I understand your concerns and I will respond fully tomorrow as I am about to leave for the afternoon and do not want to rush the response. I will not be sharing anything without your consent.*
>
> *I just want to reassure you that the process will only go forward if you and Laetitia are happy and consent to it. You are able to withdraw consent at any time including consent around information sharing.*
>
> *Concerns for the children's wellbeing and safety would be the only reason to have to share any information with social care.*
>
> *Please rest assured that nothing either yourself or [AR] have shared causes any concern or worry about the children's wellbeing or safety.*
>
> *We only want to support you as a family unit.*
>
> *I hope this puts your mind at ease a little for the time being and we can discuss it more in depth tomorrow. I will email the assessment to you later this evening.*
>
> *Thanks, Andrea"*[671]

158. Ms Fontaine accepted that this response did not push back at all against what Alphonse R had said, or seek to change his mind, although she thought that this kind of message from a family was not unusual and that she would ordinarily be able to persuade them to take a different course. She could not recall any further discussion on the issue: *"if it's not documented, I have to assume no. I can't remember"*.[672] She could not assist on why the fact that Alphonse R had, or had tried to, withdraw consent for sharing information with CYJS had not been shared with CYJS, although she agreed that it would have been important information for them to know.[673]

669 T/S: 30/66/8-68/14.

670 T/S: 30/198/21-199/20.

671 LCC002311/32 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

672 T/S: 30/201/2-4.

673 T/S: 30/201/19-202/4.

159. Ms Barrett accepted that there is no documentation indicating that Alphonse R's inappropriate attitude was challenged or that the CYJS had been informed as to what had been said. She maintained that shortly afterwards, Alphonse R provided the necessary consent for information sharing.[674] As she put it, *"trying to keep consent is really important. That's what we were trying to do. We are trying to keep a family engaged who we were struggling to engage with and that, if we'd lost that consent, we wouldn't have been able to remain open"*.

160. Although I accept that Ms Barrett genuinely believed her account, I am far from sure that her evidence was a wholly accurate recollection of what had occurred, as opposed to what she has convinced herself must have happened. I do, however, accept that there was some form of further discussion or decision by Alphonse R to soften his position. That is suggested by an email he sent after receiving the Common Assessment Framework assessment, in which he tried to make inappropriate corrections to it, but also said *"Reading the report has brought clarity and answered our concerns"*.[675] More persuasively, there was (as discussed below) a degree of information sharing between CYJS and CFWS in January 2021, which I consider would have been unlikely to have occurred had Alphonse R's withdrawal of consent still been in place – or at least unlikely to have occurred without there being some express comment on the fact that it was occurring despite a lack of consent. To that extent, this hurdle that Alphonse R sought to put in the way of appropriate multi-agency working was successfully navigated by CFWS.

161. But that does not address the fundamental underlying issues, which are threefold. First, Alphonse R was seeking to manipulate the role of consent in the CFWS process. Second, CFWS did not recognise or robustly challenge the inappropriateness and indeed risk of that behaviour, which was consistent with Alphonse R's earlier attempts to downplay AR's offending and shift blame to The Acorns School. Third, the response from Ms Fontaine demonstrates the continued lack of focus within CFWS on any issue of risk to others. CFWS should have warned CYJS that Alphonse R perceived their service in this wholly negative way as this had potential implications for how genuine the family response to CYJS was. There is no evidence that CFWS did so. Overall, this episode reinforces my view that close consideration should be given to whether the lack of consent from a family should be permitted to block the sharing of information in circumstances such as these when there are wider, fundamental considerations in play, including but not limited to the safety of others.

674 T/S: 30/69/12-70/20.

675 LCC000972/1.

162. TAF meetings took place on 4 November 2020 and 19 January 2021. There was no attendance from CYJS or CAMHS. Ms Fontaine undertook direct work with AR on 20 November 2020 and 2 December 2020 as regards his relationship with his father.[676]

163. On 14 January 2021, Alphonse R informed Ms Fontaine that *"there had just been a disagreement with AR"* which had involved AR *"lashing out, throwing water"*. He then threatened to break Alphonse R's computer and when Alphonse R stepped in to prevent this, AR kicked him.[677] Ms Fontaine provided Alphonse R with advice on managing aggression from AR. She did not at that stage make any contact with CYJS, but accepted that she should have done so.[678]

164. As I have addressed above in dealing with CYJS, on 19 January 2021 AR told Mr Fitzpatrick from CYJS that he had been assaulted by his father, although Alphonse R said that it was in fact AR who had kicked him. Mr Fitzpatrick reported this to CFWS.[679] Ms Fontaine made her own enquiries. During a home visit on 25 January 2021, she ascertained (consistent with what CYJS had also been told) that Alphonse R struck AR once on the face with an open palm after AR had kicked him in the scrotum when Alphonse R tried to prevent AR breaking Alphonse R's laptop. This was in the context of a minor household disagreement about gardening. This was the same incident as Alphonse R had reported on 14 January, although his report had lacked obviously important and relevant details regarding his own conduct. Alphonse R was very remorseful, although AR showed no regret about what happened: *"AR did not show remorse and said he wasn't sorry and he didn't injure or hurt his dad much as he was only wearing slippers not shoes"*.[680]

165. Ultimately, neither CYJS nor CFWS took any further action, although there were discussions as to whether the threshold for a referral to Children's Social Care had been crossed based on the possible risk of harm to AR from Alphonse R using physical chastisement.[681] The conclusion, on the part of both teams, was that such a referral was not necessary. I agree that no referral to Children's Social Care was necessary based on the risk of harm posed to AR by his father. Although resorting to physical violence in retaliation was inappropriate, it was also not unreasonable to have concluded that this was an isolated incident occurring only when Alphonse R had been significantly provoked by AR's own assault.

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676 LCC002311/33-37 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document); LCC000308; LCC000310.

677 LCC002311/36 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

678 T/S: 30/207/12-16.

679 LCC002311/37 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

680 LCC002311/37 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

681 LCC000488/1.

166. However, this incident is a yet further indication of the markedly narrow focus on the risks to AR, rather than risk from him. AR was still, at this point, subject to a referral order imposed by a court following his convictions for offences involving violence and weapons. Those had resulted from AR's inability to manage his responses to perceived injustice in a way that did not involve resorting to violence. AR had shown no remorse for his conduct, at least initially. This incident should have been an obvious warning marker that AR had not significantly changed. He was still unable to respond to perceived slights without the use of violence, and still unable to recognise why this was wrong.

167. Ms Fontaine accepted that there was no meaningful consideration of the risk that AR posed to others at this stage. Instead, there was an overly narrow focus on risks to AR as a child, rather than risks from him.[682] Ms Barrett accepted that they may have been *"blinkered"* on that front.[683] Instead, at the time it was concluded that it was sufficient to build *"a relationship with AR and his father"* and that the risks were reducing as *"positive change was occurring"*.[684] Ms Ashworth recognised that there was a failure to take into account AR's own violent behaviour when deciding how to respond to this incident, because the entire focus was on the risks to AR.[685]

168. I acknowledge that CYJS, who had a more direct role in managing AR's risk to others, were also on notice of this incident. I have set out my views on their response above. But I consider that this is another example of CFWS failing to engage in proper consideration of risk to others, in part because they could not see beyond the issue of risk of harm to AR. That was despite the fact that in this incident, he was the instigator of the violence, and it was an indication that there had been very little positive change since the events of December 2019.

169. On 2 February 2021, The Acorns School emailed Ms Fontaine with a copy of the Second Referral to Prevent that had been placed by the school the previous day.[686] Ms Fontaine understood what Prevent referrals are, but there is no evidence that the significance of this was properly appreciated within CFWS, and it is possible that Ms Fontaine may have entirely overlooked receiving it, which she accepted would have been a failure on her part.[687] On 4 February 2021, Ms Fontaine became aware that AR had recently been diagnosed with autism, although he was not happy about this diagnosis.[688] She was also aware that CYJS had ceased working with AR in late January 2021 because of the end of the referral order.[689]

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682 T/S: 30/210/1-12.

683 T/S: 30/75/17-19.

684 T/S: 30/76/11-77/12.

685 T/S: 31/78/8-79/3.

686 LCC001510/2.

687 T/S: 30/214/24-215/9.

688 LCC002311/38 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

689 T/S: 30/210/22-211/1.

170. Notwithstanding these factors, on 10 February 2021, CFWS closed AR's case on the basis that all the *"actions"* had been completed or were to be continued by the school. It is of note that in the closure documentation, under the heading 'Safe and Sustainable Places/Reducing Crime', it was considered there were no *"reducing crime needs in family"*.[690] This occurred despite the recent assault by AR on Alphonse R, Alphonse R asking for continued support (*"a community-based agency like yours would have helped AR immensely"*), and the recent and still-open Prevent referral.[691]

171. Ms Barrett accepted that it had been a wrong decision to close the case, which had partly been the result of this being a time-limited service. The decision to close was essentially process-driven.[692] The effect of the closure was a sudden drop-off in the level of support provided to the family, at a point when there were obvious continuing support needs, vulnerabilities and risks. The system operated by LCC as at 2021 was simply not flexible enough to respond to those matters effectively.

172. Moreover, Ms Barrett accepted that the closure documentation had missed out important information, resulting in positive rather than negative information being included.[693] This was a further example of dilution or even omission of risk information. There appears to have been something of a cultural bias within the CFWS team towards identifying factors consistent with closing cases at the expense of contrary factors for keeping them open. This is likely to have reflected the time-limited-service mentality, and possibly the pressure of caseloads.

June to September 2021: the second Children's Social Care assessment

173. The next contact with any form of social services was a request by Alphonse R to LCC on 23 June 2021 for an assessment for both his sons in respect of support for disabilities.[694] This led to a MASH assessment on 24 June 2021, with a transfer to Children's Social Care for assessment.[695]

690 LCC000093/2; LCC000096/2.

691 LCC002311/38 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

692 T/S: 30/80/25-82/3.

693 T/S: 30/82/15-22.

694 LCC000107.

695 LCC000108.

174. On 7 September 2021 Ms Haydock of Children's Social Care completed a Child and Family Assessment, following an information-gathering exercise from various different agencies, and separate home visits by her and by another social worker, Ms Janine Rhodes.[696] Ms Haydock accepted that she had not kept comprehensive notes of her meetings with AR's family.[697]

175. In the course of the visit by Ms Rhodes, AR suggested that he and Dion R were the victims of violent domestic abuse by Alphonse R.[698] This was appropriately investigated as part of the assessment. The allegations were uncorroborated by any other member of the family and were found to have been unsubstantiated. At their highest, they may have referred to the use of lawful physical chastisement by Alphonse R when his sons were much younger.

176. There are three significant matters which arise from those allegations. First, it was another clear sign that AR was prepared to lie to professionals when it suited him to do so.

177. Second, there is no evidence that those investigating these allegations were aware of the incident in January 2021. While it would not have led to any different conclusions, it would have been relevant information for them. This is therefore an example of a failure of information sharing within LCC.

178. Third, AR's response when it became apparent that his version of events was not supported by his family was to go upstairs and pour a glass of milk over his parents' bed as *"everyone had lied"*. This was witnessed by Ms Rhodes.[699] Her note also included that, *"Both parents had to whisper that they did not want to discuss anything further as this would make AR's behaviour worse as he does not like being discussed"*. There was therefore continued evidence of extreme reactions to perceived slights on the part of AR.

179. Despite her best efforts, Ms Haydock did not herself have any substantive meeting with AR, as he did not want to engage with her.[700] But her Child and Family Assessment was, overall and within the limits of the information available to her, a careful and thorough piece of work. She obtained information from a wide variety of sources, including CAMHS and The Acorns School. As well as dealing with the allegations AR had made, she correctly assessed that AR required further support. She noted, among other issues, that AR's relationship with his father was *"extremely fractured"*, that he frequently did not eat, and was socially isolated. She recommended that AR should be supported under level 3 Family Intensive Support, namely CFWS, to try to address those issues, alongside additional input from AR's General Practitioner (GP) and from CAMHS in relation to eating.

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696 LCC000247.

697 Witness Statement of Ms Haydock LCC001772/§67.

698 LCC002310/27 (the Transcript refers to LCC002301 but LCC002310 is a better version of the same document).

699 LCC002310/27 (the Transcript refers to LCC002301 but LCC002310 is a better version of the same document).

700 Witness Statement of Ms Haydock LCC001772/§29.

180. In addition, Mrs Allred of The Acorns School conveyed her view to Ms Haydock that AR needed to develop social skills. He needed *"a very skilled trusted adult to slowly build a [rapport] for approximately 3-6 months, barrier is distrust"*.[701] It was suggested that this initial 3 to 6 months should be within the family home, with further support out to 12 months before AR was ready to access social activities.[702] Ms Haydock's recommendation was that this support should be on the basis of a funded carer for AR. This recommendation was not accepted by LCC, who instead took the view that *"this need can be met without [direct payments]"* as *"his social isolation is only present by virtue of not having the appropriate provision in place during the educational day"*.[703] While it was right that The Acorns School was only providing an hour a day of schooling, this decision did not reflect the information provided by Mrs Allred. The issue was not opportunity to engage in social interaction, but AR's willingness and ability to do so.

181. The case was *"stepped down"* to CFWS as of 24 September 2021, and the referral to Children's Social Care closed.[704] The only capability within CFWS to address AR's social isolation needs was Targeted Youth Support, which was a 6-to-12 week programme. Ms Anderson agreed that it should have been made clear to CFWS on handover that in AR's case, this work was going to take 6-to-12 months, and that 6-to-12 weeks would have been ineffective.[705]

September 2021 to 14 March 2022: the fourth CFWS episode

182. Following the step down addressed above, Ms L Lewis, a family support worker, was allocated to AR's case. Ms Barrett was again the senior family support worker. A step-down meeting took place to hand the case over.[706]

183. On 4 October 2021, both Ms Barrett and Ms L Lewis conducted a home visit to 10 Old School Close. Ms L Lewis' contemporaneous note was as follows:

> *"On arrival was greeted by mum who welcomed workers into the home. Dad was hoovering and [AR] was in the living room sitting on the chair. It was explained to the family of the referral received from the SW. Parents and [AR] said they were aware of this. Spoke with [AR] and his thoughts about where he is at with school and the referral.* ***[AR] informed that he wasn't attending school and when asked why he wouldn't share only saying "not until Alphonse does what i have asked him". [AR] wouldn't elaborate.***

701 LCC002310/29 (the Transcript refers to LCC002301 but LCC002310 is a better version of the same document).

702 LCC000247/3.

703 LCC000247/9.

704 LCC000115; LCC000121; LCC000120.

705 T/S: 31/149/8-19.

706 LCC002311/40-41 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

> ***Alphonse was asked by worker, [AR] said "you don't need to tell them you don't have my permission". It was clear that Alphonse wanted to share this however mum also didn't want him to say anything saying eh, eh, eh waving her arms and indicating a zip action across her mouth.*** *[AR] was informed that he has a duty to attend school. [AR] was asked if he knew the potential repercussions of him not attending school, it was explained that his parents maybe fined which could then impact on them as a family financially.* ***[AR] didn't seem bothered saying "that he makes his own money via the internet. [AR] was asked to share what he was doing to make money, he refused saying "you don't need to know". Worker highlighted to [AR] that this can become a cause for concern. [AR] stated 'its fine its not illegal'. [AR] wouldn't allow parents to share.*** *We discussed CFW support and what can be offered and what could help him show an interest in going back to school. [AR] says he "likes news and what is going on". This gave [AR] the opportunity to talk about what is going on political in the world, he was very opinionated and raised some good points, however this came across as one sided and if said in the wrong environment this may put [AR] in a compromising position. [AR] didn't seem to understand that his opinions and thoughts may cause upset to other people. [AR] was asked if he would like to be part of a youth council which can be accessed by the targeted youth support team. [AR] said he would like this. Parents signed registration form they asked about consent and what it meant. Worker explained that CFW work with various agencies and signing the form will allow information to be shared with agencies to identify correct support for them as a family. This prompted [AR] to share his opinion on consent and information sharing and felt that anybody can access his … information and didn't want this.* ***It was explained that only CFW can access any information on the system but information can be shared with other agencies if there are concerns. He went on to say that MI5 and MI6 can access this if they want. This lead [sic] onto him beginning vocal on politics, american government and Taliban."***[707] (emphasis added).

184. Ms Barrett's recollection of this conversation is that AR's conversation was *"scattergun and sporadic"* and that he was *"asking questions"*, but *"talking about why different governments don't get punished for things when certain governments do ...why do people have a really bad vision of the Taliban when there's other governments, like the American government, who go into countries and can hurt people"*.[708] Ms L Lewis had no recollection of the conversation, but agreed that AR's reference to the Taliban would have been

707 LCC002311/42 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

708 T/S: 30/95/11-97/10.

worrying and (as set out below) at the time she obviously had concerns over the extremity of AR's beliefs and whether they suggested that he was susceptible to radicalisation.[709]

185. As well as the issue of extremism/radicalisation, there were obvious issues concerning AR dominating his parents, AR manipulating the need for consent in respect of information sharing, and regarding his online activities. Ms Barrett accepted that AR had been dominating the narrative and had told his parents not to share information.[710]

186. I do not overlook that AR's reference to the Taliban appears to have been in the context of a political discussion. Even making proper allowance for that, the content of this meeting should have caused serious concern and reflection within CFWS about how to proceed, particularly in respect of the risk of radicalisation. To some extent, it did: on 12 October 2021 Ms Barrett indicated to Ms L Lewis that information concerning groups that had been proscribed under the Terrorism Act 2000 needed to be discussed with AR's parents.[711]

187. On 14 October 2021, Ms Barrett informed Ms Deb Cardwell from the Targeted Youth Support team that there were some concerns about AR having some extreme views and the risks these could pose. She suggested this potentially needed to be reported to Prevent.[712]

188. On 1 November 2021, Ms L Lewis expressed the view in a CFWS Early Help assessment that:

> *"There has also been concerns in relation to [AR's] extreme thoughts around what is going on in the world and politics which could put [AR] at risk of being involved in left wing extremists behaviours and his thoughts being said in the wrong environment may make him vulnerable."*[713]

189. While Ms Barrett and Ms L Lewis do appear to have recognised that AR's behaviour was a cause for concern, this was never followed through in any meaningful way. In particular, nothing about this interaction was ever shared with Counter Terrorism Policing, whether by way of a Prevent referral or otherwise, or with Lancashire Constabulary. I would add that there is no evidence that it was raised with LCC's own Prevent lead. Ms Ashworth accepted that the failure to pass this information to Prevent was a significant failure on the part of CFWS.[714]

709 T/S: 29/156/17-157/13.
710 T/S: 30/93/25-95/10.
711 LCC000977.
712 LCC000780/2.
713 LCC000321/1.
714 T/S: 31/82/11-86/8.

190. The immediate reason for this failure appears to be that Ms Barrett and Ms L Lewis were under the impression that, as at October 2021, AR was the subject of an open Prevent referral made by The Acorns School.[715] This was possibly the result of their misunderstanding a reference to a previous Prevent referral in Ms Haydock's Child and Family Assessment. In fact, the last Prevent referral in respect of AR had been closed in May 2021. At some point, prior to early December 2021, Ms Barrett and Ms L Lewis became aware that the Prevent referral had been closed.[716] They did not find out when this had occurred or the reasons for it.[717] But they appear to have treated this as meaning they did not need to take any further action on their own concerns about radicalisation. I found Ms Barrett's explanation for this – that she was responding *"in terms of future protection and possible need to discuss things, yes, rather than the immediate need for a response"* – to be entirely unconvincing.[718] I am sure that it was an after-the-fact rationalisation rather than a reflection of her thinking at the time.

191. I found this evidence extremely concerning. It suggests that CFWS gave no adequate consideration to the risk AR posed, or indeed to the risks to him as someone potentially susceptible to radicalisation. Ms Barrett accepted that this information could have been a useful piece in the jigsaw if it had been shared with Counter Terrorism Policing.[719] That would have been the case if a Prevent referral was in fact open, but also if it had been closed: it would have been an additional piece of information for Counter Terrorism Policing to consider which they did not have from any other source.

192. I am sure that this should have been reported to Counter Terrorism Policing and I have addressed how they would have responded in Chapter 8: Prevent and Counter Terrorism Policing. I am also sure that the reasons were, first, because Ms Barrett and Ms L Lewis had an inadequate understanding of this kind of risk, and second, because they lacked the sufficient professional curiosity to explore this issue fully. That reflects on them, but also on LCC's systems for training and supervising them.

193. Potential extremism or susceptibility to radicalisation was not the only concern which should have been prompted by the 4 October 2021 meeting. Ms Barrett and Ms L Lewis did identify risks around AR's internet use, which were partly informed by their knowledge of his worrying online behaviour in 2019. Ms L Lewis included 'online social media safety' as a need that would have to be addressed in her Early Help assessment for AR.[720] As Ms Ashworth accepted, this was not followed through with any clear plan for how that need

715 T/S: 30/106/16-18.

716 LCC000404/2.

717 T/S: 29/160/20-167/17, T/S: 30/106/19-107/14.

718 T/S: 30/102/9-11.

719 T/S: 30/107/25-108/23.

720 LCC000321/2; T/S: 29/162/16-163/16.

should be met and *"this is therefore with the benefit of hindsight an omission from the plan"*.[721] I agree it is an omission, but not that this was only apparent with the benefit of hindsight.

194. Ms Barrett told me about the steps that she considered they had taken to address concerns around AR's online activity. She said that AR's parents said he was supervised online, using his computer downstairs, and that *"I only saw AR on his computer on one occasion and there was no concerning content as he showed me what he was looking at"*.[722] Ms Barrett appears to have accepted without any investigation or scepticism that AR was not using his tablets in his bedroom and that he only used his laptop in the living room in full view of other members of the family. She accepted what she was told in this regard because *"we weren't seeing anything that would suggest otherwise"*. This was, in my view, an entirely naïve attitude towards AR's internet usage. He had a history of disturbing online activity. He had refused, at least initially, to allow his parents to tell Ms Barrett and Ms L Lewis what he was doing on the internet to make money, and he had expressed a range of striking views which were unlikely to have been the result of purely supervised browsing. There was an obvious need, as identified by Ms L Lewis, for more focused work in this area, both with AR and with his parents. Such work would likely have identified, for example, that there were no parental controls on any of AR's devices. Although Ms Barrett and Ms L Lewis could not have known this at the time, it is salutary to remember that by this point, AR had downloaded an Al-Qaeda training manual onto one of his tablet devices.

195. The other concerns apparent from that meeting should have been AR's domination of the family and his manipulation of the requirement for consent. Ms Barrett agreed that AR was being *"dominating and manipulative"*.[723] These factors do not appear to have featured heavily in the way CFWS assessed or treated AR. That is despite the fact that they were consistent with AR's prior behaviour in previous episodes.

196. In judging this behaviour and its significance, Ms Barrett and Ms L Lewis appear to have had limited knowledge concerning LCC's previous interactions with AR. Ms L Lewis, for example, was not aware of AR's intent to use knives in both October and December 2019, or of the full extent of his disturbing online behaviour in 2019, or of his use of violence in the home in January 2021.[724] She was visibly surprised on finding out about that background in the course of giving her evidence. This was a vivid example of risk-bearing information being diluted and lost over time, a topic which I return to in my conclusions and recommendations.

721 First Witness Statement of Ms Ashworth LCC001998/§84.

722 Witness Statement of Ms Barrett LCC001711/§69; T/S: 30/97/18-100/7.

723 T/S: 30/94/22-95/10.

724 T/S: 29/147/2-150/15.

197. In order to address AR's social isolation, Ms Barrett and Ms L Lewis made a referral to Targeted Youth Support.[725] As set out above, this was a 6-to-12 week service, which in reality was never going to be sufficient to address AR's needs, but on the basis of the information that Ms Barrett and Ms L Lewis had, it was not an inappropriate option to explore.

198. On 3 November 2021 Mr Coughlan, a targeted youth support worker, along with Ms Barrett, met with AR.[726] Mr Coughlan's role was explained at this meeting as being to *"explore his social anxiety and develop his social skills"*. This is a potentially significant period because we know, from the post-attack investigation and the detail already addressed in Chapter 5: Weapons and poisons, that from January 2022 AR was seeking to obtain both the constituents of ricin and sharp or bladed weapons from a variety of sources. There is no evidence that any of the professionals working with AR were aware of this activity.

199. The first session with Mr Coughlan was on 8 November 2021.[727] AR engaged well, although he gave Mr Coughlan only a partial account of events in late 2019 (he minimised the events of October 2019 and did not refer to the 11 December 2019 attack). They next met on 18 November 2021, when AR again engaged well.[728] The following meeting, on 25 November 2021 appears to have been cancelled.[729] This was followed by instances of Alphonse R attempting to rearrange the time or date of the meetings. Alphonse R appeared to have unrealistic expectations of Mr Coughlan and his role.[730] Mr Coughlan failed to produce a report for the TAF meeting on 7 December 2021 (which AR attended), although he put extensive notes of the sessions he had with AR on the case management system.[731]

200. Mr Coughlan's evidence was that his usual practice, as a youth worker, was not to review any of the records held by LCC about a child or young person he was working with.[732] He explained that it was not his role to carry out any sort of formal assessment with a child or young person, but to carry out a specific piece of work which involved building rapport and a relationship built on mutual trust. *"Going into developing the youth work relationship with an individual, with a set of preconceptions, can damage the development of that relationship."*

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725 LCC000780.

726 LCC002311/46 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

727 LCC002311/49 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

728 LCC002311/55-56 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

729 Witness Statement of Mr Coughlan LCC001708/§§52-53; LCC000767.

730 LCC002311/59-61 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document); Witness Statement of Mr Coughlan LCC001708/§§59-60.

731 LCC002311/68; Witness Statement of Mr Coughlan LCC001708/§§61-62.

732 T/S: 29/198/8-201/14.

201. This is an obviously inadequate and potentially even dangerous approach. While I accept that building a rapport and a relationship of mutual trust with a young person is important, even vital, in youth work, the risks inherent in going in without any background understanding of the young person in question are significant. That does not mean that the youth worker needs to approach the young person with preconceived ideas. However, it is easy to see, across a very wide range of scenarios, how not knowing a young person's background is likely to make that relationship less effective and reduce the youth worker's ability to identify need or risk. Indeed, the relationship of mutual trust inherent in good youth work means that it will often be youth workers who are best placed to identify increasing risk or need. Ms Ashworth rightly accepted that Mr Coughlan's approach represented *"bad practice"*.[733] Concerningly, however, Mr Coughlan referred to this approach as reflecting LCC policy and culture, at least within the West Lancashire area.[734] It is, in my view, linked to the wider issues that are apparent in relation to dissemination of information within LCC, to which I return to in my recommendations.

202. More broadly, this period coincided with a deterioration in AR's behaviour at home. On 5 November 2021, the police were called because AR had *"trashed"* the family home when he was upset when a stranger knocked on the door.[735]

203. On 22 November 2021, CFWS were informed by CAMHS of two incidents during which AR exhibited intimidating behaviour towards his parents which included verbal threats and on two occasions he poured milk over his father.[736] The representative from CAMHS who passed on this information suggested there should be a *"multi-professional meeting considering that issues seem to be escalating in the family context"*.[737] A TAF meeting scheduled for 24 November 2021, however, was cancelled due to a lack of staff.[738]

204. On 30 November 2021, AR threw a plate of food at a rental car and jumped on it. He kicked his father. Again, police responded.[739]

205. All of these incidents were reported to CFWS within, at most, a day or two of them occurring. Indeed, after the first incident, Ms Samantha Steed from CAMHS requested consideration of stepping the case up to level 4 for a section 47 enquiry, although it is fair to say that this was primarily in relation to AR's continued making of false allegations of violence against Alphonse R.[740] Ms Barrett's response is recorded as *"CFW service discussed this with*

733 T/S: 31/52/7-53/9.

734 T/S: 29/233/4-23.

735 LCC002311/48 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document); Witness Statement of DC Connaughton LANC000408/§11; LANC000024.

736 LCC000975.

737 LCC000975.

738 LCC000892.

739 Witness Statement of PS Ward LANC000294/§§13-15; LANC000025; LANC000079.

740 LCC002311/48 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

Sam [Steed], explaining that a comprehensive assessment has been completed recently and that [AR] has not made any acquisitions [sic] of recent abuse that has not been explored".[741] In my view, this again reflected the narrowness of the focus from CFWS on questions of harm to AR.

206. Consistent with that narrowness of focus, neither the four incidents of violence in the home in November 2021 nor Ms Steed's request were raised at the TAF meeting on 7 December 2021.[742] Instead, the TAF minutes recorded that *"The plan is making small steps however they are all in the right direction and all positive for [AR] and the family"*.[743] This was by some margin an excessively optimistic assessment.

207. Mr Coughlan's sessions with AR began again on 10 January 2022, following a hiatus which had led to Ms Barrett and Ms L Lewis considering that there was some *"drift"* in the sessions.[744] This appears to have been the result of some communication difficulties between Ms L Lewis and Mr Coughlan, in the context of continued unreasonable demands from Alphonse R about the service that Mr Coughlan was providing, such as that he should re-arrange his diary at extremely short notice to accommodate AR. Although it was unfortunate that there was a lengthy gap between AR's sessions with Mr Coughlan, I do not consider that this was significant in the wider context, or that CFWS' concerns around this reflected anything other than a misunderstanding.

208. There was a TAF meeting on 11 January 2022.[745] At that meeting, it appears to have been determined that the case would close to CFWS once Mr Coughlan's sessions with AR were completed.

209. The same position was held to at the TAF meeting on 10 February 2022.[746] That followed AR declining to attend his penultimate session with Mr Coughlan on 7 February 2022.[747] Nonetheless, it was recorded that the Early Help plan was progressing with positive signs, such as AR starting to show an interest in community-based activities. AR did then attend his final session with Mr Coughlan on 21 February 2022.[748]

741 LCC002311/48 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

742 T/S: 30/110/17-111/8, T/S: 29/179/7-180/17.

743 LCC000130/3.

744 LCC000405/1; T/S: 29/219/20-220/9, T/S: 30/109/10-110/16.

745 LCC000137, though this erroneously refers to the date as being 12 January 2022. Other evidence (LCC000130, AHCH000164/6) indicates that 11 January 2022 is the correct date.

746 LCC000144.

747 LCC002311/78 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

748 LCC002311/80 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

210. On 4 March 2022, Mrs Allred from The Acorns School wrote to Ms L Lewis as follows:

> *"I hope you have been given the very good news that [AR] will be starting at Presfields after Easter and he will be visiting before Easter. As was expected, he is disengaging more from Acorns, but I am hoping this is a short-term problem that will improve when he arrives at Presfield.*
>
> *Hayley Dawson is the head at Presfield and is very pro active. I think it is a bit premature to invite her to this TAF as dad needs to be on board but perhaps ask permission from dad to share the TAF minutes with her and invite Presfields to the next one? I can forward her email."*[749]

211. The response by Ms L Lewis was to reiterate that *"after this meeting on Friday, the case will be closing"*.[750] As accepted by Ms Ashworth, this was an example of CFWS not taking the need for continuity into account over what was potentially a tricky school transition.[751] Ms L Lewis accepted that the decision to close was a premature one, contributed to by CFWS still being a time-limited service (although it was now on a 20, rather than 12, week timeframe). She also accepted that it would have been better to keep the case open at this stage.[752] Ms Barrett's perspective was that *"it was process driven"* as they were at the end of the CFWS action plan, although she stressed that *"That doesn't happen any more"*.[753]

212. The case did then close to CFWS on 14 March 2022.[754] The closure report recorded that *"There have been no recent police reports and Alphonse is reporting that things are better. [AR] is much calmer"*.[755] Although the positive of AR engaging in social activities was noted, it also recorded that AR *"has now stated he no longer wants to attend [youth group] as finds its boring"*.[756] There were, at least in hindsight, already clear indicators that any work done with AR had been of limited impact.

213. I make all allowance for the fact that Alphonse R was presenting a positive impression to the TAF group. Nonetheless, a decision to close in the near future was taken in January 2022, less than six weeks after the latest call to the police. It was then maintained despite the changing position around AR's major transition to a different school. Overall, this was a yet further example of CFWS failing to demonstrate sufficient flexibility and failing to give proper weight to the

749 LCC001003.
750 LCC001003.
751 T/S: 31/65/13-66/20.
752 T/S: 29/183/5-185/19.
753 T/S: 30/112/14-115/3.
754 LCC000155.
755 LCC000155/2.
756 LCC000155/2.

concerns of other agencies. It was a systemic issue in the sense that CFWS' structures and processes had been set up by LCC to promote or even require those outcomes, but it also reflected a lack of effective engagement with the issues in the case by Ms L Lewis, Mr Coughlan and Ms Barrett.

214. LCC has accepted that it should have held the case open to support AR through his transition to Presfield High School.[757] That would have enabled a much faster response when that placement broke down within a few weeks of the transition occurring. It would also, in all likelihood, have meant a more considered response to the incident on 17 March 2022 when AR went missing from his home address with a weapon.

17 to 24 March 2022: Children's Social Care's response to the knife on the bus incident – and events in May 2022

215. Turning to that event, three days after CFWS had closed AR's case (on 14 March 2022) at 11:15 on 17 March 2022, Lancashire Constabulary were called as AR had gone missing from his home address. I have addressed this incident in detail as regards the police response in Chapter 7: Policing, and I address here only LCC's engagement with it. Information about this incident reached LCC via three distinct routes.

216. First, Police Constable David Fairclough logged AR as missing on police systems, and this led to an automatic referral to LCC's Missing from Home team.[758]

217. Second, Ms Barrett and Ms L Lewis were notified, first by Alphonse R and subsequently by CAMHS, that AR had gone missing. In response to CAMHS, Ms L Lewis wrote as follows to Alder Hey:

> *"I am aware that [AR] has gone missing as Alphonse had contacted the office this morning. Alphonse has acted appropriately by contacting the police and that is only advice we could give. There was a high chance following the meeting last week that this may happen as Alphonse made it clear that he didn't want the support to cease from CFW on the fact [AR] may not attend Presfield and the anxieties around the transition. As agreed in the meeting by all professionals there was no outstanding work from CFW level 3 and for the family to be supported via health and school (EHCP). The case was closed to CFW after the meeting. Moving forward I'm unsure of what other support can be offered to them other than what is already in place and as parents need to be positively encouraging [AR] to attend and follow any advice from school and strategies learnt through*

757 Opening Statement on behalf of Lancashire County Council IWS000065/21/§27; Closing Statement on behalf of Lancashire County Council LCC002314/1/§2; T/S: 31/64/12-66/20.

758 T/S: 31/149/23-150/6; LANC000088.

the parenting programme. If you feel the needs of the family meets level 3, however this one instance currently would not meet threshold as parents acted appropriately calling the police."[759]

218. It is right to note by way of context that the formal route for this information to come into LCC for receiving consideration for re-opening social care involvement in AR's case was through the MASH (as to which, see further below). It was not a matter for CFWS, who had no role in taking such decisions. However, even allowing for this, this response on the part of Ms L Lewis showed an unacceptable lack of professional curiosity on her part. Whatever her intention, on an objective reading of this email Ms L Lewis was militating to CAMHS against the possibility of social care reopening the case before the true circumstances of what had happened were even known. The police were not contacted in order to obtain detailed information. It indicated a lack of willingness to work with other agencies who were involved with AR. I regret to say that in the context of a child who was still missing, for whom until three days earlier Ms L Lewis had been the lead professional, it also lacked any sense of concern for his wellbeing. Ms Barrett accepted that the whole tone of Ms L Lewis' email read as *"not for us"*. She additionally acknowledged that it reflected a culture that if the 'actions' had been completed, the case would be closed. I was told that this approach has now changed.[760] I do not doubt that Ms L Lewis was ordinarily well intentioned towards the young people and families with whom she worked, but this response was simply inappropriate.

219. Third and finally, after AR was found, Police Constable Eve Rhodes made a high-risk police safeguarding referral, which went to the LCC MASH.[761] That included the information that AR had been found on a bus carrying a small knife. He had then disclosed that he was planning on stabbing someone with the knife in order to get his social media accounts deleted, and about having previously made poison for the same reason.

220. That report was not linked with the referral to the Missing from Home team. Instead, it was allocated for investigation within the MASH on 21 March 2022, four days later. A number of telephone calls were made to Laetitia M, but with no response. A letter was sent to her inviting her to make further contact.[762] The MASH also contacted Ms L Lewis, providing very limited detail.[763] Ms L Lewis' response took a similar tone as with CAMHS, pressing upon the MASH reasons why this case should not be re-opened to CFWS and not seeking any further detail.[764]

759 LCC000966.
760 T/S: 30/116/2-24.
761 LCC000157.
762 LCC000157/5.
763 LCC000910/2.
764 LCC000910/1.

221. Part of her reasoning was *"My professional opinion is father doesn't want to take responsibility for his actions and attitude towards [AR] and will often antagonise [him] which was shown during the last TAF meeting"*.[765] That observation was very far from being a rounded view of the case, and did not properly take into account the information Ms L Lewis knew about AR's violence towards Alphonse R less than four months previously.

222. On 22 March 2022, the MASH closed the case as *"no identified safeguarding or support needs that would require CSC/CFW intervention"*.[766]

223. Separately, in response to PC Fairclough's Missing from Home notification, Ms Chapman, a support worker in the Missing from Home team, was tasked to conduct a Return Home Interview with AR. Ms Chapman candidly accepted, both in writing and in her oral evidence, that her work on this fell short of what it should have been.[767] It is fair to record that there were a number of factors in Ms Chapman's personal life at the time which are likely to have affected her approach to her work. It is also fair to note that the system, as LCC operated it at the time, was set up so that the Missing from Home team effectively worked in a silo, separate from the rest of Children's Social Care, and in circumstances where they had to conduct an extremely high volume of Return Home Interviews with minimal time or scope to read into cases in advance. Ms Chapman, who had a great deal of experience working with vulnerable children, accepted that the training she received for her role was excellent, but also expressed the view that the Missing from Home team was not adequately resourced to carry out the required number of interviews.[768]

224. Ms Chapman was aware that AR had been found in possession of a knife. But she did not see the MASH record in relation to PC Rhodes' safeguarding referral and had no knowledge that AR had referred to making poison or had referred to an intent to stab someone. She did not have any awareness of AR's background or previous interactions with LCC. She agreed with the self-evident proposition that she was put in an extraordinarily poor position to conduct an effective Return Home Interview.[769] I consider that this was a result of how the Missing from Home team was set up and was expected to work by LCC Children's Social Care, rather than a failing on the part of Ms Chapman. Ms Chapman agreed that it would be helpful if the system of notes had a means of rapidly identifying key information about a child with warning markers and the recent history.[770]

765 LCC000910/1; T/S: 29/190/17-191/25.

766 LCC000157/6.

767 Witness Statement of Ms Chapman LCC001857/§55; T/S: 29/259/13-20.

768 T/S: 29/237/25-240/16.

769 T/S: 29/243/24-248/15.

770 T/S: 29/247/8-16.

225. At the Return Home Interview itself, which took place on 22 March 2022 (shortly after the MASH had closed the police safeguarding referral), Ms Chapman took notes which she later transcribed onto an interview pro forma.[771] AR gave a very confused account of why he had gone missing, referring to the possibility of police accessing his social media accounts. He denied, in response to a direct question, that he had had anything on him that could have been a weapon. That was an obvious lie. Ms Chapman accepted that both of those issues should have been explored further, in particular the lie about the weapon.[772] She frankly accepted that this was not good enough in terms of professional curiosity. That was a sensible and proper concession, but I must also observe that the weakness of the Return Home Interview was at least in part the result of the very limited information provided to Ms Chapman. Had she been aware of AR's statements about wanting to stab someone, or about poison, she said that she would have sought to conduct a joint visit with a colleague, as a result of the risk AR posed, and would have been more likely to follow up on these issues and to recommend additional follow-up actions after the interview.[773] I accept without reservation that this is what she would have done, had she been properly informed about the case. Shockingly, at the time of the Return Home Interview, the information she needed had been held by LCC MASH for just over four days.

226. This was a very serious failure by LCC MASH to understand or act on an obvious risk to others. It reflected the collective inability to appreciate the need to address risk to others, over-reliance on consent as a pre-requisite for engaging, and an inability to share information effectively even within LCC.

227. Ms Anderson would have expected the police safeguarding referral to have led to a strategy discussion. That would have then led to a joint section 47 enquiry that would have involved the police and Children's Social Care visiting the family home, as well as involving The Acorns School, Presfield High School and CAMHS. There would potentially have been a Prevent referral given the reference to poison.[774] I would add that there should also have been a referral to CYJS, either for preventative work or following an out of court or court disposal.[775] Ms Anderson accepted the reaction constituted an extremely grave failure by LCC, given that they missed the opportunity to convene a multi-agency risk assessment which *"with what we know now, [it] would have made a huge difference to what happened in the future"*.[776] She made clear that LCC *"take responsibility for our part and we want to say sorry and I want to say sorry"*.

771 LCC000159.
772 T/S: 29/250/21-252/23.
773 T/S: 29/258/24-259/20.
774 T/S: 31/153/13-154/19.
775 T/S: 29/44/16-45/6.
776 T/S: 31/156/1-5.

228. Ms Anderson also accepted that Ms Chapman had insufficient information concerning the circumstances in which AR went missing and was later found and she failed to challenge AR sufficiently, including especially as to his lie about not having had a weapon. She was the only individual from LCC to see AR after the incident, and she was wholly lacking in relevant knowledge of the case. Ms Anderson's evidence was that the Missing from Home team has now been incorporated more closely into the rest of Children's Social Care, and that *"we now absolutely make sure that our Missing from Home workers have the history before they go out"*.[777] It is encouraging that there has been a self-identified need for improvement on the part of LCC in this regard. Ms Anderson was reluctant to accept that the system in 2022 treated Return Home Interviews as little more than a tick-box exercise, but I find that this is exactly what appears to have occurred at least in AR's case in March 2022.[778]

229. In Ms Anderson's view, exploration of these issues should have led to a safeguarding referral from the Missing from Home team.[779] I note that this ought then to have had the same consequences, such as a strategy meeting and a section 47 enquiry, as the police safeguarding referral that had already been made to the MASH, which I have set out above.

230. This was a critical missed opportunity for a substantive intervention, which is aggravated by the fact that AR had been closed to CFWS, on the erroneous basis that there was no further work to be undertaken, just three days before he went missing. I have set out in my consideration of the police response to this event what the likely consequences would have been had AR been arrested rather than simply returned to his parents. The same applies here: it is likely that had there been a proper investigation of the issues raised in the police safeguarding referral, or had there been an effective and properly informed Return Home Interview that displayed adequate professional curiosity, then the subsequent steps by Children's Social Care, police and other agencies would have led to AR's behaviour becoming the focus of intense scrutiny. The initial police response to the knife on the bus incident was clearly wrong for the reasons I have addressed in Chapter 7: Policing. But because LCC then also failed in response to this episode, there was no multi-agency reassessment of whether more action needed to be taken in response to the incident.

231. That scrutiny would have involved detailed attention to AR's history. In that context, it would also have been likely to prompt reconsideration of any action it was appropriate for Lancashire Constabulary to take. Consistent with my conclusions in respect of that issue in Chapter 7: Policing, I consider that the likely result would have included identification of AR's purchase of a ricin precursor and chemistry equipment in January 2022, and also his downloading

777 T/S: 31/107/10-15, T/S: 31/151/16-24.

778 T/S: 31/151/25-152/9.

779 T/S: 31/151/2-10.

of the Al-Qaeda manual in autumn 2021. In those circumstances, and although there is a considerable gap of time, the handling of this episode by LCC was a missed opportunity to prevent AR's attack in July 2024.

232. On 14 May 2022, just under two months later, there was a further 999 call at 4:30 to Lancashire Constabulary. AR had woken up and demanded access to a laptop. When this was refused, he threw food and locked himself in the bathroom, overfilling the bath so it flooded. His parents reported that he was *"severely autistic"* and had not taken his medication for a week. The police spoke with AR and he agreed to go to sleep. A high-risk vulnerable child report was submitted to the MASH, which concluded: *"He is getting older and stronger. His parents are struggling to cope with him. They are going to contact CAMHS and his GP. Any help would greatly assist the family"*.[780]

233. Around the same time, on 16 May 2022, the deputy designated safeguarding lead of Presfield High School made enquiries of the MASH about AR's previous contact with LCC, in the light of AR's failure to attend school and concerns over his behaviour. LCC refused to provide Presfield High School with any information without either appropriate consent or immediate safeguarding concerns. Appropriate attempts by Presfield High School to follow these referrals up with LCC did not lead to any change of position and AR remained closed to all forms of social care services.[781]

234. Ms Anderson's evidence was that concerns at this level were not sufficient to override the need for consent before information can be shared. I return to this issue in my conclusions and recommendations. She did however express the view that *"because of our interactions with the family already [...] we should have chased consent. We could have asked a worker to go out and knock the door and ask for consent. We do that now and I think we should have done it then"*.[782] I agree that these two referrals should have received more sustained attention from the MASH. The fact that they did not reflects the limited weight given to referrals from other agencies, and the limited appreciation of the full extent of AR's concerning history.

235. From May 2022 to April 2023, there was very little contact between Children's Social Care and CFWS on the one hand, and AR and his family on the other.

780 LCC000170/4.

781 LCC000165/4; LCC000168; LCC000170.

782 T/S: 31/157/20-158/1.

April to September 2023: the fifth CFWS episode

236. By way of context to this episode, on 21 March 2023 Presfield High School had called Lancashire Constabulary asking for them to carry out a welfare check, as they had not seen AR since 25 May 2022. As covered in Chapter 7: Policing, Lancashire Constabulary determined that this was not a matter for a police response.

237. Mrs Cheryl Smith from Presfield High School noted:

> *"The red tape is frightening - not under the remit of children missing education team although not seen by school since 25 May 2022. Doesn't meet threshold for police welfare check as we can't say we think a crime is committed/emergency risk to him. Sefton Welfare team tell us to do the above Lancashire SEN tell us to ring police (who won't go) and Lancashire social care MIGHT say he doesn't meet their remit. Short of breaking in I don't know how to see this kid. The only option not exhausted is Steve Baker who MIGHT go out to help us because he's attached to us."*[783]

238. The reference to Steve Baker is to an officer from Merseyside Police who worked with Presfield High School. I have addressed his contribution in Chapter 11: Education.

239. Mrs Smith's prediction in respect of 'Lancashire social care' was prescient. On 22 March 2023, Presfield High School sought assistance from the LCC MASH given that they had not seen AR since 25 May 2022, and his parents were denying access to him whenever Sefton Council's School Attendance Service visited the home. The LCC MASH recommended, however, that the matter should be closed. The reasons given were as follows:

> *"Parents were not contactable for the enquiries but have been written to and asked to call MASH if support is needed. Clearly explicit consent has not been gained for this referral. Although [AR] is likely to continue to have poor mental health in future if left unaddressed; and not achieve academically, which will impact on his future choices, it is felt there are little grounds to override consent under S47. If parents return call support options can be explored further."*[784]

240. I am concerned at this reasoning. Whether or not 'consent' had been given, bearing in mind the implications the local authority identified for AR if this state of affairs persisted, steps should have been taken to re-engage with the family to attempt to rectify what had become an enduring and seriously troubling situation. As Ms Anderson accepted, given the history to the case more should have been done to understand what was happening, even though it did not, in her view, meet the threshold for intervention under section 47.

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783 PRE000511.

784 LCC000186/5.

That could have included more sustained steps to try to obtain consent. Ms Anderson accepted that there was an apparent gap in the power to take action in cases such as these.[785]

241. On 4 April 2023, however, AR's father did revert to the MASH seeking assistance. The family was again opened to the CFWS and a new lead family support worker, Ms Williams, appointed – the fourth in under four years.[786] She was again supervised by Ms Barrett.

242. Ms Williams' view was that the situation she was dealing with was a typical level of dysfunction for CFWS to deal with. Her approach to a case where there had been prior contact was to read as much as she could of the previous records, in particular the contact records and the most recent Early Help assessment. That represents good practice. Although she was not aware of much of the detail of the incidents in 2019 to 2022, I assessed that Ms Williams had a good understanding of at least the broad themes arising from AR's earlier contact with LCC, including his history of carrying weapons, his interest in some extreme views, a varying level of co-operation and candour from AR and his family, and his ASD diagnosis.[787] That information can only have come from a relatively thorough attempt by Ms Williams to inform herself of the case history. But it is striking that important details from those earlier interactions – such as what material AR had been accessing or seeking to access online, the Prevent referrals, his interest in weapons and poison, and his intent to kill in 2019 – did not appear to be known even to a family support worker who I consider did take steps to inform herself about the background to the case. That points to a systemic difficulty in the retention, passage and ultimately dilution of information over time within LCC. I note additionally that Ms Williams did not recall any training on ASD covering the possibility that, in some cases, it could be a factor pointing to increased risk towards others.[788]

243. On 11 April 2023, Ms Williams and Ms Barrett together conducted a visit to 10 Old School Close.[789] AR was calm. He did not make eye contact or speak unless spoken to. A hole in the wall was noticed; it had been caused by AR throwing something with the intention of damaging the wall in order to get his father's attention. It was thought that a picture placed oddly might be concealing another hole in the wall. Ms Williams was aware that AR had previously been violent towards family members. Her view was that AR had the potential to be violent, although he was not acting in that way at this time as far as she could observe.[790] Alphonse R, when asked about this, said *"the family are safe and there is no longer any violence in the home"*, and *"there has not*

785 T/S: 31/158/13-160/6.

786 LCC000187; LCC002311/103 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

787 T/S: 30/127/13-130/8.

788 T/S: 30/130/9-20.

789 LCC002311/103-104 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

790 T/S: 30/135/1-6.

been any incidences of [AR] lashing out".[791] Ms Williams was clearly alert to the possibility of a lack of candour from AR and/or his parents, as she made an astute observation about AR's mobile phone apparently being broken, despite the fact that she had seen it working two days earlier.[792]

244. In the circumstances, Ms Williams did what she could to explore this issue. Her efforts to do so were hindered by a lack of proper candour or co-operation from both AR and his parents. If AR was continuing to be violent in this period, then they did not disclose it to CFWS or other agencies. Alternatively, if it is right that in this period there was little or no violence from AR towards Alphonse R, then this would only have been due to the extreme accommodations that AR's parents were having to engage in (and I note that Presfield High School's report to the MASH in March 2023 suggested that AR's parents were refusing them access as they were concerned about AR's reaction). They were plainly not wholly candid with CFWS, or other agencies, about the extent of these accommodations. If they had been, I am confident that Ms Williams would have identified this as an area which required intervention.[793]

245. Ms Williams visited again on 14 April 2023.[794] She conducted an assessment exercise with AR in which, among other things, he claimed that his online activity was limited to YouTube and that he was safe online.[795] Ms Williams and AR had a full conversation about AR's online activity. In approaching this conversation, Ms Williams was aware in general terms of previous concerns about AR's extreme thoughts or views, but nothing of concern about his online behaviour was disclosed. I am sure, in the light of Merseyside Police's findings about AR's internet usage, AR was deliberately misleading Ms Williams in this regard.

246. On 2 May 2023, Ms Williams accompanied AR on a short walk. He appeared uncomfortable about being outside and was unwilling to engage with Targeted Youth Support again but was making some efforts to re-attend school. Ms Williams was justified in considering that there was some, although limited, progress.[796] It was however short-lived. Thereafter there was a series of failed visits, on 9 and 18 May 2023, where AR simply refused to engage with Ms Williams despite her best efforts.[797] AR's attendance at Presfield High School continued to be minimal.

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791 LCC000192/2.

792 LCC002311/104 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document); T/S: 30/134/13-20.

793 T/S: 30/133/19-137/14.

794 LCC002311/104-105 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

795 LCC000357/2.

796 LCC002311/105-106 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document); T/S: 30/139/16-140/21.

797 LCC002311/107-110 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

247. On 25 May 2023, Ms Williams led the first TAF meeting of this episode, attended by Presfield High School, CAMHS and AR's parents as well as CFWS. AR did not attend the meeting.[798] It was agreed that Mr Coughlan from Targeted Youth Support would be asked to try to engage with AR over a 6-to-12-week period, on a one-to-one basis. This was an appropriate step, in particular the attempt to make use of Mr Coughlan's prior relationship with AR. It was apparent from the information shared at the meeting that AR's parents were not able even to enforce basic steps like getting AR to take his medication for anxiety at the appropriate time. Ms Williams agreed that this was not just a family that were struggling to cope at this stage, but that was not coping and was a long way away from anything like normal.[799]

248. Alphonse R asked Ms Williams to assist with an attention deficit hyperactivity disorder (ADHD) referral. Ms Williams responded appropriately that referrals for ADHD are not accepted from CFWS.[800]

249. On 1, 8, 15 and 22 June and 16 July 2023, Ms Williams and/or Mr Coughlan conducted visits to the home address, but on each occasion AR refused to engage. On 22 June 2023, Alphonse R requested that Ms Barrett visit to speak to AR, but she was absent from work due to sickness. Moreover, because she was a supervisor, she did not hold cases herself. Ms Williams was however willing to explore the possibility of a further joint visit once Ms Barrett was back at work. On 17 July, Ms Williams appropriately sought advice from Ms Barrett's line manager, Ms Della Heaton, in Ms Barrett's absence.[801] By this point, she had not seen AR in person since early May. Ms Heaton's response made clear that due to Ms Barrett's absence, a joint visit was not possible, and this would have to be explained to Alphonse R. As Ms Williams had noted in her request for advice, it was not even clear that AR would be willing to engage with Ms Barrett.

250. Following a TAF meeting on 17 July 2023, the possibility of a joint visit at some point in the future remained.[802] Additionally, Mr Coughlan wrote to AR encouraging engagement, as an alternative means of offering support. This was unsuccessful. Ms Williams agreed that it was difficult to find ways to offer AR, or his parents, support. AR's parents, particularly Alphonse R, had a fixed idea as to what support he wanted and the terms he wanted it on: *"they wanted what they wanted and nothing else was going to be good enough"*.[803]

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798 LCC000359.

799 T/S: 30/144/13-21.

800 LCC002311/112 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document); T/S: 30/144/22-145/25.

801 LCC002311/117-118 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

802 LCC002311/118 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

803 T/S: 30/149/16-151/1.

That was reflected in AR's parents' lack of engagement with the suggestion of a referral to a further specialist parenting course which Ms Williams had explored.[804]

251. A joint visit by Ms Barrett and Ms Williams to 10 Old School Close did occur on 6 September 2023. AR refused to engage, but they met with Alphonse R. Unfortunately, as Ms Williams accepted, her note of that meeting is incomplete.[805] But it is clear that the view taken by Ms Barrett at that stage was that as AR was refusing to consent to any engagement, there was nothing further that CFWS could do. Because Ms Williams was away on medical leave shortly thereafter, Ms Barrett in fact dealt with the closure which was covered at a TAF meeting on 13 September 2023.[806] The minutes of that meeting record:

> *"[AR] has made it very clear to several professionals that he does not want the support […] there are no safeguarding risks."*

252. The case was then formally closed on 29 September 2023.[807] Ms Williams agreed in evidence that this was not a case which was being closed because all of AR's needs were met. AR was in fact as bad as he had been at the start of the episode. Instead, it was closed because no one could work out how to engage with AR to get him to accept help.[808] Ms Williams' view, with which Ms Anderson for Children's Social Care agreed, was that there was insufficient evidence of risk of significant harm to AR for this to be referred to Children's Social Care for a section 47 enquiry.[809] Ms Anderson went on to say that she found it was concerning that there was no power or ability for Children's Social Care to take action in this situation. I agree, and return to this topic in my conclusions and recommendations below.

253. While I recognise the extensive steps taken by CFWS, particularly by Ms Williams but also by Ms Barrett and Mr Coughlan, to try to engage with AR in this episode, I am gravely concerned that AR's refusal to engage was in the end simply accepted as an absolute block to further work. Active consideration should have been given to stepping the case up to level 4, given:

    a. First, AR's substantive withdrawal from education and contact with the other relevant agencies;

    b. Second, his entirely friendless and isolated life, almost never leaving home;

804 LCC002311/119 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document); T/S: 30/151/2-152/1.

805 LCC002311/120 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document); T/S: 30/154/12-24.

806 LCC000365.

807 LCC000355.

808 T/S: 30/156/14-23.

809 T/S: 30/158/2-159/7, T/S: 31/162/1-165/5.

c. Third, his concerning behaviour over a number of years in relation to knives and violence;

d. Fourth, the effective loss of control over AR by his parents within the home and the violence demonstrated by AR in that context;

e. Fifth, his earlier stated intention to harm others.

It was evident that AR was spending considerable periods of time on the internet – indeed, he had no known other activity – which historically had involved AR researching wholly inappropriate and extremely violent material. Entirely excluding the knowledge of what occurred on 29 July 2024, there were strong grounds for a heightened concern that AR's circumstances were deteriorating, resulting in an increased level of danger to himself and others.

254. By this stage, this was undoubtedly a difficult case for LCC. However, given the history set out above, I consider that the decision to close the case on 29 September 2023 was simply wrong, particularly in the absence of careful consideration of stepping the case up to level 4, that of a child in acute need. The interpretation given to 'safeguarding concerns' was excessively narrow, bearing in mind his previous behaviour and his worsening circumstances, along with a lack of any understanding of how he was spending his time and his emerging thoughts and intentions. Ms Ashworth suggested that she could not say whether AR would have met the threshold for level 4, although she accepted that *"on balance"* there should have been consideration of stepping it up to that level.[810] In my view, it is likely that AR did meet the threshold for level 4, and that in any event this possibility should have been given the most careful consideration by CFWS in conjunction with Children's Social Care. Acceptance at level 4 would have meant the case being transferred to Children's Social Care.

255. I do however accept that the scope of Children's Social Care's powers in this situation would have been limited: AR had not committed any recent criminal offences, and because he was by this point over 17, it would not have been possible for a court to make any order under section 31 of the Children Act 1989. So, while I do consider that consideration should have been given to stepping AR up to level 4 in September 2023, and that the result of that consideration ought to have been Children's Social Care opening a case in respect of AR, I cannot say that by this stage that would have prevented the attack in July 2024. The tools for effective intervention at this stage were simply not available.

256. Following the closure on 29 September 2023, there was no further contact between AR or his family and LCC Children's Services until after the attack on 29 July 2024.

810 T/S: 31/76/13-77/5.

November 2023: the role of Adult Social Care

257. While there was no further involvement from LCC's children's services with AR after October 2023, on 8 February 2022, Ms L Lewis had appropriately referred AR to LCC's Adult Social Care Transitions Team. This team works with young people who are approaching their 18th birthday, to ensure a smooth transition to adult services, including with any support to which they are entitled under the Care Act 2014.

258. Despite being referred in February 2022, the Transitions Team did not carry out any assessment visit until 9 November 2023 when Ms Suzanne Walmsley, a social worker, visited to complete an assessment. Mr Matthew Embley had been assigned the case in February 2022 and by the time he left in August 2022, no work had been undertaken on the case. That was in line with the practice within this team at that time of not taking steps on a file until the child reached 17 years of age. I note that Ms Helen Coombes, LCC's Director of Adult Social Care, was clear that this did not represent good practice, as there needs to be enough time to ensure an effective transition.[811] This was a structural failing rather than reflecting on Mr Embley.

259. Ms Walmsley was allocated the case on 10 August 2022. Her first intervention was just after AR's 17th birthday on 14 August 2023 when she attempted to arrange an initial assessment. As I have noted above, this ultimately took place on 9 November 2023.

260. AR refused to engage when Ms Walmsley visited the family home that day. This was due, it was said, to AR's anxiety. Instead, Ms Walmsley spoke to AR's parents. After that meeting, there was no follow up and no further steps were taken. However, a refusal by the subject to engage should have led to consideration of a multidisciplinary team discussion, a capacity assessment and further steps to engage with the individual, including other than face-to-face.[812]

261. Ms Walmsley noted that in this period, the Transitions Team were experiencing excessive caseloads which had become increasingly unmanageable. There was significant long-term sickness in the team, and staff were not being replaced when they left their role. Ms Coombes said that now the *"business process has been completely refreshed"*, with work being prioritised and a limit to the size of caseloads.[813]

262. Ms Walmsley's lack of knowledge about the background to AR's case was notable. She failed to review the Child and Family Assessment from September 2021; she was unaware of the more recent CFWS contact because the referral came before the final episode; she did not have information on the missing from home episode in March 2022 (which, again, occurred after the

811 T/S: 31/172/11-173/11.

812 T/S: 31/180/17-181/7.

813 T/S: 31/175/8-23.

referral); and she would have had no information on AR's forensic history or the Prevent referrals. She was unaware of AR's history of violence and aggression, which – had she been aware of it – would have led to a referral to her line manager and potential liaison with Children's Social Care.[814] Ms Walmsley accepted that her preparation for the case was inadequate. In addition to her individual failings in this regard, the Transitions Team did not at that time have access to CFWS records on LCC's case management system, where very substantial information about AR was held. That was a significant and obvious systemic shortcoming which has now been rectified.[815]

263. In Ms Coombes' view, given the background to AR's case, it should have been discussed with a manager, potentially leading to further professional involvement with the family, although this may have fallen short of support under the Care Act.[816]

264. In the nine and a half months between 9 November 2023 and 29 July 2024, the visit Ms Walmsley had conducted was not written up, the assessment was not completed and no follow up was actioned. This was despite the case being discussed in supervision meetings between Ms Walmsley and her supervisor, Ms Emma Clough.[817] After the events on 29 July 2024 retrospective notes were written up, although they were acknowledged to have been completed after the event.[818] Ms Coombes accepted that if the attack on 29 July 2024 had not occurred, there could be no confidence the notes would ever have been compiled. This was a highly unsatisfactory state of affairs, for which Ms Clough as the supervisor also bears responsibility.[819] Ms Coombes' evidence was that there is now a system in place which should prevent cases being handled in this inadequate manner.

265. There have been three separate reviews into these failures.[820] There has now also been a referral to Social Work England in July 2025 in relation to Ms Walmsley, who it is only fair to observe had been experiencing personal difficulties at the relevant time.[821] I do not of course express any views on what conclusions Social Work England should reach.

266. The reality is that had AR not committed the attack shortly before his 18th birthday, there would have been no post-18 support and indeed no proper consideration of what support would have been appropriate. Despite a relatively

814 Witness Statement of Ms Walmsley LCC001805/§§111-113.

815 T/S: 31/173/12-174/5, as corrected and clarified by the Second Witness Statement of Ms Coombes, LCC002319.

816 T/S: 31/184/3-185/10.

817 T/S: 31/185/11-18.

818 LCC000438; T/S: 31/186/19-187/15.

819 T/S: 31/187/16-188/11.

820 LCC000435; LCC000462; LCC001954.

821 T/S: 31/190/2-191/19.

early referral to the Transitions Team, the work it conducted had no impact whatsoever. It might as well not have happened. Ms Coombes accepted that the Transitions Team achieved nothing as regards AR.[822]

267. I am however reassured that there have been extensive changes implemented by LCC in this area since 2023.[823]

Conclusions and recommendations

268. From the chronology above, a number of broad themes emerge.

269. Before considering those themes, I emphasise that I entirely accept LCC's submission that all its employees acted with an intention to do good. They were undertaking difficult and pressured jobs in challenging circumstances and for an important part of the chronology the Inquiry has been considering they were dealing with the substantial challenges posed by the COVID-19 pandemic. In addition, I reiterate the challenges for individual members of LCC staff, particularly those working within CFWS, in dealing with a difficult and complex case in the context of an overall framework that was, as I set out below, ill-suited to dealing with AR. Those individuals are not to blame for the systemic issues that they had to grapple with: those were the responsibility of LCC and of national-level systems and culture.

270. LCC has made some sensible concessions as to areas where its work fell short of what should have been expected. They have particularly highlighted that:

    a. There were times when LCC's role in holding and monitoring the multi-agency plan around AR was not as robust as it should have been (in particular, in early 2020);

    b. CFWS should have provided continued support to AR as he transitioned to Presfield High School in early 2022;

    c. A referral to Children's Social Care and a multi-agency assessment should have occurred following the incident on 17 March 2022;

    d. There were extensive failures in respect of the Adult Social Care Transitions Team.

    I am grateful for those appropriate concessions. I do not, however, consider that they fully reflect the extent of the failures by LCC in this case.

822 T/S: 31/188/12-16.

823 Witness Statement of Ms Coombes LCC001856/§§77-89.

Social care and children who pose a significant risk of violence to others

271. A lack of appreciation on LCC's part of the need to manage AR's risk to others was apparent at multiple points throughout the above chronology. Non-exhaustively, key episodes where this occurred were:

    a. In LCC's response to the police referral and the information from Mr Cregeen in October 2019;

    b. In the MASH's response to concerns being raised by The Acorns School about AR prior to the 11 December 2019 attack;

    c. In the MASH's initial refusal to step up AR's case following 11 December 2019, following Ms Hallaron's request;

    d. In the closure by Children's Social Care of AR's case in March 2020;

    e. In Ms Fontaine's and Ms Croll's responses to The Acorns School's concerns in May 2020;

    f. In Ms Fontaine and Mr Fitzpatrick's responses to AR's assault on his father in January 2021;

    g. In the LCC response to AR's episodes of violence in November 2021;

    h. In the LCC response to the 17 March 2022 bus incident.

272. LCC has rightly emphasised that the need to manage the risk posed by young people such as AR to others is not and was not well understood nationally. That is reflected by the fact that there was not (and still today is not) any specific multi-agency forum for considering and assessing the risk posed by AR or someone with a similar profile. The multi-agency structures that existed at the time were not targeted towards or well suited to this task, as opposed to ensuring that any risk of harm to the child was identified and addressed. There was no multi-agency process for assessing, sharing and recording risk of this kind, and only the CYJS focused on the short to medium term risk of reoffending in children. Given this issue was not the focus of concern for those working with AR, there was no process to flag long-term risk, which led to loss of detail and the dilution of the recording of risk.

273. Ms Anderson helpfully addressed this issue and explained that neither the Children's Social Care National Framework, introduced in December 2023, nor Working Together to Safeguard Children address the potential risk of harm from children to others.[824] She explained in detail how, certainly up to the time of these events, the primary focus of social work has been the risk of harm to children. Although children's services are 'involved' in the risk that

824 LCC001898.

children and young people may pose to others, the legislation 'pushes' those involved in this work to focus on the question *"is the child you are working with suffering harm?"*[825]

274. That also reflected Ms Jameson's evidence about how she understood her Children's Social Care role in December 2019 to March 2020, as well as the consistent evidence from CFWS.[826]

275. In turn, the national guidance and the culture of focus on preventing harm to children is undoubtedly consistent with the legislative provisions, particularly the relevant provisions of the Children Act 1989 and the Children Act 2004, and the guidance Working Together to Safeguard Children (in both its 2018 and 2023 editions), which focus on risks of harm to the child and not the risks they may pose to others.

276. This legislative and cultural focus on preventing harm to children is for good reason a deeply embedded feature of the culture within LCC's children's services. While the Inquiry's Phase 1 evidence was limited to the response of LCC, I have no reason to doubt that this is reflective of the national position as well. In very many cases, risks to the child will be the sole issue which they have to consider. But there are cases, of which this was one, where the risk which a child or young person poses to others must be properly understood and addressed. LCC's own policies recognised this at all material times, and Ms Anderson accepted that it was a factor to which children's services should have regard.[827]

277. I accept the submission of LCC that the present child protection system is imperfectly designed to address the problem of the risks that children and young people can pose for others. For instance, as Ms Anderson accepted in evidence, there potentially needs to be a way of monitoring *"the risk that might be happening in private in a home, in a bedroom"*.[828] I would add that this need arises for consideration in other contexts than the present. I have addressed this elsewhere in this report.

278. On the issue of whether harm to a child or young person includes the adverse experience of custody or being brought into the criminal justice system, Ms Anderson indicated that previously this has not been treated as a form of significant harm. She provided the statistic that there are 140,000 children in the United Kingdom between the ages of 13 and 17 who are believed to carry knives, and that there are 3,698 knife crime offences in that age category.[829] Her point was that if those children were brought into the definition of 'likely to suffer significant harm', that would overwhelm the safeguarding system.

825 T/S: 31/108/19-110/5.

826 T/S: 29/64/22-65/7.

827 LCC001900/15-20; T/S: 31/110/6-111/19.

828 T/S: 31/164/19-165/5.

829 T/S: 31/113/16-114/12.

279. Ms Anderson accepted the proposition the child protection services are not set up to consider this kind of risk and she considered it is not part of the primary work of Children's Social Care.[830] Instead, her view was that responsibility for assessing the risk a child poses to others rests with the multi-agency meetings such as Prevent, multi-agency public protection arrangements (MAPPA) and Multi-Agency Safeguarding Partnerships (MASP). She also emphasised FCAMHS as the body with the training to be able to assess whether a child is a risk to another as a result of any psychiatric or psychological factors. In line with LCC's concession outlined above, Ms Anderson did accept that now a more robust multi-agency plan, with clear monitoring arrangements, would be developed to address risks of this kind.[831] She also accepted that there should have been such a plan in March 2022.[832] To that extent, she appeared to accept that Children's Social Care would now have a role in co-ordinating the response to this kind of risk. In my view, it should also have done so in 2019 to 2020.

280. I do, however, accept that Children's Social Care and the Working Together to Safeguard Children framework are not apt to be re-targeted towards risk of harm from, instead of to, children. I have already set out my overarching recommendations as to the need for Phase 2 of this Inquiry to consider (1) what single agency or structure should be appointed or established to record, monitor and coordinate interventions for children and young people who present a high risk of serious harm; and (2) to consider the development of a shared multi-agency risk-assessment tool that is clear, accessible and suitable for use across public sector services. Neither should be a task for Children's Social Care departments alone, or one which in my view they should lead.

281. However, even though the management of risk of harm from children ought not to be the principal responsibility of Children's Social Care, it is vital that this risk is not overlooked or missed because of the (proper) attention given to preventing the risk of harm to a child.

> **Recommendation 39:** The Department for Education should update Working Together to Safeguard Children and the Children's Social Care National Framework. These documents should highlight that safeguarding and child protection assessments, when considering what support to put in place and planned multi-agency working, must consider the risks posed by children to others.

282. Relatedly, although more narrowly, I was also concerned by the failure, in October to December 2021, of Ms Barrett and Ms L Lewis to act appropriately in response to concerns that AR might be at risk of radicalisation, and of the failure by the MASH in March 2022 to appreciate the possible need for a Prevent referral given AR's reference to making poison.

830 T/S: 31/114/17-23.

831 T/S: 31/140/8-141/14.

832 T/S: 31/153/2-154/19.

Recommendation 40: Lancashire County Council should ensure that by 13 October 2026 all its frontline staff have received suitable training, or refresher training, on Prevent.

Structures within LCC and the impact of reforms

283. The overarching issue I have addressed above and in Chapter 1: Fundamental problems, of a lack of a multi-agency mechanism for addressing the risks that children pose to others is a national issue. There were, however, a number of more local issues which affected LCC's handling of AR's case between 2019 and 2023. The first relates to the thresholds within LCC's children's services and the impact of the 2019 to 2021 reforms.

284. I am concerned that one significant result of the process of restructuring LCC social care between 2019 and 2021 was that if a case was not at CON level 4, on the new numbering (namely a child in need or subject to Child Protection), there was necessarily less intervention by qualified social workers than had previously been the case. Instead, decisions tended to be made by family support workers. Cases were, therefore, administered without the immediate supervision of a social worker, save for those at level 4. This was in the context of family support workers dealing with more complex cases under the new model.[833]

285. I accept that this new way of working was a response to national guidance and practice, but how it was implemented and supervised was the responsibility of LCC.

286. In that context, there were also frequent difficulties and barriers when it came to 'stepping up' the case from level 3 to level 4, which involved a transfer from CFWS to Children's Social Care, or opening it at level 4. I consider that there was a culture of institutional reluctance to do so. Non-exhaustively, that can be seen from the following episodes:

    a. The refusal of the MASH to open a case at level 4 in October 2019;

    b. The refusal of the MASH to open a case at level 4 in December 2019 when The Acorns School expressed concerns prior to AR's attack at Range High School;

    c. The reluctance of the MASH in December 2019 to step AR's case up to level 4 following the hockey stick attack at Range High School;

    d. The absence of any referral to Children's Social Care following AR's assault on his father in January 2021;

    e. The failure to consider stepping the case up in November 2021;

833 T/S: 31/27/17-29/8.

f. The decision by the MASH not to open a case at level 4 in March 2022;

g. The failure by CFWS to consider stepping AR's case up in September 2023.

287. The consistent reluctance of CFWS to consider stepping AR's case up to Children's Social Care was at least partly due to their perception that requests for this to happen would not be accepted, but it was also partly due to the new model encouraging family support workers to retain control of even more complex and challenging cases. It was also contributed to by the national position in respect of risk to others, which I have dealt with above. Ms Ashworth accepted there was little evidence of the CFWS workers having reflected on the risk of harm posed by AR to others or pushing for his case to be escalated. She accepted this was a shortcoming.[834]

288. There are no doubt good reasons why many children and families do not need the kind of intensive support and oversight that Children's Social Care is there to provide, and it is proportionate and appropriate for cases to be dealt with at the lowest possible level. But this should not mean that cases which genuinely merit a higher level are not recognised.

289. It is notable that in a recent independent evaluation of threshold decision making by LCC education and children's services in relation to CON level 3 and 4 support, some similar themes emerged, with a finding that threshold decision making *"is not consistent [...] for all children"* and that *"the threshold between level 3 and 4 lacks clarity"*.[835] That is the exact threshold which in my view was inadequately applied in this case.

290. Ms Ashworth described a *"steep learning curve"* which occurred in 2019 resulting from the *"mishmash of professional backgrounds"* of the new employees coming into the service, along with fairly newly qualified workers undertaking complex cases on the margins of level 4. It seems likely that this had an adverse impact on the management of AR's case. It is therefore encouraging that LCC is presently implementing a model which involves a return to the system in which a social worker provides supervision over and oversight of cases such as the present.[836] It is important that this change is fully secured.

Recommendation 41: Lancashire County Council should ensure that its arrangements for social workers provide appropriate support and supervision for family support workers handling level 3 cases on the Continuum of Need.

834 T/S: 31/34/1-36/6.

835 LCC002194/3-5.

836 T/S: 31/33/5-25.

291. The Inquiry's exploration of the structures within LCC also revealed a significant lack of flexibility. LCC has accepted that it should have kept AR's case open to CFWS in March 2022 to support him through his transition to Presfield High School. Other examples of this lack of flexibility included the closure to CFWS in February 2021 despite significant and obvious ongoing needs, the heavy focus on CFWS being a 'time-limited' service (although this has now changed) and the commissioning of the time-limited Targeted Youth Support to provide support for AR's social isolation in October 2021 when a Child and Family Assessment the previous month had identified the need for much more sustained support over months rather than weeks.

> **Recommendation 42:** Lancashire County Council should review its processes and training to ensure decisions regarding children and families are made on the basis of assessed need rather than inflexible criteria such as duration or ease of arranging services.

292. Another aspect of this lack of flexibility was the apparent lack of consideration given to the fact that AR was repeatedly re-referred to LCC. Ms Ashworth accepted that the significance of the cumulative effect of multiple referrals in AR's case may not have been sufficiently taken into account. She acknowledged that there did not appear to have been any consideration given to the possibility of stepping the case up to level 4 because the case kept *"coming back time and again"*.[837]

> **Recommendation 43:** Lancashire County Council should ensure that its policies and training emphasise the significance of multiple referrals when considering the relevant risks relating to a child (including the risk to others).

Note taking, record keeping and information sharing

293. This was an area where there were extensive issues across LCC. I have set out the details in relation to individual episodes above, but, non-exhaustively, the issues fell into three categories.

294. The first was a failure to take proper notes of meetings, visits or correspondence. Examples include Ms Jameson's failure to take notes, or adequate notes, of a number of home visits and meetings, Ms Croll's and Mr Fitzpatrick's inadequate notes relating to AR's referral order,

837 T/S: 31/86/10-87/1.

Ms Haydock's acceptance that she did not keep comprehensive notes of her meetings with AR's family in 2021, and Ms Chapman's failure to take adequate notes of the Return Home Interview on 22 March 2022. Many types of investigation uncover poor record keeping but the frequency of such findings should not dilute their importance. In the case of LCC, poor notes being taken of meetings was a persistent theme, not limited to a single member of staff. In some cases, it has only been possible to obtain a sufficiently full understanding of the meeting by considering the records of other agencies (particularly The Acorns School who generally took a much fuller, more impressive note). Such record keeping failures are significant because they would have limited what was passed on to later staff reviewing the notes.

295. The second was the failure by some LCC staff properly to review existing information. Examples included Ms Barrett's and Ms L Lewis' failure to understand the position in relation to Prevent referrals in October to December 2021, and Ms Walmsley's failure to prepare for the transition assessment of AR in November 2023.

296. The starkest example of this was Mr Coughlan's practice of intentionally not reading the case notes in advance of working with someone referred to him. Although I understand that it is important to keep an open mind, it seems to me to risk abdicating professional responsibility not to understand the main elements of the individual's history and the particular difficulties that may need to be addressed. As Ms Ashworth said, the *"voice of the child"* needs to be balanced with *"other voices that might cast light on the circumstances"*. Not to do so, she accepted, was bad practice. For instance, they would be ignorant of hazard indicators and the risk of harm being caused to others.

297. The third, which was heavily contributed to by both of the prior failings, was the dilution of important information over time. Examples of that included the gradual loss of the information that AR had intended to kill when carrying a knife in October and December 2019, which had ceased to feature in assessments by just over a year later; the dilution of information from Children's Social Care/CFWS into the CYJS AssetPlus assessment; the fact that the January 2021 assault on AR's father was not subsequently referenced in any assessments; the fact that in April 2023 CFWS was not aware of the 17 March 2022 episode; and the generally poor passage of information about AR's Prevent referrals.

298. The IT systems and structures were a contributing factor to this issue. Adult Social Care had no access at the material time to CFWS records. While CFWS and Children's Social Care had read-only access to each other's notes, there is no 'single point of truth' for events relating to a child.

299. Ms Anderson agreed that there ought to be a *"really good concise chronology that outlines the risk factors"*, in order for someone coming into the case being able to see the significant events. Furthermore, there needed to be a more concise way of transferring the facts. She indicated that considerable work has been done on this, with artificial intelligence about to be incorporated

"to make sure it's perfect".[838] Ms Barrett indicated that the information relating to risk is now captured in a significantly improved way, with a chronology and a front page that has 'warning flags'.[839]

300. An additional point of concern as regards information sharing, is the evidence that suggested that the LCC MASH does not provide feedback on what has been done with the referral to the original referrer, even where that is another professional agency (see paragraph 23).

301. In light of these issues, I make the following recommendation.

Recommendation 44:

1. Lancashire County Council should ensure that frontline staff are required to familiarise themselves with full case information, with this being embedded through training and performance review.
2. Lancashire County Council should review its IT systems to ensure that there are adequate mechanisms to bring all relevant information speedily to someone's attention. The warning markers visible on the front page should include markers relevant to risk of harm to others and use of or access to weapons, as well as factors relating to risk of harm to a child.
3. Lancashire County Council should conduct sampling audits to monitor record-keeping practices.

Autism

302. The MASH indicated on 6 December 2019 (from a MASH education officer) that:

> *"Children with autism (which [AR] may have) often develop obsessions around death, violence and crime. This is due to their neurodevelopment […]."*[840]

303. Ms Anderson agreed that there was no apparent recognition that in some cases an autism spectrum disorder, combined with a fixation on death, violence and crime can constitute an increased risk of harm to others.[841] She said that there was a widespread misunderstanding at the time in this context. A number of CFWS staff gave evidence to similar effect. It is on one level understandable that LCC workers were keen to make allowance for AR's autism. Very many children with autism will have additional needs which are challenging for their families and care workers and involve no question of risk to others. It is, however, very important that experience of such cases does not lead to a failure to recognise

838 T/S: 31/127/6-21.
839 T/S: 30/27/20-28/3.
840 LCC000024/5-6.
841 T/S: 31/131/23-133/4.

that in some individual cases, autism can lead to an increased risk to others. AR's fixation on those he perceived as slighting him was poorly understood. This included (but was by no means limited to) LCC workers.

Recommendation 45: Lancashire County Council should ensure frontline staff receive appropriate training on autism spectrum disorder, emphasising that autism does not necessarily explain or excuse behaviour. The Department for Education should ensure this approach is applied nationally.

Consent

304. On the evidence I have heard, I would support Ms Ashworth's concerns that, in those cases not subject to a child protection pathway, the requirement of consent to work with a family can sometimes act as a bar to making appropriate progress.[842] Given the obstruction and hostility on occasion shown by AR's parents, I would support consideration of expanded opportunities for social services, when necessary, being able to intervene without consent. Alphonse R and Laetitia M on a significant number of occasions – sometimes robustly – denied access to workers from a range of organisations who were attempting to speak with AR solely in his best interests.

305. Alphonse R's email of 2 November 2020 was a clear example of him trying to manipulate the requirement for consent to his perceived advantage. While on other occasions, AR's parents' refusal to let AR be seen may have been because they feared what AR's reaction should be, it nevertheless meant that social care were often – put simply – unable to 'get eyes' on AR.

306. Likewise, AR's own behaviour in October 2021 reflected his willingness to weaponise the requirement for consent against his parents and against CFWS.

307. There were also occasions when LCC itself treated consent as too constraining a factor. Examples include:

    a. Ms Fontaine's response to The Acorns School's concerns in May 2020, and the decision to close the case in June 2020;

    b. The response of the MASH to the police's high-risk safeguarding referral in March 2022;

    c. The refusal of the MASH to share information with Presfield High School in May 2022;

    d. The refusal of the MASH to intervene in March 2023, when AR had not been seen by Presfield High School for 10 months or by any professional for two months;

    e. The closure of the case in September 2023.

842 T/S: 31/44/20-45/20.

308. I note that the March 2025 evaluation of threshold decision making by LCC's education and children's service on the provision of support at level 3 and 4 reached a similar conclusion that:

> *"Across the CSSH [Children's Service Support Hub]/MASH, duty, and assessment, on some of the more complex cases not following a child protection pathway, work is not progressed due to repeated lack of consent. Whilst it is important to work in partnership with parents, there is not sufficient consideration for the day-to-day life of the children. The process for dispensing with consent needs to be tightened."*[843]

309. In consequence, I make the following recommendation.

Recommendation 46:

1. Lancashire County Council should consider how to address repeated lack of consent or manipulation of consent within existing legislation.
2. Phase 2 should consider whether legal reforms are needed to permit agencies, when considering children and young people who pose a risk of violence to others, to override parental consent to share information, access a child or young person, or obtain information about their online activity.

Child and Youth Justice Service

310. In addition to the general points in respect of LCC's children's services, I was concerned by the impression conveyed by the evidence of Ms Callon, in conjunction with that of Ms Roberts-Bibby for the Youth Justice Board, about the performance of LCC's CYJS in 2020 to 2021. It appeared to me that this fell well short of the standard which was to be expected. I recognise, however, that this was an intensely difficult period that was seriously affected by the national response to COVID-19. I also acknowledge Ms Callon's evidence that there have been national-level changes to the approach to referral orders since that time, as well as a range of reforms and improvements to this service within LCC.[844] These included, from October 2021, a new Effective Case Management Oversight Framework.[845] Because this post-dated any contact AR had with LCC CYJS, it was not proportionate for the Inquiry to explore in detail the effect of these changes.

843 LCC002194/5.

844 T/S: 28/197/14-198/1.

845 LCC002002; LCC002003; T/S: 28/175/15-20.

Recommendation 47: Lancashire County Council, in consultation with the Youth Justice Board, should arrange for a comprehensive and independent audit to be undertaken of the Lancashire County Council Child and Youth Justice Service to report by 13 October 2026. This should include assurance that the service is holding young offenders to sufficient standards and boundaries in referral orders, and that interventions are focussed and appropriate.

311. I was also struck by the fact that no other team within LCC, and no other agency save for Ms Hallaron, appears to have considered making a referral to CYJS at any stage.

Recommendation 48:

1. Lancashire County Council should ensure that staff within Children and Family Wellbeing Service, and Children's Social Care receive training on the services available through the Child and Youth Justice Service, including prior to any court or out of court disposals such as Prevention and Diversion.
2. Lancashire County Council should offer input on this topic to Lancashire Constabulary, Counter Terrorism Policing North West, and any relevant Child and Adolescent Mental Health Service.

Young Adults Team

312. I was concerned by the failures of the Adult Social Care Transitions Team in 2022 to 2024. They were slow to assess AR, the assessment when it took place was poorly informed of AR's relevant history, and it was then not written up at all.

Recommendation 49: Lancashire County Council, with the Care Quality Commission, should commission an independent audit of the Young Adults Team to ensure assessments for transition to adult care are timely, properly reasoned and take full account of the individual's history. This should report by 13 October 2026.

Chapter 10

AR’s healthcare

Introduction

1. This chapter addresses the healthcare provided to AR by the relevant NHS trusts and other providers.
2. Although AR lived in Lancashire, his proximity to the county border is, once again, relevant context. AR was registered with a Sefton General Practitioner (GP) over the county border in Merseyside. This meant that much (though not all) of the relevant healthcare was provided by Alder Hey Children's NHS Foundation Trust (Alder Hey).
3. There were a number of interlinked strands to AR's healthcare in the relevant period. A preliminary outline of the main providers who were involved in AR's healthcare is set out below.

Neurodivergence (Alder Hey's Community Paediatric Service)

4. AR had a school assessment for attention deficit hyperactivity disorder (ADHD) in July 2019. However, the first formal medical referral for possible neurodivergence was by his GP on 14 August 2019. This was a request for assessment for both autism spectrum disorder (ASD) and ADHD. Alder Hey Children's NHS Foundation Trust were responsible for the response to this referral. It was the Community Paediatric Service within Alder Hey who dealt with this.
5. The involvement of Alder Hey Community Paediatric Service was addressed in evidence by Ms Lynsey Boggan.[846] She had some, but limited, direct involvement with AR but was well placed to provide the Inquiry with an overview of the response to the ASD and ADHD referrals in her current role as Alder Hey's clinical lead of Neurodevelopmental Services. I received a further statement following the conclusion of the oral evidence from Ms Erica Saunders, Chief Corporate Affairs Officer, correcting Ms Boggan's evidence where it related to the average waiting times.
6. After the conclusion of the Phase 1 oral evidence hearings, I also received an additional statement from Ms Lisa Cooper, Alder Hey's Director of Community and Mental Health Services, providing further evidence about the improvements made in Alder Hey's Neurodevelopmental Service.[847]
7. Autism as a neurodivergent condition is recognised as being completely different from a mental health disorder (such as depression, an anxiety disorder or a psychosis). There have been significant changes in the field of neurodiversity since 2020, with a greater recognition of the complex overlapping profiles of neurodevelopmental conditions, as well as a focus

846 Witness Statement of Ms Boggan AHCH000252; T/S: 25/1/3-96/20.

847 Witness Statement of Ms Cooper AHCH000328.

on adopting a 'neuro-affirmative' approach that recognises and values neurodiversity rather than viewing autism and ADHD as deficits or impairments requiring correction.[848]

8. In parallel with these changes, Ms Boggan explained that there have been significant changes in the way that Alder Hey neurodiversity services are organised and delivered.[849] Of note, however, is that when AR was first referred and seen (in 2019 and 2020 respectively), the Community Paediatric Service's primary focus was on diagnostic assessment. For ASD, the service only undertook diagnostic assessment. There is no 'cure' or 'treatment' for autism. Accordingly, after an ASD diagnosis, patients would be signposted to voluntary sector organisations and other commissioned services for support. The nature of that support would vary considerably, and the services selected would depend on the individual needs of the child.

9. For ADHD, the service was also mainly diagnostic, but there was a treatment arm that would consider patients who presented with significant needs where medication may be appropriate; they would be seen in the medication initiation clinic.[850]

10. Although there have been delays in the progress of the service's transformation, starting in April 2020, the restructuring led initially to separating out ASD and ADHD referrals and moving these into separate pathways, no longer under the umbrella of community paediatrics. Ultimately (as recently as September 2025) the changes led to a single Neurodevelopmental Service with two specialised teams: an assessment team and a treatment team (with the latter overseeing ADHD medication management as well as post-diagnostic support for ASD).[851] In this chapter, I focus on how the service was arranged at the time of AR's referral and initial assessments, but I have borne the significant changes in mind in considering what recommendations are appropriate.

Community mental healthcare (Alder Hey's Sefton CAMHS)

11. The main relevant provider of community mental healthcare services was Alder Hey (Sefton Locality). At all material times, AR was under 18 and so he fell within Sefton's Child and Adolescent Mental Health Service (CAMHS).

12. AR was first referred to local mental health services in April 2019 by his GP. There was a further referral by Range High School in October 2019. Neither of these referrals were accepted because (for reasons I shall later address), AR was assessed not to meet CAMHS' criteria at that stage.

848 Witness Statement of Ms Boggan AHCH000252/§7.

849 Witness Statement of Ms Boggan AHCH000252/§91.

850 Witness Statement of Ms Boggan AHCH000252/§12.

851 Witness Statement of Ms Boggan AHCH000252/§11; T/S: 25/5/14-14/13; Witness Statement of Ms Cooper AHCH000328/§§8-16.

13. However, after AR had been arrested for the hockey stick attack at Range High School, Ms Stephanie Hallaron of the Criminal Justice Liaison and Diversion Service (see below for their involvement) made a further referral on 13 December 2019. AR was then open to the CAMHS team for approximately three and a half years, until 23 July 2024, when he was finally discharged from the service. As it happened, that was just six days before the attack.

14. CAMHS was commissioned to provide assessment and, where indicated, mental health treatment to respond to mental health difficulties which impact significantly on functioning and/or were a risk to the patients themselves or to others. The CAMHS service was delivered by mental health practitioners, working within multi-disciplinary teams (MDTs). Three MDTs were functioning at the point of referral. Each MDT had an assistant clinical lead and Consultant Child and Adolescent Psychiatrist present to provide oversight of clinical delivery. MDTs took place weekly. The patient's case manager (or other involved practitioners) could raise their case for discussion with the MDT for a number of reasons such as: if a new patient was deteriorating or not improving as planned; there was a safeguarding risk; there was a request for additional treatment (including psychiatric treatment); or there was a need for transition planning or discharge.[852] CAMHS patients could cover a wide range of mental health conditions including anxiety, attachment disorders, conduct and behavioural problems, depression, emotional and behavioural difficulties associated with learning disabilities, obsessions and compulsions, psychosis, post-traumatic stress disorder, self-harming behaviour and complex psychological difficulties.

15. In providing treatment to children and young people with these underlying mental health conditions, the CAMHS teams used a diverse range of psychosocial interventions, talking therapies and pharmacological interventions. CAMHS would also conduct a risk assessment and collaborate with the young person, their parents and carers to develop a comprehensive management plan. This collaborative approach aimed to mitigate the risk the young person poses to themselves and others, as well as the risk from others.

16. The Inquiry received evidence from the following members of the CAMHS team:

    a. Dr Oonagh Victoria Killen, clinical lead for CAMHS and clinical psychologist.[853] Dr Killen gave evidence in part regarding her own direct involvement in AR's care but also by way of a corporate overview for the CAMHS service;

852 Witness Statement of Dr Killen AHCH000229/§§8-9.

853 Witness Statement of Dr Killen AHCH000229; T/S: 24/156/14-205/13.

b. CAMHS case managers:

- Mr Skott Morgan – AR's case manager from December 2019 to February 2020;[854]
- Mr Samuel Coppard – AR's case manager from May 2020 to August 2020 and family therapist allocated to AR's family from May 2022 to April 2024;[855]
- Ms Samantha Steed – AR's case manager from April 2021 to August 2022;[856]
- Ms Kathryn Morris – AR's case manager from September 2022 to July 2024.[857]

c. Consultant psychiatrists:

- Dr Lakshmi Ramasubramanian – who was involved from July 2021 to June 2022;[858]
- Dr Anthony Molyneux – who was involved from July 2022 (taking over from Dr Ramasubramanian) to April 2024.[859]

d. Other CAMHS practitioners:

- Ms Michelle Warner – AR's keyworker from November 2021 to March 2022;[860]
- Ms Emma Walker-Riley, Specialist Safeguarding Practitioner – whose involvement was limited to providing safeguarding supervision to Ms Steed;[861]
- Ms Jill Locke – who worked as case manager for AR's brother Dion R until July 2022 and attended a number of professional discussion meetings if the situation of the two brothers was relevant.[862]

854 Witness Statement of Mr Morgan AHCH000293.

855 Witness Statement of Mr Coppard AHCH000289.

856 First Witness Statement of Ms Steed AHCH000290; Second Witness Statement of Ms Steed AHCH000326.

857 Witness Statement of Ms Morris AHCH000278; Separate Transcript 23 October 2025 (Ms Morris gave evidence by a separate video recording).

858 First Witness Statement of Dr Ramasubramanian AHCH000239; Second Witness Statement of Dr Ramasubramanian AHCH000338; T/S: 24/99/8-156/10.

859 Witness Statement of Dr Molyneux AHCH000253; T/S: 24/1/3-24/99/1.

860 Witness Statement of Ms Warner AHCH000261.

861 Witness Statement of Ms Walker-Riley AHCH000259.

862 Witness Statement of Ms Locke AHCH000260.

Criminal Justice Liaison and Diversion Service (Mersey Care NHS Foundation Trust)

17. The aim of Criminal Justice Liaison and Diversion Service is to provide early intervention for vulnerable people as they come to the attention of the criminal justice system. The service supports people through the early stages of the criminal justice system, by referring them to appropriate health or social care services, with the aim of enabling them to be diverted away from the criminal justice system.

18. When AR was arrested for the 11 December 2019 hockey stick attack at Range High School, he was therefore assessed by the local Criminal Justice Liaison and Diversion Team (CJLDT). This was provided by a separate NHS trust, Mersey Care NHS Foundation Trust. As would be expected, their involvement was relatively short in duration. CJLDT work is intended to be a short-term measure which is essentially screening those referred to it; identifying the level of need, risk and urgency; and making appropriate referrals to other agencies for treatment or further support.

19. Ms Stephanie Hallaron was the Band 6 Liaison and Diversion Practitioner who assessed AR and was involved from his arrest on 11 December 2019 through to March 2020.[863] She referred AR to both CAMHS and to the Forensic CAMHS service (see below).

Forensic CAMHS (Greater Manchester NHS Foundation Trust)

20. Forensic CAMHS services provide health consultation, advice, assessment and limited intervention for young people with complex needs whose behaviours are dangerous or a risk to others. As a result, their patients may be involved with the youth justice system, but this is not a requirement.

21. Forensic mental health services for children and young people in England are divided into 13 regions. For AR, the relevant service provider was Greater Manchester Mental Health (GMMH) NHS Foundation Trust, who are commissioned to provide the Forensic CAMHS North West service. I shall refer to the service in this chapter as FCAMHS.

22. The FCAMHS referral criteria required the person referred to be: under 18 at the time of referral (there is no lower age threshold); presenting with serious conduct, emotional distress, neuropsychological challenges, severe mental health concerns or neurodevelopmental conditions, where there are valid concerns about the potential presence of such conditions; and, usually, involved in dangerous, high-risk behaviours whether they are in contact with the youth justice system or not.[864]

863 Witness Statement of Ms Hallaron MERC000026.

864 Joint Witness Statement of Dr Imran and Ms Brown GMMH000015/2-3.

23. FCAMHS can accept referrals directly from professionals working at Alder Hey. The referrer is required to obtain the child or young person's consent, or the consent of the person with parental responsibility if the individual is under 16, prior to making the referral. FCAMHS do not (and, at the relevant time, did not) take on case management responsibility and the referrer remains the lead co-ordinating professional unless another individual has agreed to take on this responsibility.

24. FCAMHS should work closely with other professionals involved with the individual to gather relevant information, to understand the young person's difficulties. The FCAMHS practitioner will provide guidance and recommendations to those working with them. This is the advice and consultation role. In complex, high-risk cases in which a specialist opinion is required, an appropriate practitioner will undertake a direct assessment. This involves carrying out interviews, including with the young person and their parents or carer. This is the assessment role, which is to be distinguished from conducting a 'risk assessment'. The practitioner will also provide recommendations and potentially refer the individual to a particular agency. The practitioner can provide supervision to community practitioners and time-limited support to young people. For the most part, FCAMHS is not commissioned to deliver interventions directly itself to young people in order to address areas of unmet need. It was unlikely, therefore, that treatments and therapy would be provided by the FCAMHS team, although they could have a role in some one-to-one interventions as part of the FCAMHS practitioner's role, which involves intervening with the young person's 'professional network'.[865,866] Overall, it is important to note that FCAMHS was commissioned as a specialist consultative and advisory service, not as a case-holding or lead agency, and this was reflected in its funding and resourcing.

25. The December 2019 referral to FCAMHS from Ms Hallaron of the CJLDT was allocated to Mr John Hicklin, a clinical nurse specialist.[867] He remained the allocated mental health nurse for the referral until AR's case was closed to FCAMHS in March 2020.

26. In addition to evidence from Mr Hicklin, FCAMHS' involvement was explored through the evidence of Dr Shermin Imran (Lead Consultant for FCAMHS within GMMH), and Ms Amanda-Jayne Brown (Head of Operations for the CAMHS Division within GMMH).[868]

865 Joint Witness Statement of Dr Imran and Ms Brown GMMH000015/3-4.

866 Witness Statement of Mr Hicklin GMMH000014/§13.

867 Witness Statement of Mr Hicklin GMMH000014; T/S: 25/96/25-157/20.

868 Joint Witness Statement of Dr Imran and Ms Brown GMMH000015; oral evidence of Ms Brown, T/S: 25/158/4-199/20; Second Witness Statement of Dr Imran GMMH000016; Second Witness Statement of Ms Brown GMMH000017.

NHS England (commissioning role in FCAMHS and CJLDT)

27. Pending further structural changes, NHS England is the national body responsible for the strategic co-ordination of healthcare services in England, and oversight of local commissioners and providers of those healthcare services.

28. Of relevance to AR's healthcare, NHS England commissioned: (1) the FCAMHS services; and (2) the CJLDT, whose roles have been briefly outlined above. NHS England's role was, however, as the commissioner and not the provider of those services, and it was the NHS trusts (not NHS England) who employed the relevant healthcare practitioners. In basic terms, NHS England acts as commissioner for some of the specialised services (like FCAMHS and the CJLDT, so called 'Tier 4 services'), whereas the community CAMHS services were commissioned by Clinical Commissioning Groups (later Integrated Care Boards) as 'Tier 1 to 3 services'.

29. NHS England provided evidence to the Inquiry from Mr Michael Gregory, the Regional Medical Director for NHS England North West region.[869]

Expert evidence commissioned by the Inquiry (Dr Tina Irani)

30. I instructed Dr Tina Irani, Child and Adolescent Forensic Psychiatrist to provide independent expert evidence.[870] Dr Irani has extensive experience of both CAMHS and FCAMHS services, as well as adolescent inpatient services, and relevant national leadership roles. As such, she was well qualified to provide evidence on the quality of CAMHS and FCAMHS involvement in AR's care, as well as a wider psychiatric perspective. Her evidence was measured, insightful and of considerable assistance to this phase of the Inquiry's work.

Relevant chronology of AR's healthcare

31. In the sections that follow, I have analysed the factual history of AR's healthcare organised in four periods:

    a. The early referrals in 2019;

    b. Healthcare in the aftermath of the hockey stick attack at Range High School: December 2019 to June 2020;

869 Witness Statement of Mr Gregory NHS000349. Without criticism, I observe that it was not known to NHS England at the time of the provision of this statement that AR had interacted with FCAMHS and CJLDT services. When this became apparent to NHS England from the Inquiry's disclosure, it offered further assistance and corrected the record.

870 Expert Report of Dr Irani DRI000001; Addendum Report of Dr Irani DRI000002; T/S: 26/1/3-103/10.

c. Healthcare from July 2020 to June 2022: this was the period in which Dr Ramasubramanian first became involved as consultant psychiatrist;

d. Healthcare from July 2022 to 23 July 2024: for most of this period Dr Molyneux was the consultant psychiatrist, although in the later period the CAMHS referral was kept open only as the family therapy aspect was continuing.

The early referrals in 2019

32. On 11 April 2019, AR was first referred to CAMHS by Dr Raphael Mohammed, a GP from the practice he attended. AR was at this time 12 years old and in year 8 at Range High School. Following his GP consultation with AR that day, Dr Mohammed explained the reason for the referral in these terms: *"last 2 yrs especially in school and around crowd [AR] feels nervous [starts] producing excess saliva in mouth – swallows. can get teary eyed is upset at home when it happens at school. sometimes cant concentrate at school when it happens – can happen with in subjects he struggles with and feels isolated with it no Bullying at school"*.[871,872]

33. This referral was discussed at a CAMHS MDT referral meeting on 12 April 2019, led by a consultant. The relevant record was short but set out the conclusion of the five-minute discussion as, *"signpost to Parenting 2000 for support around feeling nervous"*.[873] In accordance with this conclusion, the CAMHS duty clinician wrote to Dr Mohammed on 12 April 2019, suggesting that it was more appropriate for AR to access support from Parenting 2000 than CAMHS.[874]

34. This referral was closed, therefore, the day after it was made. There has – in my assessment rightly – been no criticism of this first decision. Dr Killen explained that the referral was of only mild to moderate levels of anxiety and it was appropriate to signpost AR to a partner agency offering support for anxiety.[875]

35. Parenting 2000, to whom AR was signposted for support, is a charitable organisation. It was set up in 1994 with the aim of helping families overcome the challenges of everyday life. It provides interventions at an early help and preventative stage that provide emotional and practical support and guidance to children and young people aged 6 to 25 and their parents/responsible adults. The services provided by Parenting 2000 include therapeutic counselling and support to families. Parenting 2000 can escalate concerns in relation to how a child is presenting clinically by making a referral to CAMHS, and any concerns in relation to safeguarding by contacting the local authority.[876]

871 MERP000490/23.
872 AHCH000297/6.
873 AHCH000162/1.
874 AHCH000095/1.
875 T/S: 24/164/15-18.
876 Witness Statement of Ms Lloyd PAR2000017/§§10-14.

36. Ms Claudia Aldersley was one of Parenting 2000's therapeutic counsellors.[877] Ms Aldersley worked with children and young people who required counselling on a one-to-one basis. Alphonse R requested privately-funded therapy with Parenting 2000, to enable AR to be seen while they waited for AR to reach the top of the waiting list for NHS-funded therapy (also with Parenting 2000).[878] Ms Aldersley was allocated to AR's referral. In this chapter of the report and elsewhere, I have raised criticism of AR's parents, particularly of Alphonse R. But it should not be doubted that he was motivated to get therapeutic help for his younger son and was concerned at these early symptoms of anxiety.

37. AR attended seven privately-funded counselling sessions with Ms Aldersley (on 30 May 2019, 27 June 2019, 11 July 2019, 25 July 2019, 8 August 2019, 12 September 2019 and 3 October 2019). Her notes for 27 June 2019 record that what made AR most anxious was *"Groups of people. Swallowing/saliva. Public speaking. Eating in school canteen"*.[879]

38. In July 2019, an assistant special needs co-ordinator at Range High School screened AR for ADHD. The conclusion was that AR's behaviour reflected poor conduct rather than ADHD; AR's father disagreed with the outcome of the assessment.[880]

39. On 14 August 2019, Dr Emily Arnold (another GP at AR's local practice) saw AR accompanied by his father. They raised concerns about AR having ADHD. AR reported having little or no concentration at school and his mind wandering. He was noted to have poor eye contact. Dr Arnold queried possible ASD and possible ADHD and agreed to make a referral.[881]

40. Dr Arnold made a prompt referral to the Alder Hey Community Paediatrics team in a letter dated the same day, 14 August 2019.[882] She noted AR's poor eye contact and that he seemed quite fixated on things (like school detention and his PlayStation). Dr Arnold also noted the family history, with Dion R having already been diagnosed with ASD. She requested a review of whether AR may have ASD or ADHD.

41. The referral was accepted by the Alder Hey Community Paediatric Department and AR was added to the waiting list to be seen by a consultant community paediatrician. The evidence given to the Inquiry by Ms Boggan was that the average waiting time for children receiving a first assessment was 11 weeks.[883] On the basis of that evidence, AR could reasonably expect to have been seen for an assessment by mid-November 2019. The assessment of this issue proceeded on this basis throughout the Phase 1 oral hearings.

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877 Witness Statement of Ms Aldersley PAR2000018.

878 PAR2000003.

879 PAR2000005/1.

880 T/S: 26/215/24-217/20; RAN000023, row 7.

881 MERP000490/23.

882 AHCH000091/1.

883 Witness Statement of Ms Boggan AHCH000252/§17.

42. However, as part of the statutory process for responding to areas of potential criticism, Alder Hey sought to correct the evidence that Ms Boggan had given. I asked for this correction to be provided in a formal witness statement disclosable to the Inquiry's Core Participants, and this was provided by Ms Erica Saunders, Chief Corporate Affairs Officer.[884] Ms Saunders' evidence is to the effect that Ms Boggan's average waiting time of 11 weeks was a very significant underestimate because:

    a. It was based on a *"suite"* of referrals for Community Paediatrics that was not limited to neurodivergence assessments. It included the data for very different clinics such as height and weight clinics, adoption medicals and initial health assessments;

    b. It was based on the times that patients **seen** in August 2019 had needed to wait, not the time that patients **referred** in August 2019 had to wait;

    c. The data used only included those referred from January 2019 onwards, so excluded the cohort of those longer waiting time cases referred earlier than January 2019.

    Ms Saunders states that the fuller analysis carried out of the data *"…shows that the average wait was actually 36 weeks and the maximum 56 weeks"*.[885] I make no criticism of Ms Boggan who was relying on data provided to her by others. Even allowing for the speed at which the Inquiry requested Phase 1 evidence, it is very unfortunate that the evidence provided by Alder Hey on this aspect was not accurate and not corrected until the statutory warning letter process.

43. AR was not seen for his first assessment for 46 weeks. A locum consultant first considered AR's referral by way of a discussion with Alphonse R on 2 July 2020 (see further paragraph 140). Even on the basis of Ms Saunders' corrected waiting times, it still took 10 weeks longer than average for AR to be seen for his first assessment. When she had understood the delay to have been considerably longer (based on the 11 week figure), Ms Boggan accepted this delay constituted a shortcoming by Alder Hey. Despite the work Ms Boggan had done to assist the Inquiry to understand AR's care pathway, she had not been able to identify any apparent reason why AR's assessment took so much longer than the trust's average.[886] On the basis of Ms Saunders' correction, the delay in AR being seen for a first assessment was significantly less (10 weeks longer than average rather than 35 weeks longer than average). That remains a matter of concern, not least because of the concerns professionals raised that AR's autism assessment should have been expedited because of his risk.

884 Witness Statement of Ms Saunders AHCH000339.

885 Witness Statement of Ms Saunders AHCH000339/§13.

886 T/S: 25/21/11-23/23.

44. In earlier chapters of this report, I have addressed how AR's disclosures to Childline about taking a knife into school on multiple occasions led to police intervention on 7 October 2019, and thereafter AR's exclusion from Range High School.

45. Entirely appropriately, one part of Range High School's response to this was to refer AR to CAMHS. Mr David Cregeen, the school's designated safeguarding lead, made the referral on 10 October 2019. He gave the following reasons for the referral being made:

> *"[AR] had contacted ChildLine to say he was being bullied and had carried a knife to school on 10 occasions. ChildLine informed the Police who went to the family home on 07.10.19 to discuss the matter and reported it to School. [AR] was spoken to about this in school and admitted that he had brought the knife in previously. When asked why, he said it was because he was being pushed around and that he would have used it to stab someone. [AR] appeared to lack emotion during this time even though he knew the potential consequences of carrying a knife and using it on someone. The members of staff who interviewed him were very concerned about his mental state and extremely disproportionate response to incidents in school that were under investigation. Prior to this event, [AR] had hit another pupil during a lesson and on receiving notification of a detention, was overheard saying, 'that's why teachers get murdered.' [AR] dismissed this concern saying that he was referring to a comment from another pupil who had mentioned a teacher had been murdered last year. [AR] said this, and bringing the knife into school, were not linked at all. However, it only adds to the concerns of the school regarding [AR] and why he needs support, and quickly.*
>
> *[AR] has not signed this form as he is currently suspended from school, however, his father emailed his and his son's consent for this referral to be made."*[887]

46. The referral was closed on 12 October 2019 by the MDT triage referral meeting, comprised of the same individuals as on 12 April 2019.[888] They indicated that AR should receive *"targeted youth and school support"*, and it was observed that although AR was *"at risk of crime"*, there was *"no mental health indicated in [the] referral"*.[889] The CAMHS duty clinician sent a response letter to Mr Cregeen on the same day.[890] It suggested contacting Sefton Council's 'Targeted Youth Prevention team' and that the school liaise with the family to ask what support they could put in place.

887 LCC000377/2.
888 AHCH000162/1.
889 AHCH000162/2.
890 LCC001390.

47. Mr Cregeen said that he was surprised and disappointed with the response and the matter being closed so quickly having regard to the gravity of the concerns. He also considered that the Targeted Youth Prevention team was not a suitable route as their work seemed more suited to gang-related violence, and Mr Cregeen was not concerned so much with AR's personal and social development as the state of his mental health.[891]

48. Dr Killen for Alder Hey maintained, however, that having reviewed the history, the closure of this referral was appropriate at the time.[892] I have considerable sympathy with Mr Cregeen's view of the closure of this referral. This was the second CAMHS referral made in relation to AR within about six months. The risk factors and overt concern about mental health in Mr Cregeen's referral ought to have been much closer to the threshold justifying acceptance of the referral at this stage. I accept, however, that further signposting to other agencies may not have been wholly unreasonable at this stage.

49. Five days later, however, on 17 October 2019, Ms Aldersley from Parenting 2000 contacted CAMHS Crisis Care Team by telephone to raise concerns about AR. The note of what was said made by the CAMHS mental health nurse is as follows:

> *" […] she explained she has been working with [AR] for some time around anxiety, however recently been excluded after taking a knife into school, with the intention of using it if provoked. [AR] being bullied and was talking about using it on the bullies, still [very] angry, doesn't appear to understand the potential consequences of his actions, advised we had suggested targeted youth, explained the reasoning behind our decision and support targeted youth can offer, Claudia will continue to work with [AR] in relation to his anxiety."*[893]

50. Accordingly, CAMHS was maintaining its position of directing AR (and those agencies involved with him) towards other providers of support. Ms Aldersley has explained that the purpose of her call was, first to share information with a more specialist service about her concerns that AR lacked understanding around the consequences of taking the knife into school and was unable to engage in exploring different ways he could have expressed his anger. She says the response was that the Targeted Youth Prevention team was the correct service and he would receive support around knife crime. The second reason was to ask if it was possible to have the ASD diagnosis expedited. The response to this was that *"there were no reasons why an appointment is ever expedited on the ASD pathway and there would be little point in the parents returning to the GP to ask for this"*.[894] Ms Aldersley said she felt that AR had showed an inability to understand the consequences of his actions, and a significant lack of empathy or proportion and it was at this stage that she

891 T/S: 27/3/16-4/18.

892 Witness Statement of Dr Killen AHCH000229/§15; T/S: 24/164/19-24.

893 AHCH000162/3.

894 Witness Statement of Ms Aldersley PAR2000018/§§22-23.

contacted the CAMHS crisis line to report her concerns over this, although she credits the communication lines with CAMHS and other professionals as feeling *"…appropriate, relevant and open in its nature"*.[895]

51. It is noteworthy that this telephone call of concern was coming from a qualified therapist to whom CAMHS had previously steered the earlier referral. Coming as it did less than a week after the school safeguarding lead's detailed referral, two professionals had now raised parallel concerns to CAMHS. I consider that CAMHS paid inadequate attention to the mounting cumulative indications of concern at this time and a referral should, by this stage, have been accepted.

52. Ms Aldersley of Parenting 2000 continued to provide counselling to AR from October 2019 to June 2020. Because of AR's knife-carrying in October 2019, she was able to transfer him onto a Sefton Council-funded project called Sunshine and Showers, which financed therapeutic interventions for children and young people who were at risk of entering the criminal justice system. She saw AR on 14 occasions, approximately every fortnight, though there were a small number of further sessions which AR did not attend without notice.[896]

53. These sessions focused on AR's feelings of anger and explored how his feelings of injustice fed that emotion. They looked in particular at what AR would like his mother, his brother, and his school to know. Ms Aldersley's view was that AR *"disclosed in our sessions a growing sense of injustice around how he was not listened to, both in the context of the bullying in school and within his family. This created angry feelings in him which he felt were justified"*. She considered that he *"showed an inability to understand the consequences of his actions, a significant lack of empathy or proportion"*.[897] I deal below with Ms Aldersley's further engagement with other agencies, and with the end of these sessions in June 2020.

54. AR started at The Acorns School on 17 October 2019.

55. On 20 November 2019, Mrs Joanne Hodson (the deputy headteacher and special educational needs co-ordinator (SENCO) at The Acorns School), referred AR to Lancashire CAMHS, as opposed to Alder Hey CAMHS. The Request for Involvement Form contained the following relevant justification for the request:

> *"[AR] was recently permanently excluded from his mainstream high school. He perceived that he was being targeted by a boy at school and had taken a knife into school on several occasions with the stated intention of using it. [AR] rang Childline, to tell them what was happening.*
>
> *Childline rang the police, who contacted school and home.*

895 Witness Statement of Ms Aldersley PAR2000018/§§26-28.

896 Witness Statement of Ms Aldersley PAR2000018/§14.

897 Witness Statement of Ms Aldersley PAR2000018/§21, §26.

> *[AR] started at the Acorns school on 17.10.19 and was placed on a part time timetable, in a small group of 3 pupils with a dedicated keyworker.*
>
> *On 15.11.19 in his ICT lesson, the teacher found [AR] searching school shootings in America. Dad was contacted but stated that [AR] was following the lead of another learner in class. This is untrue.*
>
> *[AR] is now stating that he is being targeted by another learner in class 'like the boy at the other school'."*[898]

56. Mrs Hodson went on in the referral to note as regards presenting difficulties that AR showed a significant lack of emotion and awareness concerning the knife he had carried, including as to the consequences of using it and the risk he posed to others. Emphasis was given to his poor social skills and his lack of friends outside of school. He was considered to have rigid and inflexible *"thinking patterns"*.[899] Mrs Hodson said that the school would like to have AR assessed for ASD.[900] Mrs Hodson was aware that CAMHS had rejected Mr Cregeen's earlier referral because this information had been passed on by Lancashire County Council's Pupil Access team to The Acorns School as the receiving pupil referral unit.[901] It was for this reason that she contacted Lancashire CAMHS; Mrs Hodson may not have been aware that Alder Hey's Community Paediatric Service had in fact accepted the referral for ASD and ADHD and that AR was on their waiting list, whereas Alder Hey CAMHS had rejected the mental health referral.

57. In any event, the next day, 21 November 2019, Lancashire CAMHS informed Mrs Hodson that they could not accept the referral because AR's GP was based in Sefton.[902]

58. Lancashire CAMHS cannot be criticised for this rejection because AR was out of their catchment area. However, Mrs Hodson understandably found this a frustrating response as she stated she had spoken to the Lancashire CAMHS practitioner at length about her safeguarding concerns for AR and the need for him to be assessed for ASD.[903]

59. Mrs Hodson sought to escalate matters the next day, 22 November 2019.

898 LCC000775/3.
899 LCC000775/3.
900 LCC001421/1-2.
901 First Witness Statement of Mrs Hodson LCC001773/§12.
902 LCC001421/3.
903 First Witness Statement of Mrs Hodson LCC001773/§30.

60. She first contacted Ms Dawn Meakin (Primary Mental Health Worker at Lancashire CAMHS) to press the need for the ASD referral.[904] Mrs Hodson may then have received some guidance concerning the involvement of Alder Hey Community Paediatrics Service because later on 22 November she emailed that service in identical terms to her email to Ms Meakin.[905] Mrs Hodson stressed that she *"really need[ed] some help"* with referring AR onto the ASD *"pathway"*. She set out details of his knife-carrying in October 2019, including his intention to use the knife on another learner, and his subsequent exclusion. She described The Acorns School's admissions meeting where AR *"was monotone, emotionless and very matter of fact about his intentions"* when asked about the incident. She referenced that CAMHS had rejected Range High School's referral to them, directing instead to the Targeted Youth Prevention team, which did not seem suitable. She highlighted AR's lack of socialising, his failure to leave his home and his lack of friends. She described his antagonistic fixation on another student in his class who he claimed was bossing him around and bullying him, even though staff had seen no evidence of this. She raised AR searching for school shootings in America. She made clear that The Acorns School's staff had *"serious safeguarding concerns with regard to [AR]"*. She explained that Lancashire CAMHS had been unable to accept the referral due his GP being in Sefton.[906]

61. On 3 December 2019, Mrs Hodson sent further information to the Alder Hey Community Paediatrics Service relating to various things that had been said or done by AR (e.g. researching school shootings in America on the internet, punching one of his hands hard with his other hand, expressing the suggested risk during a class discussion of potentially being murdered when setting up a business if he was a stranger, punching a laminate hanging from the ceiling in class, wishing to look at guns on the internet and asking to be provided with an image of a severed head).[907] She asked for this information to be added to the referral information. The Community Paediatrics team responded the same day asking for a full name and date of birth, which Mrs Hodson promptly provided.[908]

62. Ms Boggan agreed that these emails raised safeguarding concerns, as well as displaying a good working knowledge of what may be relevant to an autism diagnosis. She would have expected to see the autism service responding to the safeguarding concerns, at least by ensuring that another body or agency was addressing them. There was no record that this happened. In relation to the diagnosis, given there had now been an autism referral by the GP and then further relevant information provided by Mrs Hodson, she would have

904 LCC001421/1-2. Although Lancashire CAMHS were not the right team to address the referral, this further letter did not go unanswered. Ms Meakin responded on 25 November 2019 suggesting the Community Cohesion (Hate Crime and Diversity) Team in Preston: LCC001421/1.

905 LCC001417/3-4.

906 LCC001417/3-4.

907 LCC001417/2-3.

908 LCC001417/1-2.

expected that AR's case would have been prioritised for an autism assessment. This did not occur, not least because (as far as she was aware) there was no *"expedition process"*. She accepted this was a marked shortcoming.[909]

63. Mrs Hodson's concerns at the difficulty in navigating the healthcare referrals process were evident from an email she sent on 4 December 2019 to Police Constable Alexander McNamee of Lancashire Constabulary. I have referred to this email in Chapter 7: Policing. This was the email in which Mrs Hodson, presciently, warned that she was really worried that *"…with a West Lancs address and a Sefton GP, he is going to fall between the cracks. We are concerned there is potential for a serious incident, if we can't access the right support"*. Addressing the difficulty in accessing healthcare support, Mrs Hodson explained:

> *"Range High School referred [AR] to CAMHs at Alder Hey, but they turned the referral down and recommended a referral to Sefton Targeted Youth. It looks like this referral was never made, so Mrs Lewis has contacted our MASH team to see if they can refer him there.*
>
> *I tried to refer to Lancashire CAMHs, but they turned the referral down as he has a Sefton GP, so I have re-referred him to Alder Hey. I'm awaiting a decision by them, but given they turned him down last time, I'm not holding out much hope."*[910]

64. Commenting on this period, Dr Irani observed that the appropriate services were contacted but no lead service was identified. She noted that despite multiple services being involved, a comprehensive structured risk assessment, addressing AR's risk with the school environment and providing a risk management plan, was not completed.[911]

Healthcare in the aftermath of the hockey stick attack at Range High School: December 2019 to June 2020

65. On 11 December 2019, AR committed the hockey stick attack at Range High School and was taken into custody.

66. The Criminal Justice Liaison and Diversion Team (CJLDT) assigned Ms Stephane Hallaron to AR's case. Within a short space of time, Ms Halloran gathered helpful multiagency information from: Lancashire County Council (LCC) Social Services, CAMHS, the Prevent contact at LCC, the police themselves (including in relation to Prevent) and the Child and Youth Justice Service (CYJS).[912,913]

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909 T/S: 25/29/1-31/7.

910 LANC000059/1.

911 Expert Report of Dr Irani DRI000001/§2.1.1.

912 Witness Statement of Ms Hallaron MERC000026/4-5.

913 The CYJS is also referred to as the Youth Offending Team (YOT).

67. Ms Hallaron then saw AR face-to-face in the custody suite to conduct a custody assessment. Consistent with her approach to initial information gathering, the notes of Ms Hallaron's assessment suggest it was a thorough interview.[914]

68. AR claimed to Ms Hallaron that his intended target had previously assaulted him *"a number of weeks ago"* by pulling him to the ground and hitting him.[915] As I address in Chapter 11: Education, this account is likely to have been at best a highly subjective perception and may have been a straightforward lie. He stated the present incident had been a revenge attack on his part. He had wrapped the hockey stick in tissue paper in order to achieve a better grip and that he *"did want to kill him but I don't think I would. Ideally, I wish I did it"*. He would have used the knife if the hockey stick *"did not work"*. AR explained how he had pre-booked the taxi to take him to Range High School to carry out the attack. Having failed to find his intended victim, he attacked another boy, who he liked, because he was being chased by a teacher and he was not *"going to get taken to the Police Station for nothing so I thought I would hit him"*. He suggested he would be less *"bored in Jail"*.[916]

69. Ms Hallaron assessed AR as demonstrating traits of ASD and documented a list of 13 relevant factors she had identified.[917] She described him as being a *"pleasant"* and *"bright"* young man, but with limited understanding of the consequences of his behaviour. Given he had demonstrated *"multiple indicators of ASD"* which suggested a formal assessment was required and given the risk he *"currently poses to others"*, a referral to FCAMHS was to be made. He required some additional support and risk management in the community. Ms Hallaron accepted AR's account that he did not intend in the future to attack the boy who had bullied him. He was assessed as posing a medium risk of causing harm to others, given his lack of previous offending or violent behaviour. It was accepted that the gratuitous attack on another boy, along with his lack of empathy and remorse, were of *"concern"*. Ms Hallaron recognised that he had stated his intention had been to harm another student and that he had a *"poor problem solving ability"*. She noted there were serious concerns about his internet searches. It was recorded that AR was *"currently open to the Prevent Team around possible radicalisation"*.[918]

70. Ms Hallaron noted that a social worker was to commence an *"assessment of the family"* the following day. Ms Hallaron supported the suggestion that AR ought not immediately to re-attend school, in order *"to give time for agencies to create a safe and robust risk management plan of the risk he presents to others"*. Her *"Further risk management plan"* included the following actions:

914 MERC000009.
915 MERC000009/2.
916 MERC000009/2.
917 MERC000009/5.
918 MERC000009/6-7.

a. Contact was to be made with Lancashire Social Services through a multi-agency referral form;

b. AR was to be referred for an Asperger's/autism assessment;

c. He was to be referred to Forensic CAMHS for *"management of offending behaviour in the context of forensic risk to others"*;

d. Ms Hallaron was to discuss with her Band 7 colleague whether a SAVRY assessment was appropriate (which I discuss in more detail below).[919]

71. AR did not present as being in mental health crisis and Ms Hallaron documented the absence of any signs of 'severe mental illness'. There was no basis for an assessment under the Mental Health Act at this time. Ms Hallaron's view, shared by the on-call Mersey Care Specialist Registrar and Band 8 Operational Manager, was that risk management required a multiagency response with police and social care services also using the frameworks available to them.[920] Ms Hallaron had appropriate contact with AR's father prior to AR's release from custody, advising of her intention to make referrals to FCAMHS, CAMHS and social care services.[921]

72. The 'SAVRY' which Ms Hallaron had raised in her management plan to discuss with her manager stands for Structured Assessment of Violence and Risk in Youth. Dr Irani explained that the SAVRY tool was used to assess and guide opinion regarding the risk of physical violence:

> *"This SAVRY is composed of twenty-four risk items, ten historical, six social/contextual and eight individual and six protective factors. Each risk item is coded low, moderate or high and each protective factor is coded present or absent. The historical risk factors are mainly static in nature. The social/contextual individual risk factors are dynamic in nature and indicate potential opportunities for therapeutic interventions to reduce the risk of violence. Protective factors are similarly dynamic and represent strengths that mitigate against the adverse risk factors and can be built upon to reduce the risk of violence. Critical items of those items that seem particularly relevant to the risk of violence in individual cases. Additional risk factors can be added if they are relevant to the risk of violence in particular cases."*[922]

Dr Irani emphasised that the output of a SAVRY remains live and will help plan action if the patient deteriorates, for example by isolating themselves, or if there were further acts of violence.[923] In other words, a SAVRY produces not only a structured (research-informed) assessment of the risk to others, but also forward looking management strategies and defined interventions.

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919 MERC000009/7-8.

920 Witness Statement of Ms Hallaron MERC000026/§13.

921 Witness Statement of Ms Hallaron MERC000026/§15.

922 Expert Report of Dr Irani DRI000001/37.

923 T/S: 26/19/8-20/8.

73. Dr Irani made clear that the SAVRY process was not simple. It involved pulling together a large amount of information from different sources, and (where practicable) interviews with the young person and their parents. It is a resource-intensive process taking some weeks, if not months, to complete. As NHS England have rightly emphasised, the resources and time taken to complete a SAVRY mean that it will not be appropriate in every case, and it will be a matter for the judgement of appropriate practitioners as to whether the threshold for such an exercise had been passed.[924]

74. In raising whether a SAVRY might be appropriate in AR's case, Ms Hallaron was not, however, making the suggestion lightly. She had been in this role for over two years and (notably) had never before had to consider this course of action. For that reason, on 12 December 2019, Ms Hallaron sought advice from her managers on whether a SAVRY would be appropriate in AR's case.[925] The response Ms Hallaron received was that a SAVRY assessment was not appropriate within the CJLDT although could be looked at by FCAMHS/CAMHS.[926]

75. In addition to taking advice on the SAVRY, over the next 48 hours Ms Hallaron promptly took action on the other aspects of the CJLDT management plan formulated when AR had been in custody. These included the following:[927]

    a. She contacted (and stressed the case urgency) to LCC's Multi Agency Support Hub (MASH);

    b. She telephoned FCAMHS to seek advice concerning AR. She was advised to provide some initial safety planning advice to AR's parents and to refer the case into FCAMHS (12 December 2019);

    c. She wrote to AR's parents with the initial safety planning advice (12 December 2019) and liaised with custody staff to have the letter given to AR's parents when he re-attended for police interview that day. The initial safety plan was to encourage AR's parents to check his room for any weapons; to remove weapons he might use impulsively, such as knives; and to consider supervising AR in the community. Appropriate emergency contact details were also provided (CAMHS crisis line, Accident & Emergency, police and social care services);[928]

    d. She called CAMHS to discuss the current concerns (12 December 2019);[929]

924 T/S: 26/20/22-21/19; Closing Statement on behalf of NHS England NHS000574/10-12/§§34-35.

925 MERC000017; Witness Statement of Ms Hallaron MERC000026/§17.

926 MERC000007 (this response was sent by way of the response to a DATIX report that Ms Hallaron had lodged).

927 Witness Statement of Ms Hallaron MERC000026/§19.

928 MERC000013.

929 AHCH000162/4.

e. She called Ms Lucy Parkinson, in the LCC Early Help team (i.e. CFWS) and agreed to make a referral to LCC Children's Social Care (12 December 2019).

f. She completed that referral, making the referral at Level 4 (12 December 2019) and requesting an urgent strategy meeting. The handling of this referral by Children's Social Care is addressed further in Chapter 9: Social care. Ms Anna Jameson, the allocated social worker, called Ms Hallaron later on 12 December 2019, arrangements for an early strategy meeting were discussed and Ms Hallaron suggested to Ms Jameson involving the CYJS, although it seems that this was not pursued until post-sentence;[930]

g. She referred AR to FCAMHS (completed 12 December 2019, marked as received 13 December 2019). The referral form was detailed (replicating information from Ms Hallaron's detailed note of her assessment of AR in custody) and requested an urgent FCAMHS assessment.[931] FCAMHS accepted the referral the same day. As I have indicated in the introduction to this chapter, within FCAMHS, AR's case was allocated to Mr Hicklin;

h. She also referred AR to CAMHS (13 December 2019) for *"URGENT further assessment outside of the Criminal Justice System and with some input from parents which was missing in my assessment due to the nature of the environment in which I saw him"*.[932] In addition to replicating information from her custody assessment, Ms Hallaron referred to the open Prevent referral, and for the need for further mental health assessment given that her own assessment had taken place in custody. On 16 December 2019, Ms Hallaron chased CAMHS for a response to her referral and was told that they had agreed to place AR on an urgent wait list; they discussed attendance at forthcoming case meetings.[933] CAMHS allocated Mr Skott Morgan to be AR's case manager;

i. She chased the referral position in relation to ASD and established from the Alder Hey Community Paediatrics Service that AR was in their system and was *"due to start the assessment process next year"*. She alerted them to the risks with which AR was now presenting. The response was to indicate that he would be placed on the cancellation list but that there was no other way for AR to be assessed sooner; details of supportive services were provided in the meantime.[934]

930 MERC000011; Witness Statement of Ms Hallaron MERC000026/§§19-20; MERC000018.

931 MERC000010; GMMH000003.

932 AHCH000121/3.

933 AHCH000162/5.

934 Witness Statement of Ms Hallaron MERC000026/§§25-26; MERC000015; MERC000016.

76. The above highlights only some of the more important of Ms Hallaron's communications with other professionals in the few days after her first involvement.

77. Two points emerge from this. First, it is clear that Ms Hallaron was proactively and energetically trying to bring relevant agencies together, stressing the urgency of the case, and alerting to the concerns over risks to others. This was good practice. Second, I note that there can have been no doubt from Ms Hallaron's referrals and communications to other agencies that she was responsibly raising very real concerns about AR's risks to others. Mr Hicklin agreed that what was revealed amounted to a concoction of *"very concerning factors"*.[935] Dr Killen agreed that Ms Hallaron was describing the risk to others as being greater and of more concern than AR's risk to himself.[936]

78. The strategy meeting arranged by Ms Jameson took place on 17 December 2019.[937] I have addressed this meeting in other chapters as it relates to the other agencies who attended. From the healthcare point of view:

    a. Ms Hallaron attended the meeting on behalf of CJLDT. A copy of LCC Children's Social Care's record of the meeting appears in the CJLDT notes held on their Rio electronic records system, and in addition Ms Hallaron made her own notes on Rio;[938]

    b. Mr Morgan attended the meeting on behalf of CAMHS and made his own notes of the meeting within the CAMHS electronic patient record;[939]

    c. FCAMHS did not attend. Mr Hicklin's evidence was that he had an existing engagement and provided apologies for his non-attendance; as such, it may very well be that his own non-attendance was for entirely good reasons, although he did not appear to consider that sending an alternate (or seeking to do so) would be usual practice.[940] However, Ms Brown's evidence was that in such circumstances, there was an expectation that someone from FCAMHS would be present. I take into account the relatively short notice of this meeting. Nevertheless, other than that the FCAMHS team was a small one covering large geographical area, FCAMHS have not been able to explain why an alternate team member did not attend this obviously important meeting.[941]

935 T/S: 25/113/16-21.
936 T/S: 24/165/10-13.
937 LCC000234; LCC001346/63; AHCH000162/8-10.
938 MERC000002/51-52, 97-105.
939 AHCH000162/8-10.
940 Witness Statement of Mr Hicklin GMMH000014/§6; T/S: 25/119/12-120/5.
941 T/S: 25/180/15-181/5.

79. In addition to LCC Children's Social Care as convenors of the meeting, Merseyside Police, Lancashire Constabulary, Prevent, Range High School and The Acorns School were all in attendance.

80. Ms Hallaron alerted the meeting to the fact that AR had said that he had intended to kill his intended victim and he would have done so if had found him, and that AR had shown no remorse.[942] She also made clear her view that AR probably did have ASD and was due to be assessed the next year but there were significant waiting lists.[943]

81. In terms of mental health, AR had not yet been seen by CAMHS nor had his case been assessed by FCAMHS (who – as above – were not in attendance at the meeting). It was noted that CAMHS would be assessing AR in the course of the following week, and that he had additionally been referred to FCAMHS *"who specialise in assessing risk"*.[944]

82. In terms of information that was shared at this meeting, and in terms of what should have been known to the later healthcare clinicians, it is relevant to note that the following aspects were all raised:[945]

    a. AR had been viewing inappropriate content online in relation to terrorism. AR had aggressively denied this suggestion. However, when questioned by the police it was noted that he had laughed throughout the interview following his arrest. His mother failed to challenge this inappropriate behaviour, and it was difficult to engage with his father;

    b. AR's history of carrying knives to school on 10 occasions in October 2019;

    c. That while AR had told the police he had not intended to use the knife, he had told Ms Hallaron the opposite;

    d. AR would not accept any responsibility and would argue even in the face of evidence contradicting his own accounts;

    e. The lack of evidence that AR had in fact been bullied;

    f. AR's lack of emotion;

    g. AR's ability to manipulate situations and, thereafter, to lie about them;

    h. That AR displayed obvious ASD traits: he had no emotional range only sad or angry, no positivity and no facial expression;

    i. AR had on occasions fixated on staff members at The Acorns School;

    j. AR had researched school shootings and showed interest in beheadings, war in Rwanda and inequality in the world;

942 LCC000234/2.

943 LCC000234/3.

944 LCC000234/3.

945 See the various notes of the meeting: LCC000234; LCC001346/63; AHCH000162/8-10.

k. AR was quite a force in the household and appeared to dominate conversation. His parents potentially did not understand AR's additional needs and how best to parent him although there were some positives in their willingness to engage so far;

l. A Prevent assessment was soon to be completed and would consider if a referral to the Channel programme would be appropriate;

m. AR had researched the Manchester Arena bombing, expressing the view that it had been a *"good battle"* from the point of the view of the suicide bomber;

n. It was considered that AR was at risk of further criminality due to his impulsivity, and that more work needed to be done to understand what acted as a 'trigger'.[946]

While Mr Morgan made his own note of the 17 December 2019 strategy meeting in the electronic notes, LCC's Children's Social Care team's fuller note of the meeting was later uploaded to the CAMHS record, so all the above features were in AR's mental health records.[947]

83. Against the background of these factors, the 17 December 2019 strategy meeting concluded that there was a possibility that risks may escalate but that the plan was to proceed with the assessment work (including by Children's Social Care, CAMHS and FCAMHS) and reconvene for a further meeting when there was more professional knowledge of the family.[948]

84. In the afternoon following the 17 December 2019 meeting, Ms Hallaron emailed Mr Morgan expressing her view that there was definitely some *"further information that needs exploring from a mental health point of view"*.[949] She raised a possibility of psychosis. The context for this was that Ms Hallaron noted that at the earlier meeting, AR's rationale for committing the offence (that he had been bullied) had been contradicted by the school, as well as statements made by AR at school, which included that teachers had been poisoning his food.[950] I emphasise that no evidence of AR having psychosis or any other severe mental illness has ever emerged.

85. On 20 December 2019, Mr Morgan saw AR to carry out the initial CAMHS assessment. It lasted about 1 hour and 30 minutes.[951] AR came with his mother but was spoken to alone. As regards AR's mental health, Mr Morgan considered AR's appearance, speech, attitude, mood, insight and judgement and thoughts. Mr Morgan recorded that although AR made some eye contact, this was *"not in line with his age"* and that he was very structured in his

946 AHCH000162/10; Witness Statement of Mr Morgan AHCH000293/§17.

947 This appears to have been in early March 2020, see AHCH000162/18-27.

948 LCC000234/3.

949 MERC000020/1.

950 Witness Statement of Ms Hallaron MERC000026/§33.

951 AHCH000162/10-12.

speech and repetitive in his answers.[952] The only inappropriate attitude or belief indicated by AR was that he wanted revenge for the bullying. Mr Morgan thought AR had some insight into his actions, but he was *"very linear"* in his thinking. AR reported some paranoid thoughts following the police visit to his home, believing they had installed cameras. However, Mr Morgan did not detect any hallucinations or delusion in line with a serious mental health condition. AR did not report hearing any voices, either inside or outside his head.

86. As regards neurodivergence, AR's own perception was that he had attention deficit disorder (ADD) but not autism, having checked his symptoms online. Mr Morgan's assessment was that AR displayed atypical behaviours, including a lack of empathy (he made no mention of other people's thoughts or feelings). Mr Morgan noted that AR had been given a £3,000 gaming computer to his own designed specifications yet showed no emotion regarding this having been seized by police, in contrast to how others of his age would have seen this as a *"devastating consequence"*.[953]

87. AR gave details of the assault and his reasons for committing it but without any mention of the thoughts and feelings of others. Mr Morgan's clinical notes record that, in relation to the attack, AR felt sad that he could not find his intended victim who he had wanted to hit. AR said he *"would have only used the knife if the [hockey] stick didnt hurt him the way [AR] had been hurt"*.[954] Mr Morgan viewed AR's thinking as rigid. AR expressed thoughts of low self-esteem and low self-confidence, but not thoughts of terrorism.[955]

88. Mr Morgan spoke to both AR's parents after the discussion with AR. He recorded that they were worried about the consequences for AR *"but stated he was a 'good boy'"*; the parents were recorded as also being paranoid about cameras being placed in the home.[956]

89. Mr Morgan concluded that AR was lonely and had had to mature quickly for his age and ability. He resented Dion R, who occupied a considerable amount of his parents' time. Mr Morgan considered, however, that AR would not *"… search for terrorism/ etc online other than for teenage curiosity with intense autistic backing"*.[957]

90. Mr Morgan asked AR's mother Laetitia M to fill out a child behavioural questionnaire. When this was later completed, this showed that AR scored very high within the clinical range for aggressive behaviour. In reviewing CAMHS care in her evidence to the Inquiry, Dr Killen agreed that the questionnaire

952 Witness Statement of Mr Morgan AHCH000293/§24; AHCH000162/10-12.

953 Witness Statement of Mr Morgan AHCH000293/§27; AHCH000162/12.

954 AHCH000162/11-12.

955 Witness Statement of Mr Morgan AHCH000293/§§24-26; AHCH000162/12.

956 AHCH000162/12.

957 Witness Statement of Mr Morgan AHCH000293/§29, §49; AHCH000162/12.

indicated some significant concerns in this context.[958] This is relevant to the question of whether AR should have been diagnosed with conduct disorder, as I address from paragraph 176, below.

91. The further strategy meeting convened by LCC's Children's Social Care took place on 6 January 2020.[959] In terms of healthcare attendees at this further meeting,

    a. Ms Hallaron attended the meeting on behalf of CJLDT and again made her own notes of the meeting on Rio;[960]

    b. Mr Morgan attended the meeting on behalf of CAMHS. While he made a note of the meeting, it was exceptionally brief, recording only: *"attended Strat meeting. [AR] and dion to remai[n] Children in need until police evi[d]ence [is] back. Not escalated to s47"*;[961]

    c. FCAMHS, once more, did not attend despite the date for this further meeting having been set on 17 December 2019 and an invitation having been sent to Mr Hicklin, as to others, on 19 December 2019.[962] It is unclear why FCAMHS did not attend this second meeting. It was poor practice that they did not do so.

    As well as LCC Children's Social Care who had convened the further meeting, Prevent, Merseyside Police, Range High School, The Acorns School and the Local Authority Pupil Access team were in attendance.

92. As regards the CAMHS contribution to the meeting, Mr Morgan updated the attendees that AR had been seen (a reference to Mr Morgan's assessment on 20 December 2019) and his presentation was *"very autistic however a diagnosis remains outstanding"*. The attack was viewed as retaliatory, and AR had a sense of injustice about what happened. It was not felt that AR had any mental health issues, and he was not considered to be suffering from psychosis.[963] He also said that AR's emotions were extremes – he would hate rather than dislike. There appeared to be some degree of challenge from Ms Hallaron to the suggestion that the attack was one of retaliation, in that AR stated that he liked the boy he ended up attacking (as opposed to his intended victim).[964]

93. As regards CJLDT, Ms Halloran indicated to the meeting that AR was on the *"cancellation list"* for his autism assessment but the *"best clarity that can be gained at present is that he will be seen this year"*.

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958 AHCH000090/17; T/S: 24/165/21-167/19.

959 LCC000235; LCC001346/60-61; MERC000002/50; AHCH000162/13-14.

960 MERC000002/50.

961 AHCH000162/13-14.

962 LCC001695/1-2.

963 LCC000235/2.

964 LCC001346/60.

While FCAMHS were not present, Ms Hallaron was able to update the meeting that he was to have an FCAMHS *"appointment"* on 21 January that would *"focus on his potential risks"*.[965]

94. In terms of risk assessment, it was noted by the CJLDT at this meeting that AR could not return to education until a risk assessment had been completed – it was noted that *"Social care will take the lead on this"*.[966] While this reads as if Children's Social Care had taken on the full responsibility for conducting the risk assessment, it is unlikely this reflects what was meant. Children's Social Care's own note of the meeting recorded, *"LEA [Local Education Authority] are looking at alternative provision for AR including a possible 1-1 tutor. A risk assessment is required...."* and it is likely to be this more limited risk assessment that was being referred to (see paragraph 109).[967]

95. For patients open to CAMHS, there was a requirement for risk to be assessed every three months or when risk changed.[968] As I address further below, Alder Hey has clearly accepted that the risk assessments conducted by CAMHS were not standardised and the tool used was not completed comprehensively or regularly.[969] Instead, CAMHS practitioners completed a formal risk assessment on only five occasions. The first two were risk assessments at the triage of AR's original referrals (on 11 October 2019 and 15 December 2019). These early risk assessments are most easily viewed as reproduced in tabular form in Alder Hey's Internal Learning review.[970] The other occasions were: 8 January 2020,[971] 22 February 2024[972] and 23 July 2024.[973]

96. After consideration of risk in the earlier referrals, as just set out above, a further CAMHS risk assessment was completed (by Mr Morgan) on 8 January 2020. This included as regards the risk to others:

> ***"Intentional Risk to others and Property (harm, Forensic Hist):***
>
> *Yes - [AR] attended school to hurt another pupil but got a different one instead. he states this a was a planned revenge attack from being bullied.*
>
> *Reports from school about terrorism*
> *[AR] denies all this.*
>
> *PREVENT have also stated that they … have not found anything malicious/ radicalised with [AR]."*[974]

965 LCC000235/2.
966 MERC000002/50.
967 LCC000235/2.
968 Witness Statement of Dr Killen AHCH000229/§56.
969 Closing Statement on behalf of Alder Hey Children's NHS Foundation Trust AHCH000327/4/§11.
970 AHCH000294/191-193/§775.
971 AHCH000162/14-15.
972 AHCH000154.
973 AHCH000160.
974 AHCH000162/15; Witness Statement of Mr Morgan AHCH000293/§33.

97. When asked about this entry, Dr Killen said that this was not the standard of risk assessment in terms of quality and level of detail that she would expect to see in a case of this seriousness. She considered that the form had simply been completed too quickly by Mr Morgan on this occasion, not that it was a training issue.[975] There may be some element of mitigation (but not excuse) for this in Mr Morgan's particular personal circumstances; as detailed further below, fairly shortly after this he left CAMHS suddenly.

98. Rather than an appointment with AR (as some appear to have understood it), the scheduled FCAMHS case assessment on 21 January 2020 took the form of a multi-agency consultation meeting.[976] The attendance for this meeting appears to have been arranged by Ms Hallaron of CJLDT to ensure that the relevant agencies could feed information and their views into FCAMHS who would be represented by Mr Hicklin.[977] Mr Hicklin saw the purpose of the meeting as being to gather information about AR, in order to develop *"understanding of risk and needs"* and to provide advice to the professionals involved with him.[978]

99. The other agencies at the meeting were: CJLDT (Ms Sarah Loughrin and Ms Hallaron), LCC Children's Social Care (Ms Jameson [the allocated social worker] and Ms Julie Hamil [community support worker]), and The Acorns School (Mrs Hodson). CAMHS failed to attend this meeting.

100. The most detailed note of the meeting was taken by Mrs Hodson of The Acorns School. While not a transcript or agreed minute, it was a comprehensive and contemporaneous record. Having seen Mrs Hodson give evidence, I am sure that this note accurately reflected the key events at that meeting. It recorded that Mr Morgan had sent apologies for his non-attendance.[979] Mr Hicklin would have expected someone else from CAMHS to attend in his place.[980] Given that FCAMHS had not attended either of the two previous strategy meetings, there may be thought to be an element of double standards involved in that observation. However, it is undoubtedly the case, that the non-attendance of CAMHS at this meeting was poor practice, given the importance of FCAMHS being placed to contribute on the risk AR posed to others. Dr Killen straightforwardly accepted that it was not in line with CAMHS' service expectations, and they would have expected such meetings to be covered.[981]

101. At the meeting, Ms Hallaron gave a detailed description of her understanding of the attack, and her interview with AR in custody. She said that she could understand the rationale behind his actions given that he said that the intended victim had been bullying him, even though it was the wrong thing to do.

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975 T/S: 24/170/2-171/4.

976 LCC000020; LCC001346/61-62; MERC000002/49; GMMH000005/1-5.

977 GMMH000004/1-3.

978 T/S: 25/122/16-123/13; GMMH000004/1,3.

979 LCC000020/1.

980 T/S: 25/120/19-121/3.

981 T/S: 24/179/9-16.

But Ms Hallaron was *"very concerned"* because the child that AR had ended up assaulting was someone he liked, whom he assaulted because *"he knew he was going to be arrested, so he might as well"*. Ms Hallaron's assessment was that the assault had been severe, and that the victim was fortunate not to have been seriously hurt. The victim had avoided significant injury by putting his hand up, thereby intercepting the blows.[982]

102. Mrs Hodson confirmed to Mr Hicklin that there were concerns that AR had not in fact been bullied by his intended victim, and AR had raised similar issues at The Acorns School, yet staff (despite being *"particularly vigilant"*), had not picked up on any bullying. AR had also been targeting certain members of staff at The Acorns School. His levels of agitation had been increasing prior to the attack.[983]

103. Mr Hicklin directed an observation to Mrs Hodson that he did not have *"[…] a crystal ball, none of us have! We can't say whether he's likely to offend again. There are kids who have carried out serious offences, they still have a right to an education"*. Mrs Hodson replied that this *"might be so"*, but she was not prepared to explain to any parent why a child at her school had been seriously injured. Ms Hallaron repeated her concern that the child who ended up being assaulted was someone AR liked – there was no reason for the assault on that child – and that was why she had referred AR to FCAMHS.[984] In his evidence to the Inquiry, Mr Hicklin, while not disputing that this exchange had occurred, considered that this record of the conversation was not set in its true context and that he had been attempting to address AR's lack of education.[985]

104. Ms Hallaron updated the meeting on the involvement of other agencies: she indicated that Prevent had interviewed AR but had *"no concerns about radicalisation"* and it would be two to three months before analysis of his electronic devices was complete. She provided an update on the CPS' progress.[986]

105. Social services updated the meeting on their assessment, with the family's case being approached as a section 17 child in need case (I have addressed this further in Chapter 9: Social care).[987] Their assessment at this stage was that AR's parents were engaged and that AR did not present with any difficulties at home.

106. Mr Hicklin sought an update on the ASD diagnosis. During the course of the discussion on this, Mrs Hodson stressed that when asked why he had brought a knife to school on multiple occasions, AR had replied *"[t]o use it"*;

982 LCC000020/1.
983 LCC000020/1.
984 LCC000020/1-2.
985 T/S: 25/121/23-125/4.
986 LCC000020/2.
987 LCC000020/2.

his thinking was very literal.[988] Mrs Hodson had been frustrated in her efforts to engage other agencies prior to the hockey stick attack at Range High School in December. To this, Mr Hicklin again repeated that there were no crystal balls and that *"he would offer a £5 bet to anyone who could say what was going to happen next"*. He said that AR clearly needed some sort of specialist provision with ongoing therapy and *"social stories"*, and said to Mrs Hodson *"[b]ut unfortunately, you've been left holding the baby!"*[989] In his evidence to the Inquiry, Mr Hicklin again suggested that this description of what he had said *"lacks some context"*, in that he had been seeking some risk management strategies in order for AR to return to formal education, as opposed to considering risk.[990]

107. There was then a discussion about the potential delay in obtaining the autism diagnosis, and support options pending the diagnosis. Mrs Hodson raised the approach to AR's education, health and care plan (EHCP) in this context. It was also made clear that given there were *"no underlying mental health issues"*, CAMHS were *"only planning a short intervention"*, leading to the concern expressed that AR could be *"left high and dry with no services supporting him"*.[991]

108. Mr Hicklin continued to pursue his concern that AR, who was 13 years old, had a right to an education and that he should not be *"cooped up in the house all day"*. To this, Mrs Hodson responded that she had other students and staff to consider, and that the attack had been premeditated, given AR had booked a taxi the day before and had contacted the sister of his intended victim. AR had managed to gain access to a knife notwithstanding the steps that had been taken to hide the knives in the family home.[992]

109. Ms Jameson said that she had been directed by the strategy meeting to carry out a risk assessment but that she did not think that she could do this. Mrs Hodson indicated that in fact Ms Jameson had only been asked to do a risk assessment in regard to a tutor visiting AR at home, to which Ms Jameson indicated she thought, *"[o]h, yes, he'll be fine doing that"*.[993]

110. Finally, Mr Hicklin said that AR needed *"structure and a robust education package with other services supporting him"*.[994]

988 LCC000020/2.
989 LCC000020/2.
990 T/S: 25/125/5-128/12.
991 LCC000020/2-3.
992 LCC000020/3.
993 LCC000020/3.
994 LCC000020/3.

111. While I accept Mr Hicklin's concerns that AR needed to be kept in full time education, I was concerned at the apparent lack of understanding that was accorded to Mrs Hodson's powerful expressions of concern about the level of risk AR posed to others. Indeed, as events in due course demonstrated, Mrs Hodson's prophetic warnings were entirely justified.

112. In my assessment, rather than working effectively together, a troubling disconnect was developing between the agencies, to which I return in the conclusions of this chapter.

113. Immediate action points do not appear to have been determined (or at least none were recorded) at this meeting. Instead, the outcome from this meeting appears to have been that Mr Hicklin would provide an overview and *"initial recommendations"* in writing, and there was to be a follow-up meeting which was set for 4 March 2020.[995]

114. Mr Hicklin then wrote to Ms Hallaron on 11 February 2020. On the face of the letter, Mr Hicklin does not appear to have been copied it to any of the other agencies. If and to this extent that this may have reflected an FCAMHS practice of corresponding only with the referring agency, this was not helpful in a multi-agency case where several other agencies had been involved in relevant meetings. Mr Hicklin had spoken to Mr Morgan of CAMHS since the meeting. I set Mr Hicklin's letter out in full:

> *"Thank you for your recent referral of [AR] to FCAMHS and for arranging the meeting of professionals which took place on the 21st of January 2020. I agreed at this meeting to send this letter as a brief overview of the salient issues discussed and initial recommendations. We have a second meeting arranged for the 4th of March to review the case. I have now had opportunity to discuss the case with Skott Morgan from CAMHS. I have made Skott aware of the concerns of professionals. Skott will be attending the meeting on the 4th of March and will be able to give feedback as to the role of CAMHS.*
>
> *At the time of referral [AR] was open to PREVENT in relation to him accessing beheading and mass shooting videos. The case has now been closed to PREVENT. [AR] has been arrested on a charge of possessing a bladed article in a school setting. Seemingly [AR] returned to the school following him being the victim of an assault and assaulted another boy and was prevented from escalating this assault further. He demonstrated little insight into the potential consequences of his behaviour for himself or others. His computer is currently being searched by the police as part of an ongoing investigation. You reported that he is likely however to receive an out of court disposal.*

995 GMMH000006/1.

[AR's] presentation is seen as likely to meet criteria for a diagnosis on the autistic spectrum and there is a family history of this. He is on a waiting list with the local paediatric team for assessment. At the meeting of the professionals the expected time before a diagnosis for ASC was confirmed as being approximately 2 years. We commented that a diagnosis will be fundamental in categorising and managing [AR's] high risk behaviour, in supporting of an EHCP application and in identifying a specialist education provision. Given the level of concern that was felt by professionals, liaison with the paediatric team needs to take place to ensure that they are aware of the concerns and that the paediatric team contribute to the risk management plan. I discussed this with Skott Morgan and Skott will discuss with colleagues at CAMHS how escalation of concerns to the paediatric team can be supported by CAMHS.

I highlighted that the most important factor in managing the risk posed by [AR] will be identification and integration into an appropriate educational provision. I commented that the education service will need to complete their own risk assessment of the suitability of any identified placement. This will need to be completed in line with the process of gaining an EHCP.

We were informed that risk management strategies such as his parents hiding knives from [AR] had not worked as these strategies were in place before his offence. The pre-meditated nature of his offence was also highlighted in that [AR] booked a taxi to the school and altered the handle of the hockey stick he took to use as a weapon. It was also highlighted that [t]he boy he assaulted was someone he has previously "liked". Professionals questioned whether his being the victim of bullying was accurate or rather related to [AR's] propensity to misjudge social interaction. It was reported that [AR] has identified and communicated to teaching staff when he perceives himself to be at increased risk of acting out behaviour. It was concerning that he had begun to develop an "intensity" to some of his interactions with staff and pupils at the specialist provision 'Acorn School' similar to how he had behaved at his previous mainstream school. This behaviour has contributed to him being suspended from this specialist provision and being outside of access to full time education.

We discussed the need for parents to be provided with additional support in their parenting of children with autism. Skott Morgan highlighted that the family has been signposted to support agencies and that there may be additional services that could be accessed if needed. [AR] is socially isolated. Clearly the routine and structure of an appropriate education placement is important but [AR] will likely need additional support in accessing social activities outside of

formal education. CSC highlighted that there may be no formal role for their service as parents are compliant with the plan but [AR] would benefit from a mentor/support in accessing social provision.

I also highlighted that [AR] would likely benefit from psychologically informed interventions to address his high risk behaviour delivered with him taking into consideration his likely diagnosis of ASC. In considering reducing the risk of [AR] engaging in interpersonal violence he would benefit from such interventions being focussed on improving his ability to think consequentially; improving his capacity for an empathic response; developing a range of alternative strategies to anger and developing strategies to manage stressors in his life. These interventions should focus on emotional recognition and regulation. Skott Morgan will liaise with colleagues in CAMHS and make comment at the forthcoming meeting as to how this need may be met.

I trust this is a helpful summary. Please contact me if any clarification is needed."[996]

115. The risk posed by AR was immediate and serious, requiring a timely practical response to attempt to address and mitigate the threat to the public. Having considered the evidence of Dr Irani, I would observe that the substance of the various FCAMHS recommendations, taken individually, were generally sound. However, there were five interconnected problems:

    a. First, and fundamentally, there was no common understanding of which agency was in the lead. Mr Hicklin viewed Ms Hallaron as the lead agency and co-ordinating person, until her involvement was likely to come to a conclusion.[997] Mrs Hodson did not consider that there was a lead agency but agreed that there should have been.[998] Ms Jameson considered LCC to be the lead agency, at least as at the time that the multi-agency meetings were started in December 2019.[999] Ms Sarah Callon, on behalf of the LCC Child and Youth Justice Service, accepted that, by May 2020, there was a lack of clarity about who the lead agency was;[1000]

    b. Second, and also fundamentally, FCAMHS did not take for themselves any responsibility in the key area of the formulation of a structured risk assessment. Instead, despite the seriousness of the risks that were (or should have been) apparent, the onus was being placed back onto the agencies themselves – particularly The Acorns School – to conduct a risk assessment. This is symptomatic of the attitude

996 GMMH000006.
997 T/S: 25/129/10-24.
998 T/S: 27/199/1-13.
999 T/S: 29/77/6-10.
1000 T/S: 28/218/15-219/14.

shown by Mr Hicklin in the meeting of 21 January when he pressed the need for AR's right to an education; claimed that he did not have a crystal ball and could not say whether AR was likely to offend again; and told Mrs Hodson that she had been left *"holding the baby"*.[1001] What FCAMHS should have done was ensure that the assessment of AR's risk of harm to others was carried out. This was an area in which FCAMHS was, after all, specialist, notwithstanding that it was not commissioned as a case-holding or lead agency. The specialist tool – SAVRY – was available, although it would have been a significant task. But the use of SAVRY was justified in this case. It was neither recommended nor explained by Mr Hicklin;

c. Third, while the desirability of an autism diagnosis was understandable, it was known that this would take time. Although expedition of the process was being sought, too much emphasis was being placed on the formal diagnosis. Key professionals who (unlike Mr Hicklin) had met AR were clear and confident that he showed marked ASD traits; this has been striking to Mrs Hodson and commented on by Mr Morgan, for example. The initial formulation of risk and risk management strategies should have proceeded on the working understanding of ASD based on the experienced professionals who has assessed AR;

d. Fourth, the delegation of significant tasks to CAMHS (Mr Morgan) was unfortunately timed in that, co-incidentally, Mr Morgan abruptly left his employment during February 2020. CAMHS were stretched and there was a gap in case manager cover; and

e. In the event, there was also a wider failure to put the individual actions into effect.

116. On 14 February 2020, Mr Morgan wrote to Ms Jameson. He explained that AR presented with ASD traits and that his current convictions were *"in line with ASC [rigid] thinking and lack of empathy"*. Mr Morgan gave examples of AR's communication that was in line with ASD. He suggested that the verbal abuse from AR's intended victim, while not excusing what AR did, *"would explain [AR's] frustration in the context of having a 'meltdown'"*. This interpretation overlooked the indications that AR had not been bullied and the worrying signs that he was repeating similar behaviours at The Acorns School.[1002]

117. Mr Morgan explained to Ms Jameson that he had *"… met AR on several occasions and feel that he is aware of his behaviour and the consequences of this"*. There is a peculiarity about this statement in that if Mr Morgan had indeed met AR *"on several occasions"*, he failed to document all such interactions save for his initial assessment on 20 December 2019. The use of *"met AR on several occasions"* is inconsistent with a mere typographical error and the context of

1001 LCC000020/2.

1002 LCC000029/1.

the comment does not suggest that Mr Morgan was trying to convey that he had simply discussed rather than *"met"* AR on several occasions.[1003] It follows that Dr Killen was justified in being critical of Mr Morgan's record keeping in that he appeared to have met AR without always making appropriate records.[1004]

118. Mr Morgan's letter continued as follows:

> *"… However I also feel that [AR's] behaviour is down to the possibility of having ASC [autism spectrum condition]. I feel that the possibility of [AR] having ASC needs to be taken into account with regards to convictions and sentencing. From my meetings with [AR] and his parents he has not presented with any mental health concerns and I have not witnessed any safeguarding issues which could result in harm coming to anyone within the family home.*
>
> *[AR] is a bright young man who has a good insight into computers with potential to learn to understand the world around him. I feel that with time [AR] will learn to understand his emotions and regulate them within situational contexts."*[1005]

119. This letter appears to have been Mr Morgan's last contribution before his departure from the trust. There is no contemporaneous evidence to suggest that he addressed two tasks recommended of CAMHS in Mr Hicklin's letter of 11 February (see paragraph 114), namely:

    a. The suggestion that the ASD pathway should be expedited in liaison with the Community Paediatric Service; and

    b. The *"psychologically informed interventions to address his high risk behaviour delivered with him taking into consideration his likely diagnosis of ASC"* which were to *"focus on emotional recognition and regulation"*.[1006]

120. The follow-up professionals' meeting took place on 4 March 2020 to review progress since the first meeting.[1007] The meeting was held as a child in need meeting and was chaired by Ms Jameson as the allocated social worker supported by Ms Hamil. In terms of healthcare attendance at this meeting:

    a. CJLDT were represented by Ms Hallaron;

    b. Mr Hicklin attended for FCAMHS;

    c. CAMHS failed to attend. Mr Morgan had now left CAMHS and no replacement had been identified to pick up AR's case. Dr Killen explained that by 12 March 2020 she had raised concerns regarding the clinical capacity of CAMHS: *"just as COVID was taking hold,*

1003 LCC000029/2.

1004 T/S: 24/172/4-15.

1005 LCC000029/2.

1006 GMMH000006/2.

1007 LCC001346/58; GMMH000005/6-7; LCC002310/22 (the Transcript refers to LCC002301 but LCC002310 is a better version of the same document).

the Service had a number of children who had been in treatment but did not have allocated case managers as their previous case manager was off sick or had left the service. There was a shortage of Sefton CAMHS case managers at this time so not all children and young people could be allocated as quickly as the Service would like. [AR] was on this list following the departure of Mr Morgan from Sefton CAMHS".[1008] As with the earlier meeting, Dr Killen accepted that a representative from CAMHS should have attended the meeting on 4 March 2020 and this would have been the service expectation.[1009]

121. In terms of other agencies, those present were: Range High School (Mr Cregeen) and The Acorns School (Mrs Jane Eccleston, headteacher, and Mrs Hodson, deputy headteacher); LCC's alternative provision team, who ensure that children and young people unable to attend mainstream school receive tailored education (Ms Pita Oakes); LCC's Early Help team, i.e. CFWS (Ms Laura Davison). Additionally, AR had been sentenced on 19 February 2020 and given a 10-month referral order, so the CYJS were present for the first time, represented by Ms Anna Croll.

122. Despite the fact that actions listed in Mr Hicklin's letter of 11 February 2020 had not been completed, the record of this meeting suggests that a number of agencies (including the healthcare agencies) were in effect winding down their level of involvement:

    a. I have addressed the position of social care services in Chapter 9: Social care but the indication at this meeting was that Children's Social Care had completed their Child and Family Assessment and that AR was to be *"dropped to Early Help"*;[1010]

    b. I have addressed the position of Prevent in Chapter 8: Prevent and Counter Terrorism Policing but it was confirmed that Prevent were not going to take any further action;

    c. As regards CAMHS, it was said that *"CAMHS had not identified any further mental health issues"* and Mr Hicklin said that *"he had been updated by Scott [sic] Morgan from Sefton CAMHS and that there were no MH issues apart from possible undiagnosed ASC"*.[1011] As above, I note that concerningly there was no update on the tasks that had been allocated to CAMHS of liaison with the Community Paediatric Service over the ASD diagnosis and Mr Hicklin's previously recommended psychologically informed interventions.

1008 Witness Statement of Dr Killen AHCH000229/§20.

1009 T/S: 24/179/9-16.

1010 LCC01346/58.

1011 LCC01346/58.

123. Most of the time at this meeting was taken up in what The Acorns School note of the meeting refers to as *"a lengthy debate about risk assessment"*.[1012] LCC CFWS indicated that they did not have the capacity to do this and it was not their responsibility. The Acorns School pressed how concerned they were about the risk to others from AR and said that they were not able to put a comprehensive management plan in place because the risks had yet to be established. Ms Croll from the CYJS said that the indicator for future risk was past behaviour and that AR presented as a medium to high risk. In effect there was something of an impasse with the education attendees at this meeting stressing the (legitimate) concerns about permitting AR back on school premises in the absence of a risk assessment, while others appeared to press the need for education to continue, noting that there were no further mental health issues.

124. Despite the impasse reached over risk assessment, no consideration was given at this meeting to using the SAVRY structured risk assessment. FCAMHS could have stepped in to organise a SAVRY risk assessment as the best structured tool to analyse AR's risk to others but failed to do so.

125. On 9 March 2020, Mr Hicklin noted that he had *"attended a second [consultation] meeting in Skelme[r]sdale last week and will write a brief summary letter and discharge the case"*.[1013] If Mr Hicklin considered that the meeting of 4 March 2020 was a second FCAMHS consultation meeting, that view was not shared by other attendees: multiple other sources refer to it as a child in need meeting and as having been chaired by Children's Social Care, rather than FCAMHS. Mr Hicklin wrote to Ms Hallaron that same day closing AR's case with FCAMHS. As previously, on its face, Mr Hicklin's letter was sent to Ms Hallaron only and the other agencies were not copied in. Mr Hicklin expressly relied on Ms Hallaron, as the referrer to FCAMHS, to circulate the letter to all the other agencies.[1014] Between FCAMHS and CJLDT, the two FCAMHS letters recording conclusions after the professionals' meetings should have been circulated to all relevant agencies; it was symptomatic of the poor understanding of roles within the multi-agency working that this did not happen.

126. Again, it is relevant to set out Mr Hicklin's letter of 9 March 2020 and his reasoning in full:

> *"I am writing to thank you again for coordinating the second professionals meeting on the 4th March 2020 following your referral of [AR] to FCAMHS. I am aware that the case has been closed to your service but I am writing this summary for your record and for you to share with local agencies if this is felt to be helpful.*

1012 LCC001346/58.

1013 GMMH000004/5.

1014 GMMH000007/1.

Subsequent to our initial consultation on the 21st of January 2020 [AR] has received a 10 month referral order. Anna Croll (YOT) [Youth Offending Team][1015] is completing an AssetPlus assessment and will then be coordinating interventions to address offending behaviour. She concurred with professionals as to [AR's] presentation being consistent with a likely ASC diagnosis.

CAMHS were not present at the meeting. The case has been closed to them as [AR] is not felt to have additional mental health needs and a referral has been made on the ASC pathway. As previously indicated I had hoped that CAMHS would be able to advise as to access to local support provision and support escalation of priority to the paediatric team.

It was reported that CSC have signposted parents to the Information Advice Service to support them in an application for an EHCP. There was extended discussion as to the risk posed by [AR] in the context of his ASC presentation and concerns were raised as to his parent's lack of insight into the complexities of his needs and presentation. Education staff made comment on the likely pathway to specialist education provision and indicated that there is scope for this to be expedited.

I made comment that risk assessment will be complicated by his likely diagnosis of ASC. The known evidence in this field concurs with the discussion we had about [AR] with professionals. The following aspects of young people with an ASC diagnosis should be taken into account when considering the risk:

- *Disruption in routines and lack of motivation to change to adaptive behaviour*
- *Social naïvety*
- *Specialist interests associated with the condition*
- *Experiences of being bullied/rejected and desire for retribution, this may lead to assault on a perpetrator or displacement onto another often completely innocent person (as demonstrated by [AR])*
- *Hostility to parents*
- *Sensory sensitivities*
- *Following the lead of strong influencer*
- *Lack of awareness of wrong doing*
- *Deficits in empathy or lack of recognition of fear in others*
- *Not seeing consequences*

1015 Lancashire County Council's Child and Youth Justice Service (CYJS) was also known as Youth Offending Team (YOT).

- *Comorbid mental health diagnosis (although this has been not to be the case by CAMHS in [AR's] case)*
- *Any combination of the above Bailey, Chitsabesan & Tarbuck (2017)*

I am of the opinion that assessment by our service is not indicated as until his diagnosis is complete we would not be able to contribute further to the understanding of risk. I made comment though that [AR] being outside of access to fulltime education increases the risk and we would therefore support access to appropriate provision being expedited. He would also likely benefit from access to social support outside of the family. It was reported that the case will step down to early help and as suggested this letter can be shared with relevant professionals. The case will now be closed to FCAMHS but any professional can contact the service for clarification of this letter or if review is indicated because of a significant change in circumstances or risk behaviour."[1016]

127. Mr Hicklin's list of aspects to take into account for young people with an ASD diagnosis reflect that he was, in good faith, seeking to assist the other agencies. However, overall, the approach taken by Mr Hicklin in this letter was significantly flawed:

    a. There was no explanation in the letter as to why a risk assessment by FCAMHS needed to wait the potentially lengthy period of time for the autism diagnosis to be completed. In evidence, Mr Hicklin suggested that for the FCAMHS risk assessment to be accurate, they required confirmation of AR's autism,[1017] although I note that this approach was questioned by both Dr Ramasubramanian[1018] and Dr Molyneux[1019] during their evidence. The Inquiry's expert Dr Irani was clear that FCAMHS should have gone further and taken the lead in drawing together the information and conducting the SAVRY. She said *"…that's primarily what our function as community FCAMHS services has been … The majority of the work around the risk assessment, the lead is taken by FCAMHS but with whoever is referred into them"*.[1020] Mr Hicklin's approach was not in keeping with Dr Irani's assessment of expected practice.[1021] Ms Brown of GMMH (the trust responsible for the FCAMHS service) also disagreed with Mr Hicklin, in that she suggested FCAMHS should have flagged up the desirability of conducting a standardised risk assessment (e.g. a SAVRY) because of the complexity and the high risk that

1016 GMMH000007/2.
1017 T/S: 25/135/6-136/11; GMMH000007/2.
1018 T/S: 24/106/9-12.
1019 T/S: 24/30/11-19.
1020 T/S: 26/22/7-21.
1021 T/S: 26/22/23-23/7.

was evident in this case.[1022] This failure amounted to poor practice in her view.[1023] She observed that FCAMHS should have alerted the other agencies of the desirability of a SAVRY risk assessment (which CAMHS and the Child and Youth Justice Service would both, in all probability, have lacked the skills to undertake). CAMHS was potentially in possession of critical information in this regard;[1024]

b. Mr Hicklin was aware that CJLDT (whom Mr Hicklin had viewed as the lead service) were closing AR's case. That cannot have been surprising because they are a short-term service, and by this stage AR had been sentenced. FCAMHS were now closing AR's case too and Mr Hicklin understood that CAMHS were closing AR's case as well. Yet there was no co-ordination mechanism or lead agency identified for taking work forward. Ms Brown accepted that there should have been a further professionals' meeting to ensure that it was safe to discharge AR from FCAMHS, to give clarity as to which agency was going to progress the recommendations and which agency was to take the lead;[1025]

c. Mr Hicklin appears to have been cognisant of the fact that CAMHS had not done all that he had previously recommended (*"I had hoped that CAMHS would be able to advise as to access to local support provision and support escalation of priority to the paediatric team"*).[1026] But there was no indication of FCAMHS taking any action to purse this or ameliorate the position. Given Mr Hicklin's earlier view on the need for strategies and interventions to reduce the risk of AR acting violently towards others, the closure of the case cannot have been acceptable practice. It is particularly concerning that the measures previously recommended had included: a *"psychologically informed intervention"* to address his high-risk behaviour; assisting in improving his ability to think consequentially and his capacity to respond empathetically; developing alternative strategies to anger and to manage stress; and establishing a focus on emotional recognition and regulation.[1027] Similarly, Ms Boggan confirmed that there was no record of any communication at this stage from CAMHS, FCAMHS or other agencies with the Community Paediatrics ASD service that was responsible for progressing AR's ASD assessment.[1028] The case should not to have been closed by FCAMHS while these actions

1022 T/S: 25/174/9-175/19.
1023 T/S: 25/186/7-11.
1024 T/S: 25/175/10-176/3.
1025 Joint Witness Statement of Dr Imran and Ms Brown GMMH000015/§21.
1026 GMMH000007/1.
1027 GMMH000006/2.
1028 T/S: 25/31/8-33/1.

remained outstanding. Mr Hicklin instead closed the case expressing an opinion that FCAMHS could not contribute further in the absence of a diagnosis.

128. While CJLDT might have queried FCAMHS closing the case, it is clear that Ms Hallaron was deferring to FCAMHS's specialist knowledge. Her evidence was that her assumption now would be that due to AR not having a confirmed diagnosis of ASD, nor presenting with mental illness, he did not meet the FCAMHS criteria. However, Ms Hallaron stressed that she is not an FCAMHS practitioner. The primary responsibility here was that of FCAMHS themselves, to whom Ms Hallaron had of course referred AR precisely so they could advise on the risks to others about which she was significantly concerned. Ms Hallaron closed AR's case to CJLDT after the 4 March 2020 meeting because she considered that all of the agencies had now completed their specialist assessments and AR would now have the CYJS involvement as part of the referral order.[1029]

129. A final important aspect of Mr Hicklin's letter was the indication that the other agencies could contact FCAMHS for clarification of the letter or if review was indicated because of a significant change in circumstances or risk behaviour. As will be seen, no re-referral to FCAMHS was ever made, despite the fact that the diagnosis of ASD was later confirmed, and despite later acts of violence, especially the bus incident. CAMHS have now candidly accepted that a referral back to FCAMHS should have been made after AR's autism diagnosis and as a consequence of his conduct and ideation at the time of the bus incident.[1030] However, even if (which I find was not appropriate) FCAMHS were going to close AR's case, this should only have occurred on the explicit basis that his case should be re-referred into FCAMHS upon a positive diagnosis, or in case of any significant acts of violence, whichever was the sooner.

130. In the event, FCAMHS played no further part at all in the assessment of AR's risks to others. None of the other agencies referred AR back to FCAMHS. By April 2020, AR's case was closed to both FCAMHS and CJLDT. It was also CAMHS' intention to close AR's case but there was no case manager in place and so the formal closure did not occur.

131. The CYJS did progress an AssetPlus assessment pursuant to the referral order. However, the AssetPlus assessment was not a substitute for a violence-focused, structured formulation like SAVRY. It did not provide the other agencies with planned intervention and escalation strategies in the event of a change in circumstances. It was not a management tool in that way as SAVRY would have been. Moreover, the CYJS were only going to be involved for the following 10 months (the duration of the referral order) whereas escalatory violence from AR could and did occur later (see the bus incident in March 2022)

1029 Witness Statement of Ms Hallaron MERC000026/§68, §70.

1030 Closing Statement on behalf of Alder Hey Children's NHS Foundation Trust AHCH000327/4/§11.

In addition, as I have addressed in Chapter 9: Social care, the CYJS team's risk assessment was poor; it underestimated the risk and was only partially disclosed to the education providers.

132. Against this background, at the very end of April 2020, when healthcare input was required for AR's EHCP, it ended up being directed to Dr Killen as clinical lead. She replied on 1 May 2020 indicating that AR was *"open to our service, but limited contact. His case manager has left and his new case manager [Sam Coppard] started today"*. Dr Killen indicated that she would return the necessary EHCP forms herself.[1031] On the same day, Dr Killen also contacted the CYJS, responding to an earlier message requesting CAMHS input.[1032] Dr Killen's recollection was that the CYJS wanted reassurance that the anxiety management work being offered by that team would not clash with work being done by CAMHS. Dr Killen's notes of this call show the CYJS's AssetPlus risk assessment being discussed and Dr Killen noted *"reoffending risk – medium. significant harm risk – medium. risk to children – no"* with Dr Killen noting contemporaneously on the latter aspect, *"this seem[s] unusual as if reoffends with significant harm it is likely to be against children"*.[1033] Dr Killen documented a short plan for CAMHS in which: (1) she would complete the EHCP forms herself; (2) the CAMHS worker would *"pick up work on emotional regulation and anxiety"*; and (3) Dr Killen would check that the community paediatrics referral was in.[1034]

133. Dr Killen's involvement in the above caused her to email Mr Hicklin, Ms Jameson and Ms Croll (CYJS).[1035] She confirmed that Mr Coppard was taking over as case manager. She queried if there had been any additional concerns raised by other adults who had met AR over the past few weeks. Dr Killen then noted that she could not find the FCAMHS assessment/ consultation outcomes and requested a copy. As noted above, neither of the FCAMHS letters appear to have been sent to CAMHS at the time, only to the CJDLT. CAMHS then omitted to add this email onto the patient electronic records as Dr Killen accepts should have happened, noting the *"multiple competing clinical demands"* at this time.[1036]

134. As a result of Dr Killen's contact, the FCAMHS letters were then finally sent to CAMHS. Dr Killen has explained that that she shared the letters with Mr Coppard and sent them for scanning. Matters did not, however, end there. Concerningly, Alder Hey's system for scanning letters onto the electronic patient record failed and, unbeknown to Dr Killen, the FCAMHS letters never made it onto AR's electronic patient record. After the attack, this was the subject of a formal investigation by the trust which concluded that those

1031 AHCH000232/4.

1032 AHCH000162/30-31.

1033 AHCH000162/30; Witness Statement of Dr Killen AHCH000229/§§27-28.

1034 AHCH000162/31.

1035 AHCH000234/2.

1036 Witness Statement of Dr Killen AHCH000229/§31.

documents, together with three others *"are permanently missing/lost without any clear audit trail of where they may be"*.[1037] On behalf of the trust, Dr Killen accepted, unsurprisingly, that this was an unsatisfactory state of affairs.[1038] One important consequence was that for later CAMHS practitioners who had not been involved at the time, the FCAMHS letters were not visible on CAMHS' systems.

135. On 5 May 2020, a further CAMHS referral was sent by Dr Maria Parish, a GP at the practice AR attended. He noted that AR was struggling with feelings of nervousness (social anxiety), and that he considered that he was being watched and judged when in public, with others concluding that he is *"weird"*. He could be agitated and aggressive if asked to do something that did not meet with his wishes. The doctor noted that after Ms Hallaron's assessment in December 2019 (which had been sent to the GP surgery), CAMHS input was deemed appropriate, *"but (perhaps due to COVID) does not appear to have progressed"*. Alphonse R was worried about the risk of AR once again leaving the house with a knife. The doctor indicated that he would welcome an urgent assessment as to AR's mental state and as to interventions to assist him and his family.[1039]

136. Dr Killen completed the EHCP health advice on 14 May 2020.[1040]

137. Once he was in post as AR's new CAMHS case manager, Mr Coppard made significant efforts throughout May and June 2020 to engage AR and support him in relation to the anxiety that had been reported by AR's GP. This was a still a period of COVID-19 lockdown followed by the gradual easing of restrictions. Mr Coppard's liaison was by telephone. His statement to the Inquiry details a series of contacts initially with Alphonse R and then attempts to speak with AR. AR was reluctant to engage; sometimes not speaking with Mr Coppard, sometimes speaking but not being very forthcoming. Mr Coppard provided reading material for Alphonse R and AR but while Alphonse R reviewed these materials, AR did not do so. Mr Coppard raised with Alphonse R possible discharge because it was inappropriate to keep the service open to a patient who was repeatedly failing to engage. On 15 June 2020, for example, Mr Coppard had arranged a telephone appointment at 16:45 to maximise the prospect that AR would be out of bed. Mr Coppard spoke to Alphonse R but AR was still in bed and when Alphonse R attempted to rouse AR and pass him the telephone, AR instead cut Mr Coppard off.[1041]

138. Alphonse R was concerned about access to CAMHS in the future if AR was discharged and also because the sessions with Parenting 2000 were due to end. Alphonse R suggested a face-to-face consultation and Mr Coppard made a conditional offer of such a consultation for 2 July.

1037 AHCH000324/1.

1038 T/S: 24/184/5-186/9.

1039 AHCH000140/3-4.

1040 Witness Statement of Dr Killen AHCH000229/§§23-25; AHCH000003/2-3.

1041 Witness Statement of Mr Coppard AHCH000289/§§36-54.

This was subject to the approval of the CAMHS MDT, which Mr Coppard obtained.[1042] I can see no basis for criticism of Mr Coppard as case manager in this period; he was persistent in seeking to support AR. I note, however, the focus by CAMHS was now very much on AR's presenting symptoms of anxiety. It was appropriate and correct to offer such treatment, but it was different in nature to interventions specifically designed to tackle AR's high-risk behaviour and risk to others (minimising the risk of interpersonal violence; improving his ability to think consequentially; improving his capacity for an empathic response; developing a range of alternative strategies to anger etc.), which is what FCAMHS had recommended. To the extent that CAMHS may have thought that the CYJS would undertake such work, the CYJS in fact undertook some, but objectively speaking, very little meaningful work around AR's issues of anger management, as I have addressed in Chapter 9: Social care.

Healthcare from July 2020 to June 2022

139. On 2 July 2020, Mr Coppard was able successfully to complete a face-to-face appointment with AR and his father Alphonse R. AR reported that nerves were his main problem, with anxiety that had developed particularly in relation to social situations and eating in social situations. The problems occurred mostly at school though sometimes at home. When Alphonse R suggested that AR had encountered *"a lot of bullying and difficulties in relationships in school which had possibly made the nerves worse for him"*, AR denied this was the case. Alphonse R highlighted that AR wanted medication, but Mr Coppard explained that talking therapy was indicated and medication was not the first line treatment. Mr Coppard urged the importance of being motivated to engage, the usefulness of the educational material concerning anxiety and the need to train to tackle anxiety. They agreed to hold a further session in one week's time.[1043]

140. Also on 2 July 2020, there was finally progress in obtaining an ASD diagnosis. Alphonse R spoke with Dr Jamuna Acharya, locum consultant paediatrician in the Community Paediatrics team which was handling the assessments of AR for ASD and ADHD following the GP referral in August 2019 and the further information from The Acorns School in November to December 2019. The discussion focused on the reason for referral to the team, and the possibility of ASD, although Dr Acharya knew that AR had been referred due to concerns about the possibility of both ADHD and ASD. AR's developmental history, family history and current concerns were reviewed. It was determined that AR did not have any physical health needs requiring intervention from the Community Paediatrics team, but it was noted that his social communication rigidities warranted further assessment. It was decided to proceed, therefore, to an autism assessment. Issues of potential ADHD do not appear to have

1042 Witness Statement of Mr Coppard AHCH000289/§§55-59.

1043 Witness Statement of Mr Coppard AHCH000289/§§64-69; AHCH000162/54-56.

been explored in depth by Dr Acharya.[1044] Dr Acharya saw ASD as the priority and so concentrated on autism in the available remote clinic session time. While Dr Acharya appears to have considered that any issue of ADHD would have been addressed within the later ASD assessment, it would have been much better practice for the position on ADHD to have been expressly stated within the outcomes of this assessment.[1045]

141. Between 9 July and 11 August 2020, AR's engagement with the Cognitive Behavioural Therapy (CBT) informed work offered by Mr Coppard effectively stalled.[1046] AR did not attend several scheduled sessions, citing physical discomfort or stress, and although he attended briefly on 16 July, this was not documented in the CAMHS record. Alphonse R reported that AR had got on well with Ms Aldersley from Parenting 2000 but indicated they would have to pay privately for additional sessions or wait approximately two years via the NHS-funded route. AR had had enough, it was said, of undertaking talking therapy with different people when he had an established relationship with Ms Aldersley.[1047]

142. CAMHS considered discharge due to non-engagement at an MDT on 29 July 2020, a view confirmed again at a safeguarding supervision on 6 August 2020. AR did not attend the final planned session on 11 August 2020.[1048] Although discharge had been agreed, an administrative oversight meant AR remained technically open to CAMHS. In addition, as he accepted in his written statement, Mr Coppard did not update the CAMHS risk assessment while case manager, which should have been done every three months. His evidence was that he perceived no change in risk.[1049] While formally still open to the service, all CAMHS involvement was effectively in abeyance until February 2021.

143. As a result of AR being placed on the ASD pathway, on 28 August 2020 he was assessed by a speech and language therapist for the purposes of the autism assessment (resulting in a report issued on 27 October 2020).[1050] Following that, on 17 November 2020, Alphonse R was contacted by Ms Kate Murphy (a neurodevelopmental practitioner and a registered nurse) to explore AR's neurodevelopmental history and his developmental milestones, to gather information relevant to the diagnostic criteria for ASD.[1051]

144. On 30 December 2020, AR's ASD was formally diagnosed by a multi-disciplinary panel. The professionals completing the assessment were Dr Sultan (consultant paediatrician), Ms Ruth Mitchell (speech therapist) and Ms Dawn Devine (Physician Associate). The panel's conclusion was that AR had

1044 AHCH000100/13-14; AHCH000096/1-2; T/S: 25/33/2-34/21.

1045 Witness Statement of Dr Acharya AHCH000340/§§11-14.

1046 Witness Statement of Mr Coppard AHCH000289/§§72-79; AHCH000162/56-58.

1047 AHCH000283/2.

1048 Witness Statement of Mr Coppard AHCH000289/§§75-78.

1049 Witness Statement of Mr Coppard AHCH000289/§79.

1050 AHCH000096/4-6.

1051 T/S: 25/35/8-36/22.

ASD, and that he needed further assessment for ADHD.[1052] I note that the panel had access to the CAMHS records regarding AR's activities in the intervening period following the referral by the GP, as well as to information provided by The Acorns School and input from an educational psychologist. However, while the panel accessed the information from The Acorns School, it appears that relevant information from CAMHS regarding risk had not been summarised or distilled for them. It was notable, for example, that the panel appeared unaware of the incident where AR had attacked a pupil at Range High School, but suggested that he *"took a knife into school and is doing community service"*.[1053] Ms Boggan accepted this was a shortcoming, *"though I accept it would not have affected the panel's conclusion"*.[1054]

145. The panel's diagnosis was to be shared sensitively with AR at a feedback appointment as he did not consider he was autistic and had some negative perceptions about what autism was. Alphonse R was informed by telephone of the diagnosis on 20 January 2021 (the delay having been caused by difficulties arranging a virtual appointment).[1055]

146. On 3 February 2021 the diagnosis was shared with AR at the feedback appointment conducted by a video call. The professionals, who included Ms Boggan, attempted to present the information in a *"neuro-affirmative way"*, indicating to AR that the diagnosis simply meant that he would process and consider some things differently from his peers. AR did not have any questions about the diagnosis.[1056] During the video appointment, Alphonse R requested a re-referral to CAMHS and flagged that he thought an ADHD referral had been or was going to be done.

147. Following the video consultation, on 3 February 2021 Alphonse R sent an email to Ms Boggan explaining why he felt that a CAMHS review and an ADHD referral were necessary.[1057] On the CAMHS review, Alphonse R wanted to know whether medication could be part of the solution because AR had tried talking therapy but had abandoned it because he felt it was not helping.

148. Ms Boggan replied to Alphonse R on 9 February 2021 addressing both the ADHD query and the requested re-referral to CAMHS:[1058]

    a. In relation to ADHD, Ms Boggan explained that AR's school would need to complete a referral for the ADHD assessment, since, in line with recent National Institute for Health and Care Excellence (NICE) guidance, his symptoms needed to be observed in two or more settings, typically at home and at school. She also ensured that the

1052 AHCH000100/35-36.
1053 AHCH000100/35.
1054 T/S: 25/37/19-42/6.
1055 AHCH000100/37-38.
1056 AHCH000100/40-41; T/S: 25/47/16-51/2.
1057 AHCH000163/2.
1058 AHCH000163/1.

final report from the ASD pathway was amended to include a request that AR's school be invited to consider an ADHD referral. However, the amended final report was not then shared with AR's school due to an administrative failure within the ASD service. The result was that The Acorns School were not aware that they were being invited to consider making an ADHD referral. Without that referral from the school, because two points of referral were required, the ADHD assessment could not be, and was not, progressed.[1059] Moreover, although Alphonse R raised the issue of ADHD assessment again on 9 April 2021 (this time with Ms Samantha Steed of CAMHS), this was not followed up, in all likelihood because of understandable confusion on Ms Steed's part in relation to the changed referral process in circumstances where there was an active community paediatrics referral.[1060] I return below to further missed opportunities for AR to be assessed for ADHD;

b. As regards the requested re-referral to CAMHS, Ms Boggan told Alphonse R she had been in contact with CAMHS and requested an appointment.[1061] Mr Coppard confirmed that he received an email on 9 February 2021 from Ms Boggan to indicate that AR had received a diagnosis of ASD and that AR's father was seeking a new CAMHS appointment because of increased anxiety.[1062] Ms Boggan's evidence was that she also had a conversation with the CAMHS manager and asked for a review appointment to be arranged in order to provide support. She did not, however, emphasise in that discussion any concerns about risk arising from AR's ASD diagnosis, although she accepted it would have been an appropriate thing for her to do.[1063]

149. It was not until 16 February 2021 that the final autism outcome report was shared by letter with AR's parents (copied to the GP, but not, as set out above, to The Acorns School). The overall process had taken 77 weeks. Ms Boggan accepted this involved a significant delay. She agreed that even though ASD is not 'treatable' and so a delay in diagnosis would not make ASD worse, a delayed diagnosis can still have an adverse impact, especially for AR given he was struggling at school. In particular, an earlier diagnosis could have better informed the plans for his education.[1064] It would also, as described below, have been potentially relevant to the role of FCAMHS.

150. Following AR's ASD diagnosis, the Community Paediatrics team provided advice and signposting to other organisations explaining where to access support. However, it was not responsible for supporting an individual

1059 LCC000097; T/S: 25/52/22-56/14.

1060 T/S: 25/69/7-70/14.

1061 AHCH000163/1.

1062 Witness Statement of Mr Coppard AHCH000289/§80; AHCH000291/46.

1063 T/S: 25/51/3-52/21.

1064 T/S: 25/56/15-59/14.

post-diagnosis. Indeed, families were left to try to obtain support from local services such as community groups and the Sefton Nursing ASD and ADHD team. The onus was very much on parents to *"be their own advocates"* in terms of researching and accessing post-diagnosis support.[1065] AR was discharged from the Community Paediatrics team on 7 July 2021, following a review appointment with Dr Sultan.[1066]

151. The diagnosis of AR's ASD in early 2021 was, or should have been, a significant milestone in AR's interactions with other mental health services. Despite the terms of the 9 March 2020 letter from Mr Hicklin of FCAMHS, when CAMHS learnt of the ASD diagnosis, CAMHS did not refer AR for further advice from FCAMHS. Having been contacted by Ms Boggan, Mr Coppard could not again take on case manager responsibility for AR because of his caseload capacity. Instead, Ms Steed took on the role of case manager from 1 April 2021. But no one from CAMHS appears at this time to have given thought to an FCAMHS re-referral. Dr Killen accepted that, in light of the autism diagnosis, AR should have been re-referred to FCAMHS in February 2021. That acceptance has been fairly and clearly repeated in the closing statement on behalf of Alder Hey.[1067] Dr Killen also considered that FCAMHS' failure to carry out a risk assessment of AR had the effect of reducing their assessment of the risk AR posed to others. Dr Killen suggested that greater clarity is needed, when a number of agencies are involved, as to who has responsibility for managing the risk posed by an individual, particularly when that risk is not based on a significant mental illness.[1068] Mr Hicklin accepted that, subject to the *"nuances"* of the diagnosis, the February 2021 diagnosis should have prompted a re-referral to FCAMHS (as should, in his view, the later referrals to Prevent in February and April 2021, the violent incidents at home in November 2021 and 'the knife on the bus incident' in March 2022).[1069,1070] Ms Brown agreed that there were many missed opportunities for the case to be referred back to FCAMHS, which should have occurred given the complexities and the very high risk posed by AR. She acknowledged that the inter-agency working arrangements were inadequate.[1071]

152. The principal responsibility for the lack of a referral back to GMMH's FCAMHS service at this stage rests with the CAMHS service. The Alder Hey Community Paediatric Service was unaware of Mr Hicklin's letters outlining FCAMHS' assessment of AR (I have addressed at paragraph 134 how they had not

1065 T/S: 25/59/21-62/2.

1066 Witness Statement of Ms Boggan AHCH000252/§§45-46.

1067 Closing Statement on behalf of Alder Hey Children's NHS Foundation Trust AHCH000327/4/§11.

1068 T/S: 24/187/11-193/25.

1069 T/S: 25/143/10-145/2.

1070 T/S: 25/188/4-13.

1071 T/S: 25/190/13-19.

been scanned onto AR's electronic patient record after they were received by CAMHS). If Ms Boggan had been aware of Mr Hicklin's reports, she would have referred the case back to FCAMHS.[1072]

153. As noted above, Ms Steed took over as AR's CAMHS case manager from 1 April 2021. She held a video consultation that day with Alphonse R. Despite it being late morning (11:30), AR was initially asleep in bed and refused to join the call when he did wake up; it was documented that he threw something at his father. Ms Steed noticed that Alphonse R did not reprimand his son and appeared embarrassed.[1073] She explored AR's symptoms of anxiety with Alphonse R. It was noted that it was now one year since AR had mixed with his peers; he was angry at his father and could be physically violent to him. Alphonse R explained that AR would like to return to mainstream school and suggested that *"… this is said not to be possible due to the incidents of [AR] trying to get revenge following being bullied and hurting an innocent child by mistake. The police were involved and there was NFA [No Further Action]"*.[1074] I note that this was typical of Alphonse R's tendency to minimise AR's criminal behaviour and responsibility for it. Ms Steed's evidence is that she was aware from reading the notes and discussion with Mr Coppard that AR had been permanently excluded and that there had been youth justice involvement.[1075] Alphonse R explained AR's limited food intake (he was very underweight) and selectiveness in what food he would eat. It was noted that AR had an EHCP in place and that this may need review. Ms Steed documented that AR was on the *"waiting list for ADHD assessment"*.[1076]

154. After this first session which AR refused to attend, Ms Steed did manage to engage AR in video appointments held on:

    a. 8 April 2021;

    b. 16 April 2021;

    c. 22 April 2021;

    d. 6 May 2021 (for the first time for some of the call also with AR's mother Laetitia M);

    e. 11 May 2021.[1077]

1072 T/S: 25/64/19-65/9.

1073 AHCH000163/4-5.

1074 AHCH000163/5.

1075 First Witness Statement of Ms Steed AHCH000290/§11.

1076 AHCH000163/6.

1077 First Witness Statement of Ms Steed AHCH000290/§§18-50; AHCH000163/7-27. It should be noted that during the course of Ms Steed's time as case manager she had exchanges with social care and The Acorns School among others. This chapter concentrates on the healthcare assessments and discussions but Ms Steed's involvement with other agencies should not be overlooked and is detailed in her published statement.

In overview, there were some signs of improvement in these sessions. Ms Steed agreed to seek a consultant psychiatrist medical assessment in light of the duration of AR's difficulties. AR was being encouraged to go out more, including on walks with his father, and to get into healthier sleeping and eating behaviours. AR's plans to move to Presfield High School were also discussed and supported, as well as increasing his hours at The Acorns School. Difficulties, however, remained evident. AR was reluctant to be on camera and showed anger when he was inadvertently visible (with AR throwing or pushing the camera on one occasion), as well as displaying anger/irritation/agitation with his father over various issues. AR's father was unhappy with The Acorns School over the further referral to Prevent in April 2021 (I note that the further Prevent referral did not trigger any re-assessment of risk by CAMHS nor any consideration to a re-referral to FCAMHS).

155. Starting in May 2021, disagreements arose about the wording of AR's EHCP. I have addressed the wider impact of AR's EHCPs in Chapter 11: Education. Concerns were raised that information about the risks AR presented to others were 'watered down' in later drafts, reducing the clarity of information available to Presfield High School when considering whether a placement could be safely managed. As the EHCP process required input from healthcare, education and the LCC Inclusion Team, CAMHS – through Ms Steed – had a direct role in shaping the risk information included in the document. Her contribution to that process is addressed below, alongside the broader analysis in Chapter 11: Education.

156. EHCPs should be reviewed annually. Mrs Hodson gave evidence about the process of reviewing AR's EHCP in 2021. She has explained that she wanted to include a section which detailed the risk that AR posed to others:

> *"My efforts to include this information within the EHCP draft were met with hostility by AR's father and also by Samantha Steed (CAMHS). Ms Steed even went as far as to accuse me of racially stereotyping AR as "a black boy with a knife". Nothing could be further from the truth. We wanted to support AR and his family in finding a suitable education provision. Withholding relevant information was not going to assist him or us in that process. The statement on risk assessment remained in the EHCP. However, in the end the wishes of the family prevailed and the wording of the EHCP was re-written in many places to change the emphasis of some of the concerns in the original EHCP. For example, a reference to AR researching content online which could be viewed as sinister was changed to read "inappropriate."*[1078]

157. The process of reviewing an EHCP involved the creation of various drafts which were amended with tracked changes so that alterations were identified with strikethroughs and underlining. One draft of AR's EHCP contains some noteworthy amendments, consistent with the statement of Mrs Hodson:

1078 Witness Statement of Mrs Hodson LCC001773/§§107-109.

> *"The Educational Psychologist (May 2020) reported that when in school [AR] had little or no interaction with other pupils or relationships with the staff. [AR] can appear to become fixated on particular members of staff. There are concerns of occasions where [AR] would say and do things which have been described as ~~sinister~~. **inappropriate**.*
>
> ~~*[AR] can also appear to be cold and calculating and when in meetings with staff did not appear to be concerned about the seriousness of the meeting."*~~[1079] (emphasis in the original)

158. Mrs Hodson stated that the pressure to make these amendments was based on the professional views submitted by CAMHS on the basis that no child should ever be described as sinister and because:

> *"I perceived him to be a 'black boy with a knife'. So, in other words, I was racially profiling him and that effectively shut me up … that was the point at which I – that professionally just closes me down completely, doesn't it?"*[1080]

159. There is a contemporaneous record of this discussion in the form of Mrs Hodson's Child Protection Online Management System (CPOMS) minute dated 21 May 2021:

> *"[Alphonse R] then said he wasn't happy with the documents in the EHCP review. He said that he didn't want the sections that read 'A risk assessment to be completed to identify and minimise the risk for [AR] and those working with him'. There was some discussion about this. [Mrs Hodson] stated that the clause needed to stay and that the risk around [AR] needed to be identified and managed by any school working with him. [Alphonse R] said that he wasn't happy that school had written this. [Mrs Hodson] pointed out that she hadn't written it, it was from [AR's] EHCP plan and had been written into the plan on professional advice. [Ms Steed] asked whether parents were worried about it because [AR] was a 'young black male' and because of what people might think reading it. They nodded in agreement. [Carole Power of the LCC Inclusion Service] said she would look to see where the professional advice had come from, but that the statement would need to be included."*[1081]

160. Ms Steed failed to make her own notes of the meeting.[1082] However, her statement to this Inquiry says that she asked at the meeting:

> *"whether parental concerns about the EHCP document and the request for assessment of risk to be removed was in relation to how they felt AR might be viewed by others reading it.*

1079 LCC000132/6. A later draft was further edited: LCC000139.

1080 T/S: 27/205/21-206/23.

1081 LCC001346/29.

1082 First Witness Statement of Ms Steed AHCH000290/§51.

This may have included fears of stereotyping given AR's protected characteristics (including his heritage/race/ethnicity and neurodivergence) and his history (i.e. offending behaviour, permanent exclusion from school, prior Prevent referrals and his childhood and family experiences, which he was beginning to talk about with professionals involved)."[1083]

161. While I recognise that there may be grounds for a fear of stereotyping due to protected characteristics, I do not follow the suggestion that there could be a rational fear of inappropriate stereotyping by professionals because of AR's history. The history listed by Ms Steed was factual and those matters were crucial to any assessment of AR.

162. I also consider that it was unwise of Ms Steed to raise issues of racial stereotyping in this context, by asking if the parents' concern was related to AR being a 'young black male'. Alphonse R was articulate and there are many examples of him putting across his own viewpoint in the strongest of terms. While the contemporaneous CPOMS record does not suggest that Ms Steed made a direct accusation of racial stereotyping against Mrs Hodson, the fact that such a contentious topic was raised nevertheless served to 'close down' Mrs Hodson. Yet Mrs Hodson was raising a valid point about the need for a risk assessment. Indeed, Presfield High School were later to take issue with the lack of risk information in the EHCP and Ms Steed acknowledges that specialist support around risk assessment and formulation was required.[1084,1085] In those circumstances, Ms Steed should instead have sought to support Mrs Hodson's position.

163. One can understand the strength of the word 'sinister', particularly when used in relation to a child. Ms Steed also refers to the wording struck through in the citation above that AR could appear to be *"cold and calculating"*. Ms Steed states that she did not - and does not - feel that such wording was clear, factual and contextualised information. She did and does not consider that the wording explained the underlying clinical formulation, and she felt that it might harm AR's psychological wellbeing when made available to him in the future.[1086]

164. Ms Steed recognises that the adjectives have proven appropriate with the benefit of hindsight, given AR's appalling crimes in July 2024. However, in 2021, AR had told Mrs Hodson that he had taken a knife to his previous school *"to use it"* while looking straight at her and being devoid of remorse.[1087] In those unusual circumstances, it seems to me that the wording was both apt and necessary at the relevant time for professionals reading the EHCP. Ms Steed

1083 Second Witness Statement of Ms Steed AHCH000326/§12.

1084 T/S: 28/18/2-19/13.

1085 Second Witness Statement of Ms Steed AHCH000326/§19(c) – although I do not accept that this was clear only in hindsight.

1086 Second Witness Statement of Ms Steed AHCH000326/§17.

1087 T/S: 27/98/4-21.

should either have had faith in Mrs Hodson's professional judgement or should have sought better to understand the rationale behind the use of such wording before questioning it.

165. Ms Steed fairly accepts that her approach could have been clearer at the relevant time.[1088] Her interventions appear to show a professional who was, understandably, seeking to advance the interests of the child. However, in so doing, this is another example of insufficient emphasis being placed on the risks that child may present to others. She misjudged and underestimated the objective justification for the words originally used in the EHCP.

166. After the exchanges over the EHCP, Ms Steed continued her sessions by video or telephone with AR and his parents, while also attending professionals meetings.[1089] There were sessions on:

    a. 25 May 2021 – of note, there had recently been an incident where Alphonse R had threatened to call the police after AR had disagreed with his father and then thrown a smoothie over him; AR was frustrated, perceiving Alphonse R did not follow through in relation to promises made around meals and cooking. Ms Steed indicated she was considering asking for a psychiatric opinion;

    b. 26 May 2021 – a CAMHS professionals' MDT in the absence of AR and his parents. Part of the agreed actions were for AR to be placed on the routine medication waiting list which would involve an appointment with a psychiatrist;

    c. 11 June 2021 – AR's parents only, AR refusing to attend and Laetitia M expressing concern that AR had become more anxious and was going backwards, feeling paranoid when he went outside;

    d. 16 June 2021 – another CAMHS MDT, in which it was agreed to escalate the referral to a consultant psychiatrist from routine to urgent;

    e. 18 June 2021 – AR was sceptical about graded exposure intervention to help him go out more and was pressing for a consultant psychiatric appointment and medication; AR was not speaking to his father and said he did not trust him.

167. Against this background, on 1 July 2021, Dr Ramasubramanian (Consultant Child Psychiatrist) had her first consultation with AR, his case having been allocated to her caseload.

168. Dr Ramasubramanian was and is an experienced consultant psychiatrist. At the time of her involvement with AR, she had extensive experience and specialist interest in treating mental health difficulties in children with neurodevelopment disorders including ASD and ADHD.[1090] Dr Ramasubramanian's evidence was that she was heavily reliant on the electronic patient records along with

1088 Second Witness Statement of Ms Steed AHCH000326/§52.

1089 First Witness Statement of Ms Steed AHCH000290/§§52-67; AHCH000163/29-41.

1090 First Witness Statement of Dr Ramasubramanian AHCH000239/§§2-3.

information provided by the case manager. She had read the previous records for the three referrals to CAMHS.[1091] As set out above, the referral seeking her involvement was made by Ms Steed and had been discussed in the MDTs on 26 May and 16 June 2021.

169. Dr Ramasubramanian was aware that AR had been closed to FCAMHS and Prevent prior to her involvement, and that he was not considered to be at risk of radicalisation or involvement in terrorism, and that, more broadly, he was not considered to be a risk to others. This, she said, provided her with considerable reassurance. In her view, the assessments by FCAMHS and Prevent enabled community psychiatrists to focus on *"the presenting symptoms"* without having to be concerned about the risk to others. FCAMHS and Prevent were viewed by her as highly specialist organisations, and the psychiatrists relied on their reports and conclusions, although Dr Ramasubramanian had not seen Mr Hicklin's letters of 11 February 2020 or 9 March 2020 (considered above). She was aware, however, that neurodiverse children with autism or ADHD can be disruptive and challenging. Dr Ramasubramanian focused on AR's symptoms.[1092]

170. However, Dr Ramasubramanian said in evidence that she was **unaware** that:[1093]

    a. AR had taken a knife into school on some 10 occasions prior to his contact with Childline in October 2019 with the intention of using it (referenced in CAMHS records);[1094]

    b. On 15 November 2019, AR had searched on a school computer for material relating to school shootings in America (referenced in CAMHS records);[1095]

    c. AR was interested in degloving injuries (this was apparent from the school internet browsing history but not available to other agencies before this Inquiry and thus not referenced in CAMHS records); [1096]

    d. AR said during a lesson on 29 November 2019 when students were asked how they would promote a local business, *"people don't trust others they don't know in case they get murdered"* (referenced in CAMHS records);[1097]

    e. AR had questioned, in an art lesson on 3 December 2019, why he was allowed to look at images from a video game, but could not look at guns on the internet (referenced in CAMHS records);[1098]

1091 T/S: 24/101/10-103/6.

1092 T/S: 24/108/19-110/20.

1093 T/S: 24/113/5-116/1.

1094 Incident: LANC000065; CAMHS records: AHCH000162/9.

1095 Incident: LANC000110/1; CAMHS records: AHCH000092/4, AHCH000162/9.

1096 Incident: LCC001401, ILT000022 - Disclosed but not published due to sensitive content.

1097 Incident: LANC000058/2, CTPNW000154/3; CAMHS records: AHCH000090/67.

1098 Incident: LANC000058/2; CAMHS records: AHCH000090/67, AHCH000092/4.

f. AR asked to look at a picture of a severed head (referenced in CAMHS records);[1099]

g. AR had carried a knife during the December 2019 incident with the intention of potentially using it on his intended victim as the *"[hockey] stick didnt hurt him as [AR] had been hurt"* (referenced in CAMHS records);[1100]

h. AR posted material relating to Gaddafi on Instagram on 1 February 2021 (does not appear in CAMHS records);[1101]

i. On 20 April 2021, AR had been viewing web pages relating to the London Bridge terror attack, when he spoke in detail about the IRA, expressing the thought that MI5 were being asked to kill people in the IRA and views on the conflict in Israel and Palestine (referenced in CAMHS records);[1102]

j. AR had been researching the Manchester Arena attack, which he described as a *"good battle"* from the perpetrator's point of view (referenced in CAMHS records);[1103]

k. AR was reported on 17 May 2021 have thrown juice over his father and to have hit him (referenced in CAMHS records);[1104]

l. AR had kicked his father on 30 November 2021 and damaged a rental car (not referenced in CAMHS records);[1105]

m. On 21 and 25 January 2022, AR made comments at school about the Holocaust, the death of Princess Diana, water poisonings and the necessity, on occasion, for violence (not referenced in CAMHS records).[1106]

171. Dr Ramasubramanian accepted that those incidents viewed together and individually were highly relevant to her understanding of how AR was presenting and that any assessment of risk would be flawed without knowledge of them.[1107] Dr Ramasubramanian had started her evidence asserting that she had reviewed the whole of the CAMHS records from the point of AR's referral into CAMHS.[1108] However, faced with the detail contained in the electronic patient record regarding AR's past conduct and his risk to others of which

1099 Incident: LANC000058/2; CAMHS records: AHCH000090/67, AHCH000092/4.

1100 Incident: MERP001375, CTPNW000157/10; CAMHS records: AHCH000162/11-12.

1101 Incident: LCC000455.

1102 Incident: CTPNW000137; CAMHS records: AHCH000163/19.

1103 Incident: LCC001402, CTPNW000157/14; CAMHS records: AHCH000162/10.

1104 Incident: LCC001346/31-32; CAMHS records: AHCH000163/29-30, AHCH000172 (row 218 in the spreadsheet).

1105 Incident: LANC000025.

1106 Incident: LCC001346/12.

1107 T/S: 24/116/2-12.

1108 T/S: 24/101/10-104/4.

Dr Ramasubramanian was not aware, she candidly accepted she had failed to conduct a very thorough review of the record. She accepted she had not read it in its entirety with the result that she missed these entries.[1109]

172. It is relevant to note that there was a CAMHS standard operating procedure in place at the time which, on its face, emphasised under 'Risk and Safeguarding' that *"[i]t is important that clinicians review the whole EPR [Electronic Patient Record] record at each appointment to ensure they are aware of any risk factors, or contextual risk that might have arisen since the last appointment"*.[1110]

173. Dr Ramasubramanian sought to give context as to how her failure to spot such relevant entries arose. She expressed the view that the records did not make the truly important information immediately visible to an incoming practitioner. She suggested that when a patient is referred to psychiatry, it would be of real assistance to have a *"standardised information handover"* to psychiatry, focusing on the key areas of *"risk to self, risk to others, risk of self-neglect and risk of vulnerability"* in a one-page format. This information would additionally inform any mental health diagnosis. It would have alerted her to consider AR's preoccupation with violence and whether she could rule out, for instance, an obsessive-compulsive disorder.[1111]

174. The visibility of key risk information is an area in which Alder Hey have introduced improvements since the attack and I have considered these in the context of the recommendations section at the end of this chapter.

175. Dr Ramasubramanian stressed, however, that notwithstanding the risk information of which she was unaware, she considered that in AR's case there were no signs of serious mental disorder.[1112]

176. The Inquiry's independent expert Dr Irani essentially agrees with Dr Ramasubramanian in this regard, including in the assessment that AR did not suffer from any severe mental illness. There is, however, one important caveat concerning a diagnosis of conduct disorder.

177. Dr Irani considered that AR met the diagnostic criteria for a diagnosis of conduct-dissocial disorder (commonly referred to as conduct disorder) under the World Health Organisation International Classification of Disease, 11th Edition (ICD 11).[1113] AR never received this diagnosis either from FCAMHS or CAMHS.

178. It is important, however, immediately to stress some important features about what I accept was a missed conduct disorder diagnosis:[1114]

1109 T/S: 24/118/16-23.

1110 AHCH000309/16.

1111 T/S: 24/118/24-121/9.

1112 T/S: 24/121/1-9.

1113 Expert Report of Dr Irani DRI000001/§3.3.1.2.

1114 See generally Dr Irani's oral evidence on the conduct disorder issue, T/S: 26/57/13-66/15.

a. First and foremost, conduct disorder is not a condition which detracts from AR's responsibility for the attack. Conduct disorder is not a severe mental illness. Unlike (for example) some forms of psychosis it does not provide, nor could it have formed, a defence, whole or partial, to the murder and other charges of which AR was convicted;

b. Second, and also importantly, this is not a case where the missed diagnosis meant that there was some 'treatment' (whether by medication or therapy) which AR ought to have received but did not receive. Dr Irani's evidence on this was clear. She said that conduct disorder is a diagnosis of 'social construct' and the interventions for it are primarily focused at supporting parents in developing parenting skills and supporting young people developing pro-social skills;[1115]

c. Third, this meant that the 'treatment' for conduct disorder would have been the same kinds of therapy which were in fact offered to AR (and his parents), but in relation to which there was variable and ultimately limited engagement from AR;[1116]

d. As regards the causative effect of the missed diagnosis, Dr Irani's ultimate conclusion (perhaps counter-intuitively) was that if the diagnosis of conduct disorder had been made as it should have been, the likely effect would have been to prompt AR to be discharged from CAMHS earlier than in fact happened. This would have been justified because, in the face of AR's failure to engage, further involvement by mental health services would not have been productive. The better course would have been to discharge AR and allow social care services (and where appropriate the criminal justice system) to take the lead, re-enforced by a proper risk assessment that would have emphasised AR's risk to others and the need for supervision and monitoring;

e. As Dr Irani made compellingly clear in her oral evidence, the way that a diagnosis of conduct disorder may have made a difference was by helping to frame more clearly the identification of risk. I infer from this that, with a diagnosis of autism and conduct disorder, it could have been made clear to social care services and law enforcement not to fall into the trap of considering that AR's violent misbehaviour, when it occurred, could be excused on 'mental health' grounds on the basis that AR was autistic. It would have served to demonstrate instead that such misbehaviour and criminality needed to be tackled and challenged as acts for which AR bore responsibility. As a formulation, Dr Irani agreed that conduct disorder would have led to, for example, a more robust response to the bus incident (which I discuss in more detail below).[1117]

1115 Expert Report of Dr Irani DRI000001/§3.3.1.3.

1116 Expert Report of Dr Irani DRI000001/§3.3.1.3.

1117 T/S: 26/57/13-66/15.

179. Dr Killen, as the clinical lead for CAMHS, did not disagree with Dr Irani's conclusion that AR met the diagnostic criteria for conduct disorder. She agreed that *"consideration of conduct difficulties could have been revisited"*, although she considered (like Dr Irani) that many of the treatment options would have remained the same.[1118]

180. When she was involved in treating AR, Dr Ramasubramanian did not consider conduct disorder. She did not think in those terms because she did not think there was evidence of persistent, repetitive anti-social tendencies. His disruptive behaviour was consistent, instead, with the autism diagnosis. However, Dr Ramasubramanian accepted (*"absolutely, absolutely"*) that if she had been aware of AR's full history as set out above she would have considered conduct disorder and contacted FCAMHS for a consultation.[1119] Dr Ramasubramanian did not disagree with Dr Irani's conclusion that AR met the criteria for a diagnosis of a conduct disorder.

181. Returning to the detail of Dr Ramasubramanian's first consultation with AR on 1 July 2021, this was conducted by telephone.[1120] AR insisted his father did not join in the conversation which prevented Dr Ramasubramanian from obtaining the history from a parental perspective. Dr Ramasubramanian considered that AR's descriptions of his symptoms of anxiety were as if he had rehearsed them from a book or from the internet. His articulation was quite unusual, and it was apparent that he was trying to persuade Dr Ramasubramanian that he needed medication. During the conversation, AR disagreed on multiple occasions with Dr Ramasubramanian and he became increasingly argumentative. When it was suggested he should commence a trial of a beta-blocker, such as propranolol, he disagreed and suggested he should be prescribed a Selective Serotonin Reuptake Inhibitor (SSRI) anti-depressant. He reluctantly agreed with the prescription for propranolol but he did not seem particularly interested. It was a brief appointment, in that AR seemingly simply wanted to share his symptoms in order to secure particular medication. Accordingly, it was not the thorough initial assessment that CAMHS normally offer. In summary, AR had been demanding, argumentative and he had attempted to dictate treatment.[1121] I note that this was consistent with the pattern shown in the lead up to this consultation when AR had become rigid in his thinking that talking therapy was inappropriate for him and his determination to seek medication. AR denied he posed a risk to others. Dr Ramasubramanian accepted that she was more focused on the risks to AR than the risk he posed to others.[1122]

1118 T/S: 24/167/20-168/25.

1119 T/S: 24/129/8-10.

1120 AHCH000163/41-44; First Witness Statement of Dr Ramasubramanian AHCH000239/§§12-15.

1121 T/S: 24/121/22-124/2.

1122 T/S: 24/125/12-19.

182. Ms Steed held another video appointment with AR on 2 July 2021 (in which he engaged well, despite being off camera) and Laetitia M. Ms Steed was keen to emphasise that medication alone was unlikely to achieve the mitigation of AR's fear of leaving home and that there should be behavioural activation work accompanying the newly prescribed medication.[1123]

183. AR, however, was soon seeking once again to have his medication changed. His father informed Ms Steed that AR had researched treatments online, believed he was on the wrong medication, and refused to continue taking it until he could speak to the doctor again. In my assessment this was typical of AR's attempt to control and manipulate situations, something which Alphonse R was prone to over-accommodating. Ms Steed sent an appropriate reply on 5 July 2021 but Alphonse R replied the same day still articulating AR's desire for different medication. Ms Steed emailed Dr Ramasubramanian on 7 July 2021. That same day, however, AR reversed his position and said he wished to restart propranolol. Ms Steed liaised closely with the family and Dr Ramasubramanian over the following days. The upshot was that Dr Ramasubramanian confirmed that AR should continue propranolol for a period and her own review should not be brought forward. Although AR resumed the propranolol, tensions at home were escalating with AR becoming aggressive, and his parents felt somewhat overwhelmed and shared feelings about being judged by professionals. There were concerns that AR was managing his own medication rather than the medication being held by his parents and overseen by them, something which Alphonse R suggested AR would not countenance.[1124]

184. Ms Steed had further sessions on the following dates:[1125]

    a. 30 July 2021 – with AR refusing to join the session. One of the issues discussed was that AR was now refusing to attend The Acorns School having been shown the Third Referral to Prevent by Alphonse R. Ms Steed tried to explain to Alphonse R the benefits of social care support being re-engaged and also AR being motivated towards talking therapy alongside the medication. (I interpose that between the session on 30 July 2021 and the professional meeting on 12 August 2021, on 11 August 2021, Dr Ramasubramanian had a telephone consultation with AR and his father. AR again pressed for an SSRI to be prescribed; it was agreed to discuss this at a face-to-face meeting and that AR would continue to take the propranolol);[1126]

    b. 12 August 2021 – a CAMHS professionals meeting attended by Ms Steed, Dr Ramasubramanian; Ms Locke (Dion R's case manager) and Mr Coppard. Dr Ramasubramanian had noted the disrespectful tone of emails from Alphonse R;

1123 First Witness Statement of Ms Steed AHCH000290/§69; AHCH000163/49-51.

1124 First Witness Statement of Ms Steed AHCH000290/§§70-83; AHCH000163/46-58; T/S: 24/126/9-127/11.

1125 First Witness Statement of Ms Steed AHCH000290/§§84-125; AHCH000163/59-94.

1126 First Witness Statement of Dr Ramasubramanian AHCH000239/§19; AHCH000163/62-64.

c. 17 August 2021 – this session was not recorded in the electronic patient record. There were concerning disclosures with AR alleging that his father had made emotional threats to him, saying he would be removed from his parents and AR alleging that his father had held/waved a knife at him saying *"I could kill you now"* and alleging that Alphonse R had hit Dion R. Ms Steed appropriately shared this information with CFWS. As I have addressed in Chapter 9: Social care, these allegations were uncorroborated by any other member of the family and were found to be unsubstantiated;

d. 18 August 2021 – a further CAMHS professionals meeting;

e. 19 August 2021 – with Alphonse R. Ms Steed followed up regarding the information she had shared with CFWS. During the course of this session, Alphonse R requested a new case manager. At this time, Ms Steed was conscious of how fractured the relationship between Alphonse R and AR had become;

f. 25 August 2021 – a CAMHS MDT meeting;

g. 10 September 2021 – with Alphonse R who again requested a new case manager alleging that Ms Steed was *"exploiting AR"*. Alphonse R was also declining family therapy and did not want to consider parent support groups, although he would accept a key worker. Alphonse R suggested that he did want Ms Steed involved but disliked the way she worked and felt she listened to AR too much;

h. 15 September 2021 – a further CAMHS MDT meeting and further professionals' meeting (at this stage it was planned that Ms Coppard and Ms Steed would 'co-work' AR's case).

185. On 15 September 2021, AR (with his mother) attended a consultant psychiatric review. Dr Ramasubramanian was incapacitated with COVID-19 and accordingly this assessment was conducted by Dr Aesha Aseri, with Ms Steed attending.[1127] AR continued to report feeling anxious about going out in public and interacting with new people; his current mood was nervous and angry. He reported a difficult relationship with his father, but a better relationship with his mother. He had poor appetite. The dilution of risk information is apparent from the absence of any reference to the hockey stick attack at Range High School in Dr Aseri's notes. Dr Aseri assessed AR to have ASD with a moderate degree of social anxiety. In this review, Dr Aseri prescribed sertraline, a type of SSRI, while also re-enforcing the role of psychological support in treating anxiety symptoms. (I note that while it was ultimately Dr Aseri's decision at this consultation to consider trying an anti-depressant medication, Dr Ramasubramanian had suggested this as a possibility ahead of the appointment; she had dutifully emailed the team while on sick leave).[1128] There was to be a follow up in four weeks.

1127 AHCH000163/94-98; First Witness Statement of Ms Steed AHCH000290/§§126-127.

1128 AHCH000240.

186. After a further MDT discussion on 22 September 2021,[1129] the four-week follow-up review was carried out virtually by Dr Ramasubramanian on 13 October 2021.[1130] AR's circumstances had not improved; AR was not attending school or leaving the house. It was noted that AR was no longer on propranolol and Dr Ramasubramanian increased the sertraline dosage.[1131]

187. In around November 2021, AR reached the top of the waiting list for a CAMHS key worker. Ms Michelle Warner became AR's assigned key worker for the period between November 2021 and 22 March 2022. In that time, she had seven direct contacts with him: five face-to-face sessions, and two telephone sessions. Her last contact with AR was on 15 March 2022.[1132]

188. As I have addressed in Chapter 7: Policing, on 5 November 2021, the police were called to the family home because AR had *"trashed"* the house. Dr Ramasubramanian expressed concern that AR's parents failed to provide any information to her about this incident. This information was critical, in her view, in order to ensure that AR was given the correct support. Instead, the parents simply indicated that AR had *"improved massively"* on the medication he had been prescribed.[1133] While this was Dr Ramasubramanian's view, in fact Laetitia M had told Ms Steed (as the CAMHS case manager) about the 5 November 2021 incident and Ms Steed had included a reference to it in the electronic patient record, although the entry was made retrospectively.[1134,1135] Accordingly, while AR's parents may have been selective (or at least less forthcoming) in what they said to Dr Ramasubramanian compared to Ms Steed, Dr Ramasubramanian's lack of knowledge about the 5 November 2021 incident reflects a degree of poor communication within CAMHS.

189. On 15 November 2021, at a further follow-up appointment, Dr Ramasubramanian observed some positive changes.[1136] AR had been attending school at least on some days, and his anxiety had improved. He complained, however, that the sertraline made him tired when the dose had been increased. Dr Ramasubramanian assured AR that this was normal and said she would consider whether to increase the dosage once the tiredness had worn off.[1137] Ms Steed had a separate exchange with AR and his father on the

1129 AHCH000163/98-99.
1130 AHCH000163/107-109.
1131 T/S: 24/129/23-130/4.
1132 Witness Statement of Ms Warner AHCH000261/§13.
1133 T/S: 24/130/19-131/23.
1134 First Witness Statement of Ms Steed AHCH000290/§§138-147.
1135 AHCH000163/119-120.
1136 AHCH000163/113-116.
1137 T/S: 24/130/5-18.

same day. This exchange was less optimistic than the information given to Dr Ramasubramanian. Ms Steed noticed that AR's parents had not mentioned the 5 November 2021 incident to Dr Ramasubramanian.[1138]

190. On 21 November 2021, Alphonse R contacted CAMHS to report that there had been two further incidents at home during which AR had not caused physical harm but had demonstrated intimidating behaviour. AR had used verbal threats and on two occasions had poured milk over his father. Ms Daisy Jones, a Senior Mental Health Practitioner in the CAMHS Crisis Care Team, suggested it might be helpful to hold a multi-professional meeting given that the *"issues seem to be escalating in the family context"*.[1139] Ms Steed informed LCC CFWS of this, particularly to ensure that the family had the correct contact details should the situation escalate.[1140] It is not clear why Dr Ramasubramanian was not made aware of these incidents when they had been reported to the CAMHS team and were documented in the electronic patient record.

191. On 30 November 2021, AR kicked his father and threw a plate at a rental car, cracking the windscreen. Dr Ramasubramanian was also unaware of this incident, which was not referenced in CAMHS' records.[1141]

192. Right at the end of the year, on 30 December 2021, Dr Ramasubramanian responded to a request from AR's parents to make the next medication review (due on 24 January 2022) an in-person consultation. Dr Ramasubramanian did not consider this was necessary or appropriate based on Trust policies at the time. While Dr Ramasubramanian's evidence is that she was nevertheless willing to offer an in-person review, in the event, AR expressed a preference for it to remain a remote appointment.[1142]

193. In early January 2022, Ms Steed was involved in interactions with the family leading up to disclosures made at a Team Around the Family meeting led by CFWS on 11 January 2022. On 2 January 2022 Alphonse R emailed Ms Steed indicating that AR had been asking to speak to her face-to-face a few times. On 6 January 2022, in the course of a session on AR's EHCP, AR said he wanted to tell Ms Steed something, but it needed to be face-to-face. On 10 January 2022, Alphonse R told Ms Steed that AR was refusing to go to school until he was seen face-to-face by her. Ms Steed spoke to Alphonse R emphasising that AR should not be permitted to manipulate her or Alphonse R, in circumstances where he had refused to indicate the nature of what he wanted to speak about. At the Team Around the Family meeting the following day, AR disclosed that he had been hit with a slipper multiple times by his father and that he had been hurt by his father in this way in the past. His father admitted having hit AR in the past by way of physical chastisement. AR went on to allege that Dion R was in a wheelchair because of Alphonse R,

1138 First Witness Statement of Ms Steed AHCH000290/§§148-149; AHCH000163/116-117.

1139 LCC000975.

1140 T/S: 24/133/25-134/16.

1141 T/S: 24/134/17-21.

1142 First Witness Statement of Dr Ramasubramanian AHCH000239/§34; AHCH000163/135-136.

which was challenged by CFWS although Ms Steed said that AR was *"not feeling heard"* and that this *"adds to his frustration and impacts his mental health"*. It was agreed that family therapy (for which the family were already on the waiting list) could be helpful and Ms Steed understood that LCC's social care services would do any necessary follow-up on AR's disclosures of physical chastisement when AR was younger, which Alphonse R had in part accepted.[1143] At the CAMHS MDT that followed on 12 January 2022, Ms Steed raised the concern that AR was not being heard; the MDT was concerned at CFWS proposing to close AR's case. AR's perception that his father was not making the type of meals he had agreed to was seen as giving rise to *"a query around neglect at home re food and care from Dad"*.[1144] While Ms Steed cannot be faulted for pursuing her understanding of how AR's behaviour might be linked to a perception that he was not being heard, very little attention appears to have been paid in these exchanges to the significance of AR's violent outbursts as regards risk that AR posed to others. A face-to-face meeting was planned for 17 January 2022 for Ms Steed and AR, along with a CAMHS CBT practitioner. Ms Steed recalls that this took place, although it does not seem to have been documented.[1145]

194. On 24 January 2022, Dr Ramasubramanian held a further psychiatry review appointment with AR and his father, which was conducted by telephone. AR was positive in this session, indicating that while he was anxious about going out, his anxiety settled once he was outside. He felt he was working well with Ms Warner and had enjoyed going to the local Co-op store with her.[1146]

195. While this session was positive, Dr Ramasubramanian reflected during her evidence to the Inquiry that there were other events of which she was not aware around this time. She was not aware, for example that on 21 January 2022 AR had made comments at school about the Holocaust. She was similarly unaware that on 25 January 2022, AR talked about the death of Princess Diana and water poisonings, while also indicating his belief that violence was sometimes necessary. Dr Ramasubramanian considered that the relevant agencies had failed to share this information. This was a view shared by Dr Killen who suggested that there can be an *"assumption"* that other people in the *"system"* have information.[1147] I deal with the information sharing from AR's schools in relation to such incidents in Chapter 11: Education. However, it is fair to note here that there was a documented exchange on 11 February 2022 in which Mrs Maggie Allred from The Acorns School discussed with Ms Steed:

> *"Mrs Allred has sent an attendance record to Sam Steed (CAMHS) to inform discussions about attending school and spoken to her (10:45am) about managing the transition to Presfields.*

1143 First Witness Statement of Ms Steed AHCH000290/§§168-180; AHCH000164/1-8.

1144 AHCH000164/9-10.

1145 First Witness Statement of Ms Steed AHCH000290/§§181-182.

1146 First Witness Statement of Dr Ramasubramanian AHCH000239/§35; AHCH000164/22-24.

1147 T/S: 24/134/22-135/17, T/S: 24/181/12-25.

> *Also talked through [AR's] political viewpoints and Sam said school is managing it really well and he will probably always have an interest in global politics and it is about [AR] understanding how others might feel about his views as well as exploring his own views. Mrs Allred says this has been addressed with [AR] in school and Sam was happy with this."*[1148]

Accordingly, the fact that Dr Ramasubramanian was not aware of concerns about AR voicing certain political viewpoints may, at least to some extent, have arisen more from shortcomings in CAMHS' internal communication than in a failure of The Acorns School to pass on information. I accept, however, that it is unclear what level of detail The Acorns School went into when AR's political views were discussed with Ms Steed.

196. Regrettably, by mid-March 2022, AR had made clear that he no longer wanted to work with Ms Warner.[1149] The basis for this appeared to be that AR felt he had made progress with going out and eating in public, the areas on which Ms Warner had focused. Ms Steed felt that further sessions would have helped as she was impressed by the progress made by AR with Ms Warner's assistance. This is a good illustration of the challenges faced by CAMHS (and indeed other agencies) in that therapeutic relationships were started with initial success, but AR would prove reluctant to engage further or would decide that the support was no longer required or what he wanted. It was therefore extremely difficult, despite CAMHS' persistent efforts, to make real and lasting headway.

197. On 17 March 2022, AR went missing from home and was found on a bus in possession of a knife. He admitted to the police who detained him that he wanted to stab people and that he had either had thoughts about making poison or had done so. I have addressed the detail of this incident in Chapter 7: Policing and the response of social care services in Chapter 9: Social care. In addressing CAMHS' involvement in this chapter, I stress that CAMHS were by no means alone in responding to this incident inadequately and that they were not provided with the full information concerning the incident or what AR had said during it.

198. CAMHS had some (though limited) direct involvement on the day itself. Alphonse R contacted CAMHS by telephone to say that AR had been reported to the police as missing. Ms Steed called Alphonse R at 14:45 and was told that he had returned home from work and AR was gone and he was said to have a small knife in his possession. Ms Steed updated the CAMHS MDT and texted AR encouraging him to go back home. Ms Steed sought advice from the Alder Hey safeguarding team and was assured that as the police were

1148 LCC001346/11.

1149 First Witness Statement of Ms Steed AHCH000290/§§189-191; Witness Statement of Ms Warner AHCH000261/§51-59; AHCH000164/34-35;

already involved, no further immediate action was required save for liaison with the school nurse. Ms Steed then learnt that AR had returned safely, and she updated the CAMHS MDT to this effect.[1150]

199. The next day, 18 March 2022, Ms Steed had an appointment with AR that was also attended by his mother.[1151] Part of this appointment was a discussion about AR having gone missing from home and AR spoke to Ms Steed on this aspect when his mother had left the room. Ms Steed documented this aspect of the appointment, and it is relevant to set this out in full:

> *"I pointed out how far he has come - he was able to leave the home yesterday on his own. Mum was out of the room - he told me that he does not want his parents to know that he left the home so that he could get arrested and then the Police could get into his online accounts for which he has lost the passwords and then he could delete videos which he made of himself. I asked again about the videos which he had previously said were just silly videos he made when he was 10. We talked again about how young he was to have these online acc's i.e. tic toc and reddit and insta and he said everyone his age had them at the time. he has new acc's now but does not post just follows others. [AR] is obviously preoccupied with wanting to get into these accounts. He said a Police officer had told him that he would get into the acc's for him - I am unsure how true this is or whether the PC was trying to distract [AR] from his anxieties. We discussed how some acc deactivate themselves after periods of no use - [AR] said he does not think this is the case with the acc's he is referring to. i have wondered if the content of videos may be inappropriate, but [AR] has not alluded to anything like this and just said he was being silly/and was young. There may be a chance that someone else with an acc could search for him or he could search for his old acc. However, [AR] does not seem to want to follow this up with anyone.*
>
> *[AR] told me that he left home walked for about 6 miles then tried to get on 2 busses – his parents know this much from the Police but he has not spoken with them – there were altercations with passengers as he had no money and would not leave the bus when asked by the drivers. It seems he got off of the first bus then got on another and refused to leave was threatened by a passenger and the Police were called and took him home.* ***[AR] did not comment regarding having a knife on his person as his Dad had said he did."***[1152] (emphasis added).

1150 First Witness Statement of Ms Steed AHCH000290/§§193-194; AHCH000164/36-37.

1151 First Witness Statement of Ms Steed AHCH000290/§§195-200; AHCH000164/42-45.

1152 AHCH000164/43-44.

200. It is apparent from this contemporaneous note that Ms Steed was fully aware (from Alphonse R's earlier telephone call) that it was reported that AR had a knife on him. Moreover, Ms Steed was astute in observing that AR had made no mention of the knife in his account to her in his session. Ms Steed considered this sufficiently relevant specifically to document it.[1153]

201. However, what is concerning is that there is no record of this aspect thereafter being followed up by CAMHS. There was no challenge to AR about whether or not he was carrying a knife (and if so why, and the implications for risk). There was no apparent attempt to garner further evidence from the police about the knife. There was no consideration of further involving FCAMHS. Ms Steed's record of this assessment ended with *"Current Risk Identified: No. Change to current Care Plan: No"*.[1154]

202. Dr Ramasubramanian next saw AR on 7 April 2022 (see further below) by which time she was aware of this incident from review of the electronic patient record. There is no evidence that she was consulted about the incident, for example around advice around the fact that AR may have been carrying a knife when he left the house. Furthermore, Dr Ramasubramanian said in evidence that she was aware of Ms Steed having entered *"no risk"*.[1155] However, Dr Ramasubramanian does not seem to have proactively asked questions about the incident once she was made aware of it from reading the notes ahead of the 7 April 2022 consultation.

203. I take account of the fact that neither Ms Steed nor Dr Ramasubramanian (nor indeed CAMHS as a whole) appear to have been told that AR had said that he wanted to stab people or that he had either had thoughts about making poison or had done so. The failure of the multi-agency arrangements to ensure that CAMHS were aware of this important detail is the most striking failure in this context.

204. However, even without this information, it was important for CAMHS to have asked more questions at this stage and probed the implications for AR's risk to others. They failed to do so. In particular, the fact that AR had omitted to mention carrying a knife (in contrast to his father's account) was noted by Ms Steed at the time and specifically documented. This should have been a red flag, prompting professional curiosity and the proper exploration of what this meant in terms of AR's risk to others. It is notable that there was an MDT discussion of AR's case just five days after the incident. All that was recorded on this aspect was *"recent episode of going missing"*.[1156] That is symptomatic of CAMHS lack of sufficient attention to AR's risk to others.

1153 AHCH000164/44.

1154 AHCH000164/44.

1155 T/S: 24/135/18-139/11.

1156 AHCH000164/42.

205. It follows that – in my assessment – CAMHS (including Ms Steed and Dr Ramasubramanian) did not respond adequately to this concerning development, even allowing for the fact that they had not been informed of its full seriousness. This was a significant failure. It should, however, be seen in the context of:

    a. The earlier failures to conduct an FCAMHS-led SAVRY risk assessment, thereby establishing the structure within which such later incidents should have been managed; and

    b. The failure of other agencies to share all the known risk information about this incident with CAMHS.

206. On 22 March 2022, The Acorns School emailed Ms Steed asking her to:

    > *"... let us know how the meeting with [AR] went on Friday and clarify what were the issues that caused [AR] to act the way he did on Thursday?* ***Please give as much information as possible so we can update our safeguarding and risk assessments.***
    >
    > *It would also be useful if you can liaise with Presfield school – are you happy for me to forward your details to them?"*[1157]
    > (emphasis added).

207. Ms Steed replied within 30 minutes, stating:

    > *"[AR] came to session and engaged well. From what he shared I can let you know that he does not want to return to Acorns to say goodbye. He is looking forward to starting at Presfield and have agreement from [AR] to contact them."*[1158]

208. Mrs Hodson of The Acorns School said in evidence that the school *"…were concerned that information about this incident had been deliberately withheld from us by AR's father and that CAMHS had not been forthcoming about the true nature of the incident. We had not been told by either that AR had been found in possession of a knife, or that he had stated his intention to use it. Nor had we been told about AR's reference to making poison"*.[1159]

209. In response to a request from the Inquiry, Ms Steed provided a second witness statement addressing this issue (and the amendments to the EHCP which I have already addressed).[1160] Ms Steed vigorously denies that she deliberately withheld information from The Acorns School in relation to this incident, still less that she did so because she did not wish to derail AR's transfer to Presfield High School.

1157 PRE000357/2.

1158 PRE000357/2.

1159 Witness Statement of Mrs Hodson LCC001773/§242.

1160 Second Witness Statement of Ms Steed AHCH000326.

210. My conclusions on this aspect are as follows:

a. First, I am sure that the high point of Mrs Hodson's concerns (while genuinely held and appropriately raised) are not objectively justified. Ms Steed was not aware of the most serious aspects of the incident (that AR had voiced an intention to use the knife to stab people and had mentioned poison);

b. Second, Ms Steed's insistence in her evidence to the Inquiry that The Acorns School already knew about the incident misses the point.[1161] Mrs Hodson was not suggesting that The Acorns School did not know about the incident, or that they did not know that AR had a knife in the incident; her concern was that CAMHS had not told The Acorns School all they knew about the incident;

c. Third, the evidence does not establish any bad faith on Ms Steed's part in terms of a malign withholding of information by her. However, Ms Steed did know that Alphonse R had reported that AR was thought to have a small knife in his possession; she had a long conversation with AR about the incident in which she documented the fact that he made no reference to a knife. The Acorns School were seeking as much information as possible from Ms Steed to inform their necessary risk assessments. Ms Steed has not satisfactorily explained why she made no mention of this in the response to The Acorns School. The fact that Ms Steed's email in reply said, *"From what he shared I can let you know…"* more than hints at a decision being made about what information to share and what not to share.[1162] To the extent that a concern about therapeutic confidentiality may have been part of Ms Steed's rationale, that was not a good reason to withhold this information. The information about a knife was relevant to the risk to others (including staff and pupils at The Acorns School and Presfield High School) and should have been shared;

d. Accordingly, Ms Steed should have told The Acorns School that Alphonse R had reported that AR had a knife on him, but that AR had not mentioned this in the discussion on 18 March. Since Ms Steed had documented the difference between Alphonse R referring to the knife and AR not mentioning it, it is unlikely that Ms Steed simply overlooked this in replying to The Acorns School. It is more likely that either (1) she was unsure which account was correct (which was not a good reason to avoid mentioning the issue); or (2) she was insufficiently focused on the issue of AR's risk to others;

e. Ms Steed could also have shared AR's explanation of the bus incident more widely because that had been discussed in some detail in Ms Steed's interaction on 18 March 2022.

1161 Second Witness Statement of Ms Steed AHCH000326/§34.

1162 PRE000357/2.

211. AR had a missed appointment with Ms Steed on 4 April 2022 and there was a confusion about the re-arranged time for 7 April 2022 when AR was also meant to see Dr Ramasubramanian.[1163] Alphonse R was keen on face-to-face appointments. Ms Steed informed him that AR was now on the waiting list for *"CBT adapted [for] Autistic Spectrum Condition"* and that AR had face-to-face contact with Ms Warner but that had come to an end. She offered to see AR face-to-face later in April when he had started at Presfield High School.

212. At the 7 April 2022 consultant review, Dr Ramasubramanian discussed AR's medication with him. AR's responses appear to have been somewhat contradictory in that he said that he did not need SSRI medications, but he had anxiety about talking to people. But he also said that he wanted to try a different SSRI medication. Dr Ramasubramanian informed him that the more he exposed himself to people and situations, the more he would be able to talk to people. Since there was no evidence of social anxiety or generalised anxiety disorder, Dr Ramasubramanian suggested that SSRI medications would not be indicated for him. She was firm in her advice against trying a different SSRI medication. The short-term plan was for a slightly higher dose for two months and if that was of no benefit, it would permit the conclusion that medication was not the right approach. The plan would then be to discharge AR as he did not present with any evidence of a mental health disorder.[1164]

213. Later in April 2022, AR had messaged to report experiencing heartburn with his sertraline and asked if there was other medication he could try. Since Dr Ramasubramanian considered that there was not a current clinical indication for the medication, AR and his father were advised to stop the sertraline gradually. However, AR then told Ms Steed that he had already stopped taking it the week prior; Ms Steed cautioned that abrupt cessation in this way was contrary to what Dr Ramasubramanian had advised. Dr Ramasubramanian was concerned that AR was creating a case for stopping sertraline (heart burn was not a common side effect) and seeking a different SSRI medication, something he had already been asking for.[1165]

214. On 26 April 2022, Dr Ramasubramanian spoke to Alphonse R to discuss her concerns.[1166] She pointed out that she had advised that sertraline could be taken after breakfast and she discussed why AR had been managing his own medication and had access to all the tablets. She checked that the medication had now been taken off AR. Dr Ramasubramanian advised Alphonse R that AR should stop taking sertraline altogether given he had already stopped for a

1163 First Witness Statement of Ms Steed AHCH000290/§§203-204; AHCH000164/45-46, 49-50.

1164 First Witness Statement of Dr Ramasubramanian AHCH000239/§§42-46; AHCH000164/50-52.

1165 First Witness Statement of Ms Steed AHCH000290/§§206-207; First Witness Statement of Dr Ramasubramanian AHCH000239/§49; AHCH000164/53-57.

1166 First Witness Statement of Dr Ramasubramanian AHCH000239/§49; AHCH000164/57-58.

week (there was a potentially dangerous risk of discontinuing this medication without medical advice).[1167] Dr Ramasubramanian remained firmly against prescribing another SSRI medication. She planned to review AR in June.

215. In relation to a planned further session with Ms Steed on 13 May 2022, Alphonse R contacted Ms Steed to indicate that AR would not be able to make the session (there had been an earlier exchange to change the time of the appointment). Alphonse R raised a concern that AR was becoming isolated and going to his room when the school visited the family home. Alphonse R said that AR had started taking sertraline again but had now stopped this. Ms Steed was keen to check that AR did not have the medication in his possession, but Alphonse R said that AR would not harm himself with the medication and was not suicidal. Ms Steed reiterated that AR should not be in possession of the medication. Alphonse R was keen for Dr Ramasubramanian to see AR urgently, indicating that AR's GP had wanted CAMHS to manage AR's increased saliva which was linked to anxiety.[1168] Dr Ramasubramanian called Alphonse R believing the issues he wished to raise were urgent. She documented the call, noting a degree of frustration that the issues over saliva and sertraline were not in fact urgent but also recording that she had offered an in-person meeting.[1169] She later emailed Ms Steed commenting:

> *"[AR] is displaying a lot of control seeking behaviours which can be understood in the context of his ASC but I also note a significant behaviour component to it*
>
> *The hypersalivation cannot be explained by anxiety, it is a form of behaviour. I have explained this to dad.*
>
> *I am afraid there is nothing much that can be achieved from CAMHS input which [AR] has essentially declined - both keyworker and medication.*
>
> *He has refused to come and see you.*
>
> *[AR] is not risky so we need to consider if he needs to be open to us as it gives the system a false impression that we are doing something*
>
> *I can offer 23rd May at 11:30 at Burlington House."*[1170]

216. AR's treatment and presentation were discussed at a further CAMHS MDT on 18 May 2022.[1171] It was noted that AR was on the waiting list for family therapy, *"but things have escalated. He has stopped taking his medication and a review has been done by Lakshmi [Dr Ramasubramanian]. AR currently has a placement at Prestfield [sic] School but doesn't attend. There was an incident with his Dad at the weekend where police were called.*

1167 T/S: 24/139/16-140/6.

1168 First Witness Statement of Ms Steed AHCH000290/§§208-212; AHCH000164/62-6.

1169 First Witness Statement of Dr Ramasubramanian AHCH000239/§§55-57; AHCH000164/65.

1170 AHCH000164/66.

1171 AHCH000164/68.

There is no parental control over [AR]". I have addressed this incident in Chapter 7: Policing. It concerned AR demanding access to a laptop in the middle of the night, throwing foodstuffs and then flooding the bathroom causing the power to short circuit. Police officers attended but AR refused to speak to them.

217. The planned meeting for 23 May 2022 took place as anticipated. This was a face-to-face CAMHS meeting which included AR, Alphonse R, Ms Steed and Dr Ramasubramanian. This was the first in-person meeting between Dr Ramasubramanian and AR, although she had been his consultant psychiatrist from 1 July 2021. Concerns were expressed that AR had ceased taking sertraline, as prescribed. Dr Ramasubramanian was significantly concerned about the lack of adult supervision of AR's medication taking. AR wanted to take it himself but for safety purposes it was suggested that his father should only give him one strip at a time. AR had lost weight. There was concern at his lack of regular eating habits. AR had been referred to the dietician who had prescribed shakes and enriched drinks, which were rejected by AR. Both clinicians were concerned at AR's physical appearance; he was gaunt and thin. The plan was to restart sertraline for a week and then to increase the dose (50 mg to 75 mg). Alphonse R and AR consented to a professionals meeting with the school to discuss next steps for AR around facilitating school attendance. AR was awaiting CBT and family therapy from CAMHS.[1172]

218. AR was again discussed at a CAMHS MDT on 25 May 2022.[1173] The meeting covered the concern over AR's presentation, his weight loss and the difficulties over medication. I note that Ms Steed was in appropriate contact with Presfield High School and with AR's GP concerning AR's school attendance and marked weight loss.[1174]

219. Also on 25 May 2022, in the usual way, Dr Ramasubramanian sent a clinic letter summarising the content of the consultation that had taken place two days earlier.[1175] That letter was consistent with the discussions at the 23 May 2022 consultation and included the following:

> *"[AR] does not have regular eating habits. Due to his poor sleep pattern and as he does not go out or to school, he often misses breakfast. We were informed that he has cereal or toast made by his mother on some days. [AR] does not have a fixed meal time and eats McDonalds at least on 3 days a week and does not eat cooked dinner made by his mother as he says he does not like it.*

1172 First Witness Statement of Dr Ramasubramanian AHCH000239/§§57-63; First Witness Statement of Ms Steed AHCH000290/§§214-217; AHCH000164/69-71.

1173 AHCH000164/71-73.

1174 First Witness Statement of Ms Steed AHCH000290/§§219-221; AHCH000164/75-79.

1175 AHCH000095/24-26.

In addition, on the day he experienced heart burn, he took Sertraline in empty stomach and in a lying posture in bed. We discussed how all these could cause acid reflux and contribute to heart burn.

…

There were significant concerns around an adult monitoring his medication. Unfortunately, [AR] wants to take it himself and there is no consistent adult monitoring it due to work related commitments. So for [AR's] safety, we suggested that Alphonse only gives [AR] 1 strip of Sertraline at a time and locks away the rest. This was agreed."

220. Following this, on 31 May 2022, Alphonse R contacted Ms Steed by email complaining about the content of Dr Ramasubramanian's clinic letter stating that he was *"…astonished by some of the content of the letter"*. He set out a number of *"corrections"* about the arrangements around food and stated that as parents they did not agree with what Dr Ramasubramanian had said about concerns over medication monitoring. He used language like *"You should also mention the source of such incorrect statement"*; *"I don't know if you heard me"*; and *"I wish that a new letter reflecting our corrections be resent to all parties that the original was sent to. Also, I would like to have the email of Dr Ram"*.[1176]

221. Dr Ramasubramanian was not inclined to change her clinic letter since she considered it a proper reflection of the meeting, and I note that it also properly reflected her clinical concerns.[1177] In internal correspondence, Dr Ramasubramanian said:

"We can acknowledge the receipt of this email and it's contents, but my letter is based on the clinical impression at the face to face meeting and at previous interactions with the family.

Although I appreciate that [Alphonse R] wants the letter to be amended, I am afraid I cannot amend a clinic letter based on what the parent wants to be on it unless there is clear evidence for it.

I am afraid my concerns about [AR's] medication compliance and monitoring predates the face to face meeting and [Alphonse R] himself contradicts what he says in his email."[1178]

In my assessment, Dr Ramasubramanian was both justified and right to take this approach.

1176 AHCH000164/83-85.

1177 First Witness Statement of Dr Ramasubramanian AHCH000239/§64.

1178 AHCH000164/85-86.

222. In parallel with these developments, Alphonse R had also again taken up a request for a new CAMHS case manager to replace Ms Steed. He called CAMHS and the CAMHS note of this call record Alphonse R's reasons as follows:

> *"The family worked [very] well with Sam [Steed] and were very happy - she went out of her way to get an EHCP in place and helped a lot. The family appreciated this. -He said the sessions focussed on what the parents are doing and not the child. He said they have tried to explain themselves on email and phone but there [sic] explanations are not being [accepted]. -They say the parent focus questions have caused frictions at home and AR threatens 'he will tell Sam'. -He said he is being told he isn't feeding his son and to make him proper meals, he said he has purchased numerous recipe books and cooks sometimes for 2-3 hours for [AR] to then not eat the food. -He said the food is not healthy food - restaurant standard food with lots of oils etc. -Dad says the problem with [AR] is that he says untruthful things. -One week he will say things and then not remember the next week. -He said there is a lack of trust between Sam and parents. -He said there are 'stand offs' happening at home. -Come to Sam as a family - previous CAMHS workers have never spoken to dad like his mother, they deal with child and then call dad in and give summaries. -He said it goes beyond the re[a]lms of professionalism, no respect no trust an undermines parents. -Find really offensive at times - asked for another therapist cant carry on like this."*[1179]

Ms Steed did not feel comfortable continuing as the case manager in light of what she saw as this complaint made against her. She noted at the time, *"I do not feel able to work with parents due to their attempts to dictate what is offered/what I talk about with [AR] - especially dad"*.[1180]

1179 AHCH000164/73.

1180 AHCH000164/76-77.

223. There was a further CAMHS MDT discussion on 1 June 2022 at which it was noted,

> *"After the families last appointment with Lakshmi [Dr Ramasubramanian] she wrote a letter to the GP but Dad has emailed to complain and is acting very paranoid and defensive. He has requested that the letter be changed, and that [AR] also has a new case manager. He wants another female. Both Sam [Steed] and Lakshmi have found Dad to be aggressive and rude in his manner towards them. An incident form has been put in by Lakshmi. [AR] has also stopped working with Michelle Warner. Sam queried whether any case manager would be able to work with [AR's] Dad in present situation."*[1181]

Ms Steed also sought to follow up with AR's parents on the same day regarding his weight loss, but Alphonse R queried if this was part of her role and suggested she was accusing them of being bad parents (although he expressed gratitude for the request for urgent tests which Ms Steed had made).[1182]

224. Dr Ramasubramanian considered that Alphonse R had been intimidating and disrespectful in the exchanges before the 23 May 2022 consultation, at that consultation and in his correspondence afterwards. She considered that Alphonse R had come across as argumentative particularly in relation to his demands regarding medication, but (of note) she did not feel threatened or intimidated by AR himself.[1183] For the only time in Dr Ramasubramanian's career, she requested that there should be a change of psychiatrist on account of Alphonse R's behaviour. She felt extremely distressed. She suggested that she should be replaced by a man.[1184] Ms Steed equally considered that Alphonse R had been intimidating and aggressive.[1185]

225. The resolution that was reached within CAMHS was for Dr Molyneux to take over from Dr Ramasubramanian and for Ms Steed to step back from her work as case manager. She was not formally replaced until September 2022 and had some transitional involvement in the early weeks of Dr Molyneux having taken over.

226. Dr Killen, as clinical lead, became involved because patient safety incidents were recorded in relation to the 23 May 2022 meeting by both Dr Ramasubramanian and Ms Steed. They referenced the anger and disrespect displayed by Alphonse R. Dr Killen had a role under CAMHS' preventing

1181 AHCH000164/88-90.

1182 AHCH000164/76-77.

1183 First Witness Statement of Dr Ramasubramanian AHCH000239/§§66-67.

1184 T/S: 24/140/20-141/21.

1185 T/S: 24/162/23-163/22.

violence and harassment at work policy. In that regard she spoke to AR's parents on 9 June 2022 to understand their concerns and position, but she said she was also *"clear regarding the Service responsibilities to clinical delivery"*.[1186]

227. Before Dr Molyneux took over, Dr Ramasubramanian took the unusual step on 14 June 2022 of attending a meeting with Presfield High School along with Ms Steed. The purpose was to share all relevant information regarding AR's presentation and strategies to facilitate school attendance. This would normally have been for Ms Steed as the case manager but in light of the recent pressures, Dr Ramasubramanian attended in a supportive role.[1187]

228. On 23 June 2022,[1188] Dr Killen and Dr Ramasubramanian met with AR's parents.[1189] Dr Killen's evidence was that AR's parents:

> *"…apologised for coming across as angry and rude during their appointment on 23rd May 2022 and shared that they had felt criticised and judged and this triggered their defensive behaviour. During this meeting the parents accepted Dr Ramasubramanian's letter would not be changed as it was based on assessment and opinion and reassurance given that we were not looking to make life harder but to support the family to support AR to be physically well, eating enough and to access education as would be appropriate for someone his age. The parents were reminded of appropriate behaviour when engaging with Alder Hey Colleagues".*[1190]

In light of the difficulties encountered, it was professional and commendable for Dr Ramasubramanian to have participated in this final meeting with AR's parents. AR's poor compliance with his sertraline dose was discussed and the clinicians emphasised the importance of taking it regularly at the correct dose in order for it to have a therapeutic effect.

229. Dr Ramasubramanian had a handover discussion with Dr Molyneux, but she accepted that she did not outline the involvement of Prevent and FCAMHS in any detail or go into great detail about previous incidents involving AR or his previous behaviours. She accepted that she could not remember exactly which incidents she told Dr Molyneux about, and that she handed over *"in a kind of a holistic way"*. The focus of the handover was on the treatment AR was receiving and the concerns over his non-compliance. She suggested that there should be a standardised format adopted for this process, to be developed with CAMHS.[1191] Dr Killen agreed that there was no formalised handover process, although the standard operating procedure states that the full record needs to be reviewed. She accepted that between 2019 and 2022

1186 Witness Statement of Dr Killen AHCH000229/§§65-66.

1187 First Witness Statement of Dr Ramasubramanian AHCH000239/§66.

1188 Dr Killen refers to this meeting being on 22 June but the first electronic note of it (by Dr Ramasubramanian suggests it was 23 June. Nothing turns on this.

1189 AHCH000164/104-105, 107-110.

1190 Witness Statement of Dr Killen AHCH000229/§71.

1191 T/S: 24/142/5-144/14.

the electronic patient record was ineffective in enabling practitioners to pick up *"pertinent information"* or to gain an *"adequate picture"*. She suggested this is now *"much improved"*, in that the handover should be in writing and included in the electronic patient record.[1192]

230. On 28 June 2022, Mr Coppard began a course of family therapy with a video appointment. Alphonse R stated that AR did not want to participate. He wanted some information and strategies for helping AR; he suggested that AR needed to be in education, not spending as much time in his room, and instead staying healthy and talking more.[1193] Mr Coppard continued to deliver family therapy sessions until 23 April 2024, none of which was attended by AR.[1194] Consistent with other areas of Alder Hey practice, a number of session records are not on the electronic patient record, despite handwritten notes apparently being sent for scanning.

231. Two further aspects that span the entirety of this period are of significant relevance.

232. The first is to return to the assessment of Dr Irani, the Inquiry's expert psychiatrist. I have already addressed her findings in respect of the absence of a properly structured assessment of the risk to others and her views that a diagnosis of conduct disorder should have been made. It is important to note, in fairness to the CAMHS service, that alongside these findings, Dr Irani also considered that other aspects of CAMHS treatment was appropriate including that:

    a. The pharmacological treatment recommended by CAMHS was in line with NICE guidelines and peer approved practices;[1195]

    b. Talking therapies, which would be the first line treatment, were considered but AR did not engage;[1196]

    c. As regards the referral to family therapy that was made, this is an evidence-based approach for young people with anxiety, school refusal and conduct disorder;[1197]

    d. CAMHS had referred AR to eating disorder services and dietetics when there were concerns around his weight;[1198]

    e. CAMHS tried to engage with AR virtually, and in person. They did a home visit and tried seeing him at school;[1199]

1192 T/S: 24/159/12-162/2.
1193 Witness Statement of Mr Coppard AHCH000289/§§124-125.
1194 Witness Statement of Mr Coppard AHCH000289/§185.
1195 Expert Report of Dr Irani DRI000001/§3.3.2.2.
1196 Expert Report of Dr Irani DRI000001/§3.3.2.3.
1197 Expert Report of Dr Irani DRI000001/§3.3.2.4.
1198 Expert Report of Dr Irani DRI000001/§3.3.2.5.
1199 Expert Report of Dr Irani DRI000001/§3.4.2.1.

f. They stopped medication appropriately when they became aware of his non-compliance.[1200]

More generally, the factual narrative shows that CAMHS worked with great persistence in trying to engage AR and to provide him with support. Although this should not deflect from the significant concerns over how AR's risk to others was handled, it would equally be wrong to overlook the fact that other aspects of CAMHS' involvement were diligent and well-intentioned.

233. Secondly, returning to the question of the risk to others, there was poor adherence to CAMHS' policy which required an updated risk assessment every three months. Dr Ramasubramanian accepted that during the period of her involvement with AR (1 July 2021 to 23 May 2022), no risk assessment was conducted by the case manager, although this should have occurred at least every three months. It was the responsibility of the case manager's supervisor to ensure that this happened. Dr Ramasubramanian agreed that this was a matter of concern which *"should be flagged up"*. Dr Ramasubramanian accepted that it tended to indicate that the assessment of the risk AR posed to others had *"just fallen by the wayside"*. She was unsure as to who had responsibility for initiating a specialist risk assessment (e.g. SAVRY) and she was unaware as to which was the 'lead' agency in this context. As Dr Ramasubramanian described the position:

> *"Basically, the problem is every agency was working in silos. We were doing what we were meant to do and other agencies did their work. We didn't communicate with each other and that contributed to poor outcome."*[1201]

234. Dr Ramasubramanian agreed that the assessment of risk by CAMHS was inadequate and this meant that there was no effective intervention by social care services and FCAMHS to review AR's risk to others.[1202] Dr Ramasubramanian was asked, moreover, what steps the psychiatrists at Alder Hey would have taken if (1) they had been fully apprised as to AR's history; (2) he had been diagnosed with a conduct disorder; and (3) they were aware of his attempts to buy lethal weapons. Dr Ramasubramanian suggested that these concerns would be raised with the parents, that there might be a request for an *"actuarial risk assessment"*, and that there might be referrals to FCAMHS and Prevent.[1203] I considered that this answer vividly exposed the wholesale uncertainty as to which agency has lead responsibility for evaluating and monitoring an individual who poses a high level of risk to others.

235. For her part, Ms Steed's written evidence appeared implicitly to accept that she did not create new risk assessments during her tenure. Ms Steed states that she did review and update the existing risk assessments (for example on

1200 Expert Report of Dr Irani DRI000001/§3.4.2.2.

1201 T/S: 24/145/25-149/19.

1202 T/S: 24/149/22-150/13.

1203 T/S: 24/153/25-156/8.

12 August 2021). Looking at the later risk assessment that was completed by Ms Morris on 22 February 2024, Ms Steed's point is borne out to the extent that text within the narrative part of the risk assessment correlates chronologically with entries that are likely to have been made by Ms Steed.[1204] The fact remains, however, that Ms Steed did not produce formalised risk assessments with the regularity or in the form prescribed. And at times when there were significant issues in terms of escalation of violence – most notably the bus incident – Ms Steed does not appear to have added relevant information or completed a new risk assessment, as she ought to have done. In summary, Ms Steed is right to point out that she contributed by adding text to the existing risk assessment, but this still fell significantly short of what the CAMHS policy required in this respect.

Healthcare from July 2022 to 23 July 2024

236. Against the background set out in the previous section, Dr Molyneux became involved with AR's case in July 2022, when he took over from Dr Ramasubramanian as the consultant psychiatrist dealing with AR. Since July 2017, Dr Molyneux has held the (non-executive) position of neurodevelopmental lead for the Alder Hey Psychiatry Consultants Group.[1205]

237. Dr Molyneux had a verbal handover meeting with Dr Ramasubramanian (see above) and, as I will address below, met with AR's parents. He also conducted what he described as a *"reasonable review"* of AR's records on the electronic patient record.[1206] He was aware of the initial psychiatric letter dated 15 September 2021.[1207] However, as had been the case with Dr Ramasubramanian, it became clear in Dr Molyneux's oral evidence that there had been marked gaps in his knowledge. He was **unaware** of the following facts all of which were referenced in CAMHS records:[1208]

    a. AR had taken a knife into school on some 10 occasions prior to his contact with Childline in October 2019 with the intention of using it (although Dr Molyneux did know that AR had taken a knife into school which led to his permanent exclusion); [1209,1210]

    b. AR had intended, at least potentially, to use the knife or knives he had carried to cause very serious harm (*"to stab"*);[1211]

1204 AHCH000154.
1205 T/S: 24/2/12-16.
1206 T/S: 24/6/20-7/12.
1207 T/S: 24/10/4-11/3; AHCH000163/95-98.
1208 T/S: 24/9/17-15/4.
1209 Incident: LANC000065; CAMHS records: AHCH000162/9.
1210 T/S: 24/9/21-11/3.
1211 Incident: LANC000067; CAMHS records: AHCH000162/3, 9.

c. On 15 November 2019, AR had searched on a school computer for material relating to school shootings in America;[1212]

d. AR had attacked another student (not his intended victim) with a modified hockey stick in December 2019 (he had the intention of *"killing someone"*);[1213]

e. AR had carried a knife during the December 2019 incident with the intention of potentially using it on his intended victim if the *"[hockey] stick didnt hurt him as [AR] had been hurt"*;[1214]

f. He received a 10-month referral order for this offence;[1215]

g. AR had been researching the Manchester Arena attack, which he described as a *"good battle"* from the perpetrator's point of view;[1216]

h. On 20 April 2021 he had been viewing web pages relating to the London Bridge terror attack, when he spoke in detail about the IRA, expressing the thought that MI5 were being asked to kill people in the IRA and views on the conflict in Israel and Palestine;[1217]

i. The police were called on 5 November 2021 when AR *"trashed"* his parents' house;[1218]

j. On 17 March 2022, AR went missing and was found on a bus carrying a knife which he wanted to use to stab others and that he had tried to make poison (although there was only a partial reference to this in the electronic patient record);[1219]

k. On 14 May 2022, AR had thrown food inside his parents' house and overfilled a bath (there was a partial reference to this in the electronic patient record).[1220]

238. As I have indicated at paragraph 172, the relevant standard operating procedure emphasised that clinicians at each appointment should review the whole electronic patient record.[1221] As a result, according to the standard set by the standard operating procedure, Dr Molyneux should have been aware of all of the matters above, but he was not. I address the context to this, including the effectiveness of the electronic patient record, in the paragraphs below, as well as in my conclusions and recommendations.

1212 Incident: LANC000110/1; CAMHS records: AHCH000092/4, AHCH000162/9.
1213 Incident: MERP001375, CTPNW000157/10; CAMHS records: AHCH000162/11-12.
1214 Incident: CTPNW000157/10; CAMHS records: AHCH000162/3, 11-12.
1215 Incident: MERP000016/2; CAMHS records: AHCH000294/36/§177.
1216 Incident: LCC001402, CTPNW000157/14; CAMHS records: AHCH000162/10.
1217 Incident: CTPNW000137; CAMHS records: AHCH000163/19.
1218 Incident: LANC000024; CAMHS records: AHCH000163/119.
1219 Incident LANC000046/3-4; CAMHS records: AHCH000164/37, 43-44, 47-48.
1220 Incident: LCC000170, LANC000094/2; CAMHS records: AHCH000164/68.
1221 AHCH000309/16; T/S: 24/6/11/-7/3.

239. Dr Molyneux explained in his evidence that he would only be aware of the records from other agencies if documents had been scanned onto the electronic patient record. It would have been *"very easy"* to access physical health records, although a request would have had to be made for the GP records.[1222] Dr Molyneux did not actively seek records from other agencies and, as I have noted above, there were deficiencies in the scanning of records into the electronic patient record, most notably that the two FCAMHS letters were missing.[1223]

240. If there had been proper multi-agency information sharing and proper recording and retention of information, Dr Molyneux should also have been aware of the following which, in fact, was not known to him:

    a. AR was interested in degloving injuries (clear from the school internet browsing history but not identified or shared by The Acorns School until the disclosure process in the Inquiry);[1224]

    b. AR suggested that people considered they were at risk of being murdered by individuals they did not know (First Referral to Prevent) (referenced in CAMHS records);[1225]

    c. AR wanted to view guns on the internet (First Referral to Prevent) (referenced in CAMHS records);[1226]

    d. AR had asked to see an image of a severed head (First Referral to Prevent) (referenced in CAMHS records);[1227]

    e. AR had kicked his father on 30 November 2021 and damaged a rental car (reported to Lancashire Constabulary, not referenced in CAMHS records);[1228]

    f. On 21 January 2022, AR made comments at school about the Holocaust, the death of Princess Diana, water poisonings and the necessity, on occasion, for violence (recorded on The Acorns School CPOMS but not referred to Prevent and not referenced in CAMHS records);[1229]

    g. There had been a referral to FCAMHS and Mr Hicklin had implied that AR could be referred back to FCAMHS if he received an autism diagnosis.[1230]

1222 T/S: 24/8/13-9/16.

1223 T/S: 24/7/13-8/24.

1224 Incident: LCC001401, ILT000022 - Disclosed but not published due to sensitive content.

1225 Incident: LANC000058/2, CTPNW000154/3; CAMHS records: AHCH000090/67.

1226 Incident: LANC000058/2; CAMHS records: AHCH000090/67, AHCH000092/4.

1227 Incident: LANC000058/2; CAMHS records: AHCH000090/67, AHCH000092/4.

1228 Incident: LANC000025.

1229 Incident: LCC001346/12.

1230 T/S: 24/28/9-30/19.

241. Dr Molyneux accepted that it was critical that a psychiatrist in his position was aware of these elements of the individual's history: *"it is crucial that somebody in my position ought to know those things at that time"*.[1231] He accepted that any assessment made by the treating psychiatrist would arguably be *"deeply flawed"* if they were unaware of historical factors such as these and they would have a *"significant blind spot"*.[1232] He agreed this material would have altered his perspective as to the risk AR posed to others (*"it would have shone more light in that direction"*).[1233] For instance, when he took over AR's care, Dr Molyneux thought that the risk of harm that AR presented to others was minimal. He accepted that AR carrying a knife in the bus incident in March 2022 showed that this assessment was wrong.[1234]

242. It follows, therefore, that this information had not been drawn to Dr Molyneux's attention, although the bulk of it was set out in the electronic patient record, and Dr Molyneux had not read any of this material. Notwithstanding this lack of knowledge, Dr Molyneux refused to accept that he had paid insufficient attention to the available records. He contended that he had taken reasonable steps to glean a reasonable level of assurance from the notes, along with the verbal handover he received and during the home visit on 28 July 2022.[1235] Dr Molyneux stressed that AR's family, during the first home visit on 28 July 2022 had failed to mention this information. Dr Molyneux suggested there had been *"repeated occurrences of the family appearing to … stage-manage the presentation of information provided to professionals"*.[1236]

243. I have no doubt the Dr Molyneux was correct in highlighting the unsatisfactory way in which AR's parents shared information with the many professionals who sought to assist their son, and I address this in Chapter 12: AR's family. However, Dr Molyneux should have been alive to this risk: Dr Irani noted that there is a natural tendency for parents to underplay the wrongdoing of their children.[1237] Dr Molyneux himself said it was something that you should always have in mind.[1238] Moreover, he knew that Alphonse R's behaviour had been the reason that AR had come to him and that Dr Ramasubramanian had withdrawn from his case, which would have cast doubts on whether Alphonse R was being straightforward with CAMHS.

244. In any event, the actions of AR's parents do not excuse the way in which this critical risk information was unhelpfully scattered across hundreds of pages of internal records which had neither been read by Dr Molyneux nor brought to his attention. The electronic patient record did not have a system whereby this

1231 T/S: 24/15/5-14.
1232 T/S: 24/15/15-23.
1233 T/S: 24/25/12-16.
1234 T/S: 24/26/13-27/18.
1235 T/S: 24/22/15-23/1.
1236 T/S: 24/20/7-15.
1237 T/S: 26/71/9-72/10.
1238 T/S: 24/20/24-21/19.

important historical information was immediately visible to those reviewing the patient. Dr Molyneux agreed that, as a result, the electronic patient record was a *"very poor"* system for keeping track of the risk information.[1239] The closing statement on behalf of Alder Hey also accepts that *"[t]he system within CAMHS for keeping track of risk information was inadequate, as important historical information was not readily visible to practitioners receiving responsibility for the care of AR across the period of his involvement with the service"*.[1240] I consider this to be a gravely concerning state of affairs.

245. The unhelpful layout of the records was therefore a significant factor. Dr Irani recognised the challenges for clinicians to go through the extent of all the records and stated that what practitioners tend to do is search for risk information.[1241] It is nonetheless striking that Dr Molyneux had not alighted on any of the historical details I have set out above. Dr Molyneux's consideration of the records should have been more diligent.

246. As relayed to Dr Molyneux by Dr Ramasubramanian during the verbal handover, the key clinical issues were, *"firstly and most concerningly"*, AR's recent pattern of weight loss as a result of his low food consumption and, secondly, his longstanding refusal to leave the house. This, as suggested, was due to his symptoms of *"overwhelming anxiety in the context of an autism diagnosis"*. As I have already identified, Dr Molyneux emphasised in his evidence that autism is conventionally considered a neurodevelopmental as opposed to a mental disorder. AR's refusal to engage with the professionals was a key complicating factor.[1242]

247. Against that background, Dr Molyneux visited the family home on 28 July 2022. He spent between one and a half and two hours talking with AR's parents, while AR remained upstairs. He prescribed a one-off dose of 5 mg of diazepam, to act as a mild sedative, to help him attend the appointment on 1 August 2022. The main focus of the discussion was AR's loss of weight and his longstanding refusal to leave the house.[1243]

248. Dr Molyneux saw AR with his father on 1 August 2022. Dr Molyneux was reassured that AR appeared physically well, *"very slim (but he) did not appear underweight to a pathological degree"*. He had gained 3 kg since May 2022. Dr Molyneux formed the view that AR *"presented as stable in terms of his mental health"*, and he observed:

> *"He appeared calm (if a little guarded at the outset, though not unduly so), alert, and oriented; though untalkative, speaking really only when spoken to, he demonstrated no abnormalities of speech or thinking when he did speak; though sullen, giving every impression that he*

1239 T/S: 24/22/5-14.

1240 Closing Statement on behalf of Alder Hey Children's NHS Foundation Trust AHCH000327/4/§11.

1241 T/S: 26/83/12-25.

1242 Witness Statement of Dr Molyneux AHCH000253/§5, §58.

1243 Witness Statement of Dr Molyneux AHCH000253/§§11-12.

> *would rather not have to be attending the appointment, he appeared to be essentially both subjectively and objectively euthymic in mood (I recall that he gave a somewhat flippant answer of 'fine' or similar, when asked about his mood); there was no evidence of any thoughts of harm to self or others; there was no subjective or objective evidence of any abnormalities of perception; insight was preserved. In summary he presented much the same as many boys his own age would (and do) in similar circumstances."*[1244]

249. Dr Molyneux's assessment that there was no evidence of thoughts of harm to others was clearly and significantly in error, given the history of which he was unaware. Dr Molyneux accepted that if he had been aware of the details around the bus incident then he would have explored them with AR.[1245]

250. Dr Molyneux prescribed a low dose of fluoxetine for AR's anxiety, a change in the regimen which met with AR's approval. Dr Molyneux's view was that even though AR did not have a mental disorder (even as a possibility) it was ethically necessary to *"work with"* him, in order to address his *"evident difficulties as regards anxiety/avoidance symptoms"*. That said, Dr Molyneux recognised that given the extent of Alder Hey's workload at the time, AR's case would unavoidably and of necessity assume less of a clinical priority compared with other riskier and more complex cases, particularly those patients at risk of suicide.[1246]

251. On 16 August 2022, Mr Coppard carried out an online family therapy session with Alphonse R and Laetitia M. Alphonse R spoke about losing his authority in the home, the lack of respect from AR and AR becoming aggressive towards him. Alphonse R reflected on how he often felt like he had to give in a lot. Laetitia M was also online but Mr Coppard's evidence was that she did not respond to attempts to engage her in conversation.[1247]

252. On 1 September 2022, Dr Molyneux had a reassuring telephone conversation with Alphonse R.[1248]

253. On 2 September 2022, Dr Molyneux wrote to AR's GP stating that there were concerns around AR's weight and restricted eating, coupled with his significant reluctance to engage with professionals. He noted AR's reluctance to leave the house and that he tended to spend long periods of time in his bedroom.[1249]

254. On 5 September 2022, Ms Kathryn Morris became AR's case manager and stayed in that role until he was discharged from CAMHS on 23 July 2024.[1250] She took over from Ms Steed. Ms Morris was reliant on the CAMHS records for

1244 Witness Statement of Dr Molyneux AHCH000253/§§19-20.

1245 T/S: 24/37/2-13.

1246 Witness Statement of Dr Molyneux AHCH000253/§23, §26.

1247 Witness Statement of Mr Coppard AHCH000289/§128.

1248 Witness Statement of Dr Molyneux AHCH000253/§28.

1249 Witness Statement of Mr Coppard AHCH000289/§131.

1250 Witness Statement of Ms Morris AHCH000278/§10, §§224-229.

information about the case prior to her involvement.[1251] This meant that although a significant amount of AR's relevant history was available to her, given the deficiencies in the records, this was by no means complete. Ms Morris read through the case file, making notes of key incidents, but did not read every record.[1252] There was no verbal or written handover by Ms Steed but Ms Morris had a conversation with the Assistant Clinical Lead, Mr Coppard.[1253] She was only aware of AR carrying a knife to school on two occasions (rather than ten), the hockey stick assault, a Prevent referral which resulted in no further action, that AR had researched shootings and commented on the Manchester Arena bombing, that there had been incidents of violence at home in November 2021 and about the bus incident in March 2022.[1254] She thought, but could not be entirely certain, that she was unaware of AR's research into the London Bridge attack and his comments about Israel and Palestine. She was unaware of the following which did not appear in the CAMHS records and therefore would not have been available from review of the EPR (but could have been available with better multi-agency information sharing): his attempt to view degloving injuries and injuries to animals; his belief that strangers are at risk of being murdered; his complaint that he could not look at guns on the internet; his request for an image of a severed head; his Instagram posts relating to Colonel Gaddafi; his comments about the holocaust, Princess Diana, water poisonings, the necessity sometimes to use violence; wanting to stab others and his intention to make poison. She accepted that all of these matters were relevant to an assessment of AR's risk.[1255]

255. Ms Morris was aware that AR had been subject to a previous FCAMHS referral but was not sighted on the outcome. This was unsurprising given that the two FCAMHS letters had not been scanned onto the electronic patient record. Ms Morris was not, therefore, aware of the advice from FCAMHS that AR could be re-referred after his autism diagnosis or because of a significant change in circumstances or risk behaviour (and nor was Dr Molyneux).[1256]

1251 T/S: KM/4/6-9.

1252 T/S: KM/5/11-13; AHCH000189.

1253 T/S: KM/9/1-12.

1254 T/S: KM/6/3-10/15.

1255 T/S: KM/10/21-13/5.

1256 T/S: KM/16/1-17/5; T/S: 24/29/18-30/15.

256. Ms Morris had the following contact with AR and his parents:

    a. 26 September 2022 – AR failed to attend an appointment and there was a discussion about his engagement with Alphonse R;

    b. 18 October 2022 – a discussion with Alphonse R. Ms Morris asked Alphonse R to wake AR but he stated that he would not dare;

    c. 20 October 2022 – video appointment with Alphonse R and AR;

    d. 25 October 2022 – telephone conversation with AR;

    e. 7 November 2022 – clinic appointment with AR;

    f. 14 December 2022 – spoke to Alphonse R to discuss the possibility of CBT for AR;

    g. 16 January 2023 – clinic appointment with AR;

    h. 16 February 2023 – telephone discussion with Alphonse R.[1257]

    There were several further occasions within this time period when Ms Morris tried to contact AR's parents without response or AR failed to attend booked appointments.

257. I address some of these appointments in more detail below.

258. On 20 October 2022, Ms Morris had a video appointment with Alphonse R and AR. AR was present but did not want to appear on camera or to engage and later left the living room to return to his bedroom. He seemed uninterested in anything Ms Morris was able to offer. Alphonse R indicated AR's presentation seemed a bit better; he was eating and seemed happier but was still struggling to leave the house.[1258]

259. On 7 November 2022, Ms Morris had a face-to-face meeting with AR. He said he only carried a knife to Range High School for self-protection and he did not intend to use it. Ms Morris indicated that she did not challenge AR on the inaccuracy of this statement because she was seeking to build a rapport with AR.[1259] When Ms Morris attempted to discuss further police calls to the home address, AR disengaged, repeatedly asked for the session to end and left the therapy room. AR failed to attend the next meeting, on 28 November 2022.[1260]

1257 Witness Statement of Ms Morris AHCH000278/§§16-61; AHCH000164/120-137. As with Ms Steed, during of Ms Morris's time as case manager, she had many exchanges with social care and Presfield High School among others. She also had many exchanges with other clinicians. This chapter concentrates on the healthcare assessments and discussions but her involvement with other agencies should not be overlooked and is detailed in her published statement.

1258 T/S: KM/24/9-25/18.

1259 T/S: KM/25/22-27/25.

1260 Witness Statement of Ms Morris AHCH000278/§§33-36.

260. On 1 December 2022, Dr Molyneux spoke with Alphonse R and AR on the telephone. AR's weight had continued to improve but he had stopped taking the fluoxetine some weeks previously. AR did not consider it was having any discernible effect. AR indicated that anxiety remained his main difficulty.

261. Dr Molyneux asked AR whether he had ever been on sertraline before, to which AR stated that he had not and indicated that he would like to try it. Dr Molyneux therefore agreed to issue an initial prescription for sertraline.[1261] AR's account was in fact wrong and, as is clear from the narrative above, he had previously been prescribed sertraline by Dr Ramasubramanian. This would have been clear to Dr Molyneux from a review of the medical records, for example the entry of Dr Ramasubramanian dated 7 April 2022.[1262] Dr Molyneux *"momentarily overlooked"* this fact and he did identify the discrepancy when he re-reviewed the case on 12 December 2022.[1263] Two points to note from this are that AR clearly lied (he took a close interest in what medication he was prescribed) and that Dr Molyneux overlooked the previous prescription.

262. Dr Molyneux saw AR alone at the clinic on 29 December 2022. He looked physically healthier, and, in Dr Molyneux's view, AR's mental state was, once again, entirely stable. He was appropriately alert and oriented; he denied thoughts of harm to either himself or others, and he did not exhibit perceptual abnormalities or other such symptoms. Dr Molyneux concluded:

> *"Though mood again appeared to be euthymic, equally there remained a clear sense – as had been evident at the 1st August appointment – of sullen impatience, again giving the overriding impression that he did not particularly want to be attending, and was only doing so on the transactional basis that I might be able to provide some assistance as regards his anxiety symptoms, specifically via a pharmacological intervention."*[1264]

263. Dr Molyneux emphasised that AR *"presented, in essence, as an unremarkable, sullen, untalkative, gawky teenage boy"* and he did not display the striking and alarming facial expression as seen in the police photograph following AR's arrest on 29 July 2024.[1265] He took at face value AR's assurance that he was not a risk to others, not least because he was unaware that during 2022 he had carried a knife intending to use it to stab someone. He agreed that if he had been aware of this, he would have assessed the risk to others as being significantly higher.[1266]

1261 AHCH000164/130.

1262 AHCH000164/50-52.

1263 Witness Statement of Dr Molyneux AHCH000253/§29.

1264 Witness Statement of Dr Molyneux AHCH000253/§32.

1265 Witness Statement of Dr Molyneux AHCH000253/§34.

1266 T/S: 24/44/23-45/15.

264. AR saw Ms Morris on 16 January 2023. His sole interest was to remain open to CAMHS in order to receive medication. He denied any intention to harm others. He missed the next appointment on 1 March 2023.[1267]

265. From this point on, AR was not seen again for CAMHS case management sessions by Ms Morris. He remained open to Ms Morris, because his parents were undergoing family therapy, so that she could engage with the professionals involved.[1268] Ms Morris's evidence was that, by this stage, AR's engagement had been sporadic, and he had repeatedly stated that he did not want intervention from CAMHS other than medication.

266. Returning to the theme of missed opportunities for AR to be assessed for ADHD, Alphonse R raised the issue of ADHD with Dr Elaine Weir (a general paediatrician seeing AR in respect of his nutrition) on 31 January 2023. She requested that either the GP or CAMHS progress this referral, and this was sent to the GP practice and Dr Molyneux. However, it was seemingly not actioned by either, although it should have been.[1269]

267. AR refused to attend Dr Molyneux's clinic on 6 February 2023, and Alphonse R informed Dr Molyneux by telephone that AR had lost about 2 kgs in weight and was experiencing some adverse side effects from the sertraline. AR was self-administering his medication and, like Dr Ramasubramanian before him, Dr Molyneux was uncomfortable about the apparent lack of parental scrutiny around the taking of medication.[1270] Dr Molyneux considered reducing and then ceasing the prescription for sertraline, and he arranged to see AR on 27 February 2023.[1271]

268. On 27 February 2023, Dr Molyneux saw AR with Alphonse R at the Southport clinic. AR appeared physically well, and his mental state was assessed to be entirely stable. Dr Molyneux observed a tension between AR and Alphonse R, with the former adopting a position that tended to contradict his father and with the latter acting with a degree of *"passive aggressiveness"* towards his son. Dr Molyneux suggested another re-titration of sertraline (in liquid form), with ongoing engagement by AR in the reviews of his medication. Following a telephone call from Alphonse R, the sertraline prescription was changed to a tablet preparation. This was the last occasion when AR attended in person to see Dr Molyneux.[1272]

269. On 2 March 2023, Ms Morris attended a professional review with AR's parents, staff from Presfield High School and LCC. Ms Morris stated that she struggled to engage AR's parents with supporting AR to attend sessions. She explained that she was unsure what, if any, boundaries/structure looked

1267 Witness Statement of Ms Morris AHCH000278/§§53-56, §63.

1268 Witness Statement of Ms Morris AHCH000278/§64.

1269 AHCH000096/27-28.

1270 T/S: 24/49/19-23.

1271 Witness Statement of Dr Molyneux AHCH000253/§§35-38.

1272 T/S: 24/50/2-7.

like at home and queried a referral to Early Help (i.e. CFWS), which AR's parents rejected. Laetitia M disagreed with Ms Morris that AR discussed not wanting to go to school and did not feel that this should have been shared with Presfield High School, because she considered that Presfield High School could use this against them to remove AR's place.[1273]

270. On 8 March 2023, Ms Morris made a record of an MDT meeting and deemed AR's case to be *"stuck"* because she had not been able to complete a clear formulation of his presenting difficulties. She had met with him twice only and he had withdrawn consent.[1274]

271. The next appointment, arranged for Monday 27 March 2023, was cancelled by CAMHS at short notice. AR and Alphonse R missed the reorganised appointment on 30 March 2023.

272. On 28 March 2023, Mr Coppard carried out a family therapy session with AR's parents. Mr Coppard recorded that Laetitia M expressed the view that family therapy was pointless and she did not trust CAMHS. Both parents felt the reports that had been written about them by the ASD Pathway and CAMHS were prejudiced against them. They suggested that CAMHS was very powerful and had the authority to remove children. They suggested that in a recent meeting the CAMHS case manager had *"thrown AR under the bus"* (presumably a reference to the meeting on 2 March 2023 above).[1275] Eventually, it was agreed that Mr Coppard would send a date for a further appointment.

273. A further meeting was due to take place on Monday 15 May 2023. However, on the previous day, Dr Molyneux was sent a copy of an email from Alphonse R to Presfield High School in which he had indicated that AR would only attend school if he was allocated a less *"boring"* teacher.[1276] I will return to this issue in Chapter 12: AR's family, but it is relevant to note here that it was manifestly inappropriate for Alphonse R to seek to dictate to Presfield High School in this way. Ms Morris and Dr Molyneux agreed that AR's case was more 'systemic' than about mental health. By this, they meant that the difficulties related to family systems and the family dynamics.[1277] Ms Morris referred to AR's parents accommodating AR's behaviour and AR's relationship with his father and brother.[1278] Dr Molyneux stated in the internal CAMHS communications that he could not be sure whether it was a case of *"overaccommodation, safeguarding, gaslighting or some combination of the above"*.[1279] Ms Morris replied to state that it was all three.[1280]

1273 Witness Statement of Ms Morris AHCH000278/§§70-71.

1274 Witness Statement of Ms Morris AHCH000278/§204; AHCH000164/142-143.

1275 Witness Statement of Mr Coppard AHCH000289/§§145-148.

1276 AHCH000185/2.

1277 T/S: 24/52/7-17.

1278 T/S: KM/33/14-34/25.

1279 AHCH000185/1-2.

1280 AHCH000185/1; Witness Statement of Ms Morris AHCH000278/§§188-190.

274. Dr Molyneux's evidence was that gaslighting in this context referred to *"passive aggressive bickering"* between Alphonse R and AR at the 27 February 2023 appointment.[1281] Ms Morris stated that gaslighting referred to AR's parents, specifically Alphonse R, not sharing with agencies or contradicting things that were being said by agencies.[1282] The acknowledgment of the possibility of gaslighting, as understood by Ms Morris, could have further highlighted for Dr Molyneux the risk that AR's parents were not being frank with CAMHS (see paragraph 243).

275. In relation to overaccommodation, Dr Molyneux considered that AR was at risk of missing *"life opportunities"* as regards work and education, on account of *"parental overaccommodation"*. He considered that Alphonse R and Laetitia M capitulated to demands from AR which would be unacceptable in the adult world.[1283] Dr Molyneux accepted that there was no record of any discussion with AR's parents about setting boundaries on his internet use, the need for which had been revealed by the troubling topics that AR had been researching. Dr Molyneux, however, was unaware of this activity by AR.[1284]

276. Immediately before the appointment on 15 May 2023, Dr Molyneux received the following email from Alphonse R:

> *"Good afternoon Dr Molyneux ... [AR] is not making ready to attend his appointment today for 3:30pm. He has been awake all night reading various topics of interest and chatting with us about it. Maybe it is because of the anxiety pertaining to the idea of attending school. We really don't know. He is asleep at the moment. Regards, [Alphonse R]."*[1285]

277. Dr Molyneux sought an update on AR's medication from Alphonse R, who provided assurance that AR was taking a once-daily 75 mg sertraline dose which appeared to be having a beneficial effect. Alphonse R indicated that AR's main problem was that he tended to be awake during the night, while he slept during the day. Dr Molyneux noted that this was a not uncommon teenage problem. He prescribed melatonin although AR refused to discuss this possibility with Dr Molyneux on the telephone.[1286]

278. On 16 May 2023, Ms Morris assessed that AR's risk to others was *"not known"* when she completed the CAMHS Child and Young Person Current View form, although her evidence was that she should have entered 'none' and probably clicked the wrong box. The Current View form was to be completed every three months, alongside the risk and management tool. It required the practitioner to answer questions about the patient's presentation at that time, although it did

1281 T/S: 24/53/24-54/17.

1282 T/S: KM/35/8-11.

1283 Witness Statement of Dr Molyneux AHCH000253/§§41-48; T/S: 24/52/22-68/12.

1284 T/S: 24/55/6-56/13.

1285 Witness Statement of Dr Molyneux AHCH000253/§49.

1286 Witness Statement of Dr Molyneux AHCH000253/§§50-52.

also require the practitioner to assess the level of risk that the patient posed to others. Ms Morris stated that her entries were based on her assessment of the *"here and now, in the present"*. She suggested this form *"doesn't allow for the historic"* and that historical information will be in the risk assessment and care plan (I address this further below).[1287]

279. On 25 May 2023, Dr Molyneux joined Ms Morris at a multi-agency meeting to review AR's progress. AR's parents were present. Dr Molyneux interpreted the school's observations regarding AR's mental health as being positive.[1288]

280. Dr Molyneux stressed that, since the resolution of AR's acute weight loss issues, AR no longer met the criteria for a mental disorder; he had the capacity to refuse treatment; and he was not judged to pose a significant risk of harm to himself or others by refusing to take prescribed treatment. In those circumstances, there was no power to insist on AR receiving treatment. Alder Hey was keeping his case open as a gesture of *"goodwill"* to AR and his parents.[1289]

281. On 5 June 2023, Ms Morris wrote a care plan for AR, noting that he had been referred to CAMHS *"due to low mood, radicalisation, bringing knife to school, attack on peers, police involvement"*.[1290] It noted that no clear formulation had been attained due to poor engagement and that AR had *"expressed a wish that he does not want case manager involvement with CAMHS and would like to remain open to Psychiatry"*.

282. AR failed to attend an appointment booked with Ms Morris on 13 June 2023.[1291]

283. On 20 June 2023, Presfield High School, where AR was now only nominally attending, made a referral to the Community Paediatrics team for an ADHD assessment. In February 2024, the referral was rejected by Ms Donna Hampson, an ADHD nurse specialist in the ADHD team, on the basis that there was insufficient evidence across both home and school settings to show significant differences in attention, hyperactivity and impulse control.[1292] This was partly because Presfield High School were unable to complete several sections of the form due to AR's extremely limited attendance. Ms Boggan candidly accepted that the ADHD service's standard operating procedure did not consider risk and that Ms Hampson did not have all relevant information when making the decision. Ms Boggan's view, with which I agree, was that it would have been appropriate for the Community Paediatrics team to assess AR for ADHD.[1293] This was another missed opportunity,

1287 AHCH000164/147-149; Witness Statement of Ms Morris AHCH000278/§§90-93; T/S: KM/35/17-38/5.

1288 Witness Statement of Dr Molyneux AHCH000253/§53.

1289 Witness Statement of Dr Molyneux AHCH000253/§58.

1290 AHCH000164/155-156.

1291 Witness Statement of Ms Morris AHCH000278/§§127-128.

1292 AHCH000250.

1293 T/S: 25/73/8-76/17.

as in July 2020, February 2021, April 2021 and January 2023. Unlike with ASD, delay in diagnosing ADHD can worsen the condition through reinforcement of maladaptive neural pathways.[1294]

284. I should make clear, however, that no clinician, including Dr Irani, felt able to say that AR would in fact have been diagnosed with ADHD had an assessment taken place.[1295] In my view, it remains no more than a possibility that AR had ADHD. Moreover, even if AR had been diagnosed with ADHD, it would be speculating as to whether he would have been prescribed medication, and if so which one, particularly as at various stages some first-line ADHD medications would have been contraindicated due to AR's physical health, largely due to his nutrition.[1296] Finally, I accept Dr Irani's assessment that even if AR had been medicated, it would not have mitigated the risk he posed to others: AR's offending was not impulsive, but planned, and medication for ADHD *"would have had no impact on that risk"*.[1297] For those reasons, it cannot be said that the missed opportunities to assess AR for ADHD caused or contributed to the events of 29 July 2024.

285. Returning to AR's treatment by CAMHS, very shortly before AR's scheduled appointment to see Dr Molyneux on 3 July 2023, Alphonse R sent an email indicating that AR was refusing to attend. Dr Molyneux prescribed sertraline for the last time, in the absence of a face-to-face meeting with AR. An appointment on 18 September 2023 was cancelled by Alphonse R, again at very short notice.[1298] Following these two missed appointments, Dr Molyneux was becoming concerned about continuing to prescribe sertraline to a 16-year-old who was not providing good evidence of his own consent to that medication and therefore arranged a home visit.[1299]

286. Dr Molyneux conducted the home visit on 25 September 2023. AR remained in his bedroom throughout. AR had been in the living room prior to Dr Molyneux's arrival and went upstairs to avoid him.[1300] Alphonse R informed Dr Molyneux that AR had not been taking sertraline for two months. This indicated to Dr Molyneux that the prescription should cease. He described his rationale for this decision as follows:

> *"AR had never — according to my understanding — presented with a conclusively diagnosable mental disorder, instead demonstrating only fluctuating symptoms of anxiety and related avoidance, with occasional and transient forays into problematic patterns of*

1294 T/S: 25/59/15-20.

1295 T/S: 26/55/14-56/1, T/S: 25/76/2-17.

1296 T/S: 25/76/18-77/19.

1297 T/S: 26/56/3-57/12.

1298 Witness Statement of Dr Molyneux AHCH000253/§§61-62.

1299 T/S: 24/61/9-23.

1300 T/S: 24/61/24-62/8; Witness Statement of Dr Molyneux AHCH000253/§63.

coping behaviour such as weight loss through restrictive eating; there had certainly never been any sense of severe and enduring mental illness that could conceivably indicate compulsory treatment."[1301]

287. Dr Molyneux reflected on whether CAMHS should discharge AR from psychiatric input. As Dr Molyneux observed, when a young person is experiencing difficulties that primarily fall within the remit of social services and his or her mental health is only a relatively minor and secondary factor, CAMHS will sometimes go beyond its remit and provide support. However, when the involvement of CAMHS is *"manifestly serving no useful purpose, consideration needs to be given for CAMHS to 'step back' …"*.[1302] The only *"lingering cause of concern"* that Dr Molyneux noted was that AR had not bathed or showered for in excess of a month (although on 27 September 2023, Alphonse sent an email to Dr Molyneux indicating that AR had taken a shower).[1303] The appropriate plan, as it seemed to Dr Molyneux, was for reasonable, appropriate and proportionate multi-agency support, given that AR had persistently refused to engage with CAMHS. Dr Molyneux's view was that this was *"primarily a social care issue of parents not being able to implement boundaries"*.[1304]

288. On the same date, Dr Molyneux conveyed a summary of the visit and of his thinking to Ms Morris by email.[1305] He explained that he had not been able to see AR in over six months. AR had not been taking his medication. He could be aggressive with Alphonse R. He had attended college only a couple of times during the term. He had not had a bath or shower in the last month or so. He had not left the house for the last few months and spent all his time watching videos online, including late into the night. LCC CFWS were apparently closing the case. More positively, Alphonse R reported that AR was eating well and gaining weight and that AR was *"happy just doing what he wants to do"*. Ms Morris (who consulted with Mr Coppard) agreed with Dr Molyneux's view that it was appropriate to aim towards discharging from CAMHS.[1306] AR was discussed at an MDT on 4 October 2023, which determined that Mr Coppard would discuss the case with Ms Morris, Dr Molyneux and the family.[1307]

289. Although it is not wholly clear from the records, it appears that the outcome of these discussions was that AR would remain nominally open to CAMHS psychiatry. That is consistent with Dr Molyneux's evidence that he decided to *"hold off"* formally removing AR from his psychiatric caseload on a

1301 Witness Statement of Dr Molyneux AHCH000253/§65.

1302 Witness Statement of Dr Molyneux AHCH000253/§69.

1303 T/S: 24/75/3-76/6.

1304 T/S: 24/63/11-20.

1305 AHCH000145; T/S: 24/67/4-20.

1306 Witness Statement of Dr Molyneux AHCH000253/§§80-89; Witness Statement of Ms Morris AHCH000278/§§155-156.

1307 Witness Statement of Ms Morris AHCH000278/§158; Witness Statement of Mr Coppard AHCH000289/§163; AHCH000143.

"just in case" basis. Mr Coppard's family therapy sessions with the family were continuing, approximately one every two months, and it was conceivable that something might emerge that justified a resumption of Dr Molyneux's involvement in the case.[1308] Moreover, Alphonse R was well aware that he was able to contact Dr Molyneux in the event of deterioration in AR's mental health.

290. Dr Irani noted that, by this time, AR was out with parental control, had been presenting a risk in the family home, was withdrawn, spent considerable periods of time on his computer and was not looking after himself, going considerable periods without showering (I note that although Dr Molyneux was informed that AR had showered on 27 September 2023, a single instance of AR showering does not by itself demonstrate that he had started to look after himself properly: Dr Molyneux's view on this, that *"if a parent is saying it is good news here, good news sounds like good news,"* was facile and unrealistic).[1309] Dr Irani noted that, when AR did not attend the clinic and refused to be seen at home, no one had access to his mental state, or knowledge of what he was doing in his room, in order to inform his risk assessment. Instead, parental information was relied upon.[1310] As a result, Dr Irani considered that an intervention should have been carried out to review AR's risk of harm to others either at this point or before AR's discharge.[1311] She considered that concerns should have been raised with the relevant safeguarding lead, liaison with Children's Social Care and, given the historic risks (in practice, factors which had been lost and were unknown to those treating AR at this stage) and deterioration in presentation, there should have been consideration of a Mental Health Act assessment. She accepted that there would be a range of views as to whether an assessment should have been attempted and that it was likely that such an assessment would not have led to evidence to suggest a need for hospital treatment.[1312] However, it would have allowed an in-depth and face-to-face assessment of AR, including of his risk to others.[1313]

291. Dr Irani considered that such an assessment may have led to the earlier discharge from CAMHS with an escalation in concerns raised with LCC's social care services. Perhaps counter-intuitively, Dr Irani considered that this earlier discharge would have been preferable to AR's care remaining open (as set out below) without him being seen or the risk being assessed.[1314] I accept that AR's case was kept open in good faith and CAMHS' persistence in trying to reach AR and keeping the case open is an example of CAMHS going above and beyond in terms of its involvement with AR and his family.[1315]

1308 Witness Statement of Dr Molyneux AHCH000253/§91; Witness Statement of Samuel Coppard AHCH000289/§§165-174.

1309 T/S: 24/75/3-76/6.

1310 Expert Report of Dr Irani DRI000001/§2.1.23.

1311 Expert Report of Dr Irani DRI000001/§ 3.3.3.1, §3.4.4.1.

1312 T/S: 26/44/13-48/14.

1313 T/S: 26/41/11-44/12.

1314 Expert Report of Dr Irani DRI000001/§3.2.2.1, §§3.3.3.1-3.3.4.4.

1315 Closing Statement on behalf of Alder Hey Children's NHS Foundation Trust AHCH000327/1/§C.

However, Dr Irani was right to identify that the critical actions for AR were an adequate assessment of his risk and steps to address that risk. Unfortunately, this did not take place in September 2023 or at any point thereafter.

292. On 11 December 2023, Alphonse R sent an email to Dr Molyneux stating that *"AR is well but is struggling with sleeping"*. Dr Molyneux again offered a prescription for melatonin.[1316]

293. On 20 February 2024, Mr Coppard carried out another family therapy session with Alphonse R and Laetitia M. Both parents spoke about AR being calmer without professionals visiting the home and Alphonse R suggested that AR was less violent in the home. Alphonse R stated that he wanted to continue with family therapy, but Laetitia M stated that there was nothing she felt that family therapy could do for AR or them as a family. As Alphonse R found the meetings useful, Mr Coppard suggested another meeting in March, which only Alphonse R could make, and a joint appointment in April. Laetitia M stated that she felt that this was a way of trying to split up the family.

294. On 22 February 2024, Ms Morris reviewed the risk assessment and management tool, which ought to have been reviewed every three months.[1317] Ms Morris accepted that the assessment should have included more detail about AR's previous incidents, as well as dates.[1318] In the Child and Young Person Current View that Ms Morris drafted on the same date, she stated *"Poses risk to others: none"*.[1319]

295. In her evidence, Ms Morris stated that she would have reached a different conclusion if other agencies had shared risk information with her. However, she stated that the Child and Young Person Current View was an assessment of the current, as opposed to historical, risk. Instead, it is the risk assessment that takes into account historical risk.[1320] I found this reasoning difficult to follow. Although the Child and Young Person Current View required Ms Morris to give a *"current view"*, it also required an assessment of the risk AR posed to others. I take into account the explanation from Alder Hey that the 'Current View' document is an internal document separate from the risk management form with the latter holding the information relating to AR's risk factors, including historical risks.[1321] Even so, to suggest that such an assessment should not use historical information appears inconsistent with Dr Irani's statement that: *"previous history of violence is probably the best indicator of future risk of violence"*.[1322] AR's history was clearly relevant to his propensity to violence and therefore relevant to his current risk to others. In any event, Ms Morris had

1316 Witness Statement of Dr Molyneux AHCH000253/§93.

1317 AHCH000154.

1318 T/S: KM/51/18-52/1.

1319 AHCH000155.

1320 T/S: KM/52/2-53/5, T/S: KM/57/10-14.

1321 Closing Statement on behalf of Alder Hey Children's NHS Foundation Trust AHCH000327/7-8/§12.7

1322 T/S: 26/20/4-10. Indeed and the fact that ten of 24 risk items in the SAVRY are historical.

also not provided full detail of historical events in the risk assessment and management tool. She accepted that more detail should have been given. Indeed, later in her evidence, Ms Morris did accept that *"risk was assessed without the historic risk and I think, looking back and in hindsight and on reflection, that historic risk should have been looked at"*.[1323] She is right to have made that concession, but it does not require hindsight to recognise that this is what CAMHS (and not just Ms Morris) should have been doing throughout.

296. On 26 March 2024, Alphonse R again contacted Dr Molyneux to request a repeat melatonin prescription to help AR with sleeping, and to inform the GP that this had occurred in order to *"hand over"* responsibility for this prescription to the GP. His email did not indicate any wider concerns in relation to AR's mental health.[1324] Dr Molyneux was on annual leave and did not receive this email until at least the second week of April 2024. It appears to have prompted him to reconsider AR's case, and following discussions with Ms Morris and Mr Coppard, on 16 April 2024, Dr Molyneux thereafter discharged AR from CAMHS psychiatry.[1325] Dr Molyneux's view was that as of April 2024, there was nothing to indicate that concerns about AR had escalated from September 2023, in the light of the various positive updates he had received from Alphonse R. Dr Molyneux was not aware that (as of February) AR had been reported not to have left the house for four to five months, but in his view it would have made no difference to the decision to discharge AR. The pattern of AR not leaving the house for sustained periods was longstanding.[1326]

297. Dr Molyneux accepted that if he had been aware of the extensive history demonstrating the risk posed by AR, this would have *"put a different complexion"* on AR's increasing isolation, his disengagement from professionals, his almost total avoidance of school, and the extensive amount time he spent on computers. It would have *"flagged up"* an increase in the potential risk to others and it would have warranted further exploration. It might have led to him being kept on by CAMHS for a longer period of time. Moreover, even if AR was to be closed to CAMHS, it would have been necessary to communicate information concerning the risk AR posed to other agencies, potentially at a multi-agency meeting.[1327] Dr Molyneux accepted that AR's apparent lack of empathy increased the risk he posed, as did AR's concerning special interests such as a fascination with violence.[1328] Dr Molyneux accepted that there was an *"element of truth"* in the assertion that the risk that AR posed to others *"became almost completely lost in how CAMHS dealt with him"*.[1329]

1323 T/S: KM/73/16-19.

1324 Witness Statement of Dr Molyneux AHCH000253/§99, §104.

1325 Witness Statement of Dr Molyneux AHCH000253/§§101-105.

1326 T/S: 24/84/16-85/17; Witness Statement of Dr Molyneux, AHCH000253/§103.

1327 T/S: 24/56/8-70/5.

1328 T/S: 24/86/23-87/24.

1329 T/S: 24/89/25-90/13.

298. As in September 2023, when the provisional decision to move towards discharging AR from CAMHS Psychiatry was taken, the appropriate step in April 2024 would have been for there to be an in-depth assessment of AR's case, on a multi-agency basis. Whether or not that ought to have been a formal Mental Health Act assessment does not matter (although Dr Irani considered that it should have been): what was required was a detailed and comprehensive review of AR's circumstances, on a multi-agency basis, properly informed by full knowledge of the historical risks he posed.[1330]

299. On 23 April 2024, the final family therapy session took place. AR had not attended any of the sessions. It was agreed by AR's parents that this intervention should come to an end. Alphonse R described the sessions as having been helpful. Indeed, he wrote saying that CAMHS left them *"stronger, more self-aware and, therefore, more resilient than before the family therapy began"*. They thanked the team for their patience and support.[1331] Mr Coppard reflected that, over the course of the sessions, concerns were raised regarding parental mistrust of CAMHS, particularly from Laetitia M and noted that this may have hindered collaborative care planning.[1332]

300. With family therapy now concluded, and AR having been discharged from CAMHS psychiatry, his case was now considered by an MDT for discharge from CAMHS. On 23 July 2024, Ms Morris reviewed his file and finalised AR's discharge from all CAMHS intervention. In the assessment of risk to others on 23 July 2024, she set out the following:

> *"[AR] previously hurt a peer who he mistakenly thought was the peer who had subjected him to bullying. This occurred on the school site. [AR] attend the school site wit[h] the intention of hurting the peer who was bullying him. His intention was to exact revenge and [AR] is open about this.*
>
> *[AR] has thrown a phone in anger during a CAMHS video call with myself when the phone camera was turned on him against his wish and has shouted at his parents out of frustration.*
>
> *[AR] has been subject to a couple of referrals to PREVENT - the lates[t] in connection to [AR] speaking with a member of staff about troubles in Palestine and Israel. [AR] follows World News and appears to be well informed on these matters. School took this as concern and reported him to PREVENT – Outcome unknown to date. Previous referral to PREVENT highlighted no concerns re [AR] being a terrorist risk or being radicalized in any way.*
>
> *[AR] took the latest referral very personally and wanted to know what school staff had recorded about him – [AR's] father eventually showed him the detail of the referral. [AR] wanted to discuss this with his*

1330 Expert Report of Dr Irani DRI000001/§3.4.4.1; T/S: 26/78/19-79/7.

1331 Witness Statement of Mr Coppard AHCH000289/§181, §§185-189.

1332 Witness Statement of Mr Coppard AHCH000289/§197.

> *Teacher/support worker at school but did not attend that last few days of school. [AR] is upset but the thoughts that school had about him in relation to thinking he is a terrorist threat due to his world knowledge re matters such as Israel and Palestine. School are concerned at [AR] knowing the details of the referral and felt that it could be emotionally harmful for him to see the details. As CAMHS CASE Manager I am not aware of the content of the referral. I am aware that [AR] was upset by the referral being made and perceived this in a break in a trusting relationship which he had recently repaired or regained with his support worker. [AR] can have a real need to know the in's and out's of things - this relates to his Autistic tendencies as well as his intelligence."*[1333]

301. It is fair to note in relation to Ms Morris that, unlike previous case managers, she did complete two formal risk assessments for AR and, in this regard, she came closer to meeting the formal policy requirement for regular risk assessments than her predecessors.

302. However, as Dr Killen agreed, there was no attempt to grade this risk and a considerable amount of what AR had set out was simply taken at face value. The Child and Young Person Current View completed by Ms Morris on the same day recorded that AR posed no risk to others.[1334] Dr Killen accepted this assessment of risk was *"very far"* short of acceptable. She agreed that the tool being used by CAMHS was inadequate and that there should have been an *"actuarial risk assessment"* (such as the SAVRY, which incorporates some actuarial elements as well as structured professional assessment) carried out by FCAMHS at key stages during the events concerning AR.[1335] Dr Killen accepted that incidents such as when AR carried a knife on a bus were *"crying out for a serious re-assessment of the risk [AR posed] to others"*. She acknowledged the actuarial risk assessment should be better embedded in the multi-agency systems so that when risk arises, the historic risk is properly taken into account.[1336] Dr Irani stated that Ms Morris had set out a list of some incidents but it was not comprehensive and there was no analysis and assessment of the risk.[1337] She also considered the Child and Young Person Current View to be inadequate.[1338] There is no reason to doubt that Ms Morris was doing her best; these shortcomings principally reflect the earlier and cumulative failure by CAMHS adequately to consider AR's risk to others.

1333 AHCH000160/1-2. The record states that the case manager is Ms Morris but, in a number of places, the record states that it is a note from Ms Steed and Mr Morgan. It appears that Ms Morris has pulled together notes from Ms Steed and Mr Morgan, as well as her own input previously: see T/S: KM/50/5-23.

1334 AHCH000159.

1335 T/S: 24/198/13-199/5.

1336 T/S: 24/195/20-203/23.

1337 T/S: 26/11/11-12/1.

1338 T/S: 26/12/2-15.

303. Ms Morris accepted that by September 2023, she should have raised safeguarding concerns through children's services in relation to AR, and that the CAMHS response to AR's deterioration, including his disengagement from CAMHS, was inadequate.[1339] She agreed that following AR's autism diagnosis and deterioration, his case should have been re-referred to FCAMHS.[1340] If she had known about the incident on 22 July 2024, when AR tried to leave the house in a taxi in order to return to Range High School with a knife, she would not have discharged him from CAMHS, but instead there would have been multi-agency engagement and consideration of a Mental Health Act assessment.[1341] It is important to note here that AR's parents did not report that incident to CAMHS or indeed to any other agency (see further Chapter 12: AR's family).

304. Ms Morris agreed that the risk assessments she conducted in respect of AR were not adequately informed.[1342] She also always understood that other agencies were the 'lead' agency for AR's case, with responsibility for assessing and managing AR's risk, though the identity of the lead agency shifted over time. Her view was that CAMHS worked on the basis that any risk to others posed by AR either had been dealt with by others or was being addressed by others.[1343]

305. In dealing with the previous period of the chronology I set out the material respects – other than the assessment of risk to others – in which Dr Irani found that CAMHS's treatment of AR was compliant with expected standards (particularly the approach to medication, the referral to other services and to family therapy); see paragraph 232. Those conclusions apply equally to this period.

306. The narrative chronology I have set out above is not exhaustive, but it explains the circumstances in which AR came to be discharged from CAMHS just six days before he carried out his atrocious attack.

1339 T/S: KM/47/2-14.

1340 T/S: KM/47/15-48/4.

1341 T/S: KM/64/8-65/7.

1342 T/S: KM/59/20-60/8.

1343 T/S: KM/65/8-66/22.

Summary of findings

The early referrals in 2019

307. In the early part of 2019, CAMHS acted reasonably in signposting AR to Parenting 2000 following the April mental health referral, given the mild symptoms described at that stage. Parenting 2000 provided useful early-help support.

308. In August 2019, AR was appropriately referred to the Alder Hey Community Paediatric Service for assessment of ASD and ADHD. Although the referral was accepted, the delay of around ten weeks beyond the average waiting time was a significant shortcoming, especially once the service had been alerted by The Acorns School to escalating concerns about AR's behaviour and potential risk to others. While no formal expedition process existed, the cumulative concerns should have prompted a more proactive approach. This was a marked shortcoming, as Ms Boggan for the trust candidly accepted. While the delay was less than Ms Boggan understood it to be when she gave her oral evidence, it remains hard to understand why AR took 10 weeks longer than average to be assessed even when expedition of his case had been requested.

309. The second mental health referral to CAMHS in October 2019 should have been accepted once Parenting 2000 added their own concerns that same week. The Community Paediatric Service and CAMHS each received pieces of information that, taken together, indicated that AR required assessment. That included the concerns being strongly (and justifiably) raised by The Acorns School.

310. The two relevant services from The Alder Hey were by no means the only agencies involved at this stage. The key problem was that no single agency was gripping AR's case and taking the lead with a structured assessment of AR's risks to others. Dr Irani was right to identify this as a failure even in this early period. The Alder Hey Trust was part of this inadequate response, both as regards the delays in neurodivergence assessment, and for not recognising the cumulative features justifying accepting the mental health referral by mid-October 2019. There are understandable pressures on CAMHS resources, but by this stage CAMHS should not have just signposted AR on to other services, they should have assessed him.

Healthcare in the aftermath of the hockey stick attack at Range High School: December 2019 to June 2020

311. Given the significance of AR's attack at Range High School on 11 December 2019, this was a key period.

312. I have no doubt that those working in the CJLDT, CAMHS and FCAMHS acted in good faith to seek to address the implications of AR's offending. The positive intent can be seen by speed and thoroughness of Ms Hallaron's early engagement for CJLDT and the early multi-disciplinary meetings that were held. Critically, however, these healthcare systems ended up failing adequately to address the risks that AR posed to others.

313. A solution should have been found to handle AR's dangerousness which did not simply involve observing that The Acorns School had been *"left holding the baby"*. I make all proper allowance for the fact that in even in difficult situations, there is place for an element of humour in meetings involving professionals facing difficult tasks. However, Mr Hicklin's observation that no one could say *"what was going to happen next"* was made in the context of Mr Hicklin seemingly expecting that The Acorns School should take on an unacceptable level of risk; similarly his repeating the point that there were no crystal balls and that *"he would offer a £5 bet to anyone who could say what was going to happen next"*. This risked being cavalier.[1344] Ms Brown gave evidence that this was not how she would expect one of the professionals within FCAMHS to communicate *"with the wider system"*, given the apparent flippancy of Mr Hicklin's remarks.[1345]

314. Had Mr Hicklin and the FCAMHS team been more astute to the concerns rightly being raised by both The Acorns School and Ms Hallaron, they would have recognised that this was a case wholly suitable for the SAVRY type of structured risk assessment. They would have realised, additionally, that neither CAMHS nor the CYJS had the skill set to complete the SAVRY; similarly, CJLDT no longer had that capacity to undertake this task.

315. The failure to commission or lead such an assessment was the most consequential shortcoming in this period. The SAVRY risk assessment would not have been a panacea. However, it is deeply concerning that the best tool to address AR's risk was available but was not even used, despite Ms Hallaron raising this very early as a possible action. The principal responsibility for this failure rests with FCAMHS. While I have raised criticism of Mr Hicklin in this regard, I should note that GMMH's evidence through Ms Brown sought to suggest that the FCAMHS closure decision was understandable at the time rather than a poor professional decision, although she maintained that a SAVRY should have been undertaken.[1346]

1344 LCC000020/2.

1345 T/S: 25/183/5-184/11.

1346 T/S: 25/185/17-186/6.

316. NHS England is right to emphasise that a full SAVRY risk assessment (a process that is lengthy and resource intensive) cannot be done, and would not be proportionate, in every case. But AR's dangerousness should in fact have been clear:

    a. The December 2019 attack was not a one off: AR had repeatedly brought knives into school in October 2019;

    b. The hockey stick attack at Range High School was planned and premeditated and known to be so. He had booked the taxi the day before;

    c. As rightly troubled Ms Hallaron, when AR failed to locate his intended victim, he instead attacked someone he *"liked"* simply because he knew it was too late to avoid being detained;[1347]

    d. AR showed a complete lack of remorse and insight into the consequences of his actions;

    e. There were substantial question marks over the extent to which AR's parents, particularly his father, were accepting of the gravity of AR's conduct. They instead somewhat tended towards justifying or minimising what he had done;

    f. AR's other comments and internet use around violence were multiple and concerning, despite Prevent and Channel having not taken his case on;

    g. There were considerable doubts about whether AR had ever been bullied;

    h. The Acorns School had significant concerns that his behaviour was repeating itself, with AR fixating on certain staff and perceived slights. While AR did not yet have a formal diagnosis, several experienced professionals had recognised obvious and strong autistic traits;

    i. A formulation for seeking to manage AR's dangerousness could and should have been considered pending and in the expectation of an ASD diagnosis.

    It is not, therefore, hindsight to record that the risks were significant; they should have been apparent and the warnings from The Acorns School and others should have been better heeded.

317. In the absence of a SAVRY, CAMHS' risk assessments were not standardised, they were irregularly completed and were insufficient for decision-making. The CYJS's AssetPlus assessment was not an adequate substitute; it lacked the forward-looking planning required and underestimated AR's risk.

318. While the agencies were seeking to work together, the multi-disciplinary working was ineffective. FCAMHS did not attend the early meetings. CAMHS did not attend the later meetings. There was considerable confusion

1347 MERC000010; GMMH000006.

about who was to be the lead agency. FCAMHS and the CJLDT service closed their cases for AR despite earlier identified measures not being undertaken. Even if they did not ensure that a SAVRY risk assessment was carried out, FCAMHS should have kept AR's case open, held another professionals' meeting, and ensured that a lead agency was identified to ensure that outstanding actions were followed through. While purportedly acting in a multi-disciplinary fashion, there ended up being a marked disconnect between the agencies involved.

319. Record keeping was often poor. This is not a minor additional point; it contributed to the sense of disconnect. The minutes of the later professionals' meetings were not circulated. CAMHS later had to ask to be sent copies, and they failed to scan them into AR's notes meaning that the content was lost to later clinicians. Despite the healthcare slant to much of what was discussed, the best records of several of the meetings were often the notes taken by The Acorns School. While FCAMHS's preparedness to accept a re-referral of AR's case could have been more strongly and overtly phrased than in Mr Hicklin's letter of 9 March 2020, CAMHS did not carry forward any kind of marker or warning on AR's notes that re-referral to FCAMHS would be appropriate once AR's ASD/ADHD diagnosis was confirmed or in the event of any subsequent act of significant violence, particularly any event involving knives.

320. With the exception of some early consideration of AR being on a cancellation list (which does not seem to have assisted), the planned action of making a strong case to the Community Paediatrics ASD team concerning the need for expedition of AR's case does not seem to have been carried through. It was poor practice that the Community Paediatrics ASD team failed to expedite AR's autism assessment during this period and instead permitted it to take 10 weeks longer than the average.

321. The timing of Mr Morgan's departure from CAMHS was unfortunate and the fact that AR went without a case manager at a sensitive stage of FCAMHS involvement was poor practice. I am concerned both that Mr Morgan did not appear to follow through on Mr Hicklin's recommended interventions around mental health, specifically to tackle AR's risk to others, and that this was not subsequently picked up by CAMHS or in the multi-agency arrangements before AR's case was closed to several of the agencies. Mr Coppard diligently set about trying to build a supportive therapeutic relationship with AR in the last two months of this period. However – due to the combined effect of the failures I have already outlined – CAMHS' focus was now on trying to tackle AR's symptoms of anxiety with insufficient attention to his risk to others.

322. For all of these reasons, by June 2020 to some extent the 'damage was done' as regards the healthcare approach. By then, the absence of a structured risk assessment and the premature case closure by FCAMHS meant the risk to others was no longer at the centre of healthcare planning. CAMHS' focus was on AR's anxiety rather than his dangerousness, while their very poor record keeping meant that later clinicians would be unsighted on FCAMHS'

two letters. The cumulative effect was that the foundations for managing AR's dangerousness were not in place. There were no planned intervention measures should AR's risk to others later increase.

323. Given AR's persistent lack of cooperation, it is difficult to gauge what difference would have been made by a SAVRY being conducted and overseen by FCAMHS, and by following through on all the recommendations that Mr Hicklin had made. Difficulties are likely still to have been encountered in getting accurate information from the family home, and in securing meaningful engagement from AR in particular. However, the principal benefits would have been a more accurate definition of the risks to others (which were high), coupled with a clear plan if the risks increased, including agreed triggers for contingency steps to be put into effect. Had that approach been taken, it is very likely to have led – for example – to a proper multi-disciplinary re-assessment after the bus incident, including further input from FCAMHS. Therefore, while a precise counter-factual cannot be accurately determined, it is probable that a better healthcare response in this period would have ensured that effective contingency planning was instituted, thereby making a real difference to the handling of AR.

Healthcare from July 2020 to June 2022

324. At the start of this period, Mr Coppard made diligent and appropriate efforts to engage AR in CBT-informed therapeutic interventions. His approach was appropriate and was largely unsuccessful solely on account of AR's relative lack of engagement. Administrative weaknesses continued: case closure decisions were not actioned, record-keeping was inconsistent, and risk assessments were not updated.

325. Again, during this period, AR's ASD assessment took far longer than it should have done. The 77-week period from referral to the Community Paediatric Service in August 2019 to AR receiving an ASD diagnosis in February 2021 was unacceptably long, even allowing for the impact of the COVID-19 pandemic. While Ms Saunders' evidence establishes that the period of delay in AR being seen was less than originally understood, it still look longer than average for him to be assessed. This process should have been expedited given AR had carried out the hockey stick attack at Range High School, he had exhibited signs of constituting a high risk of harm to others, and he was the subject of properly argued concerns from The Acorns School, a specialist Pupil Referral Unit. The delay in assessing and diagnosing AR had a significant impact in two important ways. First, it meant that FCAMHS regarded itself as unable to provide further meaningful input, because there was no confirmed diagnosis. Second, although various agencies were treating AR as likely to have ASD from (at least) October 2019 onwards, an earlier formal diagnosis would have enabled a better understanding and more tailored approach to issues as diverse as AR's education, his work under the referral order, and the mental health treatment he was receiving. It is not, however, possible to say that a faster diagnosis would have prevented the events of 29 July 2024.

There have been some improvements in relation to how long ASD assessments take, and I have taken this into account in deciding on the recommendations set out at the end of this chapter.

326. Post-diagnosis support for AR's autism was minimal. The involvement of the Community Paediatric Service amounted to little more than signposting to community organisations and support groups. This has improved to an extent since these events, and again I have taken these improvements into account in considering the recommendations that need to be made.

327. AR's ADHD assessment was not progressed. Opportunities to pursue this were missed in July 2020, February 2021, and April 2021. However, as I have set out at paragraph 284, it is only a possibility that AR would have been diagnosed with ADHD, and, even with a positive diagnosis, it is uncertain what, if any, medication would have been prescribed or its effect. In those circumstances, it cannot be said that the failure to assess AR for ADHD caused or contributed to the events of 29 July 2024.

328. The ASD diagnosis in early 2021 should have triggered re-referral to FCAMHS. This was principally the responsibility of CAMHS, none of whose clinicians at the time appear to have considered it. This was partly caused by the earlier way in which AR's risk to others dropped out of focus when FCAMHS closed AR's case without requiring a SAVRY to be carried out.

329. When AR was referred back to CAMHS for increased anxiety early in 2021, Ms Steed – once appointed as the new case manager – was persistent in her efforts to engage with both AR and his parents. In common with Dr Ramasubramanian and Ms Warner, once they became involved, Ms Steed was energetic in these endeavours throughout her involvement until relinquishing her role following the breakdown of relations with Alphonse R. It is to be stressed that CAMHS worked hard to encourage AR to engage and to support his family.

330. In addition to this, CAMHS' approach in the following areas: prescribing medication for AR; trying to engage him in talking therapy; the referral to family therapy; and their preparedness to offers sessions and visits to AR, were all within acceptable and reasonable practice.

331. However, the underlying weaknesses in managing risk persisted and, in certain respects, was exacerbated:

    a. Dr Ramasubramanian had a poor understanding of the events in late 2019 to early 2020 that were relevant to AR's significant risk of violence to others. That arose because (a) there was no earlier structured risk assessment like a SAVRY and the earlier internal CAMHS risk assessment was inadequate; (b) the CAMHS electronic patient record system had no easy-to-view summary of risk information. The relevant information was 'dotted around' the earlier notes in an unstructured and unhelpful way; (c) Dr Ramasubramanian

(who in other respects I find to have been a diligent, thoughtful and reflective clinician) did not do a sufficiently thorough review of the earlier notes;

b. One effect of this was that Dr Ramasubramanian did not have a sufficient grasp of the detail of AR's history to cause her to think about conduct disorder as a diagnosis. AR should have been diagnosed with conduct disorder. However, this would not have affected the treatment pathway. Conduct disorder is not a severe mental illness or disorder. It would have served mainly to give greater focus to AR's risk of harm to others and may have precipitated an earlier discharge from CAMHS with greater emphasis on the need for other agencies to monitor and robustly tackle any signs of further violent conduct;

c. When AR acted violently in the home (on multiple occasions in November 2021) and then most starkly in the bus incident, CAMHS did not recognise or act on the upturn in risk to others, undertake any further formal risk assessments, or even consider a re-referral to FCAMHS;

d. CAMHS' failure to take adequate action after the bus incident was significant. They had been told that AR had a knife, but AR then made no mention of carrying a knife when asked about the incident. They should have asked questions about this and probed to understand the implications for the risk this raised for others. However, it is important to note that CAMHS were not told of the most concerning aspects of this incident (AR's self-admitted thoughts of using the knife to stab someone and his reference to poison). It should, additionally, be viewed in the context of the earlier failures to conduct an FCAMHS-led SAVRY risk assessment, which would have established the structure within which such later incidents would have been managed;

e. While Ms Steed worked diligently to try to support AR (including extensive liaison with other agencies), she did not comply with CAMHS policy on completing risk assessments, although she did add some information to the existing risk assessment. There are two specific areas of concern regarding Ms Steed's period as CAMHS case manager:

    1. Ms Steed was unwise to raise issues of racial stereotyping in the context of the concerns The Acorns School had raised about AR's risks in the EHCP. She should either have had faith in Mrs Hodson's professional judgement, or she should have sought better to understand the rationale behind the wording used before questioning it;

    2. While Ms Steed did not know about AR's stated intent to use the knife in March 2022 or his reference to poison, she had been told by Alphonse R that AR was thought to have a knife on him and she

then documented that AR had not himself made any mention of this. The evidence does not establish any bad faith on Ms Steed's part, but she has not satisfactorily explained why she did not tell The Acorns School about the knife as she should have done when they asked for detailed information about the incident.

332. The end of this period brought about a change in both case manager and psychiatrist because neither Dr Ramasubramanian nor Ms Steed felt that they could work with the family any more given what they felt was aggression and an unacceptable level of intimidation by Alphonse R, who was also critical of the extent to which Ms Steed supposedly took AR's side. I address Alphonse R's role in this in Chapter 12: AR's family. In short, however, I am sure that this change in clinicians only became necessary because Alphonse R acted in an inappropriately overbearing and verbally aggressive way. AR's parents faced what were undoubtedly significant challenges when tackling AR's unreasonable and often violent behaviour. There was a high risk that this would lead to frustrations with some of the professionals. This provides mitigation but it does not excuse how Alphonse R approached Dr Ramasubramanian and Ms Steed. They were justified in withdrawing from his case. The lack of continuity in treating clinicians was unhelpful and it was caused (on this occasion) by Alphonse R. CAMHS professionally managed the transition to replacement treating clinicians.

Healthcare from July 2022 to 23 July 2024

333. When AR's care transferred to Dr Molyneux, he too lacked an understanding of some of the crucial background information. I have described above issues with his consideration of the records. As with Dr Ramasubramanian, this had a material impact in the way that AR was handled, in particular in relation to management of his risk to others. Even making all possible allowances for the difficulty of giving evidence at a high-profile public inquiry, I was concerned at the markedly defensive position that was adopted by Dr Molyneux in his written statement and during his oral evidence to the Inquiry. Although he made concessions on certain issues, he was inappropriately unprepared to accept that mistakes had been made by him and by CAMHS more broadly. I do not doubt that he acted at all times in what he considered to be in the best interests of AR. It is understandable that Dr Molyneux was angered by AR's parents not conveying information that was known to them about (for example) AR having ordered weapons. But Dr Molyneux's lack of reflection about what he and CAMHS could have done differently, and his failure to recognise important learning points from this (including in relation to his own practice) was surprising and concerning from an experienced consultant psychiatrist. I should, however, add that Dr Molyneux's engagement with the Inquiry over areas of potential criticism has revealed a somewhat more reflective stance.

334. It bears repeating (in fairness to Dr Molyneux) that the lack of an earlier SAVRY and the unhelpful layout of the electronic patient record were significant factors in the fact that relevant history about AR was missed.

In particular, the electronic patient record did not have a system whereby this important historical information was immediately visible to those reviewing the patient. There have been improvements by CAMHS in this regard which Dr Molyneux also emphasised, and I have considered those in relation to my recommendations set out below.

335. Turning to the treatment provided to AR during this period, Dr Irani considered that the pharmacological treatment provided was in line with NICE guidelines and peer approved practices.[1348] She concluded that medication was stopped appropriately when AR's non-compliance was known.[1349] She considered that the treatment of AR's dietary issues was also adequate and appropriate referrals were made to eating disorder services and dietetics.[1350] I accept this evidence.

336. Dr Irani was also uncritical of the attempts made to re-engage AR with CAMHS. In fact, she noted that Dr Molyneux (and Dr Ramasubramanian) made far more attempts to see AR than would have been the case with most clinicians.[1351] I agree with Dr Irani's assessment in this regard. CAMHS cannot be faulted for the extensive efforts they made to reach AR with the support they could offer.

337. However, Dr Irani was critical of the steps taken to assess and manage AR's risks as a result of his disengagement. As I have set out above, she considered that one possibility was a Mental Health Act assessment. I agree with her evidence that this would have been beneficial in order to assess AR. It is unfortunate that a Mental Health Act assessment was not actively considered and did not take place. Dr Molyneux accepted that the question of a Mental Health Act assessment would have been given greater consideration if he had been aware of the information concerning historic risk.[1352] However, Dr Irani indicated that there was a range of views in this respect. I recognise, given Dr Irani did not consider that AR was likely to have been detained, that some practitioners would credibly not have carried out such an assessment. Given there is, therefore, a legitimate range of professional views, while I consider it would have been better if a Mental Health Act assessment had taken place, it cannot be said that CAMHS (and Dr Molyneux) were wrong not to have taken this course.

338. Significantly in this regard, Dr Irani identified that there is potentially a gap in the legislation providing practitioners with access to young people in order to assess them in the community.[1353] It is relevant in this context that the Mental Health Act 2025, once its provisions on autism are brought into force,

1348 Expert Report of Dr Irani DRI000001/§3.3.2.2.

1349 Expert Report of Dr Irani DRI000001/§3.4.2.2.

1350 Expert Report of Dr Irani DRI000001/§§3.3.2.5-3.3.2.6.

1351 T/S: 26/69/17-23.

1352 T/S: 24/79/18-80/15.

1353 T/S: 26/48/17-49/8.

will accentuate this gap as it will prevent individuals from being detained on the basis of autism alone.[1354] I return to this issue in my recommendations at the end of this chapter.

339. In addition to the issue of a Mental Health Act assessment, Dr Irani considered that AR's disengagement should have led to an increase in safeguarding concerns and a re-referral to FCAMHS should have been triggered to support a risk assessment.[1355] I agree with that conclusion. In short, whether there should have been a formal Mental Health Act assessment or an earlier decision to discharge AR in conjunction with appropriate co-ordination with other agencies, from at least September 2023 onwards the case demanded a careful and formal re-assessment, fully informed by all the historical risks that were or ought to have been known to CAMHS. That may have led to a further referral to FCAMHS, or to a decision to close AR to mental health services with a clear indication to other agencies that AR's concerning behaviours should not simply be attributed to ASD, to anxiety, or to undefined 'mental health' concerns or even to AR 'lacking capacity', as occurred on a number of occasions described in other chapters.

340. In my view, these steps were overlooked because of the continued lack of appreciation of AR's historical risk. Within this period of AR's treatment, Dr Molyneux was very largely unaware of them. Like Dr Ramasubramanian, Dr Molyneux did not conduct a sufficiently thorough review of the earlier notes. Ms Morris was aware of many of the relevant entries but appears to have misjudged their significance, placing little weight on them because they were historic. They were both unaware of the FCAMHS discharge letter, including its suggestion of a re-referral, because it had not been scanned onto the electronic patient record. This was a combination, therefore, of poor record systems and tools, along with shortcomings by the clinicians involved.

341. A diagnosis of conduct disorder, though missed, would not have changed AR's treatment pathway and would likely have led to earlier discharge. But with or without a conduct disorder diagnosis, CAMHS in this period did not do sufficient to respond to and act on the extant of AR's risk to others. The quality of their risk assessments, and the attention paid to risk, was poor. Ultimately, Ms Morris' view that risk assessment was an issue for various other 'lead agencies' typifies this approach.

Conclusions

342. Overall, although some diligent work was undertaken as regards AR, I have concluded that, even allowing for the difficulties created by the COVID-19 pandemic, the handling of his case by Community Paediatrics, CAMHS and FCAMHS was poor. The key electronic patient record records were set out in a

1354 Closing Statement on behalf of NHS England NHS000574/18-19/§53(a); see also the Closing Statement on behalf of the Adult Victims ADV000001/14/§66.

1355 Expert Report of Dr Irani DRI000001/§3.4.3.1; T/S: 26/79/8-20.

way that made it extremely difficult for practitioners, when allocated to his case, to appreciate the significance of the key historical events. There were notably poor systems in place for sharing information between the relevant agencies. The consequential lack of knowledge on the part of those dealing with his case was a troubling recurring feature and it had a fundamental impact on the approach that was taken by various key professionals to AR. I was particularly concerned that the careful and informed concerns expressed by The Acorns School were not treated with sufficient seriousness. FCAMHS was not commissioned or resourced as a case-holding or lead agency. However, even allowing for this, in the critical period after the hockey stick attack at Range High School, FCAMHS failed to ensure that a structured assessment of risk was carried out by way of using the SAVRY tool. That was exacerbated by the inappropriately early closure of AR's case by FCAMHS. Thereafter, there was a failure to re-refer him to FCAMHS when circumstances indicated that this should occur. There was no mechanism for prioritising AR's autism diagnosis, and the suggested ADHD referral was handled inadequately with a concerning cumulative number of missed opportunities to spot that the referral had not been progressed.

343. After the opportunity to use the SAVRY tool was missed by FCAMHS, the tools available to CAMHS and particularly the system for assessing risk to others was ill-suited to the type of serious and complex risks posed by AR. This was exacerbated by the failure to apply those tools appropriately or to adhere to CAMHS' own risk assessment policy. The end result was that the assessment of AR's risk to others was superficial, uninformed and inadequate. As I have identified in other chapters, there was a troubling lack of concern that no single agency had been identified as the lead agency for implementing the strategies that had been agreed. I heard contradictory evidence as to the understanding on the part of various witnesses from the service as to the identity of the lead agency.

344. Given AR's determined disengagement from the professionals who tried to assist him (save (in the main) when AR wanted to secure the prescription of medication), it is difficult to determine whether there would have been a different outcome if his case had been better handled by CAMHS and FCAMHS. The treatment and support to AR is unlikely to have been materially different. However, the most causatively significant failure in AR's healthcare is likely to have been the failure to adopt a suitable structured assessment of his risk to others, like the SAVRY. Such an approach could have set a structure for future interventions in the case of escalation. That in turn would have meant that when AR was found in possession of a knife on the bus in March 2022, there would have been a far more robust intervention and re-assessment of the risk AR posed to others. I note also Dr Irani's statement that a risk assessment process should have led to a discussion with the parents about when to alert the authorities, thereby enabling appropriate reporting.[1356]

1356 T/S: 26/72/22-73/16.

This may have resulted in AR's parents reporting AR's most concerning behaviour (e.g. purchasing knives, and his attempt to travel to Range High School a week before the attack).

345. Dr Irani's evidence was that there are insufficient resources to address violence fascinated individuals outside the criminal justice system. I am concerned by this and address it in my recommendations.[1357]

Recommendations

346. In making the recommendations below, I have taken into account the significant evidence I received in terms of improvements that have already been made on behalf of the relevant healthcare agencies. I have also been particularly assisted by the constructive and reflective closing statement made by NHS England.[1358]

347. I was concerned by the relative lack of post-diagnosis support offered by Alder Hey at the time of AR's autism diagnosis. I note however that the new Alder Hey Neurodevelopmental Service incorporates both an Assessment Team, responsible for diagnosis, and a Treatment Team, which provides post-diagnostic support for ASD as well as overseeing ADHD medication management. A workshop is now delivered to all those between the ages of 11 and 19 who receive an autism diagnosis and a 10-week training programme is offered to parents. Additionally, Alder Hey have a partnership with a community network to deliver a workshop to parents in order to explain the nature of autism and the available strategies. Since 2022, the Vanguard project has been available in Sefton in order to coach and support individuals following an autism diagnosis, including those who are vulnerable to becoming involved in criminality and who are at risk of exploitation.[1359] Accordingly, although I was concerned by the lack of post-diagnosis support available in 2021, I was reassured by the evidence that this is no longer the case and that much more extensive post-diagnosis support is now provided.

Immediate action

CAMHS' record keeping

348. I have set out my significant concern that the CAMHS electronic patient record failed to provide CAMHS clinicians with a clear distillation of the key information regarding the risk AR posed to others. In other circumstances, I would have raised this directly as a recommendation to Alder Hey. However, Ms Boggan gave evidence that the risk assessment information is now collated in a single

1357 T/S: 26/33/1-34/2.

1358 Closing Statement on behalf of NHS England NHS000574.

1359 Witness Statement of Ms Cooper AHCH000328/§§16-17; T/S: 25/79/6-82/3.

document, as the first screen of the electronic record.[1360] The relevant historic and recent information, therefore, is now set out in the same place. As a result, the long list of matters of which Dr Ramasubramanian and Dr Molyneux were unaware would now be displayed together, at the front of the case record. There is, additionally, a neurodevelopmental risk assessment for evaluating risk in the ASD service. This sits alongside the CAMHS risk assessment. There is a monthly audit to ensure that the records are being properly maintained, including by way of sharing information with outside agencies (e.g. GPs and schools). I was also reassured by Ms Boggan that significant improvements have been made as regards the old practice of scanning records. Documents are no longer scanned but instead they are simply uploaded directly onto the system and they are *"directly visible"*.[1361]

349. Given the extent of the improvements that have been implemented in this context by this particular Trust, I do not make a recommendation to Alder Hey. It is notable, however, that Alder Hey have only made these improvements relatively recently. Accordingly, I am concerned as to whether this learning and improvement has been replicated nationwide.

Recommendation 50: The Department of Health and Social Care / NHS England should ensure that all healthcare trusts involved in the care of children and young people who are at risk of acts of violence against others have systems that ensure that:

1. Key information regarding current and historic risk information is readily visible to treating clinicians in a summarised form, where appropriate with suitable warning flags.
2. Where information comes in from other agencies that is relevant to the risk of violence to others, there are robust systems to ensure that the material is uploaded to or available on their own electronic patient records. Single points of failure leading to risk-relevant communications failing to be scanned need to be designed out.

FCAMHS: approach to tools for the structured assessment of risk

350. I remain concerned at the complex (and to some extent still unclear) picture as to whether the local CAMHS service or FCAMHS 'owns' the responsibility to carry out a detailed structured risk assessment (such as SAVRY, although I stress that other tools may be appropriate in different cases).

351. Dr Killen indicated that CAMHS did not have staff trained in using SAVRY, and they would usually refer the individual to FCAMHS for an assessment to be completed.[1362] Dr Ramasubramanian similarly suggested that a SAVRY

1360 T/S: 25/91/13-96/12.
1361 T/S: 25/91/23-92/8.
1362 T/S: 24/199/21-200/6.

was a highly specialised and standardised risk assessment tool that requires training and regular supervision in order for an assessment to be completed and the results interpreted. CAMHS staff were, she suggested, not equipped or trained to undertake this task.[1363] CAMHS therefore considered this was something for FCAMHS to undertake. Mr Hicklin said that FCAMHS would do a SAVRY *"sort of … alongside local services and agencies that were able to take forward any outcome…"* and that FCAMHS' role would be a supporting one.[1364] However, in the FCAMHS joint corporate statement, it was averred that FCAMHS do not accept responsibility for assessing a young person's risk or implementing a risk management plan.[1365] This assertion is to be contrasted with Ms Brown's evidence, namely that when it came to assimilating the SAVRY inputs and scoring structure, it was likely that FCAMHS undertook that role, and FCAMHS would work alongside another agency to assist in scoring and assessing the SAVRY.[1366]

352. I am grateful for the supplementary evidence that FCAMHS have provided following the end of the Phase 1 oral hearings in an attempt to clarify this conflicting evidence. Ms Brown has suggested that, *"FCAMHS supports the lead agency (referrer or lead professional) in refining overarching risk assessments and management plans, using evidence-based tools as required. FCAMHS does not independently complete or own the risk assessment for the locality-wide system"* (emphasis added).[1367] However Dr Imran's supplementary statement provides a more nuanced position, indicating that where a direct assessment is carried out by FCAMHS and they consider SAVRY would be an appropriate tool, then *"the FCAMHS practitioner will then author and complete the SAVRY…"*. In cases where FCAMHS provides only consultation and advice, Dr Imran suggests the responsibility to author and update the risk assessment *"remains with the referring agency…"* such that *"CAMHS or Youth Justice may agree to author and complete the SAVRY…"*. In the latter case, *"FCAMHS will remain involved in an advisory role using a partnership approach to enhance professionals' skills, for example, in completing the factorial analysis, formulation and/or recommendations from SAVRY"*.[1368]

353. While I understand the distinction which Dr Imran seeks to draw, the complexity of the arrangement she describes when set against the oral evidence of CAMHS witnesses (who did not appear to understand the position in this way), leads me to conclude that there remains significant room for confusion as regards who should actually take responsibility for the completion of the SAVRY or other structured risk tool.

1363 T/S: 24/147/13-148/20.

1364 T/S: 25/106/8-107/10.

1365 Joint Witness Statement of Dr Imran and Ms Brown GMMH000015/§22.

1366 T/S: 25/172/16-175/19.

1367 Second Witness Statement of Amanda Brown GMMH000017/§9.

1368 Second Witness Statement of Dr Imran GMMH000016/§§4,9.

354. Accordingly, I make recommendations at the local and national level:

> **Recommendation 51:** At the local level, Greater Manchester Mental Health NHS Foundation Trust should liaise with all of the relevant community healthcare organisations (including Child and Adolescent Mental Health Services and Criminal Justice Liaison Services) to ensure that there is clarity about who is responsible for conducting complex structured risk assessments for children and young people who present a risk of violence to others.

> **Recommendation 52:** Nationally, the Department of Health and Social Care and NHS England should review:
> 1. Whether there is a need for further development and guidance including on the thresholds for when complex structured risk assessments (such as the Structured Assessment of Violence Risk in Youth) are required for children and young people who present a risk of violence to others. A balance may need to be struck between sufficient provision of guidance to assist as to when the more complex type of structured risk assessment may be justified and retaining the case-specific judgements by professionals that are inevitably required.
> 2. Whether national guidance is required to ensure clarity about who is responsible for conducting complex structured risk assessments (where they are appropriate) for children and young people who present a risk of violence to others. Consideration should also be given to the roles of children and young people's mental health services and wider children's services in conducting or referring for appropriate risk assessments.

355. I should record that Ms Brown indicated by way of subsequent improvements not already set out above that there is now an improved system for GMMH's FCAMHS to ensure that communications intended for professionals in other agencies are sent. They have improved, additionally, the clarity and readability of their communications. FCAMHS are now able to conduct autism assessments. They have recruited new staff in the fields of autism, speech and language therapy. They have appointed a strategic safeguarding lead.[1369]

1369 Joint Witness Statement of Dr Imran and Ms Brown GMMH000015/§33; T/S: 25/195/11-197/11.

CAMHS and FCAMHS: responsibility for carrying out agreed actions

356. I have addressed in this chapter the concern that Mr Hicklin's letter of 11 February 2020 had recommended two actions which were never completed, yet both CAMHS and FCAMHS nonetheless took steps to close AR's case.

357. Ms Brown's evidence was that FCAMHS have improved, in the sense of ensuring that action recommendations are SMART-compliant, that is to say specific, measurable, achievable, relevant and time-bound.[1370] Dr Irani stressed the importance of ensuring that healthcare related actions make clear, in a SMART-compliant way, who is meant to carry out the action or the required review. She similarly stressed the importance of SMART-compliant actions as part of a management plan following a structured risk assessment.[1371] The wider, longer-term solution to the problem of agencies working without a clear lead agency is a matter that requires consideration in Phase 2. But immediate action can – and I consider should – be taken in the healthcare sphere to ensure that the agreed actions are SMART-compliant. It is essential that responsibility for actions are clearly ascribed to a person or at least a team of clinicians, to avoid confusion as to who is responsible for their implementation.

358. While I am encouraged that GMMH has identified the need for improved quality as to how action points are recorded (including at the point of case closure or discharge from FCAMHS), it is important that this is embedded and is consistently implemented.

359. I make recommendations at the local and national level:

Recommendation 53: At the local level, Greater Manchester Mental Health NHS Foundation Trust and Alder Hey Children's NHS Foundation Trust should by no later than 13 October 2026 carry out and report on a joint audit to ensure that for cases involving both Trusts, the action points from multi agency meetings, healthcare meetings, discharge plans and management plans after risk assessments are being recorded in a SMART-compliant (specific, measurable, achievable, relevant and time-bound) way.

Recommendation 54: Nationally, the Department of Health and Social Care and NHS England should consider whether nationwide guidance should be issued on the importance of action points from all relevant meetings involving healthcare agencies, discharge plans and management plans after risk assessments being recorded in a SMART-compliant (specific, measurable, achievable, relevant and time-bound) way.

1370 T/S: 25/181/12-182/14, T/S: 25/195/19-22.

1371 T/S: 26/24/9-22, T/S: 26/34/10-14, T/S: 26/81/12-82/3.

Recommendations for matters to be further considered in Phase 2 of this Inquiry

360. I make the following recommendations for areas that I consider require wider scrutiny and consideration in Phase 2 of this Inquiry.

Multi agency working

361. There was considerable confusion as to which was the lead agency as between FCAMHS, CAMHS, the CJLDT and any other relevant non-healthcare agency. I do not make a separate recommendation on this issue in this chapter as this is covered by the recommendation made in Chapter 1: Fundamental problems. In the current context I would, however, underline that this recommendation includes the need for a significant cultural change to ensure that the relevant agencies are prepared to own and manage risk appropriately, as opposed to referring it on to others or simply assuming that other agencies have taken on this responsibility. This problem was particularly evident in the context of healthcare, as exemplified by the failure to conduct a structured assessment of AR's risk to others, leaving it to others to undertake this critical task.

Waiting times and funding

362. At the local level, the evidence from Ms Boggan indicated that there have been certain improvements in relation to how long ASD assessments take, although she indicated that nationally waiting times for assessment are, in many areas, in excess of 12 months.[1372] Ms Cooper, the Director of Community and Mental Health Services at Alder Hey has provided supplementary evidence regarding the recent changes to the referral and assessment process arising from the single Alder Hey Neurodevelopmental Service, which include a process by which an autism assessment will be prioritised when there is a concern about criminality and a risk to others, by way of a comprehensive triage process.[1373] This opportunity for escalation is assisted by the use of a risk stratification tool, which provides a fast-track for urgent cases. There is also now a specific assessment pathway for those young people who are already open to CAMHS, ensuring that the relevant information is quickly gathered and that there is an early appointment with a consultant psychiatrist and a speech therapist. A diagnosis may be reached at that stage.[1374] Although I remain concerned as to the overall national picture in relation to how long assessment of children and young people for ASD can take (see further below), I am satisfied that currently in a similar case with this trust, the assessment for ASD will be expedited.

1372 T/S: 25/56/23-57/6.

1373 Witness Statement of Ms Cooper AHCH000328/§22; AHCH000333/10.

1374 T/S: 25/82/9-83/25.

363. Looking at the wider national position, I am mindful of the political aspects of healthcare funding. This inevitably involves the allocation of necessarily finite resources across competing priorities. Nevertheless, the involvement of the healthcare agencies in AR's case has highlighted:

    a. The long wait for neurodivergence assessments (a national issue on the back of surging demand). Autism is not, of course, of itself a 'treatable' condition but a neurodivergence. However, without overlooking the fact that AR was prone to reject individual therapy when offered, it was clear from the evidence of Ms Boggan that there is a need to ensure there is greater dedicated training and specific psychological interventions within CAMHS, which are tailored for children with autism;[1375]

    b. The limitations on the involvement of FCAMHS in that they are neither funded nor commissioned to act as a lead agency, and limited in the direct interventions they can provide;

    c. A service gap regarding violence fixated children/young people who do not have a serious mental health disorder, but who would benefit from psychological intervention to mitigate the risk that they pose.

    On the third aspect, Ms Brown and Dr Imran cautioned that *"There appears to be a gap in service offer for children and young people who display high-risk behaviours, in the absence of a mental health disorder, who would benefit from structured psychological intervention"* They noted that FCAMHS is not commissioned or resourced to provide this and only exceptionally can CAMHS take on these cases if approved by the local integrated care board.[1376]

> **Recommendation 55:** Phase 2 should consider the ability of community and forensic mental health services to deliver clinical interventions to mitigate the risk from violence fixated children and young people.

Mental Health Act Assessments: gap in assessment powers

364. I have set out Dr Irani's view that AR should have been subject to a Mental Health Act assessment. Underlying Dr Irani's view was that AR's case was highly concerning because he had not been physically seen for a considerable period of time by a mental health professional (or indeed by other professionals). He was, instead, essentially locked away in his own room, refusing to meet with professional visitors. However, the challenge in this area is that the likely assessment of AR at this stage would have been that there was a lack of evidence that he was suffering from a recognised mental illness (such as severe depression or psychosis) which was potentially treatable in a psychiatric hospital. On that basis there was no Mental Health Act power to assess AR.

1375 Witness Statement of Ms Boggan AHCH000252/§88.

1376 Joint Witness Statement of Dr Imran and Ms Brown GMMH000015/§34; T/S: 25/197/12-199/1.

Accordingly, Dr Irani accepted that the decision not to carry out a Mental Health Act assessment was a reasonable exercise of professional judgement. As NHS England have observed in their closing statement, the use of a Mental Health Act assessment in such a situation represents only an imperfect solution. In reality, such as assessment may have required a somewhat artificial justification relying the possibility that AR may have been psychotic when isolating himself in late 2023 to early 2024, even though no clinician had considered that was the case, or had raised it as a possibility at any stage since AR was first arrested in December 2019. Indeed, even then, on examination, psychosis was ruled out. As both Dr Irani and NHS England acknowledge, this gives rise to a wider and difficult question as to whether there is a gap in the legislation. There is a risk of a cohort of cases (of which AR was arguably one) where mental health clinicians cannot assess a child or young person in the community despite the fact that they have completely self-isolated at home, are not attending education, have mixed neurodivergence and anxiety conditions (or similar) with marked risks of violence, and are not meeting the current thresholds for a Mental Health Act assessment. The issues to which this give rise are complex and beyond the scope of the Inquiry's Phase 1.[1377] I therefore make the following recommendation for matters to be covered in Phase 2:

Recommendation 56: Phase 2 should consider whether further legislative change is required to allow mental health clinicians to assess children and young people who are isolated from professional support and may pose a risk of violence, particularly where powers under the Mental Health Act 1983, as amended by the Mental Health Act 2025, do not permit assessment or detention.

Public Sector Shared Risk Assessments

365. As regards wider issues of risk assessment, I note that Dr Molyneux advocated a "unified system.[1378] There was a wealth of important information about AR that was known to other agencies that was not available to Dr Molyneux, unless active steps had been taken to request information. Dr Irani noted that it was unclear whether the different agencies knew who to approach for different aspects of AR's care and risk. In Chapter 1: Fundamental problems, I have already recommended that Phase 2 should consider the development of a shared multi-agency risk-assessment tool that is clear, accessible and suitable for use across public sector services.

1377 I note in particular that NHS England have flagged the interplay with: (a) the Mental Health Bill (now enacted as the Mental Health Act 2025) which once the relevant provisions are brought into force, will introduce changes to prevent people being detained under section 3 MHA on the basis of autism or learning disability alone; (b) Care (Education) and Treatment Reviews; and (c) the existing power under s135 of the MHA.

1378 T/S: 24/88/12-89/24.

Chapter 11

Education

Introduction

1. This chapter addresses key themes in how AR's three schools dealt with AR. It also addresses the local authority's involvement in AR's attendance and the sharing of information.
2. As regards the three schools, many of the events referred to this in chapter have been addressed in some detail in earlier chapters of the report or are addressed in Chapter 12: AR's family, which follows this chapter. I do not extensively rehearse the same level of detail in this chapter but cross-reference the content of other chapters where necessary.
3. I have erred in favour of including relevant detail in other chapters of the report because, with a few important exceptions, I am satisfied that in many respects, AR's three schools did much that was creditable.

Range High School

4. Range High School in Formby, Sefton, Merseyside is a secondary comprehensive academy school for pupils aged 11 to 18. From September 2019, its headteacher was Mr Michael McGarry.[1379] Mr David Cregeen was AR's Head of House (until July 2019) and thereafter the designated safeguarding lead (DSL) (and later assistant headteacher).[1380] AR joined Range High School at the normal transition point (the start of year 7) on 4 September 2017. AR was permanently excluded from the school in October 2019 after disclosing to Childline that he had repeatedly taken a knife into the school. AR returned to Range High School on 11 December 2019 where he violently attacked another pupil with a hockey stick.
5. As I expand upon in this chapter, Range High School acted entirely appropriately in permanently excluding AR. Notwithstanding the exclusion, they remained involved in multi-agency meetings for some time, seeking to ensure continuity and that other agencies were informed. While AR's father, Alphonse R, accepted AR's account that he was subjected to sustained bullying at this school, for the reasons addressed in this chapter, I do not accept that this was the reality.

The Acorns School

6. The Acorns School in Ormskirk, Lancashire is a Pupil Referral Unit (PRU) for pupils aged 11 to 16. It offers alternative education provision for children who are unable to attend mainstream school for various reasons, including those like AR who have been permanently excluded from mainstream schooling for violent conduct. It has a small roll (around 100 pupils) and

1379 Witness Statement of Mr McGarry RAN000039; T/S: 26/171/21-204/22.
1380 Witness Statement of Mr Cregeen RAN000036; T/S: 26/205/6-27/33/10.

aims to provide a supportive environment to allow children to continue their education while addressing the reasons they are unable to be in mainstream schooling. While some children are taught onsite, higher risk pupils are taught offsite. AR joined The Acorns School following his permanent exclusion from Range High School and he was on The Acorns School roll from 17 October 2019 to 28 March 2022. In April 2022 (mid-way through year 11) AR then moved to Presfield High School.

7. At the time AR joined the school, the headteacher was Mrs Jane Eccleston. Mrs Eccleston was absent for some periods in 2019 to 2022, during which time the then deputy headteacher Mrs Joanne Hodson was acting headteacher.[1381] Mrs Hodson took over as substantive headteacher from 15 July 2022; I emphasise that I consider she was a highly impressive witness. Mrs Janet Lewis was the DSL and Pupil Support Manager.[1382] Mrs Maggie Allred was a High Support Teacher at The Acorns School who supported AR on a one-to-one basis from July 2020 onwards; as such, she was a teacher who had significant insight into AR's behaviour.[1383] She said of him, *"AR's risk was very unique. He was the most complex child I have ever taught and pushed [my] professional skills to the limit. It was unusual for a child to be so academically able and articulate with such low social maturity and underdeveloped social skills. He could be highly manipulative which was relevant in determining how to teach him. It was important to be very calm and measured with him"*.[1384]

8. In broad overview, The Acorns School were rightly concerned at the risk that AR posed to others. The school was steadfast in their efforts to raise their anxieties with other agencies, often – regrettably – with limited success. They made the three Prevent referrals. They worked hard to seek to facilitate AR's greater engagement, notwithstanding the challenges of the attitude adopted by both AR and his parents (particularly Alphonse R). This chapter addresses some individual areas where there were some (I find limited) shortcomings in The Acorns School's approach, but these must be seen in the context of their otherwise overwhelmingly positive contribution.

Presfield High School

9. Presfield High School in Southport, Sefton, Merseyside is a community special school for pupils aged 11 to 19 with a diagnosis of autism spectrum disorder (ASD). It had a small roll count (around 125). The school offers tailored education to address specific needs laid out within an education, health and care plan (EHCP). As noted above, AR joined Presfield High School part way

1381 MERP000509; First Witness Statement of Mrs Hodson LCC001773; Second Witness Statement of Mrs Hodson ACO000004; T/S: 27/91/4-208/19.

1382 MERP000772; Witness Statement of Mrs J Lewis LCC001774; T/S: 27/33/15-90/25.

1383 MERP000786; Witness Statement of Mrs Allred LCC001709.

1384 Witness Statement of Mrs Allred LCC001709/§66.

through year 11 (aged 15) and was put onto the roll there on 28 March 2022. AR barely attended Presfield High School and he was formally taken off the roll on 27 June 2024, a little over a month before the attack.

10. When AR was nominally attending Presfield High School, Mr Anthony Fay was initially the headteacher (to April 2023).[1385] Mrs Lucy McLoughlin was deputy headteacher and then (from May 2023), headteacher.[1386] For the material period, Mrs Cheryl Smith was Presfield High School's DSL and an assistant headteacher from September 2023, and later deputy headteacher.[1387] The Inquiry received written evidence from a number of other Presfield High School staff.[1388]

11. In the circumstances detailed in this chapter, there was a marked failure by Presfield High School in processing and considering the information provided by The Acorns School as to AR's risk. In other circumstances, this failure could have had material and serious consequences because the school was not sighted on the full picture as to AR's dangerousness. However, since AR barely attended Presfield High School and did not perpetrate any kind of violence there, in the event no harm came of this failure. Presfield High School made extensive efforts to encourage greater attendance by AR and were not at fault for AR's very poor attendance while AR was on their roll. With AR hardly visiting the school, and Presfield High School seeking to remove AR from the roll as a result, the local education authority (Lancashire County Council (LCC)) should have stepped in.

The wider education structure: the local education authority and the Department for Education

12. Both Range High School and Presfield High School were within the Sefton Metropolitan Borough Council (MBC), while The Acorns School was within the Lancashire County Council area. As noted in the other chapters, the family home was in Lancashire. As such, it was therefore LCC who held the relevant local education authority responsibilities for AR. Although the details vary somewhat by school type, the individual schools had a large degree of autonomy and were responsible for the quality of their school provision, with inspections carried out by the Office for Standards in Education, Children's Services and Skills (Ofsted).

13. However, the local authority retains an important role. LCC had safeguarding and welfare responsibilities for AR, which extended to ensuring that he attended school (while of compulsory school age) and for providing an EHCP.

1385 Witness Statement of Mr Fay PRE001809.

1386 MERP001163; MERP000931; Witness Statement of Mrs McLoughlin PRE001808; T/S: 28/1/3-52/15.

1387 First Witness Statement of Mrs Smith PRE001806; Second Witness Statement of Mrs Smith PRE001811; T/S: 27/209/6-246/19.

1388 Witness Statement of Mr Berry (teacher) PRE001805; Witness Statement of Mrs Dawson (head of sixth form) PRE001807; Witness Statement of Mr Rigby (teacher) PRE001812.

14. Since February 2024, Mr Paul Turner has been LCC's Director of Education, Culture and Skills with overall strategic responsibility – under the Director of Children's Services – for education, culture and skills.[1389]

15. Mr Turner explained that the council's education department had roles and responsibilities including:

    a. Monitoring and advising in respect of permanent exclusions;

    b. Providing advice to parents following permanent exclusions;

    c. Brokering online education or face-to-face tutoring for children who are unable to attend school;

    d. Supporting schools with attendance matters;

    e. Monitoring children who are missing from education;

    f. Issuing attendance proceedings and fixed penalty notices;

    g. Providing training to schools;

    h. Monitoring the quality of education provision in schools; and

    i. Working with children who are electively home educated.

16. The inclusion department's roles and responsibilities included:

    a. Processing EHCP assessments, plans and reviews (I note in this respect that responsibility for an EHCP rests with the area where the child is resident);

    b. Arranging educational psychology assessments;

    c. Providing specialist teacher support for Special Education Needs and Disabilities (SEND) and preventing exclusion;

    d. Procuring and commissioning alternative education provisions; and

    e. Commissioning and arranging specialist placements for children and young people with an EHCP.[1390]

17. The difference between the education department and the inclusion team reflected the education department's responsibility for such matters as school improvements and school standards, while the inclusion team was focused on children missing from education, and those with special educational needs and disabilities. Supporting those who were missing from education came under the ambit of both the education and inclusion teams. Accordingly, there was a clear 'crossover' in order to monitor the welfare and education of the relevant children. Mr Turner (who was not in post for most of the material time) accepted that there was a significant risk of information becoming fragmented and lost when it was shared between so many different teams.[1391]

1389 Witness Statement of Mr Turner LCC001802; T/S: 26/104/6-171/10.

1390 Witness Statement of Mr Turner LCC001802/§§8-9.

1391 T/S: 26/106/2-107/8.

18. I address the detail regarding school attendance below in looking at AR's time at both The Acorns School and Presfield High School. I note however that, as regards Presfield High School, one of the complications was that in reality when a child living in Lancashire attended a Sefton-based school, Sefton MBC would normally carry out the school attendance responsibilities, because they had access to the relevant school register information.[1392]

19. Mr Turner's evidence painted a concerning picture in which, despite the profound difficulties experienced by The Acorns School and Presfield High School in getting AR to engage in education or even just attend school, LCC did not intervene or provide support in relation to AR's placement. LCC recognised that for a period of two years from 2022, AR was effectively without education and LCC did not intervene to address this, a failure which they ascribe to a lack of resource at the time.[1393]

20. At the apex of education policy, the Department for Education (DfE) has overall responsibility for setting the policy, accountability and regulatory framework for the education and training system in England. Ms Kate Dixon gave corporate evidence to the Inquiry in her role as the DfE Director of Strategy and Safer Streets, with responsibility for national policy in education settings including countering extremism.[1394] While DfE sets the policy framework, including extensive statutory and non-statutory guidance, operational delivery is substantially devolved to the local level, namely to the individual schools and the local education authorities. The DfE has recognised that the evidence in this Inquiry indicated a degree of confusion as to which local authority was responsible for attendance monitoring and for the Child Missing Education processes in 'cross-border' cases. DfE maintains, however, that its own guidance is clear that responsibility remains with the location authority for the area where the child lives (in this case LCC).[1395]

Key events: Range High School

21. As I address in Chapter 12: AR's family, AR would ordinarily have moved to Christ the King, a local secondary school in Southport, for his secondary education. His family, instead, chose Range High School because AR's brother Dion R had become wheelchair bound and Range High School, being a largely single storey site with extensive disabled access, specifically catered for children with physical disabilities.[1396]

1392 T/S: 28/68/18-70/4, T/S:26/115/23-118/5.

1393 Closing Statement on behalf of Lancashire County Council LCC002314/4-5/§9.

1394 Witness Statement of Ms Dixon DFE000256; T/S: 28/53/8-148/22; Follow up letter DFE000260.

1395 Closing Statement on behalf of the Department for Education DFE000258/5/§17.

1396 Witness Statement of Alphonse R IWS000058/§14.

AR's initial good behaviour in years 7 to 8

22. While AR appears to have felt a degree of resentment at moving to a school that was not his choice and not where most of his peers had gone, he appears to have settled reasonably well at Range High School. Mr McGarry and Mr Cregeen both gave evidence to the effect that in years 7 and 8 (that is to say September 2017 to July 2019), AR's behaviour, attendance and attainment were generally good.[1397]

23. For year 7, AR's attendance was 98.15%, and his end of year reports, *"showed his performance to be on, or slightly below target for the academic year"* with *"... no reports that AR exhibited any major behavioural concerns"*.[1398] AR's form tutor commented that he was a quiet member of the tutor group, who was friendly with most of the boys in the group, and he had achieved 187 merits for positive contributions.[1399] AR did not come to Mr Cregeen's attention in the latter's capacity of head of house at this stage save in a positive way.[1400] Alphonse R agreed that AR's year 7, his first at Range High School, seemed to go well.[1401] Dion R said that AR did not know anyone at Range High School before starting and went through a period of being upset but this subsided once he settled into year 7, and he then had a small number of friends who he would speak to and trusted.[1402]

24. In year 8, AR's attendance was lower but not of particular concern, at 94.97%. Insofar as there were some problems these tended to relate to AR being easily distracted and receiving detentions. Mr Cregeen said that this related to *"…not listening to the teachers, not submitting homework on time, etc"* and was not unusual for students of his age. Thus, AR's performance indicated, as Mr Cregeen summarised it, *"no major issues"* or *"significant underlying issues of concern"*.[1403]

Poor behaviour and allegations that AR was bullied

25. Notwithstanding that AR's performance and behaviour remained largely unremarkable in year 8, there were the first signs of change towards the end of that academic year.

26. Indeed, these problems that had undoubtedly begun to emerge in the latter part of year 8, escalated significantly in the first term of year 9. AR started to speak of his perception that he was being bullied.[1404] Alphonse R put all of

1397 Witness Statement for Mr McGarry RAN000039/§§12-13.
1398 Witness Statement of Mr Cregeen RAN000036/§15.
1399 MERP000898/3/§11.
1400 Witness Statement of Mr Cregeen RAN000036/§94.
1401 Witness Statement of Alphonse R IWS000058/§17.
1402 Witness Statement of Dion R IWS000060/§15, §17.
1403 Witness Statement of Mr Cregeen RAN000036/§16, §18.
1404 Witness Statement of Mr McGarry RAN000039/§§14-15.

AR's behavioural change down to the fact that this had occurred.[1405] As I have addressed in more detail in Chapter 12: AR's family, this was – on any view – wholly unrealistic.

27. Mr Cregeen and Mr McGarry were able to give some details in relation to relevant events in the latter part of AR's year 8:

    a. In April 2019, AR reported an incident where he alleged that another student had told him that a third student had used a derogatory and racist term while referring to AR. Mr Cregeen got the respective heads of house to investigate the claim and it was not substantiated;[1406]

    b. In June 2019, Alphonse R was in correspondence with the school concerning the detentions AR had been receiving. As was typical of Alphonse R's approach, he very much took AR's side arguing that: *"[we] have a concern regarding [AR's] detentions in relation to classroom behaviour. It seems to us that certain teachers are quick to send him in detentions when other children in similar situations get away with it, which makes [AR] and his friends feel he is unfairly targeted. We are bringing to your attention what happened today in period 5 ... We believe that [AR] picked the punishment that is way beyond the situation for something that he should not have been punished for. We would be grateful if you could review the way [AR] is punished. Our main concern is the effect that seemingly unfair punishment has on him"*.[1407] Mr Cregeen sought details from the teacher concerned but also replied noting that: *"I haven't ignored the issue of detentions, but this is [AR's] perception, not that of the teachers. Next week, I will ask teachers to comment on [AR's] behaviour in classes and I will report back to you with their feedback, as this appears to be different to [AR's]. As previously mentioned, I would appreciate it if you would review comments on Class Charts and discuss these with [AR]. Any concerns can then be taken up directly with the member of staff concerned. In the meantime, [AR] can discuss any concerns with me, or his class tutor"*.[1408] It is notable that none of these issues at this time were ascribed to any concern around bullying. It is also relevant that teachers were already noticing a marked difference between AR's perception of events (adopted in turn by Alphonse R) and what teachers were actually experiencing. In this case, the teacher concerned responded individually indicating that AR's conduct had been *"completely inappropriate"* and that she had to speak to him on numerous occasions in recent months about

1405 Witness Statement of Alphonse R IWS000058/§23.

1406 RAN000023 row 3; Witness Statement of Mr Cregeen RAN000036/§17.

1407 LCC000106/8-9.

1408 LCC000106/8.

his behaviour, attitude and inappropriate comments or contributions in class discussions. Alphonse R continued to argue AR's case notwithstanding this;[1409]

c. On 18 June 2019, AR made comments in a religious education class regarding Jihad and the Manchester Arena bombing. AR made an observation to the effect that it was a *"good battle"*. AR's religious education teacher spoke to him at the end of the lesson and asked him what he had meant. AR stated that his response was from the viewpoint of the suicide bomber and those views were not his own. While reported to the then DSL, this comment was not immediately recorded formally (but it was reported on later in 2019 when other matters of concern arose). At the time, it seems that this was put down to being an isolated inappropriate comment. Mr McGarry said he was satisfied that it had been reported to the then DSL (Mr Cregeen's predecessor);[1410]

d. Against the background of the increasing detentions AR was receiving, Alphonse R requested the school to carry out a Special Educational Needs assessment for attention deficit hyperactivity disorder (ADHD).[1411] I have addressed this in the context of Chapter 10: AR's healthcare. The outcome of school screening was the view that AR was displaying poor behavioural traits rather than ADHD symptoms. A meeting was held on 9 July 2019, and this was reported to Alphonse R who disagreed with the assessment.[1412] Mr Cregeen is recorded as having fed back to Alphonse R the key findings from AR's recent report that supported the assessment findings. He refuted Alphonse R's suggestion that AR was being singled out. Alphonse R was not at this time on the school's 'Show My Homework' system and Mr Cregeen indicated this was going to be fixed so that he could help AR get organised, reduce detentions and improve his behaviour.[1413]

28. According to Range High School witnesses, AR's behaviour thereafter deteriorated rapidly in the first term of year 9. In particular:

a. On 20 September 2019, in an English lesson, AR started hitting another boy, reportedly, *"...in a very violent manner."* AR told the teacher that this boy (the first boy) and the boy who was later to be his intended target in the attack of December 2019 (the alleged bully) had been saying things to him and the first boy had been hitting his head. The first boy when questioned said that AR had been calling him *"fat"* (which he had also done earlier in the week) so he started tapping

1409 LCC000106/17.

1410 Witness Statement of Mr McGarry RAN000039§§17-20; Witness Statement of Mr Cregeen RAN000036/§56; T/S: 26/176/18-177/18.

1411 LCC000106/28.

1412 T/S: 26/215/24-217/20; RAN000023, row 7.

1413 RAN000023, row 7.

him on the forehead. The first boy also said that AR had been teasing him about a girl. The first boy denied that the alleged bully had said anything. AR was given a detention, but the teacher concerned suggested arranging a meeting in tutorial time for the three boys to resolve matters. Despite the other boys being prepared to do this, AR declined to be involved in the resolution meeting. It was recorded that Mr Cregeen was to alert staff that the boys should not be seated together in class;[1414]

b. At some stage in late September to early October 2019, AR made the comment, *"[t]hat's why teachers get murdered"*, in relation to having been given a detention. There was an after-the-event record of this by Mr Cregeen in the house log, when it was raised with Alphonse R.[1415] According to Mr Cregeen, AR had dismissed the severity of the comment when he was questioned on why he made it, saying he was simply referring to a comment made by another student, in reference to a teacher who had been murdered the previous year.[1416] There is evidence that while Alphonse R continued to argue about the fairness of – or confusion around – AR's repeated detentions, teachers explained that AR had been given clear information, was late with homework, was given additional chances, but still did not comply.[1417] He was also continuing to receive detentions for issues such as *"[d]istracting others by talking and making personal comments to other students"*;[1418]

c. On 3 October 2019, Alphonse R contacted Mr Cregeen, complaining that the alleged bully *"who threatens him did it again yesterday"* and asking Mr Cregeen to speak to the alleged bully.[1419] Mr Cregeen's written contemporaneous reply (Saturday, 5 October 2019) was that he had forwarded the concern to the alleged bully's house and would contact Alphonse R when he had a reply.[1420] Mr Cregeen later told Alphonse R that both boys had been spoken to. The alleged bully suggested AR had stated they were going to have a fight but they were only *"messing"*. He also claimed that AR had *"said unpleasant things about his mum. He said he later asked why [AR] had said those things and [AR] said he didn't know and walked off"*.[1421] The outcome of the investigation was to ensure that the boys sat separately and for staff to remain vigilant;[1422]

1414 RAN000023, row 8; Witness Statement of Mr Cregeen RAN000036/§21.

1415 RAN000023, row 10; LCC000106/51; Witness Statement of Mr McGarry RAN000039/§24.

1416 Witness Statement of Mr Cregeen RAN000036/§34.

1417 LCC000106/43.

1418 LCC000106/49.

1419 LCC000106/50.

1420 LCC000106/51; RAN000023, row 10.

1421 MERP000898/5-6/§21.

1422 Witness Statement of Mr Cregeen RAN000036/§22.

d. The last incident in this period was that AR was involved in a fight with another student on 7 October 2019, leading to a temporary, fixed-term exclusion.[1423] Mr McGarry was notified of this incident and requested that both boys were sent home to give the school an opportunity to secure statements and investigate what had happened. This was not recorded on the house log.[1424]

29. It was in the evening of the same day, 7 October 2019, that Range High School was contacted by the Lancashire Constabulary following the disclosure made by Childline which I address further below. It is relevant to note that given AR was to say that he carried the knife into school because he was being *"pushed"* in corridors by the alleged bully, Range High School again spoke to the boy concerned. Range High School records show that the boy refuted the claims and said that AR had said some nasty comments to him about his mother having cancer.[1425]

30. Before turning to Range High School's response to the information from Childline, I would note the following in respect of the suggestion that AR was bullied at Range High School.

31. The first and most obvious point to raise in this context is that even if there had been any bullying of AR, his reaction to this (carrying a knife into school) was radically disproportionate. It cannot in any way justify what he did in October 2019 (repeatedly carry a knife into school) let alone what he did in December 2019 (when AR returned to Range High School after his exclusion to attack the boy concerned, armed with an adapted hockey stick and a knife). Because of this, it was neither necessary nor proportionate for the Inquiry to carry out a detailed investigation into the suggestion that AR was bullied at Range High School some five years before he carried out the attack. I (deliberately) did not – for example – take evidence from the boy who AR claimed was bullying him.

32. Second, I take into account that there was a relative weakness in Range High School's record keeping at this time. The school had been using a system of house logs to record incidents. Following the Ofsted inspection of November 2018 (which was, overall, one of *"requires improvement"*),[1426] the school moved to introduce new behaviour systems and an electronic system, 'Class Charts', but this was not, at the relevant time, being used for monitoring incidences of behaviour.[1427] This means that Range High School's recording of the events in 2019 was not as full as it should have been.

1423 Witness Statement of Mr Cregeen RAN000036/§23.

1424 Witness Statement of Mr McGarry RAN000039/§25.

1425 RAN000023, row 19.

1426 It included that, *"Pupils said that they know pupils who have experienced bullying and added that it is usually 'sorted out' by staff quickly and effectively. School leaders are unable to evaluate the effect of their efforts to reduce bullying, because they do not maintain adequate records."*: https://files.ofsted.gov.uk/v1/file/50048656

1427 T/S: 26/180/13-182/12.

33. Third, I take into account the evidence of AR's family. As I have noted, Alphonse R maintained that AR was being bullied at Range High School and ascribes his deteriorating behaviour to this. Dion R also said that he became aware that AR was being bullied in the latter part of year 8, but it is notable from his Inquiry Witness Statement that Dion R said that he *"learnt about it from my Dad who would tell me about it"*. AR did not discuss it directly with Dion R, nor did Dion R personally see any evidence of it.[1428] After AR was excluded from Range High School, Dion R suggested that some of his friends who had siblings in AR's year mentioned that it was *"widely known in his year group that AR was being bullied"*. In his oral evidence to the Inquiry, Dion R said he would hear this direct from the siblings.[1429] I have no doubt that AR did complain to his father that he felt he was being bullied and I accept Alphonse R's evidence that AR said such things. However, the issue is not whether AR said this at the time to his father, but what objectively was happening. Given AR's skewed perception of events, the fact that he complained he was being bullied carries relatively little weight. Similarly, I can attribute little weight to unspecific hearsay accounts of what Dion R's friends' siblings may have said some months later.

34. Fourth and relatedly, I consider it very significant that AR complained that he was being bullied at The Acorns School as well. There, however (as further detailed below under The Acorns School section of this chapter), the incident AR and his father both represented as a fight, was witnessed by teachers. What occurred was in fact merely a dispute between peers caused by AR having behaved inappropriately towards a teacher and leading to nothing more than short-lived *"jumper pulling"*.[1430] As I found in Chapter 12: AR's family, I am confident that AR substantially exaggerated his account of this incident. In relation to detentions, the same pattern could be seen. AR complained that he was being singled out but his teachers were clear that this was merely his perception when in fact he was not completing homework on time and was repeatedly acting inappropriately in class. AR was – in other words – an unreliable historian. Whether AR consciously exaggerated matters or merely perceived them in a skewed way that lacked objective justification, his own account of unfair treatment at the hands of another pupil cannot be relied upon in the absence of independent corroboration. While it was not tested before the Inquiry, I note also in this respect that the alleged bully's response was that AR had made derogatory comments to him. This is all consistent with a pattern whereby AR appeared to be both blind to his own role in provoking incidents, and prone to perceive relatively run of the mill schoolground-type disagreements as bullying.

35. Fifth, I have taken account of the evidence from the senior witnesses from Range High School. Mr McGarry, who was headteacher when AR was in year 9, recognised that every now and again things would happen in school (and still do), but he was clear as the incoming headteacher that this was not a school

1428 Witness Statement of Dion R IWS000060/§18; T/S: 32/194/21-195/7.

1429 Witness Statement of Dion R IWS000060/§19; T/S: 32/196/25-201/7.

1430 First Witness Statement of Mrs Hodson LCC001773/§56.

with a gang culture. While Dion R suggested that Mr McGarry as the new headteacher came in and tried to crack down on bad behaviour including the carrying of knives, Mr McGarry was convincingly clear that AR's own conduct in bring a knife into school was exceptional.[1431] His understanding was that the incidents that had been raised amounted to mutual name calling and *"tit for tat"*.[1432] Mr Cregeen said that the school did not have a general problem with bullying. He explained that there had been an issue with one year group. However, that was not AR's year group, and even in relation to that other year group, the problems did not relate to bullying. He said that that there was no issue with gang culture, and no culture of knife carrying.[1433] Mr Cregeen was pressed on whether bullying could have occurred and said *"There could have been incidents that were undetected but, from the investigations that we conducted, we found no evidence of that. Had we have done so, then we would have acted accordingly."* Mr Cregeen was also not aware of any credible information coming forward from other pupils after AR's exclusion to suggest that AR had been the victim of bullying. He thought that if there had been any systemic pattern of AR being bullied, the students would have got to know about it and would have informed the school.[1434]

36. Taking all these matters into account, I do not consider that Range High School had a particular problem with bullying, let alone gang culture or knife carrying. I cannot rule out that AR may have had difficulties with some other boys, including the boy he accused of bullying him during the end of year 8 and start of year 9. However, to the extent that such problems may have existed, I find they did not amount to a systemic course of bullying of AR since I consider the school would have become aware if that had been the case. Moreover, AR's skewed perception of events and propensity towards exaggeration means that any such difficulties are likely to have been more a case of mutual dislike and name calling between pupils than targeted bullying or other more serious behaviour. Further and in any event, nothing that happened between AR and one or more other boys at Range High School could conceivably have justified AR's own carrying of a knife, let alone his later attack at Range High School in December 2019.

AR reporting to Childline that he carried knives to school

37. The detail of these events is set out in Chapter 7: Policing. In summary:

    a. On 4 and 7 October 2019, AR contacted Childline about his perception that he was being bullied and made disclosures that in this context that he wanted to kill the other boy and had been carrying a knife to school;

1431 T/S: 26/185/12-188/17.
1432 T/S: 26/189/13-22.
1433 T/S: 26/211/10-213/4.
1434 T/S: 26/221/25-223/15.

b. Childline disclosed the nature of the exchanges to the National Crime Agency, appropriately applying the exception to their usual approach to confidentiality because of the risk of serious harm to a third party;

c. Lancashire Constabulary were informed and visited AR at home that night. He admitted taking a knife into school on about 10 occasions and said that he would have used the knife to kill if things got to a certain point with the bully;

d. Police Constable Alexander McNamee of Lancashire Constabulary correctly supplemented the automatic Operation Encompass referral by completing, that same evening, an online contact form on the Range High School's website and ensuring a telephone call was made in the morning.[1435]

38. To his credit, Mr Cregeen picked up this safeguarding contact despite it being after 10:00pm at night and he alerted the headteacher Mr McGarry that same night.[1436] Mr McGarry had been attending a conference and Mr Cregeen, with assistant headteacher Ms Vicky Ashworth, took the lead the following morning when AR consented to his bag being searched. No knife was found but AR admitted to bringing a knife in previously saying *"he was tired of being pushed around"*. AR also admitted that he would have used the knife to stab someone but that he would not bring one in again.[1437] Mr Cregeen was left in *"complete shock"* that AR had said that he was prepared to use the knife despite knowing the consequences of taking such action. AR had been calm when he said this, matter of fact, without emotion and expressing no remorse.[1438] AR was sent home with his father that day.

39. Range High School undoubtedly reacted appropriately in the immediate aftermath of the police report of AR repeatedly carrying a knife into school.

AR's exclusion from Range High School

40. Range High School thereafter moved rapidly to permanently exclude AR from the school. Mr McGarry as headteacher took that decision, although it was supported by Mr Cregeen and also needed approval from the school governing board and local authority. It took effect from 9 October 2019 and Mr McGarry wrote to AR's parents that day.[1439] Mr McGarry's justification was the severity of bringing a knife to school, the frequency with which it had been done, the fact that AR had stated he was prepared to use the knife, and the clear and immediate danger this presented to pupils and staff.[1440]

1435 As explained in Chapter 7: Policing, an Operation Encompass referral involved the direct transfer of information about a child from the police to their school. Full detail on Operation Encompass is set out in the Witness Statement of DI Marston LANC000407.

1436 Witness Statement of Mr Cregeen RAN000036/§§36-37.

1437 Witness Statement of Mr Cregeen RAN00036/§37.

1438 T/S: 26/228/9-230/6.

1439 MERP001170/1-3.

1440 Witness Statement of Mr McGarry RAN000039/§32, §36; MERP001170/1.

41. Alphonse R elected to make representations to the governing board when they met on 5 November 2019, but the board upheld the decision. In doing so they relied on the fact that AR had not just brought a knife to school but had stated that he was prepared to use it.[1441]

42. I have absolutely no doubt that Mr McGarry's decision to permanently exclude AR was the correct, indeed the only, justifiable course.

43. In evidence to the Inquiry, there was some attempt by Alphonse R and Dion R, to suggest that permanent exclusion did not have to be the result. Alphonse R said:

> *"I sought to challenge permanent exclusion because I knew how detrimental it would be to AR's education, life chances and wellbeing. I also believed that AR was carrying a knife because he was scared of being attacked, and while this does not justify his actions, I thought that it did not need to lead to permanent exclusion."*[1442]

Dion R said:

> *"Whilst I agree that Range High School had to take action to address AR's behaviour, I have wondered whether they tried to make an example of AR when they expelled him, rather than supporting him or trying to understand his situation. I say this because Range High School had received poor OFSTED ratings in December 2018 and there was a new headteacher, Mr McGarry, who started in September 2019, who, it was understood, was trying to crack down on bad behaviour including the carrying of knives, which I understood from friends was pretty common at our school. However, I understood that typically, if someone was caught carrying knife, they got a detention or suspension. I did not know of anyone who had been expelled for that before my brother."*[1443]

I return to Alphonse R's attitude to agencies including AR's schools and Childline in Chapter 12: AR's family. For present purposes it suffices to record that this evidence was not realistic. There was no evidence that pupils other than AR had merely received a detention or suspension for carrying a knife, and in any event, there were very aggravating circumstances in AR's case, given the frequency and stated intent. Mr Turner said that it was not unusual for pupils to be excluded for possession of a knife.[1444] Mr McGarry's evidence was that 99 times out of 100, carrying a knife into school would lead to a permanent exclusion.[1445] Ms Dixon said she saw nothing of concern in this decision in terms of process and procedure.[1446]

1441 Witness Statement of Mr McGarry RAN000039/§34.

1442 Witness Statement of Alphonse R IWS000058/§27.

1443 Witness Statement of Dion R IWS000060/§24; T/S: 33/3/2-6/11.

1444 T/S: 26/134/22-25.

1445 T/S 26/187/20-188/17.

1446 T/S: 28/65/12-66/1.

44. If there was any doubt at all about the correctness of the decision to permanently exclude AR, this was put beyond doubt by AR's later return to the school, when he trespassed on 11 December 2019 to seek to carry out a vicious attack on the alleged bully but instead attacked another pupil at random.

Referrals made by Range High School

45. I have addressed in other chapters of this report the significance of the referrals that were made by Range High School at this time.[1447] In summary:

    a. Lancashire Constabulary's involvement on 7 October 2019 had led to an automatic report to the LCC Multi-Agency Safeguarding Hub (MASH). However, on 8 October 2019 Mr Cregeen made his own referral to the MASH in support of the police's referral (he made it initially to Sefton MBC MASH but later forwarded it to LCC). Mr Cregeen appropriately selected this as a level 4 case using the thresholds I have explained in Chapter 9: Social care.[1448] Mr Cregeen stated that he made this referral because while the exclusion was necessary to keep the school safe, AR was also *"in need of a significant amount of support very quickly"*.[1449] Mr Cregeen said that the response from LCC was first that the school's referral was not required because they already had the police referral; and then that they had graded the incident as a level 2 and he was advised to forward his concerns back to the police. Mr Cregeen did make further contact with the police. He then went back to LCC on 14 October 2019. He provided them with further information and updated on the school's concerns.[1450] In taking this course, I consider that Mr Cregeen was plainly seeking to draw to LCC's attention important features about the significant risk that AR posed which supported the case for consideration of urgent support. He stressed that AR's actions were totally disproportionate to the treatment he claimed to have received; he alerted them to AR's comment about *"this is why teachers get murdered"*; he flagged AR's calmness and lack of remorse when asked about the knife. In Chapter 9: Social care, I have been critical of LCC for their lack of appreciation of the severity of the risk that should have been apparent from the information

1447 See Chapter 9: Social care for analysis of the MASH referral made by Mr Cregeen and for his later involvement in multi agency meetings; See Chapter 10: AR's healthcare for details of the CAMHS referral made by Mr Cregeen; See Chapter 7: Policing for analysis of whether Mr Cregeen was advised to make a crime report to Merseyside Police in relation to AR bringing knives into the school.

1448 RAN000005.

1449 Witness Statement of Mr Cregeen RAN000036/§72.

1450 LCC001894.

being provided by the police and by Mr Cregeen. In contrast, the reporting of Mr Cregeen on behalf of Range High School was entirely appropriate;

b. On 10 October 2019, Mr Cregeen also referred AR to Child and Adolescent Mental Health Service (CAMHS) via the Single Point of Access at Alder Hey Children's NHS Foundation Trust.[1451] This referral was closed by the Alder Hey Multi-Disciplinary Team Triage Referral meeting who recommended contacting the 'Targeted Youth Prevention Scheme'. Mr Cregeen was surprised and disappointed at this and did not consider this to be an appropriate route because it was more suited to gang violence.[1452] I have addressed the adequacy of the Alder Hey CAMHS response in Chapter 10: AR's healthcare. In the present context of the response of AR's schools, I should record that Mr Cregeen's referral to CAMHS was diligent and appropriate;

c. By bringing knives to school, AR had, of course, potentially committed criminal offences. From the point of view of Range High School, it was the police (Lancashire Constabulary) who had alerted them to AR's behaviour in the first place. I accept, therefore, that there would have been no immediate or obvious reason for them to have reported the matter to the police even allowing for the fact that the school was within the Merseyside Police rather than the Lancashire Constabulary area. As I have addressed in Chapter 7: Policing, PC McNamee said that he had, at some point, advised Mr Cregeen to report the matter to Merseyside Police. Mr Cregeen had no recollection of receiving this advice.[1453] For the reasons set out in Chapter 7: Policing, I do not think that it is likely that PC McNamee gave that advice to Mr Cregeen on 8 October 2019 or during that month. Mr Cregeen's details appear in PC McNamee's notebook in an entry on 5 December 2019 and I consider it likely that it was on that occasion that PC McNamee advised Mr Cregeen to report the matter to Merseyside Police. Mr Cregeen was a straightforward witness doing his best to assist the Inquiry. I entirely accept that he genuinely had no recollection of being advised to do this. I think the most likely explanation is that by 5 December 2019 (by which time AR had not been at Range High School for nearly two months), this would not have appeared an immediate priority. Thereafter – as I have set out in Chapter 7: Policing – it is likely that this advice became overtaken by the events of 11 December 2019. To the extent that this was something of a shortcoming on Mr Cregeen's part, I emphasise that Lancashire Constabulary (and PC McNamee) have accepted that they could have ensured that a crime report was submitted to Merseyside Police;

1451 Witness Statement of Mr Cregeen RAN000036/§40; LCC000377.

1452 T/S: 27/3/16-4/17.

1453 T/S: 26/233/4-234/19.

this was – in my assessment – more a policing matter than something for the school to resolve. Moreover, this one oversight by Mr Cregeen should be seen in the context of: (a) the diligent and responsible steps he had already taken; (b) the proactive role he continued to play despite AR's exclusion; and (c) the fact that it is perhaps understandable that this advice and task may have been overtaken by the attack at Range High School on 11 December 2019.

Passage of information from Range High School to The Acorns School

46. Having been permanently excluded from Range High School with effect from 9 October 2019, Range High School was responsible for continuing educational provision (in practice in the form of work to be completed at home) for the next five school days. From 16 October 2019, LCC became responsible for the ongoing provision of suitable full-time education for AR.

47. AR was placed on the roll at The Acorns School on 17 October 2019. Mr Turner explained that in the case of a child going to a PRU, LCC will provide to the PRU the information that is detailed on the permanent exclusion notification form sent by the previous school to the local authority.[1454] However, more information may become apparent on transition when schools transfer their safeguarding, pupil attendance, and attainment information.

48. I will address the transfer of safeguarding information between schools in greater detail in considering the later transfer between The Acorns School and Presfield High School, below. As regards the transfer of information between Range High School and The Acorns School, there appears to have been a slight delay in The Acorns School receiving the full safeguarding information about AR. However, this does not appear to have been of any causative significance because it was received by 22 November 2019.

49. Ms Dixon set out the national provisions which can be summarised as follows:[1455]

    a. When a pupil moves schools there is a statutory duty placed on local authority maintained schools to transfer data relating to that pupil to the new school. This duty is set out in the Education (Pupil Information) (England) Regulations 2005. The details of the information to be transferred are set out in Schedule 2 to the Regulations and technical recommendations for transferring the information are given in the Common Transfer File (CTF) specification;

    b. The data must be transferred within 15 school days of the pupil ceasing to be registered;

1454 Witness Statement of Mr Turner LCC001802/§20.

1455 Witness Statement of Ms Dixon DFE000256/§§376-382.

c. Where a pupil has been permanently excluded from school, the excluding school can (indeed, must) delete their name from the admission register once the review process has been completed and the permanent exclusion has been upheld. Once the pupil's name has been deleted from the admission register and the pupil has been registered at a new school, the CTF should be transferred within 15 school days of the pupil ceasing to be registered at the school;

d. The statutory exclusion guidance encourages schools to work collaboratively and transparently, especially during pupil transition, and it is considered good practice to share all relevant information with the receiving school; this should be done carefully and proportionately. The purpose of sharing exclusion information is not to prejudice the pupil's experience in their new setting, but to ensure that appropriate support and safeguards are in place;

e. In cases in which the exporting school does not know the school to which a pupil will move, they are nonetheless expected to load a CTF onto an area which can be searched by local authorities on behalf of schools who admit pupils but do not receive the CTF. Academies (and Range High School was an academy school) are not subject to this requirement but are expected to adhere to the protocols as a matter of good practice;

f. Paragraph 79 of the Keeping Children Safe in Education 2018 guidance sets out that in instances where children leave a school or college, the DSL should ensure that their child protection file is transferred to the new school or college as soon as possible.[1456] This should be transferred separately from the main pupil file, by way of a method of secure transit, and confirmation of receipt should be obtained. As Ms Dixon made clear, consideration should also be given in appropriate cases to advanced provision of safeguarding information, such as the transfer of information before the pupil starts at the new school.[1457] Thus, *"… the designated safeguarding lead should also consider if it would be appropriate to share any information with the new school or college in advance of a child leaving. For example, information that would allow the new school or college to continue supporting victims of abuse and have that support in place for when the child arrives"*.[1458]

1456 DFE000225/21/§79.

1457 T/S: 28/105/24-106/3.

1458 DFE000225/21/§80.

50. As to how the slight delay in The Acorns School receiving the full safeguarding information came about:

    a. On 11 October 2019, Mr Cregeen emailed LCC with a completed Pupil Exclusion Notification Form;[1459]

    b. On 9 November 2019, LCC wrote to Mr McGarry confirming that the review period for the permanent exclusion had ended and asking that Range High School forward AR's school file to The Acorns School and also to provide his CTF electronically to them;[1460]

    c. On 21 November 2019, Mrs Hodson from The Acorns School contacted Mr Cregeen noting their safeguarding concerns about AR. She said, *"I would be extremely grateful if you could supply any further information about the final incident or the events leading up to it. We haven't received the Headteachers report or any other supporting documentation to help us. I have attached the only information we were given"*;[1461]

    d. Notably, Mr Cregeen responded the next day attaching the information requested but commenting that this had been *"… forwarded to Lancashire several weeks ago"*. Mrs Hodson acknowledged safe receipt, so the information reached The Acorns School by no later than 22 November 2019;[1462]

    e. Mr McGarry's evidence was that as LCC assumed responsibility for AR (because it was a permanent exclusion case), Range High School provided all of the relevant documents to the local authority.[1463] Mr Cregeen said that it was not his experience that there would be a school to school transfer of safeguarding information in a permanent exclusion case. He was sure that the correct information had been sent to the local authority in the first instance (and then resent directly to The Acorns School when he later received Mrs Hodson's email).[1464] That is supported by the fact that his email of 22 November 2019 to Mrs Hodson contemporaneously referred to the information having been sent to LCC several weeks earlier.

51. There was no email audit trail to prove that Range High School had provided the CTF and safeguarding information to LCC; however, on the basis of Mr Cregeen's email of 22 November 2019 I think it likely that the school took this step. What appears to have happened is that Range High School provided the information to LCC, whereas LCC were expecting the information to be supplied school-to-school. While the latter expectation appears in line

1459 LCC001393; LCC001394.

1460 LCC001367.

1461 LCC001415/2.

1462 LCC001415/1-2.

1463 Witness Statement of Mr McGarry RAN000039/§62; T/S: 26/193/13-196/18.

1464 T/S: 27/20/14-22/12.

with the national guidance, it is of concern that there was such confusion about the appropriate routing of safeguarding and other pupil information. This may not have been helped by Range High School being late to adopt bespoke software for recording children's behaviour and safeguarding issues.[1465] I note that Mr Cregeen ensured that Class Charts software was introduced and later expanded to include this safeguarding functionality, rather than using the house log approach.

52. In the event, on this occasion the late transfer of information made no difference because the information was supplied on 22 November 2019. The Closing Statement on behalf of the DfE recognises that there is room to develop the Keeping Children Safe in Education guidance, and I return to this at the recommendations at the end of this chapter.[1466]

Further involvement of Range High School after AR's exclusion

53. Range High School inevitably had a degree of further involvement in relation to AR because he returned to the school to carry out the attack of 11 December 2019. Beyond this, however, Mr Cregeen maintained an involvement after the October 2019 exclusion. In particular:

    a. Mr Cregeen contacted The Acorns School to inform them of the 11 December 2019 hockey stick attack at Range High School;[1467]

    b. On 13 December 2019, Mr Cregeen informed The Acorns School of AR's earlier comment in the June 2019 religious education lesson concerning the Manchester Arena attack (see paragraph 27(c) above). Mr Cregeen had learned about this the day before. While it was poor safeguarding record keeping by Range High School that this had not been recorded formally at the time, Mr Cregeen acted quickly to pass it on once he was aware of it;[1468]

    c. Mr Cregeen attended the strategy meeting held on 17 December 2019 chaired by Mr Matthew Rowe of LCC;[1469]

    d. Mr Cregeen also attended the follow up strategy meeting on 6 January 2020[1470] and the further meeting on 4 March 2020;[1471]

1465 I note this was a different system to that used by The Acorns School (who used CPOMS software). Nevertheless, having the information on bespoke software rather than various house logs would still have facilitated better and easier data sharing.

1466 Closing Statement on behalf of the Department for Education, DFE000258/6-7/§20.

1467 Witness Statement of Mr Cregeen RAN000036/§54; First Witness Statement of Mrs Hodson LCC001773/§§60-61.

1468 Witness Statement of Mr Cregeen RAN000036/§§55-57.

1469 LCC000234; LCC001346/63; AHCH000162/8-10; See further Chapter 9: Social care.

1470 LCC001346/60-61; LCC000235; MERC000002/50; AHCH000162/13-14. These meetings are addressed further in Chapter 10: AR's healthcare and Chapter 9: Social care.

1471 LCC001346/58.

e. On 1 February 2021, Mr Cregeen passed on to The Acorns School the information about AR's Instagram post referring to Colonel Gaddafi that led to The Acorns School making the Second Referral to Prevent.[1472]

54. Mr Cregeen's proactivity in AR's case, which continued long after his exclusion, was good practice.

55. Range High School may have had a case for making a referral to Prevent themselves in October 2019 at the time of the exclusion.[1473] However, Mr Cregeen did not have the information about the comment concerning the Manchester Arena attack until 12 December 2019 (by which time The Acorns School had in any event already made the First Referral to Prevent). Given that Range High School were appropriately providing further information to The Acorns School as AR's new school and The Acorns School referred AR to Prevent (including the earlier events at Range High School), it is somewhat academic as to whether Range High School should have made their own earlier referral. However, I would note in this regard that these factors re-enforce the importance of schools having good record keeping in relation to all safeguarding information that may be relevant to the pupil's risk to others, and especially any terrorist or violence fixated concerns.

Key events: AR at The Acorns School

AR's admissions interview and early weeks at The Acorns School

56. AR and his parents attended an admissions interview at The Acorns School on 17 October 2019.

57. As Mrs Hodson explained, this proved to be a memorable meeting. In her statement to the Inquiry, Mrs Hodson said that:

> *"Where a pupil has been excluded from another education setting, I will typically ask them about the exclusion, not least to try and get a sense of the pupil's degree of contrition. During the meeting, I asked AR why he had brought a knife into The Range. He looked me in the eyes and said, 'to use it'. This is the only time in my career that a pupil has said this to me or behaved in a manner so devoid of any remorse. What also surprised me was that AR's parents did*

1472 See Chapter 8: Prevent and Counter Terrorism Policing; LCC001498/1-2.

1473 See the exploration of this issue with Mr Cregeen T/S: 27/9/23-15/9.

> *not flinch at this comment. His comment was said without emotion and there appeared to be no accountability for his actions which concerned me."*[1474]

Mrs Hodson was clear that this striking assessment reflected her genuine and literal impression formed at the time. It was not coloured by the tragic later events of 29 July 2024. Mrs Hodson said that she formed a very clear early impression of AR having a sense of injustice about what had happened at Range High School and that both AR and his parents viewed him as the victim of the incident rather than the perpetrator.[1475] She also concluded that AR had absolutely meant the comment he had made about having the knife to use it, and his presentation was one of the most unusual she had ever seen in a pupil.[1476]

58. I unhesitatingly accept Mrs Hodson's account of this meeting. For the reasons set out in Chapter 12: AR's family, to the extent that Alphonse R challenged her account and denied recalling that AR had said that he had taken the knife to Range High School to use it, I find Alphonse R's evidence entirely untenable.

59. As I have addressed in detail in Chapter 10: AR's healthcare, Mrs Hodson went on to make appropriate healthcare referrals to CAMHS seeking mental health support and investigation of the autism spectrum condition that she firmly considered AR was manifesting.

60. AR duly started attending The Acorns School on 28 October 2019 after the half term break. Problems soon emerged with AR's behaviour which led to the First Prevent Referral (see further below). It is notable, however, that prior to the hockey stick attack at Range High School on 11 December 2019, The Acorns School had been able to follow a programme of gradually transitioning AR into a meaningful school day. AR had a number of initial assessments. By 31 October 2019, he was assessed as being ready to join *"Willow group"*. On 1 November, AR was introduced to the pupils in the group, his tutor and his key worker. He was initially on a two-hour timetable from 4 November 2019. This increased to four hours per day from 11 November and extended again from 15 November to include staying for lunch.[1477] AR was able to join a school trip to Chester Zoo on 27 November 2019, which was successful with no issues concerning his behaviour.[1478] AR had one full day in December 2019.[1479] Despite the seriousness of the reasons for AR's permanent exclusion from Range High School, The Acorns School made an impressive start to normalise AR's school attendance and re-integrate him into the education environment.

1474 First Witness Statement of Mrs Hodson LCC001773/§13.

1475 T/S: 27/97/11-99/18.

1476 First Witness Statement of Mrs Hodson LCC001773/§17.

1477 First Witness Statement of Mrs Hodson LCC001773/§§19-22.

1478 First Witness Statement of Mrs Hodson LCC001773/§41.

1479 First Witness Statement of Mrs Hodson LCC001773/§19.

The First Referral to Prevent and AR's internet usage at The Acorns School

61. While AR was being gradually introduced to The Acorns School timetable as described above, his behaviour nevertheless caused significant concern. Even before the hockey stick attack at Range High School on 11 December 2019, this behaviour led The Acorns School to make the First Prevent Referral on 5 December 2019.[1480] I have addressed the events that caused this concern in earlier chapters, particularly Chapter 8: Prevent and Counter Terrorism Policing. In summary, in addition to the earlier behaviour of concern at Range High School, the following events occurred at The Acorns School:

    a. AR searched for school shootings in America during an IT lesson on 15 November 2019.[1481] When contacted about this, AR's father got back to the school a few minutes later to suggest that AR had only been copying the behaviour of another student and clicked on a link to the news story. However, the internet history later obtained by this Inquiry suggests that AR had been searching for mainstream news articles about a school shooting.[1482] The teacher's report at the time was also that AR had been searching school shootings in America, not that he had just clicked on one link;[1483]

    b. On 22 November 2019, AR was looking at a website containing health and safety equipment during a lesson but then navigated to look online at nunchucks (a martial arts weapon).[1484] This incident was not in fact included in the First Referral to Prevent and Mrs Hodson accepted that it ought to have been;[1485]

    c. On 29 November 2019, AR had walked up and down in class, delivering hard punches to one of his hands. When he reluctantly returned to the subject matter of the lesson, AR suggested that telling others that his business was new to the area was a not a good idea because people would think he would kill them because they did not know him. He said that *"people don't trust others they don't know in case they get murdered"*. He repeatedly got out of his seat, and he then walked under the highest part of the ceiling where he jumped up and delivered a very hard punch to a hanging laminate;[1486]

1480 CTPNW000154.
1481 LCC001346/71.
1482 ILT000022 – Disclosed but not published due to sensitive content.
1483 LCC001346/71.
1484 LCC001580/4.
1485 See Chapter 8: Prevent and Counter Terrorism Policing, T/S: 27/61/10-63/14.
1486 LCC001346/71.

d. On 3 December 2019, in an art lesson while working with oil pastels colouring 'Call of Duty' images, AR commented *"[w]hy can we have these with guns but can't look at guns on the internet?"* and *"can we have a picture of a severed head then"*;[1487]

e. Also on 3 December 2019, AR had discussed different YouTubers and YouTube videos. It appeared to the teacher that he was discussing videos of people hurting themselves. He said that if a drill bit broke it could fly off and kill someone;[1488]

f. On 4 December 2019, AR had referred to a political leader as a *"retard"*.[1489]

62. Against this background, Mrs Janet Lewis, The Acorns School's DSL made the First Referral to Prevent on 5 December 2019.[1490] The decision to make the First Referral to Prevent followed a multi-agency meeting which was called to discuss the concerns raised throughout November and early December 2019.[1491] I have addressed this meeting in Chapter 9: Social care. Mrs Eccleston, Mrs Hodson and Mrs J Lewis all attended for The Acorns School. Anne Cookson attended for LCC's Child and Family Wellbeing Service. Alphonse R attended the meeting and AR was invited in for part of it. AR accused the school of lying about the concerns that had been raised. He maintained these denials even when it was pointed out that more than one adult had witnessed some of the incidents, and even when one of the teachers was brought into the meeting to attest to what she had witnessed. As I have addressed in Chapter 12: AR's family, the following day Alphonse R characteristically further challenged The Acorns School. He telephoned the headteacher complaining that AR was being inappropriately blamed and that he was a *"good boy"*.[1492]

63. Following AR's actions on 15 and 22 November and 4 December 2019, The Acorns School prevented AR's access to the internet. He attempted to override this on 9 and 10 December 2019. This was spotted and AR was asked by teachers to continue with his work. Mrs Hodson accepted that AR attempting to override the settings in this way ought to have been added to the information provided by The Acorns School to Prevent.[1493]

64. In Chapter 8: Prevent and Counter Terrorism Policing, I have addressed in detail the circumstances in which it appears that the record of AR's internet browsing history on 15 November 2019 was raised as a concern but ended up not being reviewed by the relevant Prevent officers. For the reasons I have detailed in

1487 LCC001346/71.

1488 LCC001346/70.

1489 LCC001346/68.

1490 CTPNW000154.

1491 LCC001346/67; LCC000024/5; LCC002311/6-7 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

1492 LCC000024/6.

1493 T/S: 27/61/10-63/14.

that chapter, I conclude that there was an omission by The Acorns School in that they failed to send the browsing history at the time of the referral. This was at a time when they were seeking to send a significant volume of diverse information to Prevent.

65. In the current context, it is important that the omissions by The Acorns School to provide some of the information in their possession to Prevent is seen in its true perspective. As regards the school internet browsing history, the Counter Terrorism Policing North West officers involved in the referral should have followed this up and ensured that the browser history was sent and considered. They should not have closed the First Referral to Prevent without chasing The Acorns School for it. Additionally, while The Acorns School should have added the information about nunchucks and AR's attempts to override the internet restrictions to the information provided to Prevent, I would repeat the observations I have made about this in Chapter 8: Prevent and Counter Terrorism Policing. The Acorns School was plainly doing the right thing by making the First Referral to Prevent. More generally and seen in the round, The Acorns School acted diligently and often impressively in how they sought to handle the risks posed by AR. Accordingly, the few errors The Acorns School made in the First Referral to Prevent should not detract from the fact that they were the agency who best recognised the mounting evidence of AR's risk, and that they proactively sought to draw his risk to the attention of the other relevant agencies.

66. As I have addressed in Chapter 8: Prevent and Counter Terrorism Policing, it was wrong for the First Referral to Prevent to have been closed by Counter Terrorism Policing North West. For the reasons explored in that chapter, Mrs Hodson was right to alight upon the lack of later 'triangulation' by Prevent. Prevent did not come back to The Acorns School for further information sharing, in light of what AR had said when interviewed at home by Prevent.[1494] Had they done so, Prevent would have had greater awareness of the untruthfulness of some of AR's assertions made during their home visit to him. Put bluntly, I consider that The Acorns School, if consulted further, could have shown Prevent that AR had been lying to them.

67. I have addressed the wider issues concerning AR's use of the internet and online harms in Chapter 6: Online harms. Some of the material that AR was accessing at The Acorns School was mainstream news reporting. One can understand that such mainstream press reporting may not readily trigger a firewall. I also note that the supervision of AR's online activity by The Acorns School meant that this online browsing even of mainstream news coverage was spotted by his teachers. It is nevertheless of concern that AR was able to search for (and it seems to view) images of degloving injuries using the school IT system. This was despite The Acorns School having in place a reputable firewall system. In Chapter 6: Online harms, I have recommended that DfE re-visit the guidance it provides schools on appropriate monitoring and filtering systems and that it considers whether further guidance should be provided,

1494 See Chapter 8: Prevent and Counter Terrorism Police; T/S: 27/182/4-13.

not just in relation to the expectations on schools, but also in ensuring that the systems used are appropriate and adequate from a technical perspective. AR was technically very IT-literate and it is notable that he tried to bypass the restrictions that The Acorns School had put in place, even though the school identified that he was attempting to do this. Overall, I am satisfied that The Acorns School was seeking to follow good practice in the software that it was using, and I do not consider that the school was individually at fault for such inappropriate material as AR was able to access on the school's IT system. However, this illustrates the importance of schools receiving the best possible guidance and support in ensuring that school internet firewalls are as effective as possible.

AR's allegation of bullying at The Acorns School

68. Before turning to AR's hockey stick attack at Range High School on 11 December 2019, it is important to consider Alphonse R's later suggestion that AR carried out that attack because AR faced ongoing bullying at The Acorns School. Specifically, Alphonse R later claimed that AR's attack at Range High School was because of a *"fight"* at The Acorns School.[1495] Alphonse R repeated this in his Inquiry Witness Statement suggesting that *"the fight" "may have been a trigger"* for the hockey stick attack.[1496]

69. The Acorns School recorded events in careful detail and as a PRU, they had a high staff to pupil ratio. As a result, the evidence available to the Inquiry allows me to conclude that the explanation put forward by Alphonse R is demonstrably wrong.

70. The detailed chronology of events at The Acorns School shows that:

    a. As regards one other pupil (Pupil 1), there were some limited difficult interactions with AR. These interactions were not, however, of any real significance. AR was noted to have friendly exchanges with Pupil 1 on a number of occasions, with Pupil 1 being friendly/helpful towards AR. But there was some occasional name calling by Pupil 1 and AR had raised that he felt bossed around by him.[1497] There was one occasion when Pupil 1 was heard to say that something meant AR was *"fat"*. This was challenged by a teacher and AR was assured that he was dealing with Pupil 1 maturely.[1498] Pupil 1's parents were also contacted when Pupil 1 had been asking questions of AR about why AR was at The Acorns School. However, AR equally contributed to the difficulties between himself and Pupil 1 (such as they were). On one occasion, on 22 November 2019, AR was noted to have reacted angrily and aggressively when the two boys had exchanged

1495 LCC001580/18.

1496 Witness Statement of Alphonse R IWS000058/§§37-38.

1497 LCC001580/3.

1498 LCC001580/2.

no more than a light hearted conversation expressing a difference of opinion. On another occasion, AR said the IT teacher was annoying, and Pupil 1 pointed out that this was because AR had been looking at something he should not have been in the IT class. On a further occasion, AR was inappropriately accusing a teacher of being sexist and racist and said that the teacher had said *"[AR] you are a [racial slur]"*. Pupil 1 interjected that this comment was *"too far, that's not even funny. You can't say things like that"*;[1499]

b. As regards a different pupil (Pupil 2), on 10 December 2019, AR made an inappropriate suggestive comment about a year 11 student who was doing voluntary work reading to a young girl in a primary school. Pupil 2 and another pupil took exception to what AR was saying. Later the same day, AR was heard to suggest that a student who was walking by took drugs. Pupil 2 told AR to stop saying this, reporting that AR had also been making inappropriate comments that the year 11 student who was volunteering *"touches little girls"*. Later still on the same morning, AR made comments about hating the IT teacher. Pupil 2 remonstrated with AR to stop calling that teacher names as she was *"sound"*. Two teachers intervened and told AR to stop referring to staff in such a way. However, AR ignored this and continued to repeat comments about the IT teacher. Pupil 2 again told AR to stop or he would *"spark him"*. AR laughed and again repeated the statement and antagonised Pupil 2. Pupil 2 is recorded as then having *"squared up"* to AR who backed away and Pupil 2 said *"I thought so"*. AR then said to Pupil 2 *"[w]hat you going to do, I hate [the IT teacher]"*. At this, Pupil 2 is recorded as having pulled AR's jumper, whereupon AR retaliated by grabbing Pupil 2 and started kicking him. The two teachers then intervened separating the two boys.[1500] AR continued to behave badly later the same day over lunchtime, throwing juice at a teacher and using a mocking racist accent, walking out of the room, and arguing with another member of staff.[1501] All of this was carefully documented by The Acorns School.

71. From this, it can be seen that the so-called *"fight"* on 10 December 2019 which Alphonse R later blamed for AR carrying out the attack at Range High School the following day, amounted to no more than another boy (who had been sorely provoked by AR's repeated inappropriate behaviour) squaring up to AR and pulling his jumper. It was AR who resorted to kicking and the boys were in any event soon separated. Insofar as AR may have reported this to Alphonse R as bullying and a *"fight"*, it only shows how deceptive and manipulative AR could be. It also shows how wrong Alphonse R was so readily to accept AR's account, and to be so dismissive and critical of what the education professionals from The Acorns School were saying.

1499 LCC001580/6.
1500 LCC001580/8.
1501 LCC001580/8.

72. I am confident that the close monitoring of AR at The Acorns School meant that the school were very alive to what was happening during the school day. I am therefore entirely confident that AR was not bullied at the school. On the contrary, The Acorns School were impressively and appropriately closely monitoring AR's interaction with other pupils. To the extent that AR had some difficulties with other pupils the main reason was AR's provocative behaviour in making inappropriate comments about other pupils and teaching staff. The fact that AR deceptively suggested he was being bullied at The Acorns School is one factor that calls into serious question his similar earlier claims about his time at Range High School.

73. Accordingly, the suggestion that AR was somehow provoked into the attack at Range High School on 11 December 2019 because of a fight at The Acorns School the previous day is utterly without foundation. Alphonse R was completely wrong ever to have suggested this. I note that in his Inquiry Witness Statement, Alphonse R chose to start his section on *"Range High School Attack"* by referring to AR having got into a fight with another boy and having sustained a cut and bruising to his leg.[1502] To the extent there was any truth in this, any injury to AR's leg would have been sustained by AR trying to kick the other pupil.

The hockey stick attack at Range High School

74. Mr McGarry and Mr Cregeen were present at Range High School on the day of the hockey stick attack on 11 December 2019 and gave evidence about those events, which were also captured on the school's CCTV. A timeline of the attack is as follows:

    a. On 10 December 2019, at 8:46, AR sent a message to the sister of the alleged bully at Range High School on Instagram. He messaged *"I'm coming back"* to which the sister replied *"what"*. AR replied *"to Range"* to which the sister stated *"why would I care"*. AR replied *"no reason"*;[1503]

    b. On the same date, 10 December 2019, AR booked a taxi to take him, on the following day, to Range High School, premises from which he had been permanently excluded on 9 October 2019;[1504]

    c. The next morning, AR took the taxi while carrying a rucksack. In the rucksack, he had taken a hockey stick to which he had wrapped tissue paper around the handle.[1505] He was later to say that he had done this *"to get a better grip"*.[1506] He had also taken a knife from home. The evidence of Alphonse R was that, following the Childline

1502 Witness Statement of Alphonse R, IWS000058/§37.
1503 MERP000186/20,59.
1504 LANC000072/2.
1505 MERP000186/15.
1506 MERP000186/8.

incident, they were hiding the kitchen knives from AR behind some trays in the kitchen drawer *"so that they were not within easy reach"*.[1507] The knife was a kitchen knife with a thin blade around six inches long;[1508]

d. On the morning of 11 December 2019, The Acorns School received a telephone call from the taxi firm that had arrived to take AR to school, indicating that their driver had witnessed AR getting into a different taxi (an 'All White' taxi, another Southport firm). The Acorns School staff member called Alphonse R who was unaware that this taxi had been arranged. When the taxi did not turn up at The Acorns School, the staff member contacted the taxi firm but they refused to share any information citing *"data protection"*.[1509] The contemporaneous record made by The Acorns School on their Child Protection Online Management System (CPOMS) system suggests that Alphonse R then also called All White taxis who said they could not reveal who had make the booking but did say that it had been booked the previous afternoon by a phone number that matched AR's telephone. The Acorns School then contacted Lancashire Constabulary and were advised to contact Range High School in case he turned up there.[1510] In Chapter 12: AR's family, I noted that it was highly significant that Alphonse R immediately acted on the assumption that AR may have arranged to be driven to Range High School and that this reveals Alphonse R's true understanding of the extent of the risk that AR posed to others;

e. Meanwhile, however, AR had already reached Range High School. It was later apparent from CCTV footage that AR had thrown his bag, containing the hockey stick and knife, over the school fence.[1511] He had then tried to climb the school fence but was unable to do so. His bag was picked up by a member of school staff;[1512]

f. The school has a main entrance which visitors use and sign in for meetings. Sixth form students also use the entrance, as would latecomers. AR 'tailgated' behind someone that was signing in and managed to get into the school. While it is unfortunate that AR was able to do this, Mr McGarry stated that the school has done a safeguarding audit and have put in place measures to prevent this from happening again;[1513]

1507 Witness Statement of Alphonse R IWS000058/§47.

1508 MERP000186/16.

1509 First Witness Statement of Mrs Hodson LCC001773/§58; LCC001346/63-64.

1510 LCC001346/64. The Acorns School did contact Range High School and they later understood from Alphonse R and from Range High School that AR was present there and Merseyside Police were in attendance, AR having carried out an attack.

1511 MERP008145.

1512 T/S: 26/196/25-197/5.

1513 T/S: 26/197/8-20.

g. AR saw the member of staff who had picked up his bag and was in the process of taking it to the main office. AR stated that it was his bag and it was handed over by the member of staff. Mr McGarry made clear that AR was wearing grey trousers and black shoes so that he appeared to be a current student. The member of staff had not taught AR and Range High School is a large school so the member of staff did not know that AR had been excluded;[1514]

h. Dion R was at Range High School lining up for a lesson when he saw his brother walk past him in school uniform. He told his teaching assistant that he did not believe AR was supposed to be there. The teaching assistant said that he would go to take a look and left the room;[1515]

i. Shortly afterwards, a teaching assistant recognised AR, stopped him and asked him what he was doing on the school premises. It may be that this was Dion R's teaching assistant but there was no evidence to confirm the position. The teaching assistant took AR to the hall where Mr McGarry was delivering an assembly;[1516]

j. After Mr McGarry had finished delivering the assembly, he saw AR and approached him, asking AR why he was there and that AR should be at his new school. AR did not say anything and ran off from the assembly hall very quickly;[1517]

k. Mr McGarry asked the teaching assistant to go immediately and find Mr Cregeen or another senior member of staff and call the police then went off in pursuit of AR;[1518]

l. Dion R said that he saw AR running and being chased by his teacher, among others;[1519]

m. AR came round a corridor and approached a group of students who were blocking his way down the corridor. Mr McGarry stated that AR raised the hockey stick back as if he was going to swipe it towards those students. In so doing, he hit the arm or the side of the neck of a student who he was not deliberately trying to hit;[1520]

n. I have no doubt whatsoever that this was Mr McGarry's honest recollection of something that happened very quickly and that occurred almost six years before he was giving evidence. However, the CCTV footage shows that the assault was more serious than Mr McGarry described. AR is seen to strike a student three times

1514 T/S: 26/197/21-198/18.
1515 T/S: 33/6/12-7/5.
1516 T/S: 26/198/19-21.
1517 T/S: 26/199/6-16.
1518 T/S: 26/199/20-23.
1519 T/S: 33/6/25-7/12.
1520 T/S: 26/199/23-201/6.

with considerable force, drawing the hockey stick back on each occasion. The victim put his arms up to protect his head and suffered reddening to his left arm and pain to the index and middle fingers of his right hand;[1521]

o. At that point, AR was bear hugged by Mr McGarry and the deputy headteacher grabbed the hockey stick;

p. AR was taken to Mr McGarry's office. AR stated that he was looking for the boy that he blamed for his permanent exclusion and said that he wanted to kill him. AR showed no sense of remorse or any wrongdoing on his part. The police arrived and searched AR's bag. When the police found the knife, AR did not seem very concerned and his reaction was quite matter of fact.[1522] Mr Cregeen said that AR stated that he had brought the hockey stick to kill the student he accused of bullying him and, if that did not work, then he would have used the knife.[1523] When AR was asked why he brought the knife in, he said *"to kill him"*.[1524]

q. I have addressed the actions of Alphonse R when he arrived at the school after the attack in Chapter 12: AR's family. In short, I find that Alphonse R was verbally aggressive and challenging to police. He failed to recognise or to accept the severity of AR's behaviour and challenged inappropriately those whose duty it was to deal with it;

r. Mr Cregeen stated that AR knew the victim, but he was a fellow pupil with whom AR had never had any problems.[1525] While in custody, AR was interviewed by Ms Stephanie Hallaron, a Band 6 Mental Health Practitioner working for the Criminal Justice Liaison and Diversion Team. When she asked AR why he hit someone other than the pupil who he wanted to attack for revenge, he explained that he realised he was being chased by two teachers and he was not *"going to get taken to the Police Station for nothing so I thought I would hit him"*.[1526] Further detail is set out in Chapter 10: AR's healthcare;

s. However, on 12 December 2019 when interviewed under caution, AR provided a prepared written statement in which he denied having any intention of using the knife;[1527]

1521 MERP000186/50.
1522 T/S: 26/201/7-202/8.
1523 T/S: 27/23/1-9.
1524 T/S: 27/24/3-7.
1525 T/S: 27/23/12-25.
1526 MERP002881/1.
1527 MERP000186/17.

t. After the attack, there were rumours at the school, apparently known by the mother of the alleged bully[1528] and Mr McGarry,[1529] that AR had a 'hit list' of people to target. However, no evidence of this was established by the police investigation (see further Chapter 7: Policing).

75. The sequence of events is notable for what it reveals about AR:

a. He showed a significant degree of premeditation by: (1) booking the taxi which must have arrived at around the same time as his taxi to The Acorns School; (2) wearing what appeared to be a school uniform so that he could walk through the school; (3) adapting the hockey stick; and (4) finding and taking the knife from home;

b. He went to significant lengths on the day to carry out the attack, including an element of deception, by tailgating to get through the school security and by retrieving his bag from the member of staff;

c. He used significant violence towards a pupil with whom he had no previous problems. He was prepared to attack an innocent bystander;

d. He showed no remorse;

e. Worse still, he stated that he wanted to kill; and

f. He gave a contradictory account of his intent to the police which showed that he was prepared to lie and manipulate when it suited him.

76. The above factors make clear that AR could be extremely dangerous. The facts that I have set out above were known either at the time of the attack or revealed shortly afterwards by the police investigation. They should have been accessible to all of those who dealt with AR thereafter and acted on to the extent appropriate. AR was young at the time of this incident, 13 years old, and this was a significant warning sign about what he was prepared to do, and able to do, should the wrong circumstances arise.

77. The other issue of note was the difficulty that The Acorns School and Alphonse R had in obtaining information about AR's journey from the taxi firm. Similarly, it was Alphonse R's evidence that he had difficulty when he rang a taxi company on 22 July 2024, given he thought AR was to return to Range High School again (see Chapter 12: AR's family). Mr Liam Rice, the General Manager of One Call Taxis Ltd, and Mr Mark Toohey, responsible for the taxi licensing arrangements of Sefton MBC, both referred to the challenges that taxi companies face when asked for details of a passenger, and the risk that such requests may be made for malign purposes.[1530] However, I accept Mr Rice's

1528 MERP000186/2.

1529 T/S: 26/204/2-9.

1530 T/S: 13/74/22-78/10, T/S: 13/109/16-111/21.

evidence that a taxi company should provide information to a school when it is transporting a child, given the school's telephone number should be verifiable. I have made a recommendation in this respect in Chapter 4: The attack.

The aftermath of the hockey stick attack at Range High School

78. I have already addressed the response of the various agencies to the hockey stick attack in a number of other chapters. I addressed:

    a. The police investigation into the attack in Chapter 7: Policing;

    b. Counter Terrorism Policing North West in Chapter 8: Prevent and Counter Terrorism Policing;

    c. CAMHS in Chapter 10: AR's healthcare;

    d. LCC Children's Social Care in Chapter 9: Social care; and

    e. AR's parents in Chapter 12: AR's family.

79. From the perspective of education, AR was at The Acorns School at the time of the hockey stick attack. As is apparent from those previous chapters, The Acorns School was extremely proactive in raising their concerns about AR with other agencies. I address the key examples below.

80. Mrs Hodson attended the strategy meeting on 17 December 2019.[1531] It was reported that AR's behaviour had escalated and he had begun to create issues with other children and occasionally fixated on staff members. AR had used school computers to *"research"* school shootings. He said that he had been bullied notwithstanding this had not been evidenced. It was noted that AR's bail conditions required him not to attend The Acorns School. The actions noted that AR was not to return to school at this time and work was to be sent home from The Acorns School.

81. Mrs J Lewis and Mrs Hodson attended the strategy meeting on 6 January 2020.[1532] The update provided was that LCC were looking at alternative provision for AR, including a possible one-to-one tutor. Mrs Hodson reported that work had been sent home. There was discussion with Ms Pita Oates, LCC's Lead Officer for Alternative Provision, who stated that this was illegal.[1533] Mrs Hodson stated that a full risk assessment was required regarding the potential risk to other pupils and there was a discussion about this needing to be completed prior to AR's re-introduction to school. Ms Oates queried why an EHCP was not in place and Mrs Hodson stated that AR had only

1531 LCC000234; LCC001346/63; MERC000002/51-52. The minutes and CPOMS record Mrs J Lewis's attendance but she did not believe that she attended and thought Mrs Eccleston attended instead – LCC001774/§15.

1532 LCC000023; LCC001346/60-61; MERC000002/50.

1533 T/S: 27/143/11-18.

been attending The Acorns School since October 2019. A request needed to be made for an EHCP. The meeting decided that this would be done by AR's parents.

82. Mrs Hodson attended the Forensic Child and Adolescent Mental Health Service (FCAMHS) case assessment on 21 January 2020.[1534] Mrs Hodson expected this to be an assessment of risk by everybody, led by FCAMHS; however that did not occur.[1535] I have analysed that meeting in depth in Chapter 9: Social care and Chapter 10: AR's healthcare. In short, I concluded that Mrs Hodson advanced powerful expressions of concern about the level of risk AR posed to others, which were entirely justified. For example, Mrs Hodson referred to AR stating that he had bought the knife to Range High School on multiple occasions *"to use it"*.[1536] She stated that the police had described the CCTV footage as showing a serious attack at Range High School. Mrs Hodson described the school's frustration of trying to engage with other agencies before the incident in December. I found that Ms Jameson and Ms Hamill, of LCC, could have been left with no doubt as to Mrs Hodson's profound apprehension as to the risk that AR posed. Indeed, this was the case for all attendees.

83. I was concerned about the apparent lack of understanding that was accorded to the matters raised by Mrs Hodson. Mrs Hodson and Ms Hallaron expressed their concerns that, with the range of issues outstanding and only limited interventions planned, AR *"could be left high and dry with no services supporting him"*.[1537] Mr John Hicklin of FCAMHS suggested that AR clearly needed some sort of specialist provision with ongoing therapy and social stories, adding (addressing Mrs Hodson) *"[b]ut unfortunately, you've been left holding the baby!"*[1538] Despite this, the meeting finished without a plan in place to carry out a suitably comprehensive assessment of the risk that AR posed to others and, furthermore, without any solution being advanced to address the prospect of him being left *"high and dry"* with no agency holding responsibility for his dangerous potential. In Chapter 9: Social care and Chapter 10: AR's healthcare, I consider that all those who formed part of this multi-agency approach should have ensured this state of affairs was urgently rectified.

84. Mrs Hodson attended the third multi-agency meeting on 4 March 2020, alongside Mrs Eccleston.[1539] Again, I have addressed this meeting in depth in Chapter 9: Social care and Chapter 10: AR's healthcare.

85. Most of the time at this meeting was taken up in what The Acorns School note of the meeting refers to as *"a lengthy debate about risk assessment"*. Social care indicated that they did not have the capacity to do this and it

1534 LCC000020; LCC001346/61-62; MERC000002/49; GMMH000005/1-5.
1535 T/S: 27/159/14-160/9.
1536 LCC000020/2.
1537 LCC000020/3.
1538 LCC000020/2.
1539 LCC001346/58.

was not their responsibility. The Acorns School pressed how concerned they were about the risks to others from AR and said that they could not put a comprehensive management plan in place because the risks had yet to be established. Ms Anna Croll, AR's newly assigned social worker from the Child and Youth Justice Service (CYJS), stated that the risk was medium to high.[1540] Those involved in education made it clear that AR could not enter school premises or at any alternative venue until *"all professionals"* had completed a multi-agency risk assessment in line with Working Together to Safeguard Children.

86. In effect there was something of an impasse with the education attendees at this meeting stressing the (legitimate) concerns about permitting AR back on school premises in the absence of a risk assessment, while others appeared to press the need for AR's education to continue, noting that there were no further mental health issues.

87. Thereafter, there was ongoing liaison between The Acorns School and AR's parents. On 6 March 2020, Mrs Hodson carried out a home visit. She stated that this did not alleviate the concerns because Alphonse R stated that AR was not a risk at home or to himself but that he *"would be a risk elsewhere, because if someone did something to him, he would do something in return"*.[1541]

88. AR declined to complete the written work that he was set in this period, save for a single piece of maths work. He was set online work to do at his own pace and in short bursts. On 18 March 2020, the position was overtaken by the COVID-19 lockdown and The Acorns School was closed. Work continued to be sent and AR completed some of it online. However, there were challenges with his engagement and Mrs Hodson stated that AR's family were at times unresponsive.[1542]

Analysis

89. Mrs J Lewis recalls The Acorns School being encouraged by other agencies to keep AR on the roll but the school was concerned about the level of risk that AR presented and felt that it was unsafe to bring AR back to school without a full risk assessment being conducted by the agencies involved.[1543] Mrs Hodson felt that the decision not to allow AR to return, pending a risk assessment, was met with some resistance by other agencies, and that there was pressure from them to bring AR back to school.[1544] She felt that the concerns she raised were not being taken seriously and the response from other agencies was inadequate.[1545]

1540 Also known as Youth Offending Team (YOT).
1541 LCC001346/58-59.
1542 First Witness Statement of Mrs Hodson LCC001773/§§92-102.
1543 Witness Statement of Mrs J Lewis LCC001774/§14.
1544 First Witness Statement of Mrs Hodson LCC001773/§75.
1545 First Witness Statement of Mrs Hodson LCC001773/§89.

90. I have referred above to the comment of Ms Oates on 6 January 2020 that AR's level of attendance at The Acorns School, and the fact that he was precluded from attending, was *"illegal"*. The concern was that AR was being required to work from home and that this was a de facto exclusion.[1546] Mrs Hodson noted that the school spoke to a woman called Ms Helen Smith at LCC, in charge of attendance, who felt that the position could be put on a legal footing by making work available to AR online. Mrs Hodson was uncomfortable about putting a tutor into the house with AR without a suitable risk assessment.[1547] She stated that, around this time, the only other option was to exclude AR permanently from The Acorns School due to the hockey stick attack at Range High School. However, neither Mrs Hodson nor Mrs Eccleston felt that this was the right thing to do. It would simply have been moving the risk elsewhere and AR might have been lost to the system. The approach taken between the hockey stick attack and the COVID-19 lockdown was an interim measure.[1548]

91. Mr Turner stated that, for short term periods, the guidance for schools permits a reduced timetable, usually with the agreement of parents and with the expectation of relatively prompt re-integration, getting the pupil back into school full-time.[1549] Ms Dixon agreed that brief disruptions would not necessarily trigger an obligation on a local authority to ensure full time attendance.[1550]

92. In my view, it was entirely appropriate for The Acorns School to preclude AR's attendance. This was a proportionate response to the severity of the attack. It was understandable for Mrs Hodson to fear a similar attack at The Acorns School, in particular on the student who AR had accused of bullying and the IT teacher about whom AR had expressed he had an issue.[1551] The school had a duty to protect their own pupils and staff. The position was intended to be provisional, pending the full investigation into AR's actions and motivations and a multi-agency risk assessment. Mr Turner also considered The Acorns School decision to be appropriate.[1552]

93. The problem that developed with The Acorns School's response was that no multi-agency risk assessment was ever completed and the other agencies *"peeled away"*, as Mrs Hodson put it.[1553] In Chapter 10: AR's healthcare, I concluded that after the meeting on 4 March 2020, FCAMHS could have, but failed to, step in to organise a Structured Assessment of Violence Risk in Youth (SAVRY) as the best structured tool to analyse AR's risk to others. Moreover, as I set out in Chapter 1: Fundamental problems, this was an

1546 T/S: 27/143/6-144/3.
1547 T/S: 27/144/20-145/5.
1548 First Witness Statement of Mrs Hodson LCC001773/§232; T/S: 27/144/4-12.
1549 T/S: 26/142/5-146/17.
1550 T/S: 28/71/1-12.
1551 First Witness Statement of Mrs Hodson LCC001773/§196.
1552 T/S: 26/142/1-13.
1553 T/S: 27/140/7-141/1.

example of a fundamental problem in the way that AR's risk was understood and managed: there was a failure of any organisation or multi-agency arrangement to take ownership of the risk that AR posed. I do not, therefore, apportion any blame to The Acorns School for the impasse that arose in relation to AR's attendance during this time. Mr Turner noted that this is an area which still needs to be developed and considered. Ms Dixon referred to the Children's Wellbeing and Schools Bill, which seeks to improve multi-agency working.[1554] This element of multi-agency working is a matter that it will be important for this Inquiry to consider further in Phase 2.

94. There was some evidence about AR's bail conditions, which precluded his attendance at The Acorns School until he had received confirmation of return by social services or the appropriate authority. I do not critique this course of action given that I accept The Acorns School's decision to preclude AR's attendance pending a risk assessment. However, Ms Dixon stated that DfE would prefer that bail conditions do not prevent a child from attending their own school unless it is absolutely unavoidable and I observe that she has written to the Youth Justice Policy Unit at the Ministry of Justice about this topic.[1555,1556] I therefore do not need to consider a recommendation on this issue.

AR's levels of attendance at The Acorns School and long-term education

95. From September 2019 to July 2020, AR's attendance was recorded as 29.9%, with authorised absence (reflecting AR's part-time timetable and home learning) at 69% and unauthorised absence of 1.1%.[1557] From 6 July 2020, The Acorns School carried out a further risk assessment and AR returned to the school with two-to-one staffing. He was prioritised for his return because of concern that he was socially isolated and vulnerable.[1558,1559] His return was made easier from a safety point of view by the fact that the school was generally empty with no other pupils on site at the same time as AR and minimal staffing due to virtual lessons.[1560]

96. From September 2020 to July 2021, AR attended The Acorns School 36.4% of the time, with authorised absence of 62.6% and unauthorised absence of 1%.[1561] During this time, AR attended school for one hour a day with two-to-one staffing. From October 2020, this dropped to one-to-one staffing with Mrs Maggie Allred. Attempts were made to extend AR's timetable in

1554 T/S: 28/111/2-112/2.
1555 T/S: 28/74/15-75/14.
1556 DFE000260; DFE000261.
1557 First Witness Statement of Mrs Hodson LCC001773/§113; LCC001872.
1558 First Witness Statement of Mrs Hodson LCC001773/§198; LCC000707.
1559 First Witness Statement of Mrs Hodson LCC001773/§113.
1560 First Witness Statement of Mrs Hodson LCC001773/§233.
1561 LCC001873.

November 2020 and to re-integrate AR into classes from May 2021 but these were unsuccessful. There were, of course, also periods of COVID-19 lockdown during this period.[1562]

97. Mrs Hodson stated that the school did what they could to get AR into school and to engage. There were attempts to build up AR's timetable but they failed because AR struggled in being in a class with other pupils. AR could not manage with more than was being offered and it was *"a massive risk"* to push him beyond what he was able to do.[1563] Ms Dixon stated that, in her view, The Acorns School did a really impressive job of trying to tailor their offer to AR and that considerable effort was made by the school to engage AR in education.[1564]

98. Under section 19 of the Education Act 1996, local authorities have a statutory duty to arrange suitable full-time education for children of compulsory school age who, for any reason, may not otherwise receive it (parents have an equivalent duty under section 7 of the Education Act 1996). If a local authority determines that the provision is no longer suitable for the child then they should be taking prompt action to identify and secure an alternative setting.[1565] Ms Dixon set out her concern that AR's attendance rapidly fell at The Acorns School and referred to the large proportion of absence being described as other authorised absence. She questioned whether the local authority took action to investigate the high levels of non-attendance and put in place the necessary support at the time, although she acknowledged that the way attendance was coded at the relevant time, as per DfE guidance, made the lack of attendance less obvious.[1566,1567] She would have expected the local authority to be aware of the reasons behind the attendance levels and to satisfy themselves that they were meeting their statutory duties in relation to education and safeguarding.[1568]

99. Mr Turner accepted that it was the role of LCC to take action to investigate high levels of non-attendance and put in place any necessary support. AR's levels of absence were known to LCC but it failed to put in place any necessary support.[1569] He accepted that, if there was a gap in a child obtaining full time education, then he would expect LCC to try to bridge that gap.[1570] For example, one-to-one tutoring was suggested at the meeting on 6 January 2020 and might have addressed AR's lack of attendance at that stage, but it was never

1562 First Witness Statement of Mrs Hodson LCC001773/§114.
1563 T/S: 27/150/13-24.
1564 T/S: 28/72/25-74/10, T/S: 28/79/4-7.
1565 T/S: 28/71/13-17.
1566 Witness Statement of Ms Dixon DFE000256/§79.
1567 T/S: 28/72/7-24.
1568 T/S: 28/73/12-25.
1569 T/S: 26/146/2-7.
1570 T/S: 26/147/1-7.

provided by LCC.[1571] Mrs Hodson stated that The Acorns School applied for a specialist teaching service from LCC, however LCC eventually stopped answering her correspondence.[1572] Mr Turner accepted there was a failure by LCC to comply with its statutory obligations to provide full time education for a child who could not attend school.[1573] The reason for this was a lack of ability to commission the sort of provision that would be appropriate, find suitable people to deliver it within the timescale and a lack of resource.[1574]

100. Mrs Hodson stated that progress was not being taken forward with alternatives, such as an alternative education provider, because of the schooling preference in AR's EHCP for 2020.[1575] AR's EHCP for 2020, dated 6 August 2020, stated that the educational placement was to be a local authority maintained secondary school: in other words that AR was to be educated in a mainstream school.[1576] There is a statutory presumption of mainstream schooling for an EHCP but it was the request of AR's parents for AR to go to a mainstream school.[1577,1578]

101. As a PRU, The Acorns School was a 'short-stay school' that was not intended to be a long-term solution to any pupil's education. However, given AR's actions in relation to bringing a knife into school and carrying out the hockey stick attack at Range High School, as well as his educational needs, he was highly unlikely to be accepted by a mainstream school. Mr Turner stated that, in general terms, it is incredibly difficult to find a school that will accommodate the needs of a child that has been excluded for significant violence or carrying a weapon, without some significant conversation around how that would be handled in school. When combined with additional educational needs, he stated that it made the system *"very difficult to navigate"*.[1579]

102. Mrs Hodson stated that AR's parents were not at all receptive to her attempts to reason with them that mainstream schooling was unrealistic, noting that this had been raised at a difficult meeting in May 2020 as part of the preparation of the original EHCP.[1580] It was not until late 2021 that agreement was reached to the effect that AR should move to a special school and the EHCP was then altered.[1581] It was under two months later that AR's placement at Presfield High

1571 T/S: 26/146/8-21.
1572 T/S: 27/152/18-153/9.
1573 T/S: 26/147/8-13.
1574 T/S: 26/147/15-22.
1575 T/S: 27/152/3-21.
1576 T/S: 26/152/21-25.
1577 Section 39 of the Children and Families Act 2014.
1578 T/S: 27/153/10-14, T/S: 26/153/1-6.
1579 T/S: 26/136/1-137/8.
1580 T/S: 27/154/2-11.
1581 LCC001524.

School was arranged. Mrs Hodson stated that the preference for a mainstream school in the EHCP delayed the process of finding AR an appropriate setting to move to from The Acorns School for about a year.[1582]

103. LCC was not obliged to accept the parental preference for schooling. The statutory guidance states that the council is not obliged to provide the school requested by the parent where the school identified is a school or other institution that is unsuitable for the age, ability, aptitude or special educational needs of the child concerned.[1583] Mrs Hodson felt that parental preference should, on this occasion, have been overridden.[1584] Ms Dixon also stated that LCC delayed stating that mainstream schooling was unsuitable, and that there was a long delay in getting the right information on the EHCP, working with the parents and looking at alternatives.[1585,1586]

104. Mr Turner agreed that LCC should, potentially, have overridden parental preference and he stated that mainstream schooling was not a suitable option. However, if such a decision had been made then it may have resulted in mediation and consideration by a tribunal. He noted that the decision is based on advice from the school but also from health professionals, social care and others, and he felt that it would be wrong to make an absolute judgement as to whether parental preference should have been overridden.[1587,1588] He did, however, accept that LCC should have consulted with all mainstream settings until a suitable placement was found and, if there was none, then a search could have been carried out further afield or a school could have been directed to admit AR. He had not seen any evidence that this occurred.[1589]

105. Mr Turner accepted that alternative provisions, such as specialist schooling or tutoring, could possibly have been in place at an earlier stage than 2022 if the matter had been grasped and progressed.[1590] He described the range of options, such as identifying a maintained or independent special school, commissioning tutoring or an *"alternative provision setting"* (one that is neither a PRU nor a special school) and they can provide online education. He suggested there is a *"whole range"* of different educational options. However, the issue is their suitability and availability.[1591]

106. I am satisfied that The Acorns School took the appropriate steps to ensure that AR received as much tuition as possible. They were working in difficult circumstances on account of the combination of AR's risk, his educational needs

1582 T/S: 27/152/3-21, T/S: 27/153/15-154/1.
1583 SEND Code of Practice, also available at DFE000042/172/§9.79.
1584 T/S: 27/154/12-24.
1585 T/S: 28/76/20-77/14.
1586 T/S: 28/79/15-17.
1587 T/S: 26/153/17-154/19.
1588 T/S: 26/155/4-19.
1589 T/S: 26/157/1-10.
1590 T/S: 26/158/8-14.
1591 T/S: 26/158/15-159/1.

such as his inability to share classes with other students, a lack of multi-agency support and a risk assessment, along with the impact of the COVID-19 lockdowns. The evidence showed that AR's lessons with Mrs Allred, who was the most senior and skilled teacher and used to reaching the trickiest pupils and experienced in teaching autistic children, were a positive factor for AR.[1592]

107. I was concerned by evidential picture of LCC's inaction in terms of: (a) grasping AR's attendance levels; and (b) putting in place a plan to ensure an appropriate long term educational setting for AR. Mr Turner accepted that it was quite shocking that LCC knew that AR was not in full time education but was unable to do anything about it.[1593] Mr Turner stated, however, that further measures have now been put in place to address this issue. As well as increased resourcing, LCC now has regular attendance updates from schools with regular electronic communication of registers to LCC.[1594] I have addressed my concerns about LCC more generally in the themes and conclusions section below.

The Acorns School's involvement in the Second and Third Referrals to Prevent

108. These have been covered in detail in Chapter 8: Prevent and Counter Terrorism Policing, which I will not repeat, save to address the limited education-specific issues.

109. In Chapter 8: Prevent and Counter Terrorism Policing, I raised the question of whether The Acorns School should have shared Mrs Allred's assessment of AR with Prevent at the time of the Second Referral to Prevent. On 9 February 2021, Police Sergeant Carmen Thompson, the Counter Terrorism Case Officer from Counter Terrorism Policing North West, emailed Mrs J Lewis asking to check whether there were any further concerns other than the Instagram posts about Colonel Gaddafi.[1595] Mrs J Lewis replied stating that there were no further concerns at that time, copying in Mrs Allred and Mrs Hodson. Mrs Allred replied to this email to Mrs J Lewis and Mrs Hodson only stating:

> *"I assumed that there was a concern?*
>
> *I am concerned as I think he may not be active, but he could easily be radicalised and would be a huge risk if this happened -the risk would be very real of harm to others."*[1596]

1592 T/S: 27/196/10-197/2.
1593 T/S: 26/147/23-148/10.
1594 T/S: 26/148/11-23.
1595 LCC001526/3.
1596 LCC001526/2.

110. Mrs J Lewis replied stating that PS Thompson would be looking into this and knew the background from working with AR before. She stated that the first rule of safeguarding was not to assume and only to refer on what we see.[1597]

111. Mrs J Lewis accepted in her evidence that Mrs Allred's assessment should have been passed onto Prevent, although she was unsure if Prevent would have taken it seriously.[1598] PS Thompson was never made aware of Mrs Allred's comments and said that she would have explored this issue if it had been brought to her attention.[1599] Mrs Hodson stated that, in hindsight, the wording of the Second Referral to Prevent was insufficiently robust and that, with the benefit of hindsight, Mrs Allred's concerns should have been included in the referral.[1600] In my view, Mrs J Lewis and Mrs Hodson's evidence was correct and Mrs Allred's views should have been provided to Prevent, particularly given Mrs Allred's close work with AR. With the benefit of hindsight, Mrs Allred's view was perceptive because AR did come to present a risk of real harm to others, albeit due to violence fixation rather than conventional terrorist radicalisation. However, I am not overly critical in this respect because it is against a background of The Acorns School providing a significant amount of information to Prevent. Moreover, I am not convinced that this would have made a material difference to the handling of the Second Referral to Prevent because the issue identified in Chapter 8: Prevent and Counter Terrorism Policing with the Second Referral to Prevent was a lack of a holistic assessment of AR by PS Thompson, taking into account the information already available.

112. The emails also reveal a misconception by Mrs J Lewis about the work that AR was doing with Prevent. In fact, PS Thompson had no contact with AR at the time of the Second Referral to Prevent and had met AR once only for the First Referral to Prevent. Mrs J Lewis did have PS Thompson's details and could have sought further information from her.[1601] Ms Dixon noted the importance of greater dialogue about the risk and DfE's wider recognition of inconsistency in onward signposting either back to the referrer by Prevent or onto additional services.[1602] A greater understanding of the handling of a Prevent referral could have been addressed through Prevent training, which Mrs J Lewis had received.[1603] As addressed at the end of this chapter, I consider that the DfE should ensure that (a) improved guidance is introduced and (b) that schools put in place improved Prevent training (including refresher training). This must ensure that staff are not just aware of when to make a Prevent referral but are also aware of (a) what happens once a Prevent referral is made; and (b) the importance of ongoing dialogue, feedback and assessment between the referrer and the Prevent officer. Mrs J Lewis also suggested that refresher

1597 LCC001526/1.

1598 T/S: 27/72/7-22.

1599 T/S: 21/118/19-119/1.

1600 First Witness Statement of Mrs Hodson LCC001773/§156, §160.

1601 T/S: 27/74/16-19.

1602 T/S: 28/101/8-102/12.

1603 T/S: 27/38/10-15.

training on Prevent would assist, which was not mandatory.[1604] Ms Dixon stated that DfE's guidance places the expectations and duties on schools and does not say how this should be delivered, although it does recommend that Keeping Children Safe in Education training is refreshed annually. I agree with her suggestion that the Keeping Children Safe in Education should have increased cross-referencing to Prevent and at Recommendation 63 below I have reflected this need.[1605]

113. I have addressed the reaction of AR and Alphonse R to the Prevent referrals, in particular the fact that Alphonse R passed the Third Referral to Prevent onto AR against the wishes of The Acorns School, in Chapter 12: AR's family. As accepted by Alphonse R, AR reacted very badly to the Third Referral to Prevent and this impacted significantly on his engagement with The Acorns School. From September 2021, AR attended The Acorns School only 12.2% of the time with authorised absence of 50% and unauthorised absence of 37.8%.[1606] Between May and July 2021, AR increasingly refused to attend school. He then refused to return to school in September 2021 and did not re-attend until November 2021. During the periods of absence, the school continued to keep in contact with AR's parents. His attendance was intermittent until February 2022 and he did not attend after 28 February 2022.[1607] As I have addressed below, this resulted in AR's move to Presfield High School being expedited. AR's strong reaction to this Prevent referral may well have had a bearing on the fact that further concerning behaviour of AR was not referred to Prevent (see below).

A further Prevent referral

114. In Chapter 8: Prevent and Counter Terrorism Policing, I addressed concerning statements by AR in January 2022. On 21 January 2022, AR made various comments about the Holocaust and genocide. On this occasion, and those that follow, AR was appropriately challenged about his views by Mrs Allred. On 25 January 2022, AR talked about the death of Princess Diana and water poisonings, while also indicating his belief that violence was sometimes necessary. On 26 January 2022, AR raised similar topics once again. Mrs Allred said that she had been concerned that his comments were against Jews and she felt offended. AR suggested that all genocides should be *"advertised equally"*.[1608]

115. Mrs Hodson stated that she discussed these comments with Mrs Allred and considered whether a further Prevent referral should have been made. The decision was made to deal with the matter in school, through direct

1604 T/S: 27/38/16-39/2.
1605 T/S: 28/98/2-22.
1606 LCC001874.
1607 First Witness Statement of Mrs Hodson LCC001773/§115, §§208-211.
1608 LCC001346/12.

discussions conducted by Mrs Allred. This was because the previous Prevent referrals had not been acted upon and the Third Referral to Prevent had led to a complete breakdown of trust between AR, the family and the school. In hindsight, Mrs Hodson regretted not submitting further Prevent referrals but stated that The Acorns School had lost faith that anything would be done.[1609] In hindsight, Mrs J Lewis accepted that these comments met the threshold to make a Prevent referral.[1610] I agree with that evidence, particularly when these comments were set against AR's known history. However, as I set out in Chapter 8: Prevent and Counter Terrorism Policing I appreciate that The Acorns School may well have been more likely to have made a fourth referral if the school had been provided with fuller feedback on their earlier referrals. If a referral had been made then it ought to have led to a referral to Channel (albeit I found that to be the case for all of the Prevent referrals). I made a recommendation in relation to this issue in Chapter 8: Prevent and Counter Terrorism Policing.

116. Aside from Prevent, The Acorns School were aware that AR was under the care of CAMHS. The CPOMS records for 11 February 2022 suggest that Mrs Allred discussed AR's *"political viewpoints"* with Ms Samantha Steed of CAMHS, who considered that the school was managing this *"really well"* and that AR would probably *"always have an interest in global politics and it is about [AR] understanding how others might feel about his views as well as exploring his own views"*.[1611] As set out in Chapter 10: AR's healthcare, Dr Lakshmi Ramasubramanian stated that she was unaware of this information and considered that it should have been shared by The Acorns School. However, as I have indicated, the records suggest that The Acorns School had discussed AR's political viewpoints with CAMHS, although I accept it is unclear how much detail they went into. Mrs Hodson also referred in her evidence to conversations with CAMHS around this time, and about the decision not to make a Prevent referral.[1612] I accept Dr Ramasubramanian's evidence that she personally was unaware of this aspect but at least the generality of a concern about AR's political viewpoints clearly had been discussed with Ms Steed. As Mrs Hodson put it: *"if anything, we're oversharers"*.[1613]

1609 First Witness Statement of Mrs Hodson LCC001773/§§171-174.

1610 T/S: 27/77/2-80/4.

1611 LCC001346/11.

1612 T/S: 27/193/20-194/8.

1613 T/S: 27/182/14-23.

AR's EHCP in 2021

117. The process of preparing an EHCP involved the creation of various drafts which are amended with tracked changes so that alterations are identified with strikethroughs and underlining. The draft of AR's EHCP for 2021 contains some noteworthy amendments, for example:

> *"The Educational Psychologist (May 2020) reported that when in school [AR] had little or no interaction with other pupils or relationships with the staff. [AR] can appear to become fixated on particular members of staff. There are concerns of occasions where [AR] would say and do things which have been described as ~~sinister.~~* ***inappropriate****.*
>
> *~~[AR] can also appear to be cold and calculating and when in meetings with staff did not appear to be concerned about the seriousness of the meeting."~~*[1614] (emphasis and strikethrough in the original)

118. There is a further draft of the EHCP for 2021 which contains still further alterations.[1615] To give one example, the words *"he does not like perceived injustice"* have been struck through and 'corrected' with: *"[AR] has a good sense of right and wrong, but requires support to work through scenarios where an injustice may have occurred"*. Both are signed on 15 December 2021, however, they are drafts because the final EHCP is produced in a 'clean' format.[1616]

119. I have addressed the preparation of AR's EHCP in 2021 in other chapters of this report. In Chapter 12: AR's family, I address the evidence of Mrs Hodson that Alphonse R made efforts to amend the wording in the EHCP to *"water it down"*. In Chapter 10: AR's healthcare, I address Mrs Hodson's evidence that Ms Steed for CAMHS played a role in this process, including by raising the issue of racial stereotyping.

120. I do not criticise Mrs Hodson for her involvement in this process. She did not agree with the changes, and she raised this as an issue in her evidence to the Inquiry. Mrs Hodson's evidence was that she sought to ensure that certain pieces of information were retained in the EHCP for 2021. This included, as set out below, the need for AR to be risk assessed and for the new school to do work with AR around understanding the consequences of his actions to himself and others.[1617] The Acorns School ensured that significant amounts of risk information were provided to Presfield High School as I have set out below (albeit not at the same time as the EHCP was provided). I have addressed hereafter the impact that the toning down of the EHCP had on AR's placement at Presfield High School.

1614 LCC000132/6.

1615 LCC000139/6.

1616 T/S: 28/10/7-19.

1617 T/S: 27/123/10-125/2.

The bus incident in March 2022

121. On 17 March 2022, AR went missing from home armed with a knife. He was reported missing and subsequently found on a bus with the knife by police. He made concerning comments to police about intending to stab someone, and about making, or having an interest in making, poison. I have already addressed this incident in Chapter 7: Policing, and Chapter 9: Social care. I will consider AR's family role in this incident in the next chapter, Chapter 12: AR's family.

122. The incident occurred on a day on which AR was supposed to be having a transition visit to Presfield High School, albeit he remained nominally on the roll of The Acorns School for around a further couple of weeks. As I have noted in Chapter 12: AR's family, in those circumstances it is telling that Alphonse R telephoned Range High School when he realised that AR was missing.[1618]

123. Otherwise, the most significant matter, in relation to issues of education, was the information sharing with Ms Steed of CAMHS. I have addressed this in depth in Chapter 10: AR's healthcare. In short, on 22 March 2022, The Acorns School emailed Ms Steed asking her to provide as much information as possible about AR's actions on 17 March 2022 so that they could update their safeguarding and risk assessments and asking Ms Steed to liaise with Presfield High School. Ms Steed replied stating that AR had engaged well at the session, he did not want to return to The Acorns School to say goodbye, he was looking forward to starting at Presfield High School and that she had agreement from AR to contact that school.[1619] Ms Steed was not aware that AR had stated that he intended to use the knife to stab people or had mentioned poison. However, Ms Steed should have told The Acorns School that Alphonse R had reported that AR had a knife on him, and that AR had not mentioned this in the discussion on 18 March.

124. I do not raise any issues with the approach of The Acorns School in relation to this incident: they appropriately sought risk information from CAMHS, and asked CAMHS to liaise with Presfield High School. As I set out below, they also passed on significant information about the incident to Presfield High School themselves. I will come to address Presfield High School's approach to that information below.

1618 Witness Statement of Alphonse R IWS000058/§§138-139; T/S: 33/189/8-190/8.

1619 PRE000357/2.

Key events: AR at Presfield High School

Transfer of information: when Presfield High School offered AR a place

125. The process of AR's transfer to Presfield High School began on 11 January 2022 when LCC requested a place for AR at Presfield High School.[1620] The school was provided with AR's EHCP from 2021 alongside the placement request. Initially, the intention was that AR would join the sixth form in September 2022.

126. As addressed above, AR's EHCP for 2021 had been toned down. The draft of the EHCP included in Presfield High School's disclosure did include previous comments struck through. Presfield High School were told not *"to really consider"* the struck through information which was to be removed from the finalised version.[1621] The EHCP referred to the following in relation to AR's risk to others:[1622]

    a. AR being quite rigid in his thinking;

    b. AR disliking and being unable to let go of any form of perceived injustice;

    c. AR struggling to show empathy;

    d. AR appearing to become fixated on particular members of staff;

    e. Concerns of AR saying and doing things described as sinister. The word *"sinister"* was struck through and replaced with *"inappropriate"*;

    f. AR being cold and calculating and unconcerned about the seriousness of meetings. This was struck through;

    g. AR having difficulty managing when things go wrong, then becoming angry and that he could hit out when angry;

    h. An 'outcome' that AR would be able to identify and avoid inappropriate behaviours, including those which placed himself and/or others at risk and may lead to serious consequences both inside and outside the educational context. A risk assessment was to be completed to identify and minimise the risk for AR and those working with him;

    i. There was a reference to the involvement of the Youth Offending Team (YOT), AR's YOT order and that AR continued to be reviewed by the YOT (the referral order had in fact ended by this time).[1623]

1620 Witness Statement of Mr Fay PRE001809/§9.

1621 T/S: 28/9/25-11/13.

1622 PRE001739.

1623 Lancashire County Council's Child and Youth Justice Service (CYJS) was also known as the Youth Offending Team (YOT).

However, the EHCP had no detail of AR's previous incidents of concern, including the Childline incident, the hockey stick attack at Range High School and the matters included in the Prevent referrals.

127. Mrs McLoughlin stated that she was, however, aware of the knife incident at Range High School (that is to say the attack with the adapted hockey stick at Range High School on 11 December 2019 when AR was also armed with a knife). This was provided in some documents that came along with the EHCP. However, this did not include any information about AR's intent to use the knife.[1624] I accept Mrs McLoughlin's evidence that the sense of AR's intent during this incident, and other incidents, was important but was not clear from the EHCP.[1625]

128. On 20 January 2022, the Head of Sixth Form, Mrs Hayley Dawson, visited The Acorns School and met with AR and Mrs Allred. Mrs Dawson states that no concerns were raised with her during this meeting in relation to AR's previous behaviours or incidents. When the transfer is from a school with which Presfield High School had worked previously, Mrs Dawson says that there are often frank exchanges at such meetings, asking the question *"what do we need to know"*. As a result, Mrs Dawson states that her knowledge about such issues was limited to the contents of the EHCP.[1626] On the basis of the EHCP and the meeting with AR and Mrs Allred, Presfield High School made an offer of a place for AR on 21 January 2022.[1627]

Analysis

129. As noted above, Mrs Dawson suggests that no concerns were raised with her during her meeting with Mrs Allred on 20 January 2022, regarding AR's previous behaviours or incidents. Mrs Allred's statement refers to a discussion with Mrs Dawson around the time of the bus incident on 17 March 2022 (this may relate to the discussion with Mrs Smith on 21 March 2022 below) but does not refer to any earlier discussions.[1628] The note of the meeting on 20 January 2022 states that it was *"very positive"* but does not address the issue of the transfer of risk information.[1629]

130. Mrs McLoughlin was asked about the paradox between a suggested lack of risk information provided at the meeting between Mrs Allred and Mrs Dawson on 20 January 2022, compared with the significant information provided by The Acorns School at the time of AR's transfer (see below). Mrs McLoughlin noted that AR's transfer to Presfield High School was, at the time of the

1624 T/S: 28/16/14-24.
1625 T/S: 28/14/23-25.
1626 Witness Statement of Mrs Dawson PRE001807/§§5-8, §§13-14.
1627 Witness Statement of Mr Fay PRE001809/§13.
1628 Witness Statement of Mrs Allred LCC001709/§46.
1629 LCC001679/4.

meeting, due to be in September 2022 and that the transfer was later accelerated.[1630] As a result, the transfer of information about AR's risk would have been less urgent in January 2022.

131. In addition, Mrs McLoughlin referred to the guidance, practice and expectations between schools when a pupil is transferred. The DfE policy in relation to the transfer of information is set out at paragraph 49 above. In short, local authority maintained schools (such as The Acorns School) are required to transfer data relating to the pupil (the common transfer file) to the new school within 15 days of the pupil ceasing to be registered. The child protection file is transferred separately and this must be done within five days of an in-year transfer or within the first five days of the start of the new term.[1631] The Keeping Children Safe in Education 2018 guidance stated that the DSL should ensure that their child protection file is transferred to the new school or college as soon as possible. Consideration should be given to whether it would be appropriate to share information in advance of the child transferring. However, while providing this in advance is encouraged, there is no obligation. The receiving school is not entitled to safeguarding information before the transfer takes place.[1632]

132. I do not make factual findings about whether risk information was shared at the meeting on 20 January 2022 in the absence of oral evidence from Mrs Allred and Mrs Dawson. Even if no information about the risk was shared by Mrs Allred at this stage, this would not have been in breach of the duties and guidance. At that point, AR's transfer to Presfield High School was thought to be around nine months away. Moreover, the responsibility for sharing such information fell on the DSL, Mrs J Lewis, rather than Mrs Allred. Mrs J Lewis was not party to the conversations and did share risk information at a later stage, in line with the duties and guidance set out above.

133. Mrs Dawson did have sight of AR's EHCP when considering whether to offer a place to AR. While this contained information of concern, set out above, it did not include any detail, including examples, of AR's previous history of violence and carrying weapons, e.g. the hockey stick attack at Range High School. Mrs McLoughlin stated that an EHCP should include information to allow the school to assess the risk to other pupils, given the EHCP was the only information Presfield High School had to work from.[1633] Dr Oonagh Killen of CAMHS also suggested that all relevant risk information should be within an EHCP, especially when a pupil is changing schools.[1634]

134. Mrs Hodson stated that risk information is not necessarily written into EHCPs, which tend to address learning difficulties, and educational and social needs.[1635] Mr Turner agreed with Mrs Hodson's view, stating that the SEND

1630 T/S: 28/23/9-24/24.

1631 T/S: 28/25/15-26/1.

1632 DFE000224/21/§§79-80 (guidance also available online); T/S: 28/25/3-9.

1633 T/S: 28/18/2-17.

1634 T/S: 24/181/12-182/3.

1635 T/S: 27/203/10-17.

Code of Practice does not specifically require an EHCP to include information about risk, but agreed that a school needed to be sighted on absolutely everything to make a rounded decision about the ability of that school to meet that child's needs.[1636] Ms Dixon also felt that this information should be shared but it would be wrong to rely on an EHCP as the place for the risk to be recorded.[1637]

135. Mrs McLoughlin also noted that each local authority has a different format for EHCPs and a pupil's history is made clearer in some formats compared to others.[1638] She stated that a standardised approach would assist and the format could require the provision of risk information.[1639] Dr Risthardh Hare, Executive Director of Children's Services and Chair of the Sefton Safeguarding Children Partnership, stated that schools must now ensure that section D of an EHCP includes information about risk and risk-taking behaviours, to enable the potential receiving school to put in place risk assessments.[1640]

136. I am concerned that EHCPs may be ineffective at passing on information about the risk a pupil poses to other pupils, as in this case. This is particularly so given the EHCP is one of the documents considered when a place is offered. I accept Mrs McLoughlin's suggestion that consideration should be given to a standardised EHCP and to requiring the provision of information about risk and risk-taking behaviours (as is now the case in Sefton). I make a recommendation to this effect below. However, I do not consider the EHCP to be a complete solution. Not all pupils who pose a risk to other pupils will be subject to an EHCP. Mr Turner stated that there should be further information provided in addition to the EHCP.[1641] I have therefore considered the wider provision of information between The Acorns School and Presfield High School below.

137. Mrs J Lewis provided the CPOMS records to Presfield High School after a place had been offered but before AR transferred (see below). However, she stated that the usual practice was that the transfer of safeguarding information, including CPOMS, is done only after the pupil is actually on the roll of the new school.[1642] Mrs Hodson confirmed the same position for the common transfer file.[1643] In fact, Mrs J Lewis stated that The Acorns School tended not to receive CPOMS and risk assessments and this was general practice within the authority. She agreed that the risk that a student poses to other students should be transferred before a place is accepted at that school.[1644] She accepted that there was nothing to preclude information being

1636 T/S: 26/159/16-160/10, T/S: 26/161/10-13.
1637 T/S: 28/80/1-81/21.
1638 T/S: 28/18/18-19/17.
1639 T/S: 28/19/18-20/10.
1640 Witness Statement of Dr Hare SEF000171/§60.
1641 T/S: 26/160/3-23.
1642 T/S: 27/87/4-20.
1643 First Witness Statement of Mrs Hodson LCC001773/§256.
1644 T/S: 27/87/21-88/12.

shared at an earlier stage and that this could be helpful.[1645] Mrs Hodson stated that the lack of information provided pre-transfer is a weakness and a challenge.[1646]

138. I am concerned at the extent of the information which was transferred at the time that Presfield High School offered a place to AR. I am not critical of The Acorns School which acted consistently with its duties, guidance and general practice. Nevertheless, there was a missed opportunity for Presfield High School to learn about AR's risk to others, so that preventative measures could be put in place once AR started at school there. More fundamentally, Presfield High School agreed to offer a place to AR without knowledge of the risk that he posed to other pupils and teachers. Mrs Dawson states that, if she had been aware of the information that existed about AR, her recommendation would have been not to offer AR a placement on the basis that autism was not his primary need and Presfield High School would not have been able to meet his educational needs.[1647] Mr Fay, the former headteacher, stated that if the school had been aware of AR's full history then a lengthy discussion about offering him a place would have taken place although he could not predict the outcome with any certainty.[1648] Mrs McLoughlin stated that Presfield High School would not be able to meet the needs of a pupil who had a history of carrying a knife, particularly where there was intent to harm somebody with that knife, and would not have offered a place to AR if it was aware of his history.[1649] The evidence therefore shows that if the relevant information had been transferred, then AR might well never have been offered a place at Presfield High School.

139. On the one hand, although The Acorns School was not suitable in the long term for AR, witnesses described the need for children to have a fresh start at a new school. For example, AR's form tutor at Presfield High School, Mr James Berry, suggested that *"there was no need to pursue any further information as this can taint the perception of the student prior to arrival; everybody deserves a fresh start"*.[1650] There is a risk that more dangerous pupils cannot find appropriate education. Presumably for these reasons, a school can be obliged to provide a placement, if that school is named on an EHCP, although Mrs McLoughlin said that in practice there are discussions between a school and the local authority when a request for placement is made.[1651]

140. On the other hand, there is no use in a pupil being offered a place at a new school when it is unsuitable, particularly if this is because of the risk that the new pupil presents to others. By way of example, The Acorns School was used

1645 T/S: 27/88/23-89/10.

1646 T/S: 27/207/17-208/14.

1647 Witness Statement of Mrs Dawson PRE001807/§§15-16.

1648 Witness Statement of Mr Fay PRE001809/§57.

1649 T/S: 28/15/20-16/4, T/S: 28/35/25-36/11.

1650 Witness Statement of Mr Berry PRE001805/§11.

1651 T/S: 28/8/6-21.

to dealing with pupils who carried weapons and it was standard practice for The Acorns School to wand students as they arrived at the start of the school day to detect weapons.[1652] Presfield High School did not have such systems in place as standard.[1653]

141. AR did not engage with Presfield High School and, as set out above, Presfield High School were unaware of the risk that he posed to others. As a result, the question of whether Presfield High School could manage the risk that AR presented to others never became an issue. However, if Presfield High School had appreciated the risk information provided about AR, it was entirely foreseeable that a decision would have been made that it was unable to keep him on the roll. If that decision had been made after AR's transfer to Presfield High School then AR would have lost further time in education because the process of finding him with new education would have had to re-start.[1654] Ms Dixon accepted that Keeping Children Safe in Education could be more descriptive about examples of when it might be appropriate to share risk information in advance of a transfer between schools and greater emphasis could be given to the requirement to pass the information as soon as possible, rather than relying on the backstop of five days after the transfer.[1655] I consider that the duties, guidance and practice concerning the transfer of risk information before a place is offered ought to be reviewed and I make a recommendation in this respect below.

Transfer of information: before and after AR's transfer to Presfield High School

142. Following the offer of a place at Presfield High School, AR became further disengaged from The Acorns School. As a result, The Acorns School asked whether AR could start earlier at Presfield High School.[1656] Mrs Dawson agreed that AR could be accommodated in the sixth form and it was agreed, very quickly on 23-24 February 2022, that AR could take his place at Presfield High School earlier.[1657] As a result, an *"enhanced"* transition was put in place so that AR had a series of transition visits while he remained on the roll at The Acorns School. These were arranged from 14 March 2022 and AR was due to join Presfield High School from April 2022.[1658]

1652 T/S: 27/40/11-23.
1653 T/S: 27/214/19-215/6.
1654 T/S: 28/36/12-37/7.
1655 T/S: 28/105/24-106/12.
1656 First Witness Statement of Mrs Hodson LCC001773/§263.
1657 LCC001346/8-9.
1658 T/S: 28/23/9-24/24.

143. AR did not attend all of the planned transition visits, including missing one on the day of the bus incident on 17 March 2022.[1659] In the aftermath of this latter event, and ahead of AR transferring onto the roll at Presfield High School, there was further transfer of information between The Acorns School and Presfield High School.

144. On 18 March 2022, Mrs J Lewis emailed the school business manager at Presfield High School asking who the DSLs were because she had some safeguarding information regarding AR to provide. She was given the email addresses of Mrs Smith, DSL at Presfield High School, and Mr Mark Rigby who was the Deputy DSL.[1660] On 21 March 2022, a CPOMS record states that Mrs Allred spoke to the deputy headteacher of Presfield High School (Mrs McLoughlin) and then Mrs Smith rang back for more information. The information shared by Mrs Allred with Mrs Cheryl Smith included that:[1661]

    a. AR ran away from home on 17 March 2022 with a kitchen knife with a plan to stab somebody;

    b. This was as a result of taking literally information from Ms Samantha Steed, his CAMHS worker;

    c. AR would be unlikely to do anything at school but would need to be carefully supervised;

    d. The Acorns School had asked all staff to be aware of AR's actions and to check him carefully on arrival into school;

    e. Presfield High School were asked not to discuss the incident with AR because he would probably be very keen to give a good impression.

145. The CPOMS record of 21 March 2022 also recorded that a full CPOMS report had been sent to Presfield High School. An up-to-date report was to be sent with the Operation Encompass report. Mrs Smith said that she had not seen the CPOMS report.[1662] Mrs Allred thought that Mrs Dawson had seen the CPOMS, however she agreed to get a full report re-sent to Mrs Smith. Mrs J Lewis agreed to do this and the email addresses for Mrs Smith and Mr Rigby were noted on CPOMS.[1663]

146. Mrs J Lewis sent a copy of the CPOMS reports to Mrs Smith (only) via Egress on 22 March 2022 with the subject line *"[AR] CPOMS"*.[1664] However, Mrs Smith did not open the email until after the attack, in September 2024, when she was told that The Acorns School had sent the CPOMS records.[1665] In addition, both The Acorns School and Presfield High School used the

1659 Witness Statement of Mr Fay PRE001809/§14.

1660 PRE001730.

1661 LCC001346/4.

1662 PRE000358; T/S: 27/86/17-87/12, T/S: 27/225/24-226/9.

1663 LCC001346/4.

1664 PRE001717.

1665 First Witness Statement of Mrs Smith PRE001806/§8.

CPOMS system. It is possible to request the records of a pupil on CPOMS after a transfer but this never took place.[1666] This meant that Presfield High School was never aware of the contents of the CPOMS records, which included all the information from the Prevent referrals and details of the serious incidents, including the Childline report, the hockey stick attack at Range High School and the bus incident. I consider this further below.

147. AR moved onto Presfield High School's roll on 28 March 2022. On 27 April 2022, Mrs Allred emailed Mrs Dawson further documents by way of handover to Presfield High School.[1667] This included The Acorns School pupil risk assessment for AR.[1668] The risk assessment included the following information:[1669]

    a. AR had alleged that he was being targeted by another learner and appeared aggressive towards them;

    b. AR had informed Childline that he had been carrying a knife to school with the intention of harming another learner and this was on more than ten occasions;

    c. AR had hit another learner at Range High School;

    d. AR had visited Range High School to find another learner who had bullied him and had assaulted a learner who was not connected with the event. AR was charged with assault and completed a community order with the YOT;

    e. AR said that he would hit a peer at his new school if they would not agree with his political viewpoint;

    f. AR had made the comment *"that's why teachers get murdered"*;

    g. AR had a significant lack of emotion and awareness as to why he was excluded from his previous school;

    h. The severity of the behavioural concerns was said to be: risk of aggression to peers – moderate; violence to peers – moderate and severe; the risk of violence to staff – severe; and use of weapons – severe;

    i. The report referred to liaison with the YOT who were managing the risk and advising the school if there was any known risk of re-offending. The case was said now to be closed and the risk low.

148. On 4 May 2022, Mrs Dawson gave Mrs Smith a paper copy of a risk assessment from The Acorns School. This was uploaded by Mr Rigby onto the Presfield High School CPOMS.[1670] However, it does not appear that any further action was taken in response to the risk assessment.

1666 T/S: 28/21/23-23/1.

1667 LCC001595.

1668 First Witness Statement of Mrs Hodson LCC001773/§270.

1669 LCC000707.

1670 First Witness Statement of Mrs Smith PRE001806/§10.

Analysis

149. Mrs Smith failed to open the CPOMS records which were apparently sent by The Acorns School on two occasions. I note the following context:

    a. Mrs Smith was working on the morning of 21 March 2022, the day on which she was called by Mrs Allred, but had to leave work after becoming unwell;[1671]

    b. She did not return to work substantively until 3 May 2022 and missed this email when catching up with her inbox;[1672]

    c. Mrs Smith stated that she should have sought further training and support on using CPOMS[1673] and her evidence was that she also struggled to find space in her timetable to become equipped to use CPOMS;[1674] and

    d. Mrs Smith was dealing with a very serious illness of a close family member at this time.[1675]

150. Nevertheless, dealing with this sort of information was fundamental to Mrs Smith's role as DSL, given that safeguarding included the risks posed by a pupil, as well as the risks to a pupil.[1676] Moreover, Mrs Smith was told that AR had ran away from home with a kitchen knife with a plan to stab somebody by Mrs Allred on 21 March 2022. She should have known that the CPOMS records concerning AR were of great importance and her failure to process them, or request them electronically via the CPOMS system, was a serious error. A post-attack investigation by Presfield High School uncovered that CPOMS information had not been requested for 53 children and this was not, therefore, an isolated incident on the part of Mrs Smith.[1677]

151. At the same time, Presfield High School knew that Mrs Smith was suffering from ill health and Mrs McLoughlin accepted that there should have been arrangements for providing cover while she was on leave, including by way of checking her emails.[1678] Presfield High School states that since the July 2024 attack and with changes introduced in Mrs McLoughlin's period as headteacher, it now has failsafe mechanisms in place because the entire senior leadership team are DSLs, with elevated access to CPOMS, regular reminders are in place, there are regular meetings to discuss placement requests and

1671 First Witness Statement of Mrs Smith PRE001806/§32.
1672 First Witness Statement of Mrs Smith PRE001806/§29.
1673 First Witness Statement of Mrs Smith PRE001806/§§75-77.
1674 T/S: 27/226/19-227/8.
1675 T/S: 27/220/8-12.
1676 T/S: 28/25/10-14.
1677 Witness Statement of Mrs McLoughlin PRE001808/§27.
1678 T/S: 28/27/21-28/8.

there is a central safeguarding email address.[1679,1680] Mrs McLoughlin did, however, state that Mrs Smith had received training on CPOMS and that she had been transferring CPOMS files both before and after AR's transfer to Presfield High School, which undermines the suggestion that Mrs Smith lacked the requisite technical knowledge.[1681]

152. These were not the only missed opportunity for Presfield High School to appreciate information about AR's risk. As set out above, The Acorns School risk assessment was provided to Presfield High School and seen by Mr Fay, Mrs Dawson and Mrs Smith.[1682] Mr Berry appears to have been aware of it but was not allowed to see it because it was confidential.[1683] It was uploaded onto the Presfield High School CPOMS by Deputy DSL Mr Rigby.[1684] The Acorns School risk assessment contained detail of all the significant past incidents involving AR and referred to a number of moderate and severe behavioural concerns. Although the risk assessment stated that the YOT assessed the risk to be low, both Mrs Smith and Mrs McLoughlin accepted that it was clear, on reading the risk assessment, that AR posed a considerably higher risk from the perspective of Presfield High School.[1685,1686] There is no evidence that this information was recognised, appreciated and acted upon by anyone at Presfield High School. This was another fundamental failure to process crucial information.

153. The lack of appreciation of AR's risk is most clearly demonstrated by Presfield High School's risk assessments of AR dated April and June 2023.[1687] There is no written risk assessment dated earlier than these, despite the fact that one should have been prepared on AR's arrival.[1688] The risk assessments from 2023 assessed risks relating to AR's lack of road awareness, lack of social understanding and the fact that he may not respond to instructions straight away. There was no consideration whatsoever of the risk that AR might present to other children. This was a naïve assessment of AR, that could only have been prepared without appreciation of the information that was available to Presfield High School. Both Mrs Smith and Mrs McLoughlin accepted that the

1679 T/S: 28/29/1-18.

1680 Witness Statement of Mrs Dawson PRE001807/§27.

1681 T/S: 28/28/13-25.

1682 T/S: 28/30/3-8, T/S: 28/32/20-34/16.

1683 Witness Statement of Mr Berry PRE001805/§11.

1684 Second Witness Statement of Mrs Smith PRE001811/§3; Witness Statement of Mr Rigby PRE001812/§§6-7.

1685 Mrs McLoughlin having only been provided with a copy of the risk assessment after 29 July 2024.

1686 T/S: 27/234/21-235/21, T/S: 28/31/25-32/6.

1687 PRE001742; PRE001741.

1688 Witness Statement of Mr Fay PRE001809/§33.

risk assessment was inadequate.[1689,1690] While Mrs Smith was not responsible for preparing or quality assuring the risk assessment, she accepted that, if she had been aware of the information sent to her in the CPOMS records, then she would have ensured that the risk assessment was updated and amended to reflect the risks both to AR and those posed by AR.[1691] She would also have called Prevent to inform them of the bus incident on 17 March 2022.

154. There were, therefore, a number of serious errors and oversights by Presfield High School staff. These contributed to a position whereby those at Presfield High School were concerned about AR's welfare but not about the welfare of those to whom he might present a risk.[1692]

155. Ultimately, this made little difference because AR rarely attended Presfield High School or even came to meet Presfield High School staff when they attended his home. Nevertheless, the lack of an effective risk assessment could have been disastrous if AR had decided to carry out an attack at Presfield High School or on Presfield High School staff during home visits. Given his actions at Range High School, this was a possibility.

156. Ms Dixon accepted that the guidance should make clear that there should not be single points of failure for the transfer of safeguarding information, such as a single email address for a recipient (e.g. Mrs Smith) and there should be consideration given to a failsafe mechanism such as a standard check done at a fixed time to ensure that safeguarding information has been seen.[1693]

157. In her follow up response to the Inquiry, Ms Dixon confirmed the department is already working on revised content for Keeping Children Safe in Education guidance 2026 that will make it clearer that schools should implement robust cover arrangements for periods when the DSL is unavailable to mitigate the risk in relation to a single point of failure, alongside providing examples of the sort of information on risk that would be helpful to be shared in advance of a pupil starting a new school.

158. I note in this regard that the DfE opened a consultation on proposed changes to the Keeping Children Safe in Education guidance on 12 February 2026.[1694] On information sharing, the consultation documents states:

> *"We have strengthened guidance on the transfer of child protection files when a pupil moves to a new school or college. The update clarifies that the designated safeguarding lead (DSL) or a deputy should share any information indicating that a pupil may pose a risk*

1689 Mrs McLoughlin having, again, only been provided with the documents after the attack occurred.

1690 T/S: 27/236/20-237/5, T/S: 28/32/16-19.

1691 First Witness Statement of Mrs Smith PRE001806/§30.

1692 First Witness Statement of Mrs Smith PRE001806/§14; T/S: 28/34/23-35/13.

1693 T/S: 28/107/7-108/18.

1694 ILT000085, available at: https://consult.education.gov.uk/independent-education-and-school-safeguarding-division/keeping-children-safe-in-education-2026-revisions

> *to themselves or others, such as concerns about serious violence or harmful behaviours, with the receiving setting. In addition, we recommend that DSLs or a deputy from both settings have a direct conversation where there are significant issues or concerns, as good practice, to ensure continuity of safeguarding support."*[1695]

There is revised wording in paragraphs 144 to 145 of the draft Keeping Children Safe in Education guidance 2026 that forms part of the consultation.[1696] I recognise that these may well meet the issues I have raised. However, no changes have yet been made and accordingly I have made recommendations in relation to these issues for DfE.

159. I am satisfied that Presfield High School has now put in place measures and safeguards to prevent such issues from re-occurring. However, I am concerned that there is a wider issue of schools failing to transfer risk information. There were issues with the transfer of risk information between Range High School and The Acorns School, albeit less significant. Moreover, I am aware that there have been other examples of failures to transfer similar information. The Manchester Arena Inquiry identified *"several examples of failures to transfer information"* between schools.[1697] Open source reporting suggests that similar issues have been raised in relation to the death of Harvey Willgoose on 3 February 2025.[1698] Ms Dixon stated that she would expect to hear from Ofsted and possibly the National Safeguarding Panel, schools or Children's Social Care if there were wider vulnerabilities in the transfer of safeguarding information from schools.[1699] I note that Mr Turner referred to the fact that LCC offers a safeguarding audit for schools; however, he stated that it would be very difficult for LCC to audit all of its schools with current staffing levels. He also referred to Ofsted's framework for ensuring safeguarding.[1700] I consider that there are grounds for a wider system of auditing to ensure that safeguarding information is being passed between schools, whether via DfE guidance, input from Ofsted or local educational authorities and I have made recommendations in this respect at the end of this chapter.

1695 ILT000086/29, available at: https://consult.education.gov.uk/independent-education-and-school-safeguarding-division/keeping-children-safe-in-education-2026-revisions/supporting_documents/keeping_children_safe_in_education_2026_government_consultationpdf

1696 Keeping Children Safe in Education guidance 2026 that forms part of the consultation'. ILT000087/41-42/§§144-145. Available at: https://consult.education.gov.uk/independent-education-and-school-safeguarding-division/keeping-children-safe-in-education-2026-revisions/supporting_documents/keeping_children_safe_in_education_2026_draft_for_consultationpdf-1

1697 Manchester Arena Inquiry Volume 3/30/§22.150.

1698 The Guardian, 'Harvey Willgoose's family says 'too many red flags' missed before school stabbing', 2026. Available at: www.theguardian.com/education/2026/feb/03/harvey-willgoose-mother-too-many-red-flags-missed-school-stabbing

1699 T/S: 28/58/5-59/1.

1700 T/S: 26/138/18-141/6.

AR's attendance at Presfield High School

160. AR's level of attendance at Presfield High School was only 0.7%.[1701] However, Presfield High School witnesses set out the numerous steps that were taken to encourage AR's attendance:[1702]

a. Providing AR's favourite foods for lunch;

b. Altering the curriculum to allow him to attend on a one-to-one basis;

c. Procuring a personal tutor to teach him his favourite subjects;

d. Allowing him to play his favourite sport of basketball;

e. Giving him his own room in which to study;

f. Allowing him to sit with his back towards the classroom door so as not to see other pupils in the corridor;

g. Encouraging him to attend when other students were away so that he would be the only pupil present;

h. Allowing transition visits over a prolonged period so that he became familiar with pupils and staff;

i. A reduced and bespoke timetable;

j. Home visits in order to build relationships;

k. Specialist input from the speech and language therapist and from the occupational therapist; and

l. Transport from home to school.

161. Mrs Dawson stated categorically in her evidence to the Inquiry that the school went above and beyond what was expected. Mr Fay stated that staff worked extremely hard to engage with AR, often at the expense of other students.[1703] Mrs McLoughlin indicated that they tried all options to get AR through the door and that the steps taken were more than adequate.[1704] I agree. Presfield High School did all it could to secure AR's attendance at the school.

Welfare visits

162. Given AR was not attending the school, Presfield High School took further steps. Firstly, it sought to arrange visits to AR's home address to build a relationship with him and to ensure his welfare. Secondly, it sought LCC's assistance in securing appropriate education for AR. I address these in turn.

1701 T/S: 28/4/8-9.

1702 Witness Statement of Mrs Dawson PRE001807/§18; Witness Statement of Mrs McLoughlin PRE001808/§39; T/S: 28/38/17-40/6.

1703 Witness Statement of Mr Fay PRE001809/§36.

1704 Witness Statement of Mrs McLoughlin PRE001808/§§39-40.

163. In relation to the visits, Mr Berry's evidence was that he made numerous visits.[1705] He referred to one visit, on 3 May 2022, when AR's father was concerned that AR might get angry and attack him: a comment which belies the suggestion that AR's risk was only to members of his family (see Chapter 12: AR's family).[1706] Mrs McLoughlin had taken part in some visits but was not able to see AR. Quite often, AR's parents did not allow staff into the house and, when they were allowed in, AR was either said to be sleeping or refused to be seen.[1707] Mrs Smith carried out three or four home visits and was also prevented from seeing AR.[1708] Mrs Smith was concerned that Presfield High School did not know what was going on while AR was not at school.

164. As a result of AR's lack of engagement and the challenges in seeing AR during home visits, as well as a lack of awareness of the parenting skill of AR's parents, Presfield High School staff, and Mrs Smith in particular, sought the assistance of other agencies to carry out welfare visits.[1709] I address some key examples below.

165. Dr Risthardh Hare, Executive Director of Children's Services and Chair of the Sefton Safeguarding Children Partnership, noted that Presfield High School is within Sefton MBC's jurisdiction. He noted that AR was only of compulsory school age for 13 weeks of his time at Presfield High School and, during that time, he was on a bespoke timetable as part of his transition to the school, as well as being treated by CAMHS. His evidence was that it would not have been appropriate to initiate legal proceedings against AR's parents for AR's non-attendance during this period. Sefton MBC could not have carried out enforcement proceedings once AR was above compulsory school age. By that stage, given AR's age, Sefton MBC was under no duty to provide attendance support.[1710]

166. Even when a pupil is above compulsory school age, the responsibility for maintaining and reviewing an EHCP rests with the area where the child is resident. In AR's case, that was LCC. This obligation continued while AR was subject to an EHCP, which can continue until a person is 25 years old. AR was under an EHCP when he started at Presfield High School until it was withdrawn on 20 March 2024. As a result, throughout this period, LCC was obliged to implement the provisions as set out in the EHCP (see section 42 of the Children and Families Act 2014).[1711] AR's EHCP required him to have an education placement and several of the outcomes required him to be in education.[1712]

1705 Witness Statement of Mr Berry PRE001805/§7.

1706 Witness Statement of Mr Berry PRE001805/§§16-17; PRE000037; PRE000359.

1707 T/S: 28/40/8-24.

1708 T/S: 27/217/21-218/8.

1709 First Witness Statement of Mrs Smith PRE001806/§48, §§53-58.

1710 Witness Statement of Dr Hare SEF000171/§§27-28.

1711 T/S: 26/118/14-119/1, T/S: 26/126/2-9

1712 PRE001739.

167. Mrs Smith sought the assistance of LCC to carry out welfare visits. However, unlike Sefton MBC (see below), LCC did not have a welfare visit service. Instead, on 6 July 2022, Mrs Smith was directed to a 'Children's Champion'; however, he lived a 90-minute drive away and it was not his role to carry out such visits.[1713] Another example was on 21 December 2022, when Mrs Smith wrote to LCC referring to Sefton MBC's first day response team who will conduct home visits, noting that she was unaware of any similar service for LCC.[1714]

168. Mrs Smith sought the assistance of Sefton MBC's First Day Support Response Team. Ms Angela Maguire of Sefton MBC visited AR's home on 20 March 2023. However, Laetitia M is recorded as having aired her annoyance and confusion and flatly refused to permit Ms Maguire to see AR (again, see Chapter 12: AR's family).[1715] Sefton MBC was not, at that stage, under any duty to provide attendance support or carry out a welfare visit, indeed it went beyond its statutory duties in so doing.[1716] Sefton MBC and LCC advised Mrs Smith to request a welfare check from Lancashire Constabulary.[1717]

169. On 21 March 2023, Mrs Smith called Lancashire Constabulary and spoke to call handler Mr Robert Correy. I have addressed the actions of Mr Correy in Chapter 7: Policing. By this stage, Presfield High School had not seen AR since May 2022 and no professional had seen AR since a CAMHS visit in January 2023. For reasons that I address in Chapter 7: Policing, applying the Right Care Right Person policy, Mr Correy determined that it was not appropriate for the police to attend. I concluded that this was the correct decision under the policy, although Mr Correy should have sought details about AR in order to make a fully informed assessment. It is noteworthy that Lancashire Constabulary do not provide any kind of Safer Schools Officer to carry out welfare visits, unlike Merseyside Police (see below).

170. The difficulties Presfield High School were having is best demonstrated by an internal email sent by Mrs Smith on 21 March 2023:

> *"the red tape is frightening — not under the remit of children missing education team although not seen by the school since 25 May 2022*
>
> *Doesn't meet threshold for police welfare check as we can't say we think a crime is committed/emergency risk to him*
>
> *Sefton Welfare team tell us to do the above*
>
> *Lancashire SEN tell us to ring police (who won't go) and Lancashire social care MIGHT say he doesn't meet their remit.*

1713 T/S: 27/241/3-15; PRE000064.

1714 PRE000101.

1715 T/S: 27/240/15-24; LCC000186/2.

1716 Witness Statement of Dr Hare SEF000171/§36.

1717 PRE000216.

Short of breaking in I don't know how to see this kid. The only option not exhausted is Steve Baker who MIGHT go out to help us because he's attached to us."[1718]

171. On 23 March 2023, the LCC Children Missing Education team emailed staff at Presfield High School stating that: *"given that [AR] is no longer of compulsory school age (within CME's remit) and is currently on school roll, there really isn't a role for us to play or advice we can give unfortunately"*.[1719] The email noted that AR was under an EHCP and it was copied to the Inclusion team and AR's allocated SEND case manager. However, it does not appear that any active steps were taken by those copied into the email, despite LCC's obligation to implement the EHCP.[1720]

172. Police Constable Steve Baker of Merseyside Police was posted to local policing in Southport as a Safer Schools Officer. He covered a cluster of schools including Presfield High School. He received an email from Mrs Smith on 27 March 2023 asking whether he would visit AR. However, AR attended Presfield High School later the same day. Mrs Smith noted in her evidence that *"[t]he request was unorthodox as a Merseyside Officer was conducting a welfare visit within the area of another force"*, that of Lancashire Constabulary.[1721] AR was raised with PC Baker again in July 2023 and he agreed to a visit. He noted that AR resided in the Lancashire Constabulary force area but AR attended a Sefton school within the Merseyside Police area and the address was just down the road from the school. As PC Baker was not investigating anything, he considered it appropriate to attend. He visited the family home on 18 July 2023 and recalls that a member of school staff spoke with AR and AR's father about the need for AR to attend school. PC Baker tried to talk to AR but his engagement was limited. There were further visits on 13 September 2023, 17 November 2023 and 8 December 2023 but PC Baker could not recall the details of what occurred.[1722]

173. The Presfield High School staff were clearly frustrated by the lack of assistance from other agencies, in particular LCC. Mrs Smith stated *"I felt that Lancashire Council were finding reasons to not support us or AR"*, *"[i]t felt that no-one wanted to help"* and *"I was disappointed by the inaction of Lancashire Council as AR was a child for whom they had responsibility"*.[1723,1724] She stated that there was no cross-border cooperation or policies between LCC and Sefton MBC.[1725] She found that the *"response from Lancashire Council was*

1718 PRE000223.
1719 PRE000226/1.
1720 Witness Statement of Mr Turner LCC001802/36-37; T/S: 28/41/7-21.
1721 First Witness Statement of Mrs Smith PRE001806/§58.
1722 Witness Statement of PC Baker MERP008318/§§19-39.
1723 First Witness Statement of Mrs Smith PRE001806/§22.
1724 First Witness Statement of Mrs Smith PRE001806/§55.
1725 First Witness Statement of Mrs Smith PRE001806/§61.

very poor, there was no co-operation and no constructive responses".[1726] Mrs McLoughlin noted that there was significant turnover at LCC and the school had no idea who was responsible for AR's plan within LCC.[1727] She felt that the support the school got from LCC was *"virtually non-existent"*.[1728]

174. Mr Turner accepted that Presfield High School were not provided with any assistance of substance.[1729] LCC did not have the ability to conduct visits at this time, given the team was extremely small.[1730] Mr Turner suggested there were excessive demands on his department, particularly in light of the complexity of their work, which had increased exponentially since 2020. He accepted that there was a significant risk of information becoming fragmented and lost when it was shared between so many different teams. LCC has since expanded the number of members of staff and, following his appointment in February 2024, Mr Turner has sought to address ineffective cross-team working (see further below).[1731]

175. Dr Hare's evidence is that Sefton MBC has changed its policy so that where parents refuse to allow school attendance workers to see a child who is not attending school, this will now be escalated to the appropriate service such as children's services and, in more serious cases, the police.[1732]

176. I am also concerned by the regional variation in resources and approach that means that there is less assistance with welfare visits (from both the council and the police) for those within the LCC and Lancashire Constabulary jurisdiction than those within Sefton MBC and Merseyside Police jurisdiction. Mr Moss KC suggested in questioning Ms Dixon that there could be work done by DfE to *"bring greater clarity about who should provide assistance to schools in welfare checks when there are higher risk cases."*[1733] I am aware of the work Ms Dixon referred to about violence fixated individuals, but it seems to me that this is a wider issue to which I return in the recommendations at the end of this chapter.

177. Finally, I am concerned by the impact of AR living in the jurisdiction of one local educational authority (LCC) but attending Presfield High School in another (Sefton MBC). While LCC held responsibilities for ensuring that AR attended school (while of compulsory school age) and for providing an EHCP, Mr Turner pointed out that attendance data would be held by the local education

1726 First Witness Statement of Mrs Smith PRE001806/§72.

1727 T/S: 28/45/2-10.

1728 T/S: 28/51/3-7.

1729 T/S: 26/163/2-5.

1730 T/S: 26/165/17-23.

1731 T/S: 26/109/3-24.

1732 Witness Statement of Dr Hare SEF000171/§§58-59.

1733 T/S: 28/83/17-84/11.

authority for the school. As a result, he suggested that the reality is that the local educational authority for the school sees the registers and has the data to identify failing attendance rates.[1734]

178. Dr Hare stated that, for children of compulsory school age, Sefton MBC's standard practice is to perform its educational duties as if the child resides within its borough.[1735] However, he recognised confusion in the correspondence as to which local authority was responsible for AR missing education.[1736] He stated that, in 2023 and 2024, Sefton MBC added cross-border working into its local procedures and it has written to neighbouring local authorities to ask them to share their protocols in response to the updated statutory guidance for attendance.[1737]

179. Ms Dixon stated that the guidance is clear that the responsibility sat with the local authority where the child lives (in this case this was LCC) and that information should be shared between local authorities.[1738] Dr Hare referred to DfE's statutory guidance 'Working together to improve school attendance', as of 19 August 2024, which provides that a school's local authority should alert the home local authority which maintains the EHCP about any significant issues emerging over attendance. This was incorporated into the council's local procedures in 2024.[1739] However, based on the evidence, I am concerned both that there is a risk that each local educational authority is unclear on its role and also that data is not appropriately shared across jurisdictions, particularly in circumstances where a child is above compulsory school age but subject to an EHCP. I return to this in the recommendations at the end of this chapter.

Alternative education provision

180. On 14 July 2022, Mrs Dawson wrote to Mr Iain Calderbank, Senior Special Educational Needs and Disability Officer of LCC, stating that AR's placement offer for September 2022 was being withdrawn because of AR's *"devastatingly low"* attendance figures and his struggles with mental health and anxiety, which were impacting his ability to leave the home. She noted that LCC had failed to attend AR's annual review meeting on 7 July 2022 despite several invites.[1740]

181. Mrs McLoughlin stated that this action was taken because it was clear that the school was not going to be able to meet AR's needs. Alphonse R spoke about AR's anxiety and mental health. Mr Fay was told that AR had stopped taking his medication.[1741] Presfield High School did not have the specialisms to

1734 T/S: 26/116/5-118/13.
1735 Witness Statement of Dr Hare SEF000171/§9.
1736 Witness Statement of Dr Hare SEF000171/§50.
1737 Witness Statement of Dr Hare SEF000171/§55, §61.
1738 T/S: 28/68/18-70/15.
1739 Witness Statement of Dr Hare SEF000171/§56.
1740 LCC000178/19-20.
1741 Witness Statement of Mr Fay PRE001809/§19.

support AR with his mental health and it was decided that AR should receive treatment from a different provider, whether in a school setting or otherwise. There was also a doubt as to whether AR wished to attend Presfield High School. As a result, the school sought to *"almost force Lancashire's hand to find a provision"* that would be able to support AR.[1742]

182. Mrs Smith noted that Presfield High School was oversubscribed[1743] and stated: *"I felt that there was a place provided but AR was a non-attender, I felt this was a waste of resource when another student who would like a place at Presfield could have benefitted from the place to gain education and qualifications – something we were not able to provide for AR."*[1744]

183. On 5 September 2022, Alphonse R wrote to Mr Fay stating that LCC's Inclusion team was to contact Presfield High School to ensure that AR's place was not revoked due to his difficulties with attendance. On the same day, Mr Fay replied explaining that the school could not meet AR's need and that, as stated by their letter on 14 July 2022, the placement had been withdrawn. He stated that LCC would have a duty to find a setting and package of support best suited for AR's needs if AR was no longer on Presfield High School's roll. Mr Fay subsequently had several conversations with LCC staff who stated that AR could not be removed from the roll.[1745]

184. In January 2023, AR's parents provided the parental input for the annual review of AR's EHCP. By this stage, they did not consider Presfield High School was suitable and asked the council to identify another placement.[1746] Nevertheless, no alternative provisions were explored by LCC.

185. On 3 February 2023, Mr Fay emailed Ms Sharon Rowland, SEND Case Manager at LCC, about confusion concerning AR and his place *"or lack of"* at Presfield High School. On 6 February 2023, Ms Rowland responded stating that AR was on the roll and Presfield High School was on AR's EHCP. She asked Presfield High School to demonstrate, via annual review documentation, that it could not meet AR's need. Mr Fay replied on 10 February 2023 stating that the termination of the placement was discussed at the annual review meeting on 7 July 2022, which LCC did not attend. He stated that there had been no response to the letter of 14 July 2022 or subsequent requests. He referred to the attempts made to seek clarification from LCC, as well as numerous calls and messages which were also unanswered. He referred to the frustration Presfield High School had felt with LCC's SEND department and their lack of engagement, stating: *"[w]hile I appreciate staff turnover and poor communication between teams may have contributed to this situation we have tried to be proactive in the best interest of [AR]. I don't believe I can say the*

1742 T/S: 28/42/2-43/9.

1743 T/S: 27/245/20-246/2.

1744 First Witness Statement of Mrs Smith PRE001806/§23.

1745 Witness Statement of Mr Fay PRE001809/§§20-21; PRE000117.

1746 LCC001892/4.

[same] for [LCC]." He stated that Presfield High School had tried to work with LCC but found them to be a barrier. Presfield High School was not meeting AR's needs and AR should be supported to find another provision.[1747]

186. In his statement, Mr Fay said that he was *"very frustrated with the lack of collaboration from [LCC] and their seeming reluctance to look beyond Presfield for the needs of AR"*.[1748] He suggested that, because AR remained on the roll, he was not a priority for LCC and did not impact on their figures of children not in education.

187. The problem was not experienced by Presfield High School alone. In AR's parent input form for his EHCP annual review, dated 24 January 2023, Alphonse R stated:

> *"I am also concerned about Lancashire SEND team['s] lack of communication …. In 5 months nothing has happened and it feels like no one cares … [s]ince 1st September 2022, to date the Inclusion Team has not been responding to our concerns regarding [AR's] being out of education and we are ignored by the LA. In fact, we have been abandoned by the Lancashire LA since September 2022. As a result, [AR] has not have [sic] access to Lancashire home education nor has he found a new school that meets his needs because Presfield has clearly not been suitable for him. I would like to see this changed and the Inclusion Team improve their communication with us and actively seeks to help [AR] with home education … It has been a shambles."*[1749]

188. Mr Turner accepted that LCC's communications with the school should have been more regular and clearer, and LCC should have been more proactive in response to concerns about AR's non-attendance. He accepted that it was most unsatisfactory that there was confusion as to whether AR was on the roll at Presfield High School.[1750]

189. There appears to have been little, if any, consideration within LCC as to whether Presfield High School was an appropriate placement or whether there were more suitable alternatives. Mr Turner accepted that LCC should have reviewed the placement at Presfield High School – *"looked at everything in the round"* – and investigated alternative options.[1751] He accepted that it may

1747 PRE000152/1. Mr Fay notes that the concerns expressed in the letter dated from before Ms Rowland's time.

1748 Witness Statement of Mr Fay PRE001809/§46.

1749 LCC001892/3-4.

1750 T/S: 26/164/6-15.

1751 T/S: 26/165/2-8.

have been appropriate to secure the education through another means, such as at home,[1752] or through therapeutic offers[1753] and LCC should have brokered additional support.[1754]

190. LCC's failings meant that for two years AR was left without any meaningful educational provision, during which period he became increasingly isolated. LCC should have recognised that AR was not engaging with Presfield High School, despite Presfield High School's best and extensive efforts. They should have considered alternatives, rather than requiring Presfield High School to keep AR on the roll. In failing to do so, LCC failed to comply with its statutory obligations in relation to the EHCP.

191. Mr Turner suggested the failings were principally the result of a lack of resources.[1755] He stated that the number of EHCPs in Lancashire had almost doubled within the last five years.[1756] Mr Turner suggested there were excessive demands on his department, particularly in light of the complexity of their work, which had increased exponentially since 2020. He accepted that the main means of communication (namely, via email) was convoluted and the quantity of information was sometimes overwhelming. Additionally, emails were, on occasion, left unanswered particularly if someone in the authority had left their post.

192. It is hard to know whether things would have changed if LCC had properly considered an alternative education provision for AR. I recognise that the options for AR were limited, given his history of carrying a knife, his lack of engagement, his educational needs and the limited options within a reasonable travelling distance of home.[1757] Mr Turner stated that it would have been difficult to find a substitute educational placement for AR to attend, given the limited resources. Nevertheless, if LCC had been able to put in place a therapeutic placement, a bespoke package or one-to-one tutoring, then AR may have engaged. This would certainly have reduced his isolation and provided him with purposeful activity.[1758] It may have reduced his opportunity to research violent content online and possibly directed his interests elsewhere, as well as providing a measure of supervision. However, I cannot draw any conclusions as to whether it would have prevented the attack.

193. LCC's handling of information was notably ineffective and was overly dependent on emails passing between various individuals. This resulted in a continuing risk that relevant information was not shared or stored, or that it was simply lost. LCC have implemented (for roll out during 2026) an *"Education, Health and Care Plan portal"*. This will constitute an add-on to

1752 Witness Statement of Mr Turner LCC001802/§§41-42.

1753 Witness Statement of Mr Turner LCC001802/§46.

1754 Witness Statement of Mr Turner LCC001802/§44.

1755 T/S: 26/166/25-167/10.

1756 T/S: 26/134/4-12.

1757 Witness Statement of Mr Turner LCC001802/§49.

1758 T/S: 26/169/24-170/2.

their systems to allow more effective communication between parents and workers. This should address the high volume of emails that arrive on a daily basis.[1759] I return to this in the recommendations at the end of this chapter.

194. LCC has also expanded the number of members of staff. The SEND team has increased by 50% since Mr Turner joined LCC in February 2024. The Children Missing Education teams and Elective Home Education teams have still got small numbers of staff although the teams have doubled in size (albeit from a very low starting point). He described this as a very heavy investment, but they still require more staff given the pressure on LCC's educational services has *"grown exponentially"*. They have implemented improved processes and practices, by way of improved data, increased oversight and a larger staff.[1760]

The end of AR's time at Presfield High School

195. Ultimately, AR's EHCP was rescinded and funding for AR's place at Presfield High School was withdrawn on 20 March 2024, on the grounds that AR had not been in education for two years. This was appealed by Alphonse R who noted that removing AR from the roll would affect the family financially because it would impact their entitlement to benefits.[1761] However, AR was informed he was no longer on the roll on 12 June 2024 and he was formally removed on 27 June 2024.[1762] This was almost exactly a month before the attack. Mr Turner accepted that LCC should not have sought to cease the EHCP because AR was under the age of 18 without assurance that no special education provision was required.[1763] The EHCP was ceased, moreover, unusually quickly and there should have been more exploration of possible placements and support for him.[1764]

1759 T/S: 26/111/8-23.
1760 T/S: 26/170/7-71/3.
1761 PRE001298/2.
1762 T/S: 28/47/7-24.
1763 Witness Statement of Mr Turner LCC001802/§45.
1764 Witness Statement of Mr Turner LCC001802/§46.

Conclusions

Range High School

196. The central decision taken by Range High School was AR's permanent exclusion for repeatedly carrying a knife into school in October 2019. The school was absolutely right to take that decision. Moreover (with few and limited exceptions) Range High School carried out diligent follow through actions in making appropriate referrals for AR to healthcare and social services, as well as liaising with the police. Mr Cregeen, as DSL, remained involved in multi-agency meetings for some months after the permanent exclusion and his was one of the voices warning of the significant change in AR and the risk that he posed.

197. I cannot rule out that AR may have had difficulties with some other boys, during the end of year 8 and start of year 9 at Range High School. However, to the extent that such problems existed, they did not amount to a systemic course of bullying. Any such difficulties are likely to have been more a case of mutual dislike and name calling between pupils than targeted bullying or other more serious behaviour. Further and in any event, nothing that happened between AR and one or more other boys at Range High School could conceivably have justified AR's own carrying of a knife.

198. Notwithstanding these findings I note that at the time Range High School was relying on a system of house logs that was less effective at recording and tracing safeguarding concerns than bespoke software. They have now adopted use of bespoke software. The lack of such an effective IT system at the time may have contributed to the slight delay in safeguarding information being transferred to The Acorns School (since e-transfer of information is easily facilitated by the relevant software). However, there was a degree of confusion about whether such transfer should have been direct from school to school, or (given that AR had been excluded) via LCC as the local authority.

The Acorns School

199. In the overwhelming majority of respects, The Acorns School stands out as an organisation that recognised the risks that AR posed to others, and responsibly and proactively sought to ensure that those risks were shared with the other relevant agencies and addressed. As reflected in the findings in other chapters of this report, the strongest reflection about the role of The Acorns School has to be that other agencies should have paid greater heed to the prescient warnings of Mrs Hodson and other staff. As a PRU, The Acorns School was very used to pupils with significant behavioural difficulties including violence.

200. The Acorns School took sensible steps in the early weeks to integrate AR gradually back into an appropriate education timetable. The school kept good safeguarding records and monitored AR's behaviour and interactions

with other pupils closely. Alphonse R wrongly saw this as overly punishing when it was entirely appropriate given AR's behaviour. The close monitoring of incidents involving AR meant The Acorns School promptly made the First Referral to Prevent. They omitted to send AR's internet browser history for 15 November 2019 to Prevent in the context of the First Referral to Prevent, and two pieces of additional information ought also to have been passed to Prevent. However, the relevant Prevent officers should have chased the non-receipt of the browser history.

201. The Acorns School's detailed records also demonstrate the complete falseness of Alphonse R's suggestion that AR carried out the hockey stick attack at Range High School on 11 December 2019 because he had been bullied at The Acorns School including a *"fight"* the day before.

202. After AR's hockey stick attack at Range High School on 11 December 2019, The Acorns School was extremely proactive in raising their concerns about AR with other agencies (social care, healthcare (CAMHS and FCAMHS), police, Prevent). Given the gravity of the 11 December attack, it was entirely reasonable for The Acorns School to seek to prevent AR from attending until a proper multi-agency risk assessment had been carried out. The Acorns School was, in effect, let down by the other agencies and the multi-agency framework. Between them, the other agencies failed to carry out any such effective or adequate risk assessment.

203. Against the additional challenges of the COVID-19 pandemic, The Acorns School did all that it could to get AR back into school. It is a marker of the priority they gave AR that they managed to permit AR to come back into school in person in July 2020 before the summer holidays, with a (risk-assessed) two-to-one staffing ratio. By October 2020, AR was permitted to attend with a one-to-one staffing ratio with the dedicated support of Mrs Allred. The Acorns School were unable to extend AR's timetable over time, despite attempts, meaning that AR remained on a part time timetable. AR's engagement and attendance dropped off dramatically after the Third Referral to Prevent, in March 2021. I am satisfied that The Acorns School took the appropriate steps to ensure that AR received as much tuition as possible.

204. The Acorns School appropriately made the Second and Third Referrals to Prevent. In addition, staff should have referred the concerns of AR's teacher, Mrs Allred, onto Prevent. More significantly, AR's concerning comments in January 2022, including concerning the Holocaust, should have led to a further Prevent referral. While The Acorns School witnesses accepted that, in hindsight, this was a mistake, at the time it was done for understandable reasons because the previous referrals had been refused, with limited feedback, and the Third Referral to Prevent had seriously harmed the relationship between the school, AR and AR's parents. These shortcomings must be set against the wealth of information that The Acorns School did share over the course of AR's time at the school.

Presfield High School

205. Before AR actually transferred to Presfield High School, there were missed opportunities for Presfield High School to learn about AR's risk to others, so that preventative measures could have been put in place once AR started there. This meant that Presfield High School agreed to offer a place to AR without knowledge of the risk that he posed to other pupils and teachers. More seriously, however, there was a number of serious errors and oversights by Presfield High School staff once AR had actually started at the school which meant that they did not review the safeguarding information that they had been sent. As events in fact played out, these shortcomings were – I find – of no causative effect. But had circumstances been different (for example if AR had carried out an attack on staff or pupils at Presfield High School), the position would have been very different. I am satisfied that Presfield High School has recognised the seriousness of this situation and taken remedial action.

206. In other respects, Presfield High School maintained consistent, impressive and supportive action to try to engage AR in proper attendance at the school. From the steps I have summarised at paragraph 160 above, and the evidence of Presfield High School witnesses, I am satisfied that they went beyond what could reasonably be expected in seeking to encourage AR to attend school.

207. From markedly soon after AR had transferred to Presfield High School, the school reasonably and appropriately alerted LCC to the fact that they were not meeting (and not able to meet) AR's needs. Thereafter, LCC did not provide Presfield High School with appropriate support. With AR barely attending school, Presfield High School had to navigate the complications arising from AR living in Lancashire, with LCC responsible for his EHCP, but the school being in Sefton, Merseyside. There were significant differences between LCC and Sefton MBC and between Lancashire Constabulary and Merseyside Police, in the support that could be offered in terms of assistance with welfare visits and seeking to secure school attendance. Given AR's exceptionally low school attendance and that Presfield High School had exhausted all options open to them, the school acted reasonably in seeking to have AR removed from their roll.

Lancashire County Council

208. Mr Turner was frank about the challenges faced by LCC during the period in question. Those challenges are obvious from the failings and omissions that I have described and analysed above. LCC failed in its obligation, over a substantial period of time, to investigate AR's prolonged absence from school (indeed, it lacked any proper awareness that this was the case). Given the difficulties encountered first by The Acorns School, and then particularly by Presfield High School, LCC were put very clearly on notice that AR was a child who had an EHCP, but whose schools were unable to meet his needs. LCC failed to grip the need to reconsider AR's education place including, if necessary, by considering one-to-one tutoring.

209. The options for AR were limited. I accept that it would have been difficult to find a substitute educational placement for AR to attend, given the limited resources. Nevertheless, if LCC had been able to put in place a therapeutic placement, a bespoke package or one-to-one tutoring, then AR may have engaged leading to a decrease in his isolation. The uncertainties around whether AR would have engaged and the speculative nature of any difference this would have made, means that I cannot draw any conclusions as to whether more effective action by LCC as the local education authority would have prevented the attack. LCC has received improvement notices in May 2016 and June 2025.[1765] As a result, there is a new action plan and a system of monitoring.[1766] I accept Mr Turner's evidence that changes have been made. Nevertheless, I must record the significant concern that arises from LCC's prolonged period of inaction in relation to AR's education placement.

210. I am also concerned at the seeming continuing lack of provision on the part of LCC for violence fixated young people who have been excluded either for acting violently or for carrying knives to school.

211. Ms Dixon stated that, in general, DfE is aware that local authorities are very stretched in their resourcing.[1767] I recognise that the funding of local authorities is a political issue involving difficult questions of the allocation of finite resources. Nevertheless, I am concerned at the impact of combined underfunding and underperformance at LCC which saw no meaningful intervention in alternative education provision for AR for the final two years before the attack. AR's was a challenging case where he may not have engaged in any alternative provision of education. That does not, however, explain or excuse the lack of consideration that was given to what alternatives there were.

1765 T/S: 28/86/15-18.

1766 T/S: 28/86/19-87/9.

1767 T/S: 28/82/10-18.

Recommendations

Immediate action

212. I make the following recommendations for immediate action.

213. I recognise that it is difficult to formulate targeted effective action to reflect the generalised concern that other agencies did not sufficiently listen and act upon the concerns that were raised by The Acorns School supported by observations of concern by Range High School. However, I make the following recommendation:

> **Recommendation 57:** The Home Office (for police forces nationwide) Counter Terrorism Police Headquarters (for Prevent), Department of Health and Social Care (for all healthcare providers) and Ministry of Housing, Communities and Local Government (for all local authorities regarding their social care functions) should issue a nationwide reminder to all agencies considering the risk that children pose to others of the importance of respecting the insight offered by the child's school if they raise concern about the severity of risk that the child poses to others. As was the case with AR at The Acorns School, teachers will often spend more time observing the child (and their interaction with peers) than is available to other professionals. Warnings from teachers and/or schools with particular expertise (including but not limited to Pupil Referral Units) should be given particular weight.

214. At the time of the drafting of this report, the DfE has gone out to consultation on changes to the Keeping Children Safe in Education guidance for 2026.

Recommendation 58: The Department for Education, in finalising the Keeping Children Safe in Education guidance 2026, and in any necessary amendments to other policy and guidance, should ensure that:

1. In cases where a child leaves a school because of permanent exclusion, there is absolute clarity concerning the relative responsibilities of the excluding school and the local authority over the transfer of (i) the Common Transfer File and (ii) safeguarding information to the next school.
2. Better guidance is given of the circumstances in which safeguarding information is to be shared in advance of: (i) an offer of a placement; and (ii) the transfer of a pupil. This should include, in particular, where this would aid arrangements that may be necessary for the safety of other pupils or staff because there is relevant information concerning the child's risk to others.
3. There is absolute clarity over the extent to which risk to others information is expected to be covered in an Education, Health and Care Plan. There should be consistency (which is currently lacking) about whether risk to others is addressed in an Education, Health and Care Plan. However, it must be made clear that an Education, Health and Care Plan (even if one is in place) is not a substitute for the proper exchange of information between schools on the risk that a student may pose to others.
4. The arrangements for the exchange of safeguarding information are not prone to a single point of failure (such as a Designated Safeguarding Lead who is absent or unwell and does not read an incoming email). While the current guidance refers to obtaining confirmation of receipt, there is a case for strengthening the guidance with a clear mechanism at a fixed time to ensure the exchange of information has been effected. There is also a case for the introduction of a formal 'sign-off' by the Designated Safeguarding Lead (with appropriate contingencies in place) to confirm that safeguarding information has been received, reviewed and acted upon prior to a pupil being offered a place and prior to the pupil moving to the school.
5. Ensuring that appropriate safeguarding information about a pupil joining a school is shared with relevant staff at the school (e.g. form tutors) before the pupil begins at school.
6. Ensuring that incidents of serious concern, particularly including the use of weapons and intent to seriously harm other pupils, are given appropriate prominence when safeguarding information is shared.
7. Ensuring, where a pupil has a history of possession of a knife or other offensive weapon, that the Designated Safeguarding Lead of the receiving school carries out a risk assessment and implements a safety plan prior to their transfer.

215. I retain concerns about the transfer of safeguarding information. Even with the recommendation I have made above concerning improving the guidance, I consider further work is necessary to check compliance.

> **Recommendation 59:** The Department for Education should carry out an audit to ensure that safeguarding information is reliably being passed between schools and should consider what further role Ofsted may play to strengthen protection in this area.

216. I have noted in this chapter the difference between Range High School (who at the time were maintaining safeguarding information on a generic log) and The Acorns School who were using bespoke software. There are very clear benefits (ease of recording, visibility, transferability) to the use of appropriate bespoke software. I need make no recommendation regarding Range High School who have since adopted the use of bespoke software.

> **Recommendation 60:** The Department for Education should ensure (either by direct guidance or through Ofsted) that all schools are required to record safeguarding information in a system that is fit for purpose.

217. While noting the changes the LCC have made to seek to strengthen and improve the provision for children missing education (including those over 16 but with an EHCP), the failures of LCC in this regard were significant, as I have addressed earlier in this chapter.

> **Recommendation 61:** Lancashire County Council should, by no later than 13 October 2026, carry out and report on an audit (preferably involving an experienced independent external member) to review:
> 1. The speed of response to cases where a need for alternative education provision is raised including for those over 16 with an Education, Health and Care Plan.
> 2. The effectiveness of its monitoring of (and action in response to) school attendance with particular attention being given to (i) children who live in Lancashire but attend school in neighbouring counties; (ii) the resourcing of home visits in appropriate cases; (iii) whether appropriate action is being taken where parents refuse to allow school attendance workers to see a child who is not attending school.
> 3. The effectiveness of the Education, Health and Care Plan portal approach which has been put in place.

218. I consider that it is undesirable that there should be such marked variations across county boundaries as to the extent to which both local education authorities and police forces will carry out welfare visits in relation to children (including those over 16 who have an EHCP) who are persistently absent from school.

Recommendation 62: The Department for Education and the Home Office should review whether further guidance and/or minimum guidance is required in relation to local education authority and police visits to children not attending their place of education.

219. While The Acorns School appropriately made three Prevent referrals, another Prevent referral would have been warranted in January 2022 and the schools did not always appear to understand the stages of Prevent referrals.

Recommendation 63: The Department for Education should ensure that (i) its own policy guidance for teachers and schools (outside the Statutory Guidance for which the Home Office is responsible) is strengthened; and (ii) schools put in place improved Prevent training (including refresher training). This must ensure that staff are not just aware of when to make a Prevent referral but are also aware of (i) what happens once a Prevent referral is made; and (ii) the importance of ongoing dialogue, feedback and assessment between the referrer and the Prevent officer.

220. I appreciate that the DfE considers that its guidance regarding monitoring school attendance is clear as regards cross-border cases (in that the responsibility lies with the local authority for the area in which the child lives) and has been strengthened since August 2024, when the guidance was also made statutory. However, since the channel of information on registration details normally flows from the school to local education authority where the school sits, the evidence to the Inquiry has suggested that the practical application of the responsibilities in cross-border cases may be more challenging than is currently appreciated.

Recommendation 64: The Department for Education should undertake a targeted review, engaging with a representative sample of local authorities, to check both that the current (improved) guidance is now sufficient and understood and that the system for monitoring school attendance is being followed in practice and meets the need in cross border cases.

221. I am concerned at the combined underfunding and underperformance at LCC regarding their sustained failure to tackle AR's non-attendance and alternative education provision for him.

Recommendation 65: The Department for Education should consider what remedial steps can be put in place to assist in circumstances where, whether through underfunding or underperformance, local education authorities are failing to respond adequately to the need for alternative education provision for children who may pose a risk to others. Reforms currently being developed to Special Education Needs and Disabilities (SEND) and alternative provision may be part of the necessary solution.

Chapter 12

AR’s family

Introduction

The approach of this chapter

1. In Chapters 4 to 11 of this report, I have considered in detail the involvement of each of the main agencies who dealt with AR, as well as his history of buying weapons and poisons, online harms and the attack itself. It is neither necessary nor appropriate for me to repeat that detail in this chapter when considering the position of AR's family. What follows in this chapter is not, therefore, a comprehensive chronology of the involvement of AR's family. Instead for each relevant period, I have taken some illustrative examples focusing on the involvement of AR's family in the key events. I also consider in greater depth three critical events: (1) when AR disappeared from home and was found with a knife on a bus on 17 March 2022; (2) AR's aborted attack on Range High School on 22 July 2024; and (3) AR's family on the day of the attack.

2. Throughout this chapter, I continue to refer to AR's family as Dion R (AR's older brother), Alphonse R (AR's father) and Laetitia M (AR's mother). This approach was adopted because I was aware from early engagement with the victims that even hearing the family surname was traumatic for many of AR's victims.

The importance of understanding the dynamics of AR's family

3. In earlier chapters of this report, I have already highlighted areas where I am critical of AR's parents and there is further analysis of these matters within this chapter. For the reasons set out herein, I am strongly critical of the moral failure of AR's parents to warn the authorities about AR's weapons and what I find was their fatalistic approach to the risks that AR posed of violence to others.

4. At the outset, however, it is important to frame such issues in their proper context. The horror of AR's attack on 29 July 2024, combined with the fact that (on any view) AR's parents had some knowledge of his possession of weapons and knew of the aborted attack on Range High School the week before, means that they have featured prominently in the media. It is easy to fall into the trap of simply demonising AR's parents. To do so would be wrong for three reasons. First, it fails to understand the complexity of the family's position and the challenging environment with which AR's parents had to cope, wholly inadequate though aspects of their conduct undoubtedly were. Second, as I address in more detail below, it is likely that AR's parents were affected by the psychological and personal consequences of the Rwandan genocide and their subsequent flight from their country of birth. Third, demonising AR's parents risks overlooking the important lessons that need to be learned as to why AR's family was not, ultimately, a sufficient protective factor able to prevent the attack.

5. As I shall outline in this chapter, AR had a largely unremarkable early childhood. Dion R was clearly a bright child who was academically high achieving. AR himself started off doing quite well at school. Alphonse R and Laetitia M held responsible jobs, and they (particularly Alphonse R) clearly had high expectations for the academic attainment of their sons. As it would do for any family, the physical condition that Dion R developed leaving him as a wheelchair user brought challenges, including the need for a change of secondary schools. While throughout this chapter I will refer to occasions where Alphonse R's expectations of schooling for AR were unrealistic (in the sense that he thought AR should remain at or return to mainstream schooling despite the gravity of his violent behaviour), there is no doubt that this was borne of a genuine desire on the part of both parents to secure the best opportunities for AR. They funded early counselling privately. To an extent they fought AR's corner with outside agencies or at least fought for what they subjectively saw as being right for him. No one should doubt the challenge that AR's behaviour presented for his family. His verbal aggression, rudeness and physical violence towards his father notably increased over the period examined by the Inquiry. His increasing reclusiveness was also a source of obvious desperate concern for his parents. As illustrated in this chapter, AR's parents were perhaps slow to recognise the extent to which AR could simply lie and manipulate, but it is by no means unusual for parents to find it difficult to appreciate the extent of the deceitfulness of their own child. Ultimately, things escalated to the stage where within the home, there was a concern that AR might fatally attack Alphonse R, as evidenced by his threats to kill his father. These factors do not diminish the gravity of the failures by Alphonse R and Laetitia M identified in this chapter and elsewhere in the report, but they are the essential context in which their conduct needs to be set.

Alphonse R, Laetitia M and Dion R as witnesses

6. Within this introduction it is appropriate to outline some overall observations on each family member as witnesses.

7. I make no comparison between the effects of AR's criminality on his victims and its effects on his own family. They cannot and should not be compared. It is nevertheless right to recognise that the knowledge of the deaths and grievous injuries that AR inflicted on the victims and his rightly extensive prison sentence will have had a huge impact on AR's own family. I have taken that into consideration throughout their evidence and in my assessment. So too the fact that AR's parents were affected by the Rwandan genocide and Laetitia M in particular found it very difficult when knives were raised as an issue. Each family member gave evidence via video link. Appropriate adjustments were made in particular in light of Dion R's autism.

8. Alphonse R was an unsatisfactory witness. He provided a helpfully detailed written statement which, to an extent, is reflective on the events he addressed. Even making all proper allowance for the nature of a high profile hearing, it was telling that in his oral evidence Alphonse R was far less reflective in his

approach; he resorted to his earlier criticisms of various of the agencies which had been involved with AR and he displayed, on occasion, a lack of insight into the inappropriateness or gravity of AR's conduct. As detailed in this chapter, I have been unable to accept Alphonse R's explanation on a number of points. In places, I consider he lied. I have treated his account therefore, when it was uncorroborated, with a degree of scepticism.

9. It is also necessary to set out at an appropriately early stage of this chapter that I have reviewed the psychological reports that were prepared for the special measures applications for AR's parents.[1768] With Alphonse R, I have borne in mind that he has demonstrated symptoms potentially indicating post-traumatic stress and low mood, which may have impacted on his daily functioning. He may have exhibited denial and avoidance strategies.

10. Laetitia M described her memory as being extremely poor. On the basis of her experiences (including in Rwanda), she may, at the time of some of the events under consideration, have suffered from 'dissociation'. This is a safety strategy for individuals to cut themselves off from experiencing emotions they cannot tolerate. It can impair the individual's memory and their ability to focus on new information, thereby leading to 'gaps' in their recall. Although Mr Moss KC as Counsel to the Inquiry directed Laetitia M's attention to many of the important incidents relating to AR's deteriorating behaviour, in the main she was unable to provide assistance because she said she could not recall what had happened.[1769] Given the extent of Laetitia M's distress when giving evidence, Mr Moss focused questioning on the most central issues in dispute. For the most part, it was impossible for me to judge the extent to which Laetitia M's suggested lack of recollection was genuine during her evidence to the Inquiry. However, I have no doubt that Laetitia M found the multiple examples of AR's worsening state extremely distressing. At the time, she preferred to avoid being told the details, and it was obvious to me that revisiting them in evidence against the background of AR's horrific crimes was extremely difficult for her.[1770] She explained that AR's deterioration was particularly notable following his complaints of bullying and his exclusion from Range High School.[1771] From 2020, his outbursts *"got worse and worse"*, and they were particularly noticeable if AR lost an argument or if someone came to the house who he was not expecting. AR had a tendency to smash things, sending *"pieces flying everywhere"*.[1772] I accept her evidence that this kind of behaviour made her feel physically unwell. However, at the same time, Laetitia M must have been aware of the main events concerning AR at the time when they occurred. She was at home at the time of some of these incidents, she saw AR every day and there would inevitably have been discussion between her and Alphonse R about

1768 IWS000067; IWS000068 – Both disclosed but not published due to sensitive content.

1769 Witness Statement of Laetitia M IWS000056/§4; T/S: 34/121/6-17.

1770 Witness Statement of Laetitia M IWS000056/§§81-82; T/S: 34/131/12-132/14.

1771 T/S: 34/124/14-22.

1772 T/S: 34/127/18-131/24.

the major occurrences which happened when she was not at home. As with Alphonse R, there were aspects of her evidence which I have been unable to accept, including some where I do not consider her evidence was truthful.

11. Dion R was a very different witness. He gave considered answers and I did not doubt that – for the very main part – he was doing his best genuinely to assist the Inquiry. I found him to be a generally truthful witness. To his credit, while clearly still loyal to his parents, he had the courage to give an account of some aspects of the main events which notably differed from what had been said by his mother and father. With few exceptions, I felt able to accept Dion R's evidence as being accurate, reflecting his own genuine view. Where Dion R's evidence conflicted with that of his parents – in the absence of independent corroboration – I found Dion R's evidence to be the more credible and the more reliable.

The family history and AR's early years to the summer of 2019

12. Alphonse R was born in Rwanda in 1975 and lived through the 1994 Rwandan genocide. Many members of Alphonse R's family, including his parents and his three sisters, were killed during those terrible events. On one occasion, Alphonse R has said that he was seized by armed men and questioned, and he was threatened on a number of occasions.[1773] Laetitia M was born in 1972.[1774] As I have already indicated, she too lived through the Rwandan genocide and was significantly adversely affected by it.

13. Alphonse R and Laetitia M came to the United Kingdom from Rwanda in 2002 and were granted asylum in 2003. Initially they lived in Cardiff, where they both took degree courses. Dion R was born in 2004, and AR was born on 7 August 2006. Both Alphonse R and Laetitia M worked in short-term positions until Laetitia M secured a full-time post in the North West of England, leading, in 2012, to the family moving to Southport. Alphonse R retrained as a taxi driver, which enabled him to synchronise his working hours with his wife's shifts and to provide childcare. The family working patterns meant that Alphonse R took on a significant part of the responsibility for the day-to-day arrangements for their sons. In 2018, Laetitia M started a new job which involved a longer commute.[1775]

1773 Witness Statement of Alphonse R IWS000058/§§5-6.

1774 Witness Statement of Laetitia M IWS000056/§7.

1775 Witness Statement of Alphonse R IWS00058/§§8-13; Witness Statement of Laetitia M IWS000056/§§8-11.

14. Alphonse R and Laetitia M discussed the genocide in Rwanda with their sons once they reached school age, sparing them the most graphic details. The children did not appear to be adversely affected when they learnt about these events. Dion R did not consider he had been traumatised by what he learnt from his parents in this context.[1776]

15. Alphonse R was aware, however, that Dion R and AR appreciated they were a small family with only a few friends from Rwanda and that they were relatively isolated when compared with their friends from school. There were two other families from Africa with whom they frequently socialised.[1777]

16. AR's early childhood in the UK appears to have been largely unremarkable. Laetitia M described AR as a *"picky eater"* even as a young child and he was someone who needed to win arguments.[1778] But there was nothing more notable than this. Dion R described the intense way in which he and AR spoke with each other while at primary school, which, no doubt, was in part due to their shared autism. They each felt strongly about the issues they discussed.

17. As just described, Dion R is older than his brother, AR, by two years. Dion R was diagnosed with autism in 2017. In addition, when Dion R was 12 years old, it was first identified that he suffered from a condition which meant he became a wheelchair user. Dion R's disability was the cause of tension between the brothers, in part because there was a shift in parental attention from AR, as the younger child, to Dion R on account of the assistance he required. Dion R believed that AR resented this change in the family dynamics.[1779] Laetitia M agreed that AR may have felt somewhat overlooked once Dion R needed more attention having become a wheelchair user.[1780]

18. In terms of the children's relationship with their parents, Dion R confirmed that the limit of any physical chastisement was that Alphonse R had smacked him and his brother, when they were younger, for fighting, including with a slipper. In Dion R's view, AR's later allegations against Alphonse R of violence on his part were a fabrication. As I will come to, they included the invention of a false and no doubt distressing story that Alphonse R was responsible for Dion R's disability.[1781]

19. In February 2017, Dion R moved from Christ the King School to Range High School, given the lack of a lift at the former which presented accessibility problems. Additionally, he had been told by his psychologist that Range High School was well equipped to address the needs of autistic students.

1776 T/S: 32/163/14-165/2.

1777 T/S: 33/78/1-80/3.

1778 Witness Statement of Laetitia M IWS000056/§16; T/S: 34/122/14-21.

1779 Witness Statement of Dion R IWS000060/§12; T/S: 32/166/22-167/10.

1780 Witness Statement of Laetitia M IWS000056/§23; T/S: 34/123/7-15.

1781 Witness Statement of Alphonse R IWS00058/§192; T/S: 32/188/2-17.

20. Dion R's change of school was therefore decided upon for the best of reasons and motives. However, it had a knock-on impact on AR. In other circumstances, AR would himself have moved locally to Christ the King School with many of his primary school peer group in the autumn of 2017. However, that would have left the parents having to tackle the logistics of the boys going to different towns for school, a problem which would have been exacerbated by the transport and other needs related to Dion R's physical disability. As a result, AR joined his brother at Range High School at the start of year 7, aged 11.

21. AR resented this move, which undermined the very strong friendships he had formed given most of his peer group from primary school started at Christ the King school.[1782]

22. Although Alphonse R later regretted having sent AR to Range High School, at the outset AR did well academically, without any notable incidents.[1783] In particular, AR's behaviour was not of particular concern and he formed a small circle of friends.[1784]

23. The problems, however, began in year 8 (the academic year 2018 to 2019). AR stopped talking to Alphonse R about school life and spent a considerable amount of time playing video games. Laetitia M confirmed there was a deterioration in AR's behaviour from year 8 onwards, with him exhibiting violent moods and becoming increasingly silent and isolated.[1785]

24. AR became more withdrawn when he was 12 years old and he spent a considerable amount of time playing the video game Fortnite (which had a 13 plus rating). Alphonse R suggested that AR was relentless in his demands to be allowed to play the game, telling his father that he felt lonely because his friends were allowed to use it. Alphonse R changed the parental controls on the PlayStation to enable AR to play.[1786] I acknowledge that giving in to AR over Fortnite was perhaps understandable, when viewed in isolation. There was no evidence, including from the Inquiry's child forensic psychiatric expert Dr Irani, that AR's use of video games (as opposed to the internet) played a role in the troubling changes to his thinking and attitude. Furthermore, the fact that many millions use video games without adverse effects indicates it would be wrong to treat this as a factor contributing to his extreme deterioration. However, the failure to maintain any adequate parental controls on the games console was an early example of a wider and more serious failure by AR's parents to exercise proper supervision over AR's activities, in particular his online behaviour.[1787]

1782 Witness Statement of Dion R IWS000060/§§14-15; T/S: 32/167/11-168/6.

1783 Witness Statement of Alphonse R IWS000058/§§15-17.

1784 Witness Statement of Dion R IWS000060/§17; T/S: 32/194/12-16.

1785 Witness Statement of Laetitia M IWS000056/§§73-78.

1786 Witness Statement of Alphonse R IWS000058/§19; T/S: 33/84/5-85/23.

1787 T/S: 33/84/9-85/23.

25. In the period under investigation by the Inquiry, AR spent a considerable amount of his time at home online. Alphonse R accepted that the parental controls on the home network had been turned off because *"[a]s far as (he) could tell"*, his sons were accessing age-appropriate material. Having given some highly evasive answers, he finally conceded the following explanation: *"I didn't because I wouldn't have been able to manage his destructive behaviour. I wouldn't do that because he […] he would have forced me to put it back on, so that wasn't really an option"*.[1788]

26. Laetitia M agreed that she and her husband did not attempt to control this activity. She claimed that it never occurred to her that he would *"look at bad things"*.[1789] I found this suggestion difficult to credit, certainly once reports started to emerge from his school that he had been attempting to access wholly inappropriate websites and had been discussing violent subjects. Laetitia M, like her husband, should have been alive to the risk that his home internet activity reflected these worrying preoccupations.

27. I have addressed this topic in Chapter 6: Online harms. For the purposes of this chapter, the following points are relevant:

    a. It may be thought that, at the outset and before AR's behaviour seriously deteriorated, failing to set parental controls and having an awareness of his internet use was simply naïve and inadvisable. However, once AR's parents knew of his taking a knife into school, the December 2019 hockey stick attack, reports from school of accessing inappropriate material online, and later that he had ordered a large knife online, this reflected a failure to put in place appropriate boundaries on AR and a failure of parental control;[1790]

    b. While I recognise the evidence about AR's violent outbursts in the home, Alphonse R did not even attempt such measures;

    c. Rather than act – in the home setting – on the implications of The Acorns School's concerns about what AR was viewing online, AR's parents (particularly Alphonse R) tended to take AR's side and doubt the veracity of the school's account;

    d. I have no doubt that the failure to put in place any parameters, and the failure to support others when they were seeking to investigate AR's online activity, meant that AR was able to pursue his ongoing obsession with violence, an obsession which substantially contributed to AR carrying out the attack on 29 July 2024.

1788 T/S: 33/118/18-121/6.

1789 T/S: 34/129/21-130/2.

1790 T/S: 33/117/6-121/14.

Before the Range High School attack: summer 2019 to 10 December 2019

28. Although there had been some changes noticed earlier in year 8, by early summer of 2019, there were clearer indications that AR's behaviour was deteriorating. This resulted in Range High School giving him multiple detentions. This in turn led to friction between Alphonse R and the teaching staff. For instance, on 13 June 2019 Alphonse R wrote to Mr David Cregeen (AR's housemaster at Range High School who in due course became the designated safeguarding lead) complaining that AR was being unfairly targeted and punished by the teaching staff.[1791]

29. What is apparent from these complaints is that Alphonse R repeatedly accepted his son's account in preference to that of the teaching staff. He suggested that he believed that AR was honest with him whenever he had done something wrong. Accordingly, he took his son's side whenever he challenged the account of his teachers (*"each time I approached the teachers, it's because I believed what he was saying, that's why I did it"*).[1792] Even during his evidence to the Inquiry and notwithstanding the events of 29 July 2024, Alphonse R was seemingly wholly unprepared to accept that AR might have been giving him a distorted account of events at school. In a similar vein, he contended that prior to his exclusion from Range High School and while at The Acorns School, AR's problem – that which *"got him in trouble"* – was that *"[h]e was not careful with his words"*.[1793] I considered that, following his exclusion from Range High School, this was a wholly unrealistic assessment by Alphonse R: AR's violent actions, including carrying knives and his inappropriate attempted internet searches, were the principal cause of his difficulties at school. Alphonse R did accept, however, that AR had held a grudge against another pupil, leading to the later attack at Range High School on 11 December 2019.[1794]

30. I have addressed the suggestion that AR was the subject of bullying at Range High School and at The Acorns School in more detail in Chapter 11: Education. For the reasons set out in that chapter, I do not accept that AR was bullied at either school.

31. In Alphonse R's inquiry statement, he acknowledged that he had been too slow in recognising his son's poor behaviour and had been excessively accepting of AR's explanation that he had been the victim of bullying and singled out by his teachers. When Alphonse R was invited to confirm this passage from his statement in oral evidence, instead of doing so he responded, *"I wouldn't say yes or no"*. He then backtracked on his written evidence, stating that

1791 IWS000053/2.
1792 T/S: 33/89/14-91/8.
1793 T/S: 33/129/10-24.
1794 T/S: 33/98/1-24.

he believed AR had told the truth about bullying (*"I took it 100 per cent that [what he said] was true"*). The limit of his agreement with his earlier account was that he *"may"* have been too accepting of AR's description of how he had been treated by his teachers. As I have indicated in the introduction to this chapter, Alphonse R's shifting evidence over issues of substantial significance such as these meant that I treated his account, when it was uncorroborated, with a degree of scepticism. I recognise that Alphonse R accepted, perhaps unsurprisingly, that it was wholly inappropriate and disproportionate for AR to have taken a knife into school.[1795]

32. While there was a strong element of AR's parents questioning the school, they did in some respects respond in a more positive and proactive way. In the third term of year 8, spring/summer of 2019, they sought to obtain support for AR. They paid for private counselling sessions (£40 each) with Parenting 2000 in Southport. Alphonse R recalls that that AR had 12 sessions in total (six of which were ultimately funded by the NHS). Alphonse R's recollection was that these stopped when AR was excluded from Range High School in October 2019 because of the impact of the expulsion on AR's mood, confidence and interests. In fact, the sessions continued until June 2020, as discussed in Chapter 10: AR's healthcare. Although I accept that this was Alphonse R's genuine recollection, it reflects the extent to which AR's exclusion came to be seen by Alphonse R as a watershed moment. That is consistent with Alphonse R's evidence that the outbursts by AR became significant after he had been excluded from school (see below).[1796] Apart from suggesting this kind of behaviour could erupt *"several times"* or *"twice a day"*, Alphonse R was unable to provide any assistance as to how often these events occurred. He indicated that one of the triggers was when Dion R or Alphonse R disagreed with AR, who held grudges against his father and brother.[1797]

33. The reason for AR's exclusion from Range High School was the report by AR to Childline in early October 2019 that he had taken a knife to school, intending to kill another student who he claimed had been bullying him. This led to a visit to the home address on 7 October 2019 by Police Constables Alex Wood and Alexander McNamee of Lancashire Constabulary, which I have addressed in detail in Chapter 7: Policing.

34. PC McNamee and PC Wood, correctly, gave clear advice to AR's parents, particularly Laetitia M, about AR's access to knives. Whatever steps Laetitia M and Alphonse R took in relation to knives, they were markedly ineffective: AR was able to find the kitchen knife they concealed in the home, first in December 2019 and then again in March 2022. Moreover, in the years following AR's report to Childline, Laetitia M did not discuss the issue of carrying knives with AR because she was *"very scared"*. Although she had a close relationship with AR, it depended on her avoiding challenging him

1795 Witness Statement of Alphonse R IWS000058/§23; T/S: 33/135/15-136/1, T/S: 33/137/17-138/3.

1796 Witness Statement of Alphonse R IWS000058/§§59-62; T/S: 33/134/13-135/4.

1797 T/S: 33/93/23-95/7, T/S: 33/96/22-97/8.

or telling him off. In her view, this was the only way to make their family life possible.[1798] I note that the two occasions in Laetitia M's evidence where she became exceptionally distressed were when she was asked (quite properly) about knives. She said, *"I'm very traumatised about knives. I hate knives. I hate anything to do with a knife"* and referred to what she had been through in the genocide in Rwanda.[1799] I accept that her experiences there will have made it harder for her to confront the reality of AR's sustained interest in and use of knives, but they should equally have reinforced the importance of addressing those difficult issues.

35. The police records of that visit include AR telling them that he was *"pretty certain"* in his intention to use the knife.[1800] This was corroborated by Dion R, who was present when the police officers called and recalled that AR was *"quite direct"* in saying that he had intended to use the knife that he had been carrying. Dion R believed that both his parents were present at this point.[1801]

36. Conversely, Alphonse R thought the police spoke to AR alone and then briefed him and his wife. He could not recall whether AR had accepted in his presence that he intended to kill his intended victim while the police were at the house.[1802] PC McNamee recalled Alphonse R arriving towards the end of the discussion with AR and Laetitia M, however, the exact extent to which he was a party to the discussion was unclear. I have no hesitation, however, in accepting PC McNamee's clear recollection of what occurred, which was consistent with his contemporaneous notes and Dion R's less certain recollection. The officers did not speak to AR alone, but in the presence of his mother, and then later with both his parents. Although, I do not make a positive finding that Alphonse R heard AR saying on 7 October 2019 that he had carried a knife to school intending to kill another student, I nonetheless find that Alphonse R, in his evidence, was seeking to minimise his direct knowledge of AR's intentions. In particular, Alphonse R had knowledge of AR's intentions in October 2019, as demonstrated by the paragraphs below.

37. On 8 October 2019, the day after the police visit to his house, AR attended Range High School with Alphonse R.[1803] AR was met and searched by Mr Cregeen. AR admitted that he had brought a knife into school previously because he was *"sick of being pushed around"* and he admitted that he would have used the knife to stab someone.[1804] AR was sent home with Alphonse R.

1798 T/S: 34/146/9-147/2.

1799 T/S: 34/148/14-21, T/S: 34/178/3-20.

1800 LANC000041/6.

1801 Witness Statement of Dion R IWS000060/§79.

1802 T/S: 33/139/20-141/9.

1803 T/S: 26/182/15-183/11.

1804 T/S: 26/228/1-230/24.

38. The next day, 9 October 2019, Mr Michael McGarry, headteacher at Range High School, sent a letter to AR's parents informing them of the decision to permanently exclude AR from that date. The letter stated: *"I realise that this exclusion may well be upsetting for [AR], you and your family, but the decision to permanently exclude [AR] has not been taken lightly. [AR] has been excluded due to the fact that he admitted to being in possession of a knife over a prolonged period whilst in school. He also claimed that he was quite willing to use it if he thought it necessary. I deem this as completely unacceptable when considering the safety of [AR] and all other members of the school community"*.[1805]

39. During the admissions meeting at The Acorns School on 17 October 2019, which Alphonse R (and Laetitia M) attended, Mrs Joanne Hodson, the then deputy headteacher, asked AR why he had brought a knife into Range High School. He replied *"to use it"*.[1806] Although his evidence was markedly contradictory on this issue, Alphonse R stated during his oral evidence that he did not recall AR saying, in cold terms, to Mrs Hodson at this meeting that he had been carrying a knife because he had intended to use it. When pressed, he tentatively accepted that this had been said by his son, although he suggested AR's autism explained this statement: Alphonse R postulated that *"he just said those kind of things"* and he communicated like a four or five year old.[1807]

40. To the extent that, certainly at one stage, Alphonse R attempted to deny hearing AR make this troubling admission, it is untenable to suggest that he would not have recalled this extraordinary statement by his son. I saw Alphonse R in the witness box and I have no doubt that he is an intelligent man who cared for his younger son; in those circumstances, the notion he would not have been gravely concerned by this admission is utterly implausible.

41. By 28 October 2019, PC McNamee had informed Alphonse R that when they were talking to AR, *"he said several times to us that he would have used it on the male in question due to 'bullying'"*.[1808]

42. Given the knowledge demonstrated above, it was remarkable, in my view, that on 28 October 2019 Alphonse R telephoned Childline to complain that the organisation had passed information to the police. He maintained that Childline and the NSPCC should instead have intervened to assist with the *"fall out"* of AR's actions. Alphonse R was equivocal in his answers when asked to accept that Childline had a responsibility to break the usual terms of confidentiality bearing in mind that AR clearly posed a significant risk to at least one other individual.[1809]

1805 MERP001170/1.

1806 T/S: 27/98/4-11.

1807 T/S: 33/148/15-149/18.

1808 LANC000069/1.

1809 Witness Statement of Alphonse R IWS000058/§26; T/S: 33/141/10-145/5.

43. This was not the only remarkable behaviour by Alphonse R that day. Alphonse R sought to have AR re-instated at Range High School by making representations at the school's governing board meeting. On 28 October 2019, he attempted to enlist the assistance of PC McNamee for the forthcoming meeting, stating that *"[i]n all of what unfolded since [AR] asked for help from the Child Line, it seems to us he has become a victim again"*, suggesting a gang culture at the school (an allegation that I address in Chapter 11: Education), stating that AR deserved credit for reporting himself carrying a knife, and that AR was *"a good boy"*.[1810]

44. PC McNamee, entirely appropriately, responded that carrying a knife on multiple occasions presented a risk of *"horrific escalation"* and that, notwithstanding his admission, AR did not seem fully to understand the possible repercussions of his actions and failed to show any remorse. PC McNamee declined to attend the meeting to speak in support of AR remaining at Range High School.[1811] The attempt by Alphonse R to enlist the support of Lancashire Constabulary against Range High School is an example of his tendency to try to turn professionals against each other. Furthermore, Alphonse R's email minimised AR's conduct and failed to acknowledge AR's responsibility for his actions. It is to PC McNamee's credit that he recognised and resisted this.

45. I am unable to accept as genuine Alphonse R's attempt to downplay the significance of what AR said, both at the time and in his oral evidence, set out above. Given AR's repeated admission that he intended to use the knife that he had been carrying, it is inconceivable that Alphonse R would simply have interpreted this as an unserious juvenile statement by AR which, at least in part, was the result of his probable autism. Alphonse R suggested that, although he and his wife did not react to what was said by AR during the meeting with Mrs Hodson, they were nonetheless anguished, shocked and ashamed.[1812] But having made that observation, Alphonse R then tried, in my view without any justification, to blame Range High School for AR's deteriorating behaviour. He stated as follows:

> *"We sent a beautiful boy, who was capable, who was very well dressed, who looked after himself very well to Range High. By the time they sent him back to us, he was broken, disappointed, traumatised, changed completely beyond belief […]"*[1813]

46. The implication of this observation is that Range High School had caused the entirety of AR's gravely deteriorating behaviour, thereby absolving Alphonse R and Laetitia M, and AR, of responsibility. This either reflects a wholesale lack of understanding on the part of Alphonse R as to the sensible – indeed inevitable – steps that the school considered needed to be taken to protect other school

1810 LANC000069/2.

1811 Witness Statement of Alphonse R IWS000058/§28; LANC000069/1; T/S: 33/145/6-146/10.

1812 T/S: 33/149/19-150/15.

1813 T/S: 33/150/16-21.

users or it was a wholly unrealistic attempt on his part to avoid responsibility for what occurred. The decision to expel AR from Range High School once he admitted, without apparent remorse, that he had taken a knife to school on 10 occasions to kill another student was entirely justified. The level of threat posed by AR was extremely high, and the school would have been in breach of their duty of care to other school users if they had not taken that step. There were no suitable mitigations that could have been put in place, given this expression of intent by AR.

47. As a result of PC McNamee's referral to the Multi Agency Safeguarding Hub (MASH), AR was allocated to a Child and Family Wellbeing Service (CFWS) family support worker from Lancashire County Council (LCC), Ms Lucy Parkinson. She, and the senior family support worker Ms Anne Cookson, made efforts to contact the family. Despite some limited initial engagement, including an introductory meeting on 6 November 2019, there were ultimately a number of unanswered telephone calls and letters.[1814] Ms Katherine Ashworth of CFWS said that the service *"actually didn't have any significant meaningful direct engagement with the family (...) or with AR himself."*[1815]

48. On 5 December 2019 there was an urgent meeting at The Acorns School to discuss concerns over AR.[1816] Alphonse R, Mrs Jane Eccleston, headteacher, Mrs Hodson and Ms Cookson attended, with AR participating for part of the discussion. The principal concerns were AR's internet searches, along with particular observations he had made to others at school. He had searched for school shootings, nunchucks, he had talked about guns and decapitated heads, and he had indicated that he liked to watch videos in which people got hurt. When confronted with this history at the meeting, Alphonse R adopted an entirely defensive position. He said he had spoken with AR, who either denied that the incidents had occurred or suggested that what was reported had been taken out of context. Alphonse R went so far as to claim that since he knew AR better than anyone, he was able to say that AR was not a danger to himself or others, and that he never lied. In evidence, he accepted that this statement was *"very naïve"*.[1817] This exchange at the meeting was followed by a markedly unhelpful response by Alphonse R when he was asked if, as a consequence of AR never lying, this meant that AR had told the truth when he said he had intended to use the knife he had carried into school. Alphonse R declined to accept this, and instead contended that AR had been misunderstood: when he said he intended to use the knife, he had not explained **how** he would use it. Given the importance of this meeting, in my view it was irresponsible of Alphonse R to refuse to accept the legitimacy of the concerns that were being

1814 LCC002311/2-7 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

1815 T/S: 31/8/21-9/11.

1816 LCC002311/6-7 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

1817 Witness Statement of Alphonse R IWS000058/§§33-36; T/S: 33/169/3-171/1.

expressed and, instead, to deploy arguments that were either wholly unrealistic or involved splitting hairs. He went so far as to accuse the staff at The Acorns School of having been *"malicious"*.[1818]

49. When AR joined the meeting, he disputed the significance of what was being discussed. He denied the allegations made against him and accused his teachers of lying. AR persisted in his denials even when the classroom assistant was invited into the meeting and repeated what AR had said. Alphonse R challenged the teachers in the presence of AR, accusing The Acorns School of being like a prison, with staff who magnified and exaggerated their accounts of what had occurred. He complained that AR could not speak without what he said being logged and challenged. AR suggested he was being singled out when other children behaved in a way that was inappropriate. Alphonse R requested *"recorded evidence"* of the incidents, and he refused to accept the evidence collected from multiple teachers and staff. In his evidence to the Inquiry, Alphonse R said that he did not trust that staff at The Acorns School were not manipulating the information they had recorded, that they used emotive language and that he did not trust them.[1819] This was highly indicative of Alphonse R's combative and unhelpful attitude, which was still apparent in his evidence to the Inquiry.

50. At this meeting, Alphonse R also denied being aware that Ms Parkinson had been trying to contact him. Given the contemporaneous records of extensive telephone and letter contact, I find that this was untruthful. On subsequent occasions, there was a clear element of Alphonse R trying to evade attention from the professional agencies with which he did not want to engage.

51. It is characteristic of the attitude of Alphonse R that on the following day, 6 December 2019, he telephoned Mrs Eccleston to suggest that the school staff were inappropriately blaming AR, who he said was a *"good boy"*.[1820] In other words, despite having been properly and appropriately challenged by the head and deputy head at The Acorns School, as well as a senior family support worker within CFWS, Alphonse R did not reflect on his attitude or position at all. Instead, he persisted in it.

52. In Dion R's view, in September 2019 there was a noticeable deterioration in AR's mood: AR became despondent and less happy than previously. He was prone to frequent violent outbursts. AR had grown physically, to the extent that he could hurt Dion R when he hit him. Until AR was excluded from Range High School, this violence directed at Dion R usually occurred when they were together in their parents' car. As a consequence of this behaviour, Dion R became increasingly wary of AR. The latter's short temper and tendency to resort to violence most particularly occurred if issues about which they had been arguing remained unresolved. Additionally, AR's tendency to act violently towards his parents emerged as an issue following his exclusion from

1818 T/S: 33/171/2-181/16.

1819 T/S: 33/175/6-176/4.

1820 LCC001346/67.

Range High School. Dion R suggested that the school should have taken a less severe and more understanding approach than expelling AR, given, in his view, this punishment made the situation worse.[1821] Dion R's perception was that AR was made an example of, with Range High School acting more leniently towards others found with knives. I have addressed this issue in Chapter 11: Education, finding that this was not the case. For the reasons set out above, I entirely reject the suggestion that Range High School could have acted any differently.

53. By way of an overall description, Dion R suggested that his *"sense of family routine and togetherness which we once had, started to fade when I [Dion R] lost the ability to walk but, after AR's expulsion, it broke down completely"*. By way of example, AR started breaking china and glassware. Dion R was particularly cautious in his approach to AR, who had become increasingly withdrawn.[1822]

The hockey stick attack at Range High School and immediate aftermath

54. The lack of justification for Alphonse R's criticisms of Range High School and The Acorns School was demonstrated six days later, on 11 December 2019, when AR carried out the attack with the hockey stick at Range High School. Alphonse R was contacted by a representative of The Acorns School who informed him that AR had not arrived, and that he had not been collected by the driver booked to take him to school. Instead, he was seen being driven away in a different taxi.[1823]

55. It is highly significant that Alphonse R immediately acted on the assumption that AR may have arranged to be driven to Range High School, given he had repeatedly carried a knife there previously, he had been permanently excluded and he held a grudge.[1824] In my view, this reveals Alphonse R's true understanding of the extent of the risk that AR posed to others, and it exposes the extent to which he had been less than forthright when he spoke to the representatives of various agencies about AR. As discussed elsewhere in this chapter, it is highly likely that Alphonse R felt compelled to portray AR in a false and favourable light, at least to an extent, in order to maintain some kind of equilibrium at home.

1821 Witness Statement of Dion R IWS000060/§§23-24, §78; T/S: 32/172/5-174/22.
1822 Witness Statement of Dion R IWS000060/§§25-27; T/S: 32/173/17-174/22.
1823 Witness Statement of Alphonse R IWS000058/§41; LANC000072/2; T/S: 33/151/1-9.
1824 Witness Statement of Alphonse R IWS000058/§42; T/S: 33/151/10-17; LANC000073.

56. Dion R was at Range High School on 11 December 2019 and he saw his brother prior to the attack with the hockey stick. He told his teaching assistant that he did not believe AR was supposed to be on the school premises. Dion R was deeply troubled by this incident when he learnt, probably from his parents, that AR had intended to kill the alleged bully.[1825]

57. Once Alphonse R arrived at Range High School following the attack, he had a conversation with the headteacher, Mr McGarry. Instead of demonstrating a responsible appreciation of the seriousness of what AR had done, Alphonse R started criticising the police over the arrest of AR and where AR was going to be taken into custody. He complained it should have been somewhere closer to his home.[1826] He seemed unable to appreciate why AR had been placed in handcuffs. Mr McGarry recalled the officers being sufficiently concerned at Alphonse R's behaviour that they emphasised to him the seriousness of what AR had done.[1827] Mr McGarry recalled that Alphonse R's unrealistic attitude and concerning behaviour was sufficiently extreme to result in a threat of arrest if he persisted in his dispute with the officers.[1828]

58. Alphonse R challenged the accuracy of what was said by Mr McGarry about his behaviour. In his evidence to the Inquiry, Alphonse R said that he would want to see video recordings made by the police *"if I did what they said I did"*, and that *"the last thing I would have done is argue with the police"*.[1829] The contemporaneous accounts by the police officers who attended do not mention Alphonse R attending Range High School.[1830] One of the officers, in his witness statement for the Inquiry, says *"[t]o the best of my recollection neither of AR's parents were present at [the] school"*.[1831] However, this statement was made almost six years after the event. Mr McGarry's witness statement, dated 11 December 2019, records that AR's parents were present and Alphonse R accepts that he was present.[1832]

59. Mr McGarry was a measured and careful witness, with no motive to fabricate, and gave a detailed account that was unlikely to result from errors of memory. His first account of Alphonse R becoming challenging and verbally aggressive to police was given to Merseyside Police on 14 August 2024. This was shortly after the events of 29 July 2024 when Mr McGarry had no reason to dissemble.[1833] This was a rare and significant event in the life of his school, and likely therefore to have stuck in his mind. Conversely, the fact that Alphonse R's behaviour was not mentioned at the time by the police officers is likely to be

1825 Witness Statement of Dion R IWS000060/§§80-82; T/S: 33/6/12-8/3.
1826 T/S: 26/202/21-204/1.
1827 MERP001413/7; MERP002566/5-6.
1828 T/S: 26/203/21-24.
1829 T/S: 33/152/21-155/18.
1830 MERP002904; MERP002907.
1831 Witness Statement of PC Clarke MERP008138/§19.
1832 MERP002902/1.
1833 MERP001413/7.

because this sort of behaviour is unfortunately part and parcel of their work. Alphonse R, on the other hand, had substantial incentives to deny that his initial reaction to his son being arrested for assaulting another pupil with a weapon was to go on the verbal offensive against the attending officers.

60. In the circumstances, I have no hesitation in preferring Mr McGarry's evidence about Alphonse R's behaviour to that of Alphonse R. This is therefore a further example of Alphonse R failing to recognise or to accept the severity of AR's behaviour and challenging inappropriately those whose duty it was to deal with it.

61. Laetitia M attended AR's interview under caution on 12 December 2019 as his appropriate adult. The interviewing officer, Detective Constable Paula Murphy noted the complete lack of challenge to AR from her. This was apparent even when AR acted inappropriately by, for example, laughing at some of the questions he was asked.[1834] This was, in my view, consistent with Laetitia M's general approach of challenging AR to the minimum possible extent, even when it would have been amply merited.

62. Two days after the attack, on Friday 13 December 2019, Police Constable Paul Harrison went to 10 Old School Close to discuss safeguarding with AR's family. Of particular note is that he spoke with Laetitia M about *"supervising AR at all times"* and ringing the police should he disappear. This advice, with dire consequences, was not followed over the ensuing years. PC Harrison correctly formed the view that AR's parents were *"playing... down"* the situation and AR's behaviour, certainly in the way they frequently described these matters to the representatives of the various agencies with whom they were involved.[1835]

63. The First Referral to Prevent had been made by The Acorns School after the meeting on 5 December 2019 discussed above. Alphonse R said that by the time of the visit by Prevent officers to the family home, on 3 January 2020, they had lost control over AR and he had no authority as a father. AR questioned everything, including:

> *"…the way I'd speak; why am I at home; Mummy should be at home, I should be working. By now, I was just reduced to somebody -- a man -- my name was "Alphonse". I was no longer "Dad" because I didn't deserve it. Somebody who (fed) him, who (did) what he asked, had no power at all left to stop him from accessing anything he wanted online".*[1836]

64. In relation to the First Referral to Prevent and the suggestion that AR had researched school shootings, The Acorns School asked Alphonse R to reinforce to AR that this was not appropriate use of the internet at school. Alphonse R instead adopted AR's version of events and does not appear to

1834 T/S: 18/76/22-77/2, T/S: 18/78/14-79/9.

1835 LANC000110/2.

1836 T/S: 33/180/7-17.

have contradicted or questioned this explanation when it was given by AR to Prevent.[1837,1838] I consider Alphonse R's approach to the later Prevent referrals below. I should note in this context that Dion R was familiar with AR's unusually deep and intense feelings about politics, history and global injustice, to the extent that he would lash out at Dion R when they used to discuss these issues. However, Dion R was unaware of AR's Prevent referrals or the concerns over his internet browsing history.[1839]

65. Alphonse R and Laetitia M had relatively little input into the steps taken by LCC Children's Social Care and other agencies following the 11 December 2019 offending by AR, although their views and concerns were appropriately sought for the Child and Family Assessment conducted by Ms Anna Jameson, an LCC social worker.[1840] They did not, for example, attend the strategy meetings on 17 December 2019 and 6 January 2020 or the Forensic Child Adolescent Mental Health Service (FCAMHS) meeting on 21 January 2020. That is not a criticism of them: they were not expected to attend these professionals' meetings. They did, however, seek to influence the discussions.

66. The most striking example of that is AR's parents' email of 2 March 2020, to Ms Jameson, setting out a long list of complaints against The Acorns School.[1841] It was sent from Alphonse R's email account but signed by both parents. This was sent two days before the child in need meeting on 4 March 2020 in the knowledge that Ms Jameson would be meeting The Acorns School that week. The email objected to the school focusing on AR's behaviour, including diligently recording his actions.[1842] It stated the *"environment at Acorns and resulting frustrations have contributed to [AR] returning to Range High to find the student who bullied him"* and noted that AR was *"a good boy, modest and respectful"*.

67. Alphonse R objected strongly, at the time and during his evidence to the Inquiry, to the steps taken by The Acorns School in relation to AR's behaviour. He suggested, in my view erroneously, that the regime there was responsible for making AR *"worse and worse"* and that it was the *"wrong school"*.[1843] Given the risk that AR posed, I have no doubt that The Acorns School's approach was appropriate.

68. The email also suggested that AR had been involved in a fight with another pupil at The Acorns School. However, this event was witnessed by teachers who said it amounted to no more than some short-lived *"jumper pulling"*

1837 LCC001346/71; T/S: 27/43/13-44/4.

1838 CTPNW000135/1.

1839 Witness Statement of Dion R IWS000060/§59; T/S: 33/13/4-15/4.

1840 LCC000027/7.

1841 LCC000482; LCC002310/21 (the Transcript refers to LCC002301 but LCC002310 is a better version of the same document); T/S: 33/156/20-162/2.

1842 LCC000482.

1843 T/S: 33/158/20-159/8.

before the two teenagers were separated.[1844] I have no doubt that AR substantially exaggerated an account of this incident at The Acorns School. Alphonse R was wrong and naïve to accept AR's account of this incident, let alone to suggest thereafter that it had somehow been the cause of AR's attack on 11 December 2019.

69. Alphonse R's persistent complaint that AR should not have been sent to The Acorns School is equally unjustified. Given AR's violent behaviour, he was sent, wholly appropriately, to a Pupil Referral Unit which is designed specifically for children who are unable to attend mainstream education. The Acorns School, therefore, as a specialist unit with a high staff-to-pupil ratio was intended to deal with serious cases such as AR's. Alphonse R's suggestion that AR should have been transferred to Christ the King School was unrealistic given it was a mainstream school, ill-equipped to cope with a potentially dangerous pupil such as AR. Following the attack on 11 December 2019, there was no prospect of AR returning to a mainstream school, without the clearest possible evidence that the risk he posed had abated.[1845] That evidence was never forthcoming. Instead, as observed elsewhere in this report, AR's parents failed on a significant number of occasions to support AR's schools and Prevent when concerns were raised.[1846]

During AR's referral order: March 2020 to January 2021

70. Following the hockey stick attack at Range High School of 11 December 2019, AR was sentenced on 19 February 2020, with the court ordering a 10-month referral order. Following the child in need meeting on 4 March 2020, the principal agencies involved with AR therefore became CFWS, Child and Youth Justice Service (CYJS) in respect of AR's referral order, and The Acorns School.[1847] It must be remembered that the first period of national lockdown as a result of COVID-19 was announced on 23 March 2020. Schools did not begin to re-open until 1 June, and all services were still heavily disrupted.

71. There was sporadic contact between AR's parents and these three agencies towards the start of this period. No doubt the COVID-19 lockdown formed part of the context for this, but it is notable that engagement was less than The Acorns School, in particular, were achieving with other parents. As recorded in an email from The Acorns School to Alphonse R on 4 May 2020, *"[c]ontact with you is minimal and you do not answer the phone or return our*

1844 T/S: 33/159/10-161/13.

1845 Witness Statement of Alphonse R IWS000058/§55; T/S: 33/166/3-167/8.

1846 Chapter 6: Online harms; Chapter 8: Prevent and Counter Terrorism Policing and Chapter 11: Education

1847 Also known as the Youth Offending Team (YOT).

calls. Our records show that you do not respond to most of the daily calls".[1848] Ms Andrea Fontaine from CFWS and Ms Anna Croll from CYJS both also had difficulties maintaining contact with the family, with Ms Fontaine accepting that it was *"virtually impossible"* to contact them and that AR's parents, particularly his father, stopped answering or responding to telephone calls.[1849] This is a further example of AR's parents seeking to avoid, rather than engage with, the statutory services that were available to them. Given that this continued both before and after lockdown, I infer that lockdown was not the only cause of this level of relative disengagement. Instead, it is more likely that it reflected unhappiness at the imposition of the referral order and the fact that their complaints about The Acorns School had not been accepted.

72. The level of engagement increased from early May 2020 onwards. At this point, AR was still not in school and was refusing to do work set for him to complete at home. There had been very limited engagement with CYJS during telephone appointments. Alphonse R continued to push for AR to obtain a different educational placement. In a Team Around the Family (TAF) meeting on 19 May 2020, Alphonse R once again pressed the narrative of AR having carried out his attack on a pupil at Range High School because of events at The Acorns School, of AR being a victim rather than a perpetrator, and of justifying or defending AR's decision to carry a knife.[1850] As Mrs Hodson of The Acorns School put it, *"neither Dad nor [AR] seem to have moved on in their thinking in the 6 months since the incident"*.[1851] She was concerned that Alphonse R might well undermine any work that The Acorns School or others were able to do with AR as to how he responded to difficult situations. In my view, Mrs Hodson's assessment of the situation was entirely accurate and appropriate. Alphonse R's attitude to AR's behaviour, and to the agencies involved with them, was deeply combative, verging on hostile. Alphonse R's inability to accept that AR was responsible for his own inappropriate actions was a significant contributory factor to the challenges those agencies faced in dealing with AR.

73. Alphonse R's controlling attitude towards a number of the agencies involved with AR is exemplified in a message he sent to Ms Fontaine of CFWS on 2 November 2020. He requested a copy of the impending updated assessment report because he was only prepared to *"consent"* to it being shared with AR's school, CYJS (referred to here as the Youth Offending Team or YOT), or any other third party after he had read it. He said:

1848 LCC002311/19 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

1849 LCC002311/20 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document); T/S: 30/174/7-22.

1850 LCC002311/23 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

1851 LCC002311/23 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

> *"As you are well aware, this service is voluntary with the child and family at the centre. When we feel comfortable, we can be inadvertently or innocently share personal information that no other family shares, not to say that there is something sinister but because it is not necessary. Therefore we trust that you use your professional judgement not to share sensitive irrelevant information with the offending team (YOT), social services, nor the school for that matter. We treat your service like the service of a counsel[l] or, so we expect a high degree of confidentiality and sensitivity. [AR] can trust you and say stuff as a child, but we don't expect you to record or share some information with others that can turn our family upside down … In other words, we commissioned you (the CAF) to help us (that is between you and us only) and to help [AR] receiving meaningful education and that is where the school comes in. I don't get why the YOT in charge of punishing [AR] has anything to do with your assessment report. We don't want them in this matter please. They should not know more than they need to see out their enforcement work and they don't need your input. Please don't involve them anymore. Also please share with Acorns only part of the report that they need to improve [AR's] education."*[1852]

74. When questioned about this stance by Mr Moss, Alphonse R suggested in a highly troubling answer that *"AR had proven himself to get in trouble for the things he said carelessly"* and that he was worried that what he described as Childline's *"confidentiality breach"* would happen again and AR would end up in trouble.[1853] This demonstrates that Alphonse R had failed to appreciate the devastating significance of AR's repeated admission that he had carried a knife to school on multiple occasions intending to kill a fellow pupil who he perceived as having bullied him. Instead of understanding that CYJS was trying to help his son, he regarded them as punishing him. Moreover, Alphonse R persisted in focusing on matters he considered to be in the interests of AR while remaining insensible to the grave risk he posed to others. During his evidence, Alphonse R eventually conceded that he had inappropriately attempted to manipulate the agencies dealing with his son.[1854]

75. Indeed, as set out in Chapter 9: Social care, Ms Sharon Barrett, a LCC senior family support worker and Ms Fontaine's supervisor, accepted that this was an example of Alphonse R attempting to direct or manipulate the agencies, particularly as regards sharing information. Ms Barrett agreed that Alphonse R should have been working closely with the CYJS and that his attitude,

1852 LCC002311/32 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document); T/S: 34/2/13-3/22.

1853 T/S: 34/3/25-4/8.

1854 T/S: 34/6/22-7/2.

as disclosed by this message, represented an increased risk.[1855] Ms Fontaine accepted that *"looking back"* this message was an obvious attempt to drive a wedge between her and the CYJS in terms of sharing information.[1856] I agree.

76. I note that a general theme that emerges from this period is Alphonse R's unwillingness, or inability, to enforce boundaries or requirements on AR. As well as not dealing effectively with AR's refusal to do schoolwork, he did not enforce AR's obligation to co-operate with CYJS. When AR declined to engage with CYJS, Alphonse R's response was simply to convey that to them. This was in keeping with AR's parents' general tendency to try to placate AR as a means of minimising the chance of *"outbursts"*. This finding was corroborated by Dion R, whose view was that from 2019 his parents lost the ability to control AR. He gave evidence of there being a *"heavy risk"* for his parents if they tried to discipline or punish AR. AR resorted to violence if he heard Dion R talking to his friends on the telephone in his room at night. Dion R believed that, in around 2020, AR should have been treated away from his home setting and given intensive mental health support, for instance at the instigation of social services or Child and Adolescent Mental Health Service (CAMHS).[1857] I have dealt in other chapters with the responses of those agencies, but the fact that AR's own brother, admittedly with hindsight, took that view of what was required gives an indication of how severe the issue had already become. AR's violent and often manipulative behaviour posed a huge challenge to his parents. However, their response of downplaying the significance of that behaviour to outside agencies (including in front of AR), of not setting boundaries, and of placating AR can be seen now to have been a dangerous combination. Alphonse R and Laetitia M were not candidly sharing the full nature of their concerns about AR's behaviour to the agencies which were there to support them, hence making it harder for those agencies properly to appreciate risk.

77. There was a single occasion, on 14 January 2021, when Alphonse R met AR's violence with violence. This was towards the very end of the referral order. AR argued with Alphonse R about the latter mowing the lawn or cutting a plant close to where his pet hamster was buried. AR threatened to break Alphonse R's laptop and kicked Alphonse R in the groin. Alphonse R then slapped AR. Alphonse R accepted that AR hated him by early 2021.[1858] Alphonse R reported this to CFWS on the day it happened, but not to CYJS. His initial account to CFWS omitted the fact that he had struck AR, something which only came to light when AR told CYJS his version of events five days later.[1859] This is a telling instance of Alphonse R's willingness to mislead, at least by omission.

1855 T/S: 30/66/8-25.

1856 T/S: 30/198/21-199/8.

1857 Witness Statement of Dion R IWS000060/§75; IWS000057/1-2; MERP001217/6; T/S: 32/183/9-185/9, T/S: 32/188/20-24, T/S: 32/176/11-177/3.

1858 Witness Statement of Alphonse R IWS000058/§§83-84, §86; T/S: 33/98/25-99/20.

1859 First Witness Statement of Ms Callon LCC001712/§§137-141; LCC000488/3.

78. Following the end of the referral order on 29 January 2021, CYJS ceased to work with AR. CFWS also closed its case on 4 February 2021, shortly after AR had been informed of his ASD diagnosis. Alphonse R was keen that CFWS support should continue, as *"your professional perspective helps him learn. [...] That doing house chores is not slavery or running errands around the house is not a favour ... I think you are leaving too soon. Not to say that I want social services to get involved but to have a community based agency like yours would have helped him immensely"*.[1860] Notably though, at the final meeting with Ms Fontaine, it was noted *"both Alphonse and AR feel that things are improved and have settled significantly"*.[1861] The extent of the accommodations that Alphonse R and Laetitia M were having to engage in by this time to avoid AR's *"outbursts"* was not made apparent.

79. Dion R explained that AR showed increasingly less empathy towards other people as time passed. He lost contact with all of his friends, partly as a result of the COVID-19 pandemic, and he developed a profound fear of the outside world which resulted in him not leaving the house. When representatives from, for instance, his school or the local authority visited the home to see AR, he regularly refused to come downstairs; moreover, on occasion, these visitors were not even invited to enter the house. His parents risked a violent response from AR if Alphonse R and Laetitia M insisted that he met these representatives. However, Dion R noted that AR met regularly with social workers from CYJS between February 2020 to January 2021 while he was subject to the referral order. Dion R considered that AR's behaviour, including his isolation and his mood, deteriorated when these visits ceased, although his parents regularly attempted to persuade AR to attend school.[1862]

March 2021 to early March 2022

80. With CYJS and CFWS having stepped away from AR, the key services from February 2021 until June 2021 were The Acorns School and CAMHS. The Acorns School made the Second Referral to Prevent on 1 February 2021. Alphonse R gave evidence that, in his view, only this Second Referral to Prevent, in relation to posts about Colonel Gaddafi, was justified and that the other two referrals were inappropriate.[1863] As set out elsewhere in this report, I consider that each of the referrals was appropriate, and that there were in fact a number of further occasions when referrals ought to have been made.

1860 LCC002311/37-38 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

1861 LCC002311/38 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document).

1862 Witness Statement of Dion R IWS000060/§50, §66, §§76-77; T/S: 33/10/24-13/3.

1863 T/S: 33/181/7-182/13.

81. Alphonse R was aware of this Second Referral to Prevent at the time it was made. He discussed it with AR, who *"dismissed the seriousness of the internet search and his posts and again claimed that others were doing it. I told him that he was getting himself into trouble and that he must stop"*. He said that AR *"did not seem concerned by this Prevent referral but I was extremely concerned and I knew how serious they were"*. He said as well that *"any attempt to restrict his internet use would have caused a huge fight and resulted in damage to property at home. [...] There was also an element that when AR was online things were calm and manageable at home. If AR was not occupied in this way and if we had tried to monitor and restrict his online activity, there would have been a violent outburst"*. Alphonse R also said that *"I genuinely thought that his main online interests were educational and for entertainment"*. Given that this was the second occasion on which AR's concerning internet activity had been flagged, Alphonse R should have appreciated there was a wider concern about AR's internet use.[1864]

82. The Third Referral to Prevent followed on 22 April 2021. Mrs Hodson stated that Alphonse R was asked not to share the details of the referral with AR.[1865] Alphonse R nonetheless did share it with AR. Alphonse R said he could not recall being asked not to do so, but he accepted that AR reacted very *"poorly"* and confronted the staff at the school over its contents.[1866] AR told the staff that his father considered that school was like a prison and that the staff were *"evil"*.[1867] I note that at a meeting in December 2019, Alphonse R had described The Acorns School as being like a *"prison"*, and it is likely that he did so again in the context of discussing the Third Referral to Prevent with AR.[1868] Alphonse R refused to accept that he had repeatedly expressed an *"utter disregard"* for the attempts by The Acorns School to impose boundaries and discipline, which was a consequence of his inability to accept that AR had done wrong and needed boundaries and discipline.[1869] He did not accept that his disparaging attitude towards The Acorns School – which was still apparent in his evidence to the Inquiry – would not have discouraged AR from his inappropriate behaviour. I consider that this must have been the case: Alphonse R did not conceal his views on The Acorns School from AR, and AR would have known that his father would take his side in any dispute with The Acorns School about his conduct.

1864 Witness Statement of Alphonse R IWS000058/§85-92.

1865 T/S: 27/128/1-7.

1866 T/S: 33/183/19-184/18.

1867 LCC001346/41.

1868 LCC002311/6 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document); LCC001346/41.

1869 LCC002311/6-7 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document); T/S: 33/184/9-187/16.

83. Alphonse R's disparaging attitude to The Acorns School only became more entrenched following the Third Referral to Prevent. By way of example, on 27 April 2021, Alphonse R sent an email to The Acorns School in intemperate terms complaining about the school's treatment of AR. The email included allegations that The Acorns School were spying on AR, threats of legal action to *"get [AR] out of Acorn's grip"*, accusations that *"you are abusing your duty of care for a vulnerable child that we placed in your care"* and that The Acorns School had been *"extracting unnecessary opinions from my son, then tak[ing] it out of context and do[ing] things that kill his character"*.[1870] Alphonse R referred in evidence to the relationship between The Acorns School and AR's family as having broken down: *"we weren't good for each other"*.[1871] However, in my view, this was firmly down to Alphonse R's attitude towards The Acorns School and his inability to work constructively with them.

84. Turning to CAMHS, as I have noted in Chapter 10: AR's healthcare, Ms Samantha Steed took over as AR's CAMHS case manager from 1 April 2021.[1872] She held a video consultation that day with Alphonse R. Despite it being late morning (11:30), AR was initially asleep in bed and refused to join the call when he woke up; indeed, it was documented that he threw something at his father. Ms Steed noticed that Alphonse R did not reprimand his son and appeared embarrassed.[1873] She explored AR's symptoms of anxiety with Alphonse R. It was now one year since AR had mixed with his peers. AR was angry at his father and could be physically violent to him. Alphonse R explained that AR would like to return to mainstream school and claimed that *"… this is said not to be possible due to the incidents of [AR] trying to get revenge following being bullied and hurting an innocent child by mistake. The police were involved and there was NFA [No Further Action]"*.[1874] I observe that this was, once again, indicative of Alphonse R's tendency to minimise AR's criminal behaviour and responsibility for it.

85. There was an annual review of AR's education health and care plan (EHCP) in 2021 via a meeting in May 2021 and further discussions. There is a *"tracked changes"* draft of the EHCP dated 2 December 2021.[1875] I have addressed the input of Ms Steed, in particular in the meeting in May 2021, in Chapter 10: AR's healthcare. As part of the EHCP review, Alphonse R was invited to make comments and to suggest changes. He did so for many of the proposed entries, suggesting changes or deletions. By way of example, Alphonse R pressed for the deletion of the entries *"[AR] can become fixated on particular members of staff"* and *"[t]here are concerns or occasions when [AR] would say and do things which have been described as sinister. inappropriate"*. Alphonse R considered the language was negative,

1870 LCC001346/37-38.
1871 T/S: 33/186/8-187/16.
1872 First Witness Statement of Ms Steed AHCH000290/§8.
1873 AHCH000163/4-5.
1874 AHCH000163/5.
1875 LCC000139.

portraying AR in a bad light as someone who was dangerous and who needed to be *"carefully considered"*.[1876] The problem with this objection is that these entries were, at the time and without the benefit of hindsight, objectively entirely justified. As Mr Moss suggested to Alphonse R, it was not negative or unfair to describe AR as sinister and his actions as inappropriate given he had looked for information on school shootings on the internet, asked for pictures of severed heads and complained that he was not allowed to view guns, and suggested that *"teachers get murdered"* when they give children detention. Indeed, the words *"sinister"* and *"inappropriate"* may be considered to have understated the position, particularly given AR's history of carrying knives in order to kill another student and his serious attack with a hockey stick on a random pupil at his former school.[1877] Alphonse R's response to this draft EHCP is characteristic of his refusal or inability to acknowledge the risk that AR posed to others.

86. There was, however, over the following weeks generally good engagement between AR, and AR's family, and CAMHS, with AR attending video appointments roughly weekly, and showing some limited signs of improvement, including going out on walks with his father.

87. On or about 23 June 2021, Alphonse R sought monetary assistance from LCC Children's Social Care.[1878] He and his wife were struggling financially because of the time Alphonse R was spending looking after Dion R and AR. The local authority turned down the request for financial help but offered to take AR into care for a short period *"so that Laetitia and I could take some time to recover"*. However, they resisted this suggestion, even if it was only for a short period, because *"we did not want AR to be taken into care"*.[1879] I have no doubt that Alphonse R and Laetitia M wanted the best for both AR and Dion R, and it is understandable that they were reluctant for AR to be taken into care, even for a short period. However, this fear that AR might be taken into care was to become a critical factor that AR's parents allowed to outweigh dealing appropriately with AR's risks to others.

88. In August 2021, AR reported to CAMHS, and also to Children's Social Care (who were still carrying out the assessment outlined above) that Alphonse R had hit him when he was eight years old. AR additionally suggested that Alphonse R had hit Dion R recently. In his oral evidence, Alphonse R said that AR generally suggested that his father used to *"beat [him] up"*.[1880] Alphonse R maintained that he had been attacked by AR. I have addressed above the single occasion in January 2021 when Alphonse R responded to AR's own violent behaviour in kind. In addition, Alphonse R stated that he had smacked Dion R and AR when they were younger for fighting, including with a slipper.

1876 LCC000139/7; T/S: 33/162/13-164/13.

1877 T/S: 33/164/14-165/11.

1878 LCC000108/3.

1879 Witness Statement of Alphonse R IWS000058/§108; T/S: 33/134/23-135/4.

1880 LCC000247/5; T/S: 33/95/18-19.

This account was corroborated by Dion R, who denied that he had been hit by Alphonse R.[1881] Otherwise, I have seen no evidence of Alphonse R, or any other member of AR's family, engaging in inappropriate physical chastisement or other violence against AR. Against this background, Alphonse R accepted that AR could be an *"outright liar"*.[1882] It is telling, however, that while Alphonse R knew that AR had lied to agencies on this issue, he continued to believe AR's accounts about events at school as opposed to the considered and reasoned views of multiple teachers.

89. The result of the Children's Social Care assessment was a further period of engagement from CFWS from September 2021 to March 2022. Laetitia M agreed that they allowed AR to control important aspects of their lives in this period. For instance, Ms Louise Lewis and Ms Barrett from CFWS visited the home on 4 October 2021. AR refused to say why he was not attending school until Alphonse R *"does what I have asked him"*. Although Alphonse R appeared to want to speak, AR said his father did not have permission to speak. It was recorded by the visitors that AR was encouraged by Laetitia M, who made a *"zip"* gesture across her mouth which was directed at Alphonse R, that is to say Laetitia M supported AR's manipulative attempts to stop Alphonse R speaking to the two family support workers. Laetitia M said that she probably acted in this way to avoid an outburst by AR and violence occurring once Ms L Lewis, and Ms Barrett had left.[1883] This is a good example of the inappropriate degree of parental deference to AR that was occurring by this point in time.

90. I note that this was the meeting where AR expressed his thoughts on attitudes towards the Taliban, as well as refusing to tell CFWS how he was making money on the internet. Ms Barrett stated (and I accept) that she was told by AR's parents that they supervised AR's online activity.[1884] That is obviously starkly inconsistent with Alphonse R's evidence, summarised above, that any attempts to restrict AR's internet usage would have been met with violent outbursts and so they did not do so. It provides a further example of AR's parents deliberately and dishonestly concealing the full extent of the challenge AR posed from professionals. If AR's parents believed that they were unable to put in place measures at home for fear of AR's violence, they ought to have supported the authorities when they questioned AR's online activity, rather than simply putting forward AR's own excuse or wrongly suggesting that he was supervised. Moreover, it should be noted that AR's comments on this occasion were inconsistent with Alphonse R's professed view that AR's internet usage was solely for education and entertainment.

1881 T/S: 32/188/2-17.

1882 Witness Statement of Alphonse R IWS000058/§107; T/S: 33/128/8-129/9.

1883 T/S: 34/132/15-134/18.

1884 T/S: 30/97/11-100/7.

91. On 5 November 2021, Laetitia M called the police in response to AR's violent behaviour. Alphonse R described this incident as a good example of how they were *"walking on eggshells"* around AR, and how he could *"be triggered and take offence at everyday interactions and spiral out of control"*. AR disliked being observed while he was sleeping. Someone called at the house and Alphonse R answered the front door. He forgot to close the living room door meaning that AR was visible while sleeping. Alphonse R described in his Inquiry statement that, when AR realised that he had been seen while asleep, he went crazy, became violent and damaged the house by throwing things. Alphonse R noted that his wife found these outbursts to be *"incredibly traumatic"*.[1885]

92. Slightly later in November 2021, following further *"outbursts"* by AR which had involved him pouring liquid over his father's head, AR's parents informed CAMHS of AR's violent behaviour, without informing the police.[1886] Alphonse R gave evidence that he assumed that information of this kind was shared between the relevant agencies. Furthermore, he considered that ringing the CAMHS out-of-hours number was *"akin"* to calling 999.[1887] I find that this evidence was less than entirely candid. As demonstrated by his attempt to control information sharing in November 2020, Alphonse R had a relatively sophisticated understanding of how agencies interacted with each other, and the importance of consent to that process. I do not accept that he thought at the time that informing CAMHS would mean other agencies automatically became aware of what they had been told. I find that this was a further instance of AR's parents, particularly Alphonse R, seeking immediate help for AR, but also seeking to control the narrative around him, as well as who was informed.

93. On 30 November 2021, there was another 999 call from AR's parents, received by Lancashire Constabulary's Force Control Room at 18:47. AR had become angry at the food his parents had cooked him for tea. He had again thrown food around, but he had also thrown a plate of food at a rental car parked in the driveway, thereby damaging it. The caller reported being scared of AR, and that they were having trouble with him on a daily basis. Police officers attended and a decision was taken not to arrest AR.[1888]

1885 Witness Statement of Alphonse R IWS000058/§114; T/S: 33/99/21-102/10.

1886 LCC000975.

1887 Witness Statement of Alphonse R IWS000058/§§117-118; T/S: 33/102/11-104/2.

1888 Witness Statement of Alphonse R IWS000058/§120; Witness Statement of PS Ward LANC000294; LANC000418; LANC000025; LANC000078; LANC000079; T/S: 33/104/3-105/6.

94. Alphonse R described his reaction to this incident as follows:

> *"This incident is an example of how any attempt to impose discipline at home was met with an escalation of AR's behaviour. As mentioned, I became conditioned to AR's behaviour and I allowed him to abuse and assault me, and to cause damage at home, without response, because this was the only way of getting through the day. AR's outbursts would blow over quite quickly and would be followed by a period of relative calm. I am ashamed that this was my response and I felt demeaned, but I did not know what else to do."*[1889]

95. Alphonse R considered that, over time, he had become the particular focus of AR's aggression, and this was corroborated by the contemporaneous descriptions of AR's conduct. That much is accurate. I note, however, that AR's violent conduct was not directly raised at the TAF meetings in December 2021 or January, February or March 2022 which Alphonse R attended.[1890] That was an opportunity to flag to professionals that AR was essentially beyond parental control and that additional intervention was needed. Although in other chapters I have made findings about how other agencies failed to appreciate or act on the information they had available, it is relevant that Alphonse R was not sharing clear information with them about AR's behaviour, and at times was suggesting that the position was far rosier than it was. I consider that this reflected the following interrelated factors:

    a. His fear that AR would be removed from his and Laetitia M's care;

    b. His reluctance to challenge AR in any way, because of the reaction it would provoke from AR;

    c. His increasingly unrealistic desire for AR to receive a full mainstream education. I note that at the TAF meeting on 12 January 2022, it was recorded that *"Alphonse main views are that he wants the right educational provision for [AR] and will continue to pursue this and that he feels he is making the right decisions for [AR] and is a good parent"*;[1891] and

    d. His adversarial relationship with professional agencies, in particular with The Acorns School.

96. It is fair to stress that Alphonse R was not withdrawing all co-operation from professionals. To the contrary, during this period he attended the 'Triple P' parenting course, was willing to attend further parenting courses and family therapy and was highly engaged in the transfer of AR from The Acorns School to Presfield High School. Alphonse R also had to contend with further manipulative behaviour on the part of AR. As I have addressed in Chapter 10: AR's healthcare, at the TAF meeting on 11 January 2022, AR alleged that he had been hit by his father (which in fact related to a degree of physical

1889 Witness Statement of Alphonse R IWS000058/§121.

1890 LCC000130; LCC000137; LCC000144; LCC000153.

1891 LCC000137/3.

chastisement when he was younger), but also alleged that Dion R was in a wheelchair because of Alphonse R and that his father had *"made Dion use a wheel chair"*. Ms Barrett of CFWS was recorded on the CAMHS record as having shut AR's comments down, making the point that his claims were unfounded and had been investigated by Children's Social Care.[1892] This was a fabrication by AR to try to get his father into trouble, which I accept would have been deeply distressing for any parent who had sought to support their child in coming to terms with a significant physical disability.

97. At the same time, however, Alphonse R continued to try to control interactions with agencies to a very high degree, with utterly unrealistic expectations about the service they could provide, as shown by his peremptory demands to Mr Carl Coughlan of the Targeted Youth Support Service that worked with AR from November 2021 to March 2022. These included trying to reschedule appointments at little or no notice and attempts to become overly involved in what was meant to be an independent relationship between Mr Coughlan and AR, such as by trying to influence the content of the sessions.[1893]

98. The view of a number of professionals around this time was that the fractured relationship between Alphonse R and AR was a serious problem. Ms L Lewis of CFWS, in the context of the 17 March 2022 missing from home episode discussed below, said that *"the issues are [AR] and father's relationship which is fractious and always will be. Father has completed work on the triple p parenting programme, they are also waiting to attend riding rapids course ... My professional opinion is father doesn't want to take responsibility for his actions and attitude towards [AR] and will often antagonise [him] which was shown during the last TAF meeting"*.[1894] Although I have elsewhere in this report made findings about the appropriateness of this email, I do not consider that this was an inaccurate assessment of Alphonse R, although it did not reflect the extent to which AR equally antagonised and indeed assaulted his father.

99. CFWS closed its support for AR on 14 March 2022, following the end of the programme of Targeted Youth Support sessions. Alphonse R was keen for CFWS support to remain in place through AR's transition to Presfield High School, which had been brought forward. Alphonse R's wish for CFWS support to remain open at this stage was a reasonable and sensible position, as I have addressed in Chapter 9: Social care. However, it would have been far easier, as well as making it more obvious that such support was required, had Alphonse R and Laetitia M, been more transparent with all the relevant agencies as to how difficult home life with AR had become.

1892 AHCH000164/5-6. AR had hinted at the same baseless allegation the previous August, see LCC000247/5.

1893 LCC002311/59 (the Transcript refers to LCC002302 but LCC002311 is a better version of the same document); LCC000137/3; T/S: 29/211/7-213/12.

1894 LCC000910.

17 March 2022: AR carrying a knife on the bus

100. I have dealt in Chapter 7: Policing and Chapter 9: Social care with the very significant incident on 17 March 2022 when AR left the house armed with a knife, was reported missing and was subsequently found on a bus by police. He made concerning comments to police about intending to stab someone, and about making, or having an interest in making, poison. I focus here on the actions and knowledge of AR's family.

101. I stress that when Alphonse R realised that AR was missing, he had appropriately called the police, his wife and, as he recalled matters, Range High School.[1895] Alphonse R also contacted Ms Steed at CAMHS, mentioning a knife, and LCC's CFWS, the service which had closed to AR three days earlier.[1896,1897] Although Alphonse R gave equivocal evidence as to why he contacted Range High School, I have no doubt that it would have been because he feared AR was intending to carry out another attack. Contacting AR's previous school otherwise simply made no sense and, as Mr Moss suggested to Alphonse R, AR was unlikely to have been going to the school from which he had been excluded on a social visit.[1898]

102. As described in Chapter 7: Policing, Police Constable David Fairclough, as the first police responder to the report that AR had gone missing, met Laetitia M at 10 Old School Close shortly after the call was made. Alphonse R was not present, but was making his own efforts to search for AR. PC Fairclough obtained a substantial amount of information from Laetitia M. Despite this, Laetitia M has no recollection of being at home, having returned from work, when a police officer attended while AR was missing. She accepted that she did not have a very good memory of this day.[1899] I am sure that PC Fairclough's recollection, supported by the contemporaneous records, is correct.

103. Laetitia M informed PC Fairclough that AR had no friends or extended family. She referred to attention deficit hyperactivity disorder (ADHD) and autism, and the fact that he had been prescribed sertraline.[1900] She told him that she believed AR had taken a small kitchen knife which was missing from the kitchen, and that AR was supposed to be meeting the teachers at Presfield High School and having a tour of his new school.[1901]

104. Given the events of 29 July 2024, it is of particular significance that Laetitia M informed PC Fairclough of AR's exclusion from Range High School, and they discussed the attack on a student at Range High School on 11 December 2019.

1895 Witness Statement of Alphonse R IWS000058/§§138-139; T/S: 33/189/8-190/8.
1896 AHCH000164/36-37, 44.
1897 LCC000966.
1898 T/S: 33/190/2-191/20.
1899 T/S: 34/150/7-151/5.
1900 LANC000028.
1901 LANC000273/§16; T/S: 18/130/13-23.

She did so only when PC Fairclough prompted her about what had happened at Range High School, which he was aware of from the incident log.[1902] While gathering information from Laetitia M, PC Fairclough generated a Missing from Home report, in which he recorded:

> *"Parents believe he has gone missing as he does not wish to attend a meeting with his new school teachers. Parents believe he could be in possession of a small knife which is missing from the kitchen. He has never threatened or attempted self-harm."*[1903]

105. I am concerned that this was not a fully candid account by Laetitia M to PC Fairclough. While accepting that there was evidence that she had potentially significant memory gaps, she nonetheless was able to provide PC Fairclough with a significant quantity of accurate information about AR, as set out above. I consider it likely that she, as with Alphonse R, was fearful that he had left home with a knife to carry out another attack. It is improbable that she had forgotten such a significant incident, which had substantial similarities with the situation at hand. On that basis, not raising such a significant and similar incident to PC Fairclough without prompting indicates at best an inability to face up to the reality of what was happening, and at worst a degree of deliberate concealment. In either case, it is likely that Laetitia M's response of not immediately volunteering information about the earlier Range High School attack was rooted in a fear that history was repeating. However, that said, I do not entirely discount the possibility that Laetitia M's memory lapses may have played a role as regards the information that she failed to provide, at the outset, to PC Fairclough.

106. I set out the details of how and when AR was found, and what he said to the police officers before arriving home in Chapter 7: Policing. When PC Fairclough and Police Constable Eve Rhodes arrived at 10 Old School Close with AR, they initially spoke to both Alphonse R and Laetitia M. The officers informed both parents that AR had been found in possession of a knife and that he had indicated his intention was to stab someone. Alphonse R said that he was hugely concerned to learn that AR had admitted that he had gone out intending to stab a member of the public. He considered this showed some kind of insanity or madness on the part of AR.[1904] Laetitia M, on the other hand, did not recall being told about AR's comments in the back of the police vehicle. As discussed in Chapter 7: Policing, I accept that the officers squarely raised, with both parents, AR's comment about intending to stab a random member of the public in order to get his social media accounts deleted.

107. Dion R was not present during this conversation, but recalled the police speaking *"to my parents, but maybe just my mum"*. He was present, however, for a conversation between Laetitia M and AR after the police left, in which he *"learnt AR had told the police that he was going to go out to stab someone to*

1902 T/S: 18/113/3-19.

1903 LANC000009/3.

1904 T/S: 33/192/12-194/1.

get rid of his social media account".[1905] That corroborates the police evidence, and the evidence of Alphonse R, that Laetitia M was aware of this important information. Dion R noted that stabbing a random person to get rid of a social media account *"doesn't sound logical but in [AR's] mind it would"*.[1906]

108. According to PC Fairclough, he took Laetitia M aside to speak to her about poison, given that AR had expressed a preference for police and other professionals to speak to her, rather than Alphonse R. This receives some slight support from Dion R's partial recollection that police spoke to Laetitia M alone. AR's preference is also consistent with AR's general attitude towards Alphonse R. PC Fairclough said that, when he informed Laetitia M that AR had spoken about poison, she said that AR had mentioned poisons to her prior to this incident and she appeared shockingly unconcerned by AR's comments.[1907]

109. Conversely, Laetitia M's evidence was that she had no memory of AR mentioning poison to her prior to the incident on 17 March 2022 and she denied lying about this.[1908] Alphonse R also denied that any earlier discussion had taken place about AR's interest in making poisons with Laetitia M before his arrest on the bus. He suggested that something of such importance was not an issue that they would have kept from each other. Indeed, he suggested that there was no conversation about poisons following AR's arrest. By implication, he suggested that the police had invented this conversation.[1909] Dion R did not recall anything about poison in connection with this incident, including in discussions with his mother afterwards.[1910]

110. Given their importance in the present context I repeat here central findings that I have made in Chapter 7: Policing:

    a. Although PC Fairclough did not make a contemporaneous record of having spoken to Laetitia M about poison, it would be unthinkable for a conscientious officer who was obviously concerned about the risk posed by AR, and to AR, not to have relayed his concern to AR's parents. This was not a point of fine detail, but one of substance and of considerable significance. It was not something that is likely to be a mistaken recollection. PC Fairclough first mentioned this conversation in passing in his initial witness statement after the attack in July 2024,[1911] and he was asked to expand on it in a second witness statement: that is inconsistent with any suggestion of post-attack

1905 Witness Statement of Dion R IWS000060/§84(c); T/S: 33/27/16-28/5.

1906 MERP001217/2-3; T/S: 33/28/18-29/24.

1907 Witness Statement of PC Fairclough LANC000273/§43, §§88-90; LANC000019; LANC000023; LANC000045; T/S: 19/23/15-28/15, T/S: 19/42/9-44/9.

1908 Witness Statement of Laetitia M IWS000056/§137; T/S: 34/151/20-153/7.

1909 Witness Statement of Alphonse R IWS000058/§141; T/S: 33/194/2-197/17.

1910 T/S: 33/28/6-17.

1911 LANC000019.

fabrication.[1912] I add that I found PC Fairclough throughout to have been doing his very best to assist the Inquiry; he was a patently honest and credible witness;

b. At one point, his evidence was genuinely and honestly mistaken, on whether the knife was returned to a knife block in the kitchen: I accept Dion R's evidence that there was no such knife block.[1913] But it is notable that unlike his recollection of telling Laetitia M about poison, the detail about the knife block first appeared in PC Fairclough's witness statement for the Inquiry in 2025, not in his statements given to Merseyside Police in 2024. It is also the sort of relatively inconsequential detail about which I readily accept a witness trying to help the Inquiry, who has been asked about events on a number of occasions, could come to be honestly mistaken. For the reasons given, I do not consider that PC Fairclough's recollection of discussing AR's interest in poison with Laetitia M is comparable in this regard;

c. On the other hand, Laetitia M's general recollection of her contact with the police on 17 March 2022 is extremely poor. As noted above, she did not, for example, remember PC Fairclough attending the home address in the morning, or PC Fairclough and PC Rhodes saying anything about AR having taken the knife in order to stab someone when they brought AR back to the home address,[1914] even though this was corroborated by Dion R[1915] and Alphonse R.[1916] While she maintained that it was not possible she had known something about poison in March 2022 but had now forgotten it, that must be seen in the context of the significant gaps in her memory of these events;

d. For those reasons, I am satisfied it is more likely than not that PC Fairclough did tell Laetitia M about AR's comments regarding poison, and that she did indicate AR had spoken to her in similar terms previously;

e. I am also satisfied that it is more likely than not that the substance of what PC Fairclough said would have been shared with Alphonse R afterwards. Alphonse R was clear that Laetitia M would have shared this kind of information with him, and it would be entirely natural for him to ask her what it was PC Fairclough had said.[1917] However, I do accept that its significance may not have been fully appreciated even in March 2022, and that over two years later, the link to some of the items and substances found in AR's bedroom on 22 July 2024

1912 LANC000023.

1913 T/S: 19/41/8-20; T/S: 33/33/5-7 (Dion R).

1914 Witness Statement of Laetitia M IWS000056/§156; T/S: 34/150/20-151/19.

1915 Witness Statement of Dion R IWS000060/§84(c); MERP001217/2-3.

1916 Witness Statement of Alphonse R IWS000058/§§140-143; T/S: 33/191/21-192/11.

1917 T/S: 33/196/2-197/16.

> may not have been made. I accept that this was not shared with Dion R and was not the subject of frequent, or even any, further discussion in the home, either because it was not understood to be especially significant or, conversely, because it was too disturbing to contemplate. But I consider it more likely than not that Laetitia M and Alphonse R did have some prior knowledge of AR's interest in poison as a result of PC Fairclough discussing it with Laetitia M, and Laetitia M then inevitably discussing it with Alphonse R.

111. The following day, at a scheduled meeting with CAMHS, Laetitia M discussed what had occurred with Ms Steed.[1918] Although she expressed her worries about AR having gone missing the previous day, there is no indication that she flagged to Ms Steed that AR had had a knife (though Ms Steed was aware of this in any event from CAMHS' dealings with Alphonse R the previous day). On the contrary: she spent some time speaking about all the things AR used to engage in and comparing his activities unfavourably with those of Dion R and described AR as *"fine at home"*. This conduct is striking given that Alphonse R and Laetitia M had told police officers the day before that they would take AR for a mental health assessment. In fact, there appears to have been very limited appetite to address what had happened.

112. That pattern then continued when LCC made its efforts to follow up on this episode. Laetitia M did not respond to the repeated efforts by the LCC MASH to contact her.[1919] When Ms Amanda Chapman, from LCC's Missing from Home team, carried out a home visit on 22 March 2022, she made a note that she *"discussed the missing episode with mum and she agreed she does not need any further support"*.[1920] Ms Chapman agreed that if Laetitia M had said anything about contacting CAMHS or AR's GP or had said anything about knives and the need to hide them from AR, she would have recorded it.[1921] I accept Ms Chapman's evidence on this. But it would have been obvious to Laetitia M that more support was required, and that these were key matters to raise with Ms Chapman. In my view, this was an attempt by Laetitia M to downplay what had occurred, in all likelihood because of her misguided tactic of attempting to minimise conflict with AR.

113. While it was Laetitia M who had direct contact with LCC and CAMHS in the days immediately following 17 March 2022, there is no evidence of Alphonse R taking any steps to seek help or raise concerns about what had occurred.

114. I do not overlook the findings I have made in other chapters about the inadequate response of a range of professional agencies to this incident. It should not have been necessary for AR's parents to sound the alarm at this stage: there were sufficient indicators and warnings for professionals to step in. As I have found, had that happened, the attack on 29 July 2024 would

1918 AHCH000164/42-44.

1919 LCC000344/5.

1920 LCC000159/5.

1921 T/S: 29/255/21-256/10.

probably not have occurred. Even if AR had not been robustly dealt with under the criminal justice and/or Prevent routes, resulting in a thorough search of the contents of his room and his electronic devices, this incident should – at the very least – have led to the implementation of a framework for risk mitigation. That should have included a plan, agreed with AR's parents, which stipulated – unequivocally – that they should report any future incident of AR leaving the home if it was possible he was carrying a knife.

115. However, in the absence of police, CAMHS, FCAMHS (who were not even told of it) or LCC intervening effectively after this concerning incident, AR's parents could, and morally should, have done more to highlight the increasing risk that AR posed. This incident should also have acted as a warning sign to AR's parents to treat as being extremely serious any future occasion where AR left the home potentially armed with a knife.

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116. During this period, it is right to recognise that AR's behaviour became even more challenging for this family. While there were variations over time, the overall pattern was of continued aggression (verbal and physical) towards his father, being distant from his brother Dion R, and becoming increasingly isolated within the family home.

117. An example of this was that in the early hours of the morning on 14 May 2022 AR flew into a rage, almost undoubtedly over something trivial. He demanded that Alphonse R hand him his laptop because he wanted to break it as a punishment for whatever had prompted his anger. Although Alphonse R hid the laptop from AR, the latter found it and took it into the bathroom where he smashed it and then put it in the bath which he filled. Indeed, he left the bath to overrun, thereby flooding the house and forcing his parents to switch off the electricity. He also put some of Alphonse R's clothes into the toilet.[1922] The police were called.

118. While the incident demonstrates how difficult it was for AR's parents to deal with his behaviour, it also illustrates how they failed to follow through with the support agencies as might reasonably have been expected. I accept the accuracy of the police written record that Alphonse R and Laetitia M said to Police Constable Peter Andrews that they were going to inform CAMHS and AR's GP of this incident.[1923] Alphonse R attempted to deny in evidence that they had given this commitment but I am confident that the near contemporaneous record of Lancashire Constabulary compiled by PC Andrews is correct.[1924] This was one of a number of occasions when AR's parents were deliberately

1922 Witness Statement of Alphonse R IWS000058/§150; T/S: 33/110/15-111/2.

1923 Witness Statement of PC Andrews LANC000272/§15; LANC000094/2.

1924 T/S: 33/111/13-113/9.

selective as to which of the agencies they informed of AR's violent and destructive behaviour. It is probable in my view that the parents attempted to control the provision of information to avoid the risk of AR being removed by the authorities from the family home.

119. During his evidence, Alphonse R accepted that he over-accommodated AR and he failed to set boundaries or to discipline him appropriately, but he suggested he had no other choice because AR would otherwise act violently.[1925] While I accept that both Alphonse R and Laetitia M faced very considerable difficulties in this regard, two points are of note. The first is that there is no evidence that AR's parents attempted any sustained period of trying to set appropriate boundaries despite AR's likely response. The second is that this undoubted difficulty in parenting AR does not excuse the selective way in which AR's parents engaged with the supporting agencies, including in regard to the sharing of information.

120. Although Alphonse R was resistant to the suggestion, I have no doubt that he was reluctant to have social workers involved with AR's deteriorating behaviour because he feared that his younger son might be forcibly removed from the home and either taken into care or into custody. He was additionally afraid of the violence, including fatal violence, which AR might inflict within the home.

121. This failure by AR's parents, but especially Alphonse R, to trust and engage with the relevant agencies and to seek to set boundaries is particularly evident in the context of the items – including weapons – that were being delivered to the family home. After AR's expulsion from Range High School in October 2019, the attack on Range High School in December 2019, and the bus incident in March 2022, AR's parents can have been in no doubt that any sign of AR trying to get hold of weapons signalled real danger. Yet the pattern of AR's orders and deliveries to the family home from 2022 onwards is deeply concerning.

122. The first indications of concern ought to have arisen even before this period. As I have addressed in Chapter 5: Weapons and poisons, as early as January 2022, Alphonse R knew that AR was organising for parcels to be delivered to the next-door house, given the neighbour voiced a complaint. It was in my view a failure in parental responsibility on the part of Alphonse R and Laetitia M that they did not ask AR why he was using an incorrect name for some of his deliveries (in the early deliveries in January 2022, it was his father's name) and why some parcels were being delivered to their neighbour. Alphonse R maintained that he had simply *"accepted everything that [AR] was doing, just to have peace at home"* and *"I knew that any questions would be met with a violent outburst"*. He suggested, moreover, that he had concluded that the deliveries to the neighbour were simply a mistake on AR's part. I have not overlooked Alphonse R's evidence that he *"had terrible fear of [AR]. I mean, it wasn't normal the way things were at home. I was scared of him"*. But even allowing for the undoubted problems that AR presented as a son,

1925 T/S: 34/9/12-10/7.

I found that this evidence by Alphonse R constituted a deliberate and worrying abdication of responsibility, given his knowledge of AR's deteriorating and dangerous behaviour.[1926]

123. Alphonse R realised that one of the deliveries to the house was of seeds and, although he had never seen his son do any gardening, he did not query the reason for the purchase. He said he was traumatised and simply did not ask any questions. He feared any questions would be met with a violent outburst. The WhatsApp messages, however, reveal that he had discussed these orders with AR. Via orders made on 18 and 19 January 2022, there had been deliveries to AR of ricin seeds, together with Isopropyl Alcohol and associated equipment and materials. The bigger order (including the ricin seeds and alcohol) went to the neighbouring house.[1927] I accept that neither Alphonse R nor Laetitia M knew that the seeds purchased at this stage were ricin seeds, or of the potential for the seeds to be used as a highly lethal toxin. However, AR was only 15 years old at this time, and they should have been far more inquisitive about why AR was ordering items in his father's name to be delivered to their neighbours.

124. As I have set out in detail in Chapter 5: Weapons and poisons, from March 2022 onwards, AR was involved in the purchase of weapons online. This started with conventional archery equipment (a bow and hunting arrows) ordered in AR's own name in March 2022. In May 2022, AR then started exploring the potential for buying a crossbow. Alphonse R said that he only became aware of the bow and arrows at some later stage and there is no evidence that either parent was aware of the purchase when it was made or of AR's online exploration of the purchase of a crossbow. The difficulty, however, is that having failed to intervene over the purchase of seeds and chemical equipment delivered to the neighbours' house, and with no parental controls over AR's online devices, Alphonse R and Laetitia M had permitted a lax regimen within the family home, in which AR clearly felt able to test and explore what weapons he might be able to 'get away' with purchasing. This was to manifest in earnest the following year when AR progressed to seeking to buy machetes (see further below).

125. I have set out in Chapter 10: AR's healthcare, the circumstances in May 2022 which gave rise to the change from Dr Lakshmi Ramasubramanian to Dr Anthony Molyneux as treating psychiatrist for AR, and Ms Steed relinquishing the role as case manager. As I have explained there, both Dr Ramasubramanian and Ms Steed considered that Alphonse R had been intimidating and aggressive around this time. This included his attitude when they met and in his email communications, both of which Dr Ramasubramanian considered to be intimidating and disrespectful. His emails, she said, were aggressive and demanding.[1928] Ms Steed equally

1926 Witness Statement of Alphonse R IWS000058/§129; T/S: 34/23/15-25/21.

1927 Witness Statement of Alphonse R IWS000058/§126; T/S: 34/24/20-26/12; AMA000096 rows 26, 33, 34, 35, 37, 38; MERP000164. See further Chapter 5: Weapons and Poisons.

1928 Witness Statement of Dr Ramasubramanian AHCH000239/§66; T/S: 24/162/23-163/8.

considered that Alphonse R had acted in this way. Alphonse R did not accept Dr Ramasubramanian's description of his alleged behaviour prior to 23 May 2022, during their meeting on the 23 May 2022 and in their communications thereafter.[1929] However, I accept Dr Ramasubramanian's evidence that, notwithstanding her position as a very experienced consultant, she felt unsafe continuing to work with Alphonse R. This was the only time in her career when she had taken this step. I am sure that this change in clinicians only became necessary because Alphonse R acted in an inappropriately overbearing and verbally aggressive way.

126. As I have emphasised in this chapter, AR's parents had very great challenges in trying to support AR when tackling his unreasonable and often violent behaviour. It was inevitable that they would have frustrations with professionals. This is some mitigation for, but does not excuse, how Alphonse R approached Dr Ramsubramanian and Ms Steed. On one level, it is of course understandable that Alphonse R was frustrated by what I accept he subjectively saw as undue criticism of AR's diet and the family arrangements around mealtimes. On a more objective level, however, the underlying theme of Dr Ramasubramanian's clinic letter was the overaccommodation of AR's wishes, which Dr Molyneux would later also accurately identify. Alphonse R had become resigned to allowing AR to control the home environment. When outside agencies raised concerns that questioned this – such as Dr Ramasubramanian's perfectly justified concerns that AR was allowed to have possession and control of his own medication – Alphonse R was prone to react in a defensive if not hostile way. I am sure that he genuinely felt a strong sense of frustration that, as he saw it, agencies did not fully understand how difficult it was to set boundaries for AR given AR's violent outbursts if he did not get his own way. However, a deeply unhelpful trait in Alphonse R's behaviour was that this sense of frustration played out in him seeking to control and direct the agencies' engagement, and to criticise their professionalism. In this instance, this was particularly evident in his request for Ms Steed to be replaced and the language he adopted in criticising Dr Ramasubramanian's clinic letter.

127. In the autumn of 2022, Dion R went to university and from that stage, he was living away from home save for the university vacations.[1930] He explained that before he had left for university, from 2021, AR had come to dominate the living room with the result that Dion R thereafter never used it. By the end of 2022 (when he would have returned from his first term at university), Dion R had become fearful that AR might kill a member of the family, particularly his father during one of his arguments with AR. Although he was not sure, he thought that AR may on one occasion have tried to stab his father during an incident in 2022. He described AR's treatment of his parents as *"shocking"* and that *"fear"* defined or *"marked"* these incidents. Dion R thought that his parents reported the high levels of violence in the home to CAMHS.[1931]

1929 T/S: 34/10/8-14/9.

1930 Witness Statement of Dion R IWS000060/§2.

1931 T/S: 32/190/23-191/7; T/S: 32/181/8-184/6; T/S: 32/178/1-180/3; IWS000057/1-2.

128. I am satisfied that Dion R's account of the level of fear about his brother was accurate and truthful. It was vividly illustrated by the fact that, on 14 December 2022, Dion R sent a message on the Discord App to a friend in which he indicated that he had a *"major concern"* that AR could do something *"potentially fatal"* if there was an attempt to *"restrain him"*. He indicated that AR could be violent and his father had to be careful. Dion R added *"The fights are scary because of the danger of someone dying. My brother doesn't really show mercy so my dad just has to try not to die"*. Alphonse R in his evidence suggested that Dion R was exaggerating and that he was not providing an accurate account of what had been happening.[1932] I prefer Dion R's evidence to that of his father.

129. Without diminishing how challenging the home situation had become, three episodes from the spring of 2023 further illustrate how AR's parents' attitudes in response to the agencies' attempts to support the family had become problematic. The context was that AR was not attending or engaging with Presfield High School who felt that they had effectively exhausted the tools available to them to seek to support AR to attend. Against this background:

    a. A professionals' review was held on 2 March 2023, attended by LCC school inclusion service, CAMHS, Presfield High School and AR's parents.[1933] At this meeting, Ms Kathryn Morris, the CAMHS case manager, explained that there was no engagement from AR – he failed to attend several CAMHS sessions and was expressing that he wanted no engagement with CAMHS.[1934] She also said that she had struggled to engage AR's parents with her sessions. She suggested that basic wellbeing needed to be addressed before attempting a return to school. In this context, Ms Morris raised (as many had done previously) that AR had a dysregulated sleep pattern, being up very late at night and sleeping all day, and she said she was unsure what the boundaries and structure in the home looked like. She raised the need for support for AR's parents and a possible further referral to LCC's CFWS seeking assistance for AR's parents. On any objective basis, such concerns on the part of CAMHS were entirely justified. However, at the meeting Laetitia M was recorded not only as disagreeing with Ms Morris, but additionally taking issue with her for sharing (at this meeting) what AR had said about not wanting to attend school (*"…didn't feel this should be shared with school …"*). At the family therapy session on 28 March 2023, Laetitia M expressed that she felt that the family therapy was *"pointless and she did not trust camhs"* who were *"very powerful, having the power to remove children"*. Within the same session, Alphonse R and Laetitia M *"spoke about observing the frustration of professionals working with*

1932 IWS000057/1-3; T/S: 33/131/11-134/6.

1933 Witness Statement of Ms Morris AHCH000278/§§65-73; AHCH000164/140-142.

1934 AHCH000164/141-142.

them and how they felt in a recent meeting the camhs case manager had 'thrown [AR] under the bus' when speaking about [AR]".[1935] While it would undoubtedly and understandably have been difficult for AR's parents to attend meetings at which the lack of home boundaries were raised as a concern, this was a legitimate professional issue. AR's parents responded with a degree of resentment and sought to criticise the (entirely legitimate) sharing of information between agencies;

b. On 20 March 2023 Ms Angela McGuire from the Sefton Metropolitan Borough Council's school attendance team sought to visit the family home to discuss AR's long-term absence from school (10 months). The record of this attendance recorded that Laetitia M had *"aired her annoyance and confusion"* over the council's involvement. Further, on explaining it was a welfare visit, Ms McGuire was *"… greeted with a complaint from mum who it was said saw no reason for the visit and she flatly refused for Angela to see [AR]"*.[1936] Laetitia M struggled to remember this incident. She said that it could be that AR was sitting in the living room when they arrived and he would have broken *"things"* if she had allowed Ms McGuire to enter the house. This would have prompted an outburst. She apologised for what had appeared to be rude behaviour but said she and her husband had been trying to maintain calm in the home at a time of a lot of difficulties and stress.[1937] While it is understandable that Laetitia M was concerned about AR's reacting to an unexpected welfare visit, the purpose of this visit was explained to her, and AR had been absent from school for very many months. Neither a concern about AR's reaction nor the undoubted cumulative stress of AR's behaviour can justify or explain the response by Laetitia M of complaining that the visit had taken place when its purpose was so obviously to try to help;

c. On 14 May 2023, Alphonse R sent an email to Mrs Hayley Dawson at Presfield High School in which he had indicated that AR would only attend school if he was allocated a less *"boring"* teacher. He suggested his son fell asleep as a consequence of this teacher.[1938] I do not doubt that AR had observed that the tutor in question was supposedly *"boring"*. However, it was manifestly inappropriate for Alphonse R to adopt AR's complaint and seek to dictate AR's teacher in this way, particularly on the basis of an assertion by his son, who, to his father's knowledge, was manifestly unreliable. This episode, while perhaps relatively trivial in itself, evidences how far Alphonse R had fallen into the trap of overaccommodation. He appears to have

1935 AHCH000164/145-146.

1936 LCC000186/2.

1937 T/S: 34/136/6-140/14.

1938 PRE000475/2.

no insight into how unreasonable and inappropriate it was to repeat in the blunt terms of this email a requirement for a different teacher, rather than to challenge his son's manipulative demands.

130. As I have set out in Chapter 5: Weapons and poisons, June 2023 saw a number of further concerning online purchases by AR. On 10 June 2023, he ordered: (a) a 2.7 kg sledgehammer; (b) lighters, duct tape and hurricane survival matches; (d) the first of the three machetes (see further below). On 12 June 2023, AR also ordered an undisclosed item from French archery specialist Hatilla.[1939]

131. Alphonse R's involvement with AR's first machete is significant. It will be recalled that, for this machete, AR had used the false name of 'Alice' supported by a driving licence in that name. The machete was delivered on 14 June 2023 by DPD. Because Springfields of Burton sought to meet the statutory requirements then in place, the delivery was age verified, and the package was marked very clearly with a red box stating *"Bladed Items Delivery To 18+ Only"*.[1940] Alphonse R accepts that he received delivery of this machete. He states that he understood it was a knife rather than a machete. The package was heavy and in the shape of a knife. Moreover, the delivery driver told Alphonse R that it was a knife. However, Alphonse R accepted in his oral evidence to the Inquiry that he knew it was not a small kitchen knife.[1941] He also knew that AR had been furtive about the purchase because Alphonse R had seen the false name 'Alice' on the delivery label.[1942]

132. AR overheard the conversation between Alphonse R and the delivery driver and unexpectedly did not protest when Alphonse R refused to give him the parcel.[1943] Alphonse R then hid the package on top of the wardrobe in his and Laetitia M's bedroom. It remained there unopened until after the 29 July 2024 attack, when it was found during the police search of the house (although AR did seek it from Alphonse R, threatening him in the process, on 22 July 2024 – see below).

133. Alphonse R has said that he accepted this package because he believed that AR had ordered it and he was worried that if there was an attempt to redeliver it when he was not at home then it might have fallen into AR's hands. He now accepts he should have refused to accept the package and he ought to have reported the incident to the police.[1944] He also says that he did not raise the package or what was in it with AR, or open the package because he feared that this would lead to escalation in the form of a violent and dangerous reaction from AR; it was not his property and he feared being attacked violently.[1945]

1939 See Chapter 5: Weapons and poisons.

1940 See Chapter 5: Weapons and poisons for further details.

1941 T/S: 34/29/13-16.

1942 T/S: 34/30/2-4.

1943 Witness Statement of Alphonse R IWS000058/§163.

1944 Witness Statement of Alphonse R IWS000058/§§159-162; MERP008267.

1945 T/S: 34/27/20-29/12.

Alphonse R said that he thinks he did tell Laetitia M about this knife *"…but it's the kind of thing she doesn't want to hear. She'll just push it away to the point that she doesn't even remember that it ever happened"*.[1946]

134. While understanding the fear of violence in the family home, in my assessment it was reckless and wholly inappropriate for Alphonse R to have simply hidden this item and not to have opened it to discover what was inside. Particularly given AR had found the other knives in the house, this was a far from secure hiding place. Indeed, it is extremely surprising that AR did not successfully search for it. It is a matter of the gravest concern that AR's parents did not attempt to question him about this delivery or report it to the police and the other relevant agencies, including his school, social services and CAMHS. They must have realised that this large knife (or machete as in fact it was) had been bought, in all likelihood to be used offensively: AR did not cook, garden or follow outdoor pursuits and had only ever used knives for offensive purposes in the past. AR therefore posed a real and immediate risk to the lives of others.[1947]

135. Alphonse R accepted that he had not provided CAMHS with information about the weapons that AR had been accumulating, and that he *"fell short"* in this regard.[1948] Alphonse R also said in evidence that he regrets *"so much"* not informing the police about this delivery and that he is sorry for not doing so.[1949]

136. In an attempt to justify not sharing this critical information, Alphonse R suggested in evidence that he thought he was the only person at risk from AR's violence. I reject this explanation. From other evidence, it was clear that Alphonse R was gravely concerned that Dion R was in danger and, given AR's earlier behaviour which involved leaving the house to stab either a former fellow pupil or members of the public, I am wholly confident that Alphonse R was alive to the risk that AR posed generally to others. Indeed, after the disclosure to Childline, Alphonse R and Laetitia M hid the kitchen knives from AR behind some trays in the kitchen drawer *"so that they were not within easy reach"*.[1950] As I have noted above, this was unsuccessful because AR took one of these knives when he attacked the pupil at Range High School with the hockey stick. Alphonse R and Laetitia M then disposed of all their kitchen knives save for a *"bendy"* bread knife and a 4" kitchen vegetable preparation knife which AR took from the house when he was found on a bus in March 2022 intending to stab a member of the public. Once again, AR had taken it from the house, this time from a new hiding place in a cupboard. For these reasons, I find that Alphonse R's suggestion, that he did not report the fact that AR had ordered a large knife because he thought only he was at risk, is simply untrue.

1946 T/S: 34/32/2-13.

1947 Witness Statement of Alphonse R IWS000058/§§163-165; T/S: 34/31/23-32/1.

1948 T/S: 34/17/24-18/4.

1949 T/S: 34/31/15-22.

1950 Witness Statement of Alphonse R IWS000058/§47-48.

137. Despite this, in giving evidence to the Inquiry, Alphonse R had to some extent self-critically reflected on the significance of his failure to report the delivery of this large knife, as he believed it to be. He recognised that if he had told the police about this delivery *"what happened on the 29th wouldn't have happened"*.[1951] Although it is impossible to assess precisely what the outcome would have been, I am nonetheless confident that Alphonse R was correct in this assessment. Given the admissions by AR to Childline, his attack with the hockey stick at Range High School and the bus incident, all of which involved an acknowledgment by AR that he had been carrying a knife in order to kill, this attempted clandestine delivery of a large machete would have led to a robust response by the authorities. The police would have searched his room and would have found the ricin, steps which would have led to his arrest and a criminal prosecution, followed by a possible custodial sentence.[1952] It is likely that AR would have been unable to delete his internet browsing history which may have been revealing; indeed, by then he had downloaded the Al-Qaeda training manual on more than one occasion. More generally, it would have been impossible for the authorities to have ignored or to have been equivocal about this undeniably alarming development. I have no doubt that it would have prompted a proper risk assessment and, whether AR was taken into custody or care, accepted onto Channel or subjected to a more intensive regime of intervention by the authorities, I have no doubt that the course of his life would have been significantly different. Alphonse R recognised that by failing to challenge AR on this delivery of a machete, he may have emboldened him to order other weapons.[1953] It follows that the key events in AR's life would have unfolded in a very different way, meaning that it is highly unlikely that the attack on 29 July 2024 would have occurred.

138. At some stage during the summer of 2023 there was an occasion when Dion R was going to see friends and Alphonse R and Laetitia M invited AR to say goodbye to him. Instead, AR threw a metal bottle in the direction of Dion R. Dion R said that was the last interaction between the brothers. Indeed, Dion R said that AR ceased talking to their father during the latter part of 2023, meaning that the only person with whom he had any meaningful contact was his mother.[1954]

139. As I have detailed in Chapter 5: Weapons and poisons, on 6 October 2023, AR ordered a second machete, this time from Knife Warehouse and using a different false name ('Olakunle') for delivery to the family's home address. Although Alphonse R could not rule out the possibility that AR took delivery

1951 T/S: 34/32/14-33/6.

1952 On balance, I find that AR would have made the crude preparation of ricin by this stage, around a year and a half after he had ordered the ricin seeds, alcohol and laboratory equipment.

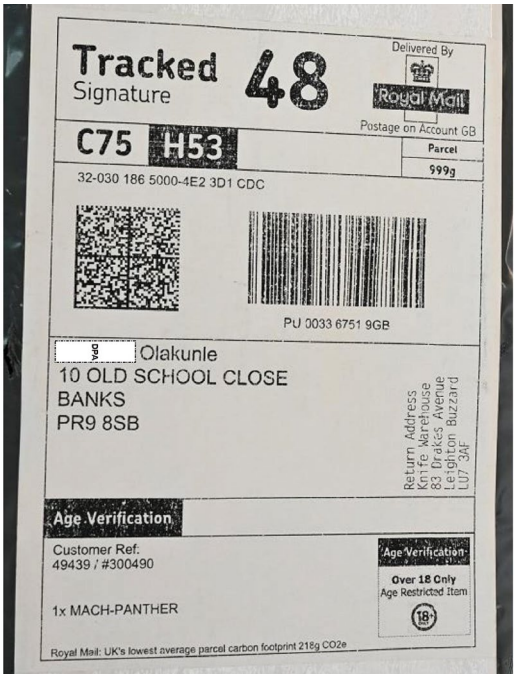
1953 T/S: 34/33/7-16.

1954 Witness Statement of Dion R IWS000060/§56; T/S: 32/192/11-193/19.

of this item, he accepted that it was probable that he dealt with the delivery driver.[1955] For the reasons I have set out fully in Chapter 5: Weapons and poisons, I have no hesitation in finding that Alphonse R did accept this parcel.

140. The more difficult question in relation to this second machete order is what Alphonse R knew about the contents of the package.

141. The parcel was not identified by police in the initial search of the home following the attack. AR's room was obviously searched in depth and so it is clear that AR had not taken the parcel and put it under his bed where he had hidden other weapons. As I have set out in Chapter 5: Weapons and poisons, one of the images taken by Merseyside Police during the house search shows a parcel which is entirely consistent with the Knife Warehouse parcel lying among other post and parcels.[1956] That means that Alphonse R took delivery of this parcel at the door and then probably left it lying somewhere in the house among other deliveries. AR could therefore easily have accessed this machete had he wanted to, although in fact it seems that it was left lying unopened with other parcels. While I have found that Alphonse R's response to the first machete delivery was wholly inadequate, he did at least intercept it and seek to hide it. Given that this delivery was not hidden but merely left in a pile of parcels, this may tend towards a conclusion that Alphonse R did not actively appreciate that this parcel contained a knife or machete. Linked to this is the poor labelling of this delivery from Knife Warehouse. The label indicated that it was an age verified item, but that warning was not as prominent as it might have been, and did not state it was a bladed item:[1957]



1955 Witness Statement of Alphonse R IWS000058/§§195-196, §199.

1956 MERP007784/15.

1957 MERP008292/19 – Disclosed but not published due to sensitive content.

142. On the other hand, there are features that would suggest that Alphonse R did appreciate that this parcel contained a knife or machete:

    a. Alphonse R told the police in interview that there were **two** occasions when there was a delivery of a box that *"felt like a heavy knife"*.[1958] When this was put to him in his oral evidence to the Inquiry, Alphonse R sought to rebut this and he said that he only knew about one knife delivery and this reference in interview had been to the delivery of a knife to 'Alice'.[1959] In his written statement to the Inquiry, Alphonse R also maintained that he only ever took delivery of one package that he knew to be a knife;[1960]

    b. In the same interview, Alphonse also referred to being aware that AR had started to use *"Nigerian names"* for deliveries.[1961] In his oral evidence, Alphonse R suggested that this referred to the name 'Olakunle' appearing on delivery boxes that were in the living room or by the main door, but not to a knife delivery;[1962]

    c. The packaging (as shown above) described the contents as *"1 x MACH-PANTHER"*.[1963] While this was in short form (short for 1 x Machete – Panther), combined with the false name on the label and the age verification label, it might be expected that this would have alerted Alphonse R to the nature of the parcel;

    d. The package was sent using an age verified delivery service from Royal Mail. Alphonse R was asked to, and did, provide a year of birth when he accepted the parcel (1975). It would, therefore, have been abundantly clear to him that this was an age verified item and not a normal delivery.

143. Given that Alphonse R was aware that a first knife had been delivered to the home with a false name in June 2023, it was – at best – reckless of him to receive this age verified parcel in a false name and leave it lying around without checking what the parcel contained. On any objective basis, Alphonse R had strong reasons to suspect that this was another knife. Alphonse R ought to have dealt with it differently, if he had been acting conscientiously and responsibly. On the evidence, it is however unclear whether Alphonse R did in fact realise at the time that this was likely to be another knife or bladed weapon. If he was genuinely unaware of that fact, that can only have arisen because he had a casual lack of interest in the parcel's content and that was of itself highly blameworthy given the earlier delivery in June. If Alphonse R did appreciate this was likely to be another knife, it was grossly irresponsible of him to leave

1958 MERP001430/12.

1959 T/S: 34/35/12-38/3.

1960 Witness Statement of Alphonse R IWS000058/§171.

1961 MERP001430/47.

1962 T/S: 34/37/13-21.

1963 MERP008292/19 – Disclosed but not published due to sensitive content.

it in a pile of parcels where AR could have accessed it rather than dispose of it and report it to the authorities, or even just hide it as he had done with the June delivery.

144. As I have detailed in Chapter 5: Weapons and poisons, on 14 October 2023, AR purchased a third machete, this time from Hunting and Knives, using the false identity of *"Olakunle"*. In the circumstances I have addressed in Chapter 5: Weapons and poisons, this machete – wholly inappropriately – ended up being delivered without any age verification requirement at all. This machete was found under AR's bed in the search of the house conducted after the attack. The likelihood is that AR was able to take delivery of this item himself (it was delivered at 09:51 on 26 October 2023). There is nothing to suggest that AR's parents were aware of this delivery. However, it is notable that AR felt he could get away with trying to order yet another machete. I have no doubt that AR felt confident enough to do so precisely because his parents had done nothing about the first machete order save that Alphonse R had refused to hand it over. AR would have known that it had not been reported to the police or any agency with whom the family was involved. It follows that AR's parents' failure to challenge AR on the first machete purchase had engendered in AR a level of confidence that he could order knives to be delivered at home and not get reported to the police.

145. Dion R was aware of parcels arriving for AR, which the latter told him not to touch. Subject to the events on 29 July itself to which I return below, I accept that Dion R only became aware that his brother had been buying weapons after the attack on 29 July 2024. He harboured a general concern that the parcels *"had something bad in them"* and *"something dangerous"* but nothing that he believed represented *"an imminent threat to my life"*. Dion R's anxieties about violence were focused on the risk at home rather than more generally.[1964]

146. By 2024, Alphonse R described AR's behaviour and attitude at home as very frightening. He had turned into *"another person"* and was *"scary"*.[1965] On one occasion, AR poured a significant quantity of oil over Alphonse R's head and threatened to kill him in markedly menacing terms. Alphonse R said that in his view AR was in crisis; he noted his eyes were red; he seemed to be in some kind of mental anguish or pain; and he paced about. Of notable significance for later events, during this incident involving the oil, AR positioned himself in front of his father, poked him in the chest and said *"[i]f you get me out of here, this house, it may take a day, it may take a week, maybe a month, maybe years, I will kill you and trust me I will kill you"*; he made it clear that he would return, however long it might take, in order to kill Alphonse R. He appeared to be serious and Alphonse R found this *"quite frightening"*.[1966] The reference to AR leaving the family home was based on an incident the week before, when there

1964 MERP001217/3-4; Witness Statement of Dion R IWS000060/§§100-102; T/S: 33/34/9-41/3.

1965 Witness Statement of Alphonse R IWS000058/§219; T/S: 33/117/19-20.

1966 Witness Statement of Alphonse R IWS000058/§219; T/S: 33/113/10-114/16.

had been a discussion about the impossibility of AR and Alphonse R continuing to live in the same house and that AR might have to leave. In his statement to the Inquiry, Alphonse R set out the following:

> *"I was very scared of AR as was Laetitia and the combination of fear and the desire to avoid confrontation (by not enquiring into his activities and accepting his punishments) undoubtedly prevented me from doing things that would be expected of a parent such as to monitor and restrict AR's internet activity. This same tendency is what stopped us from enquiring about the items he was ordering and the packages that he kept around the house. This had catastrophic consequences for which I am desperately sorry."*[1967]

147. AR had earnt money from an online genealogy business. According to Alphonse R this ceased in 2022 but, in fact, the records suggest that this continued until April 2023.[1968] AR's other source of income was from his parents who, for instance, rewarded him with sums such as £40 for taking a shower. Alphonse R suggested that he had not connected *"the dots"* and realised their money could be funding AR's purchases of weapons.[1969] When Mr Moss asked Alphonse R why he did not exercise control over what AR was purchasing, Alphonse R replied:

> *"That train had already past a long time ago. Yes, we wouldn't be doing that with him. So if he want money, we give him money. But I didn't ask, "What do you want to do with the money?" I don't know how much his mum was giving him."*[1970]

148. By this stage I find that Alphonse R and Laetitia M had largely abandoned any attempt to influence AR. They were frightened of him, he was completely beyond their control, and they believed that, if challenged, Alphonse R was at real risk of being attacked, potentially fatally.

149. It is against this background that AR sought to purchase knives online in the summer of 2024.

The delivery of knives in July 2024

150. There are no grounds to believe that Alphonse R or Laetitia M were aware of AR's attempt to buy a chef's knife from Hunting and Knives in June 2024. This would only have been apparent from AR's own emails, and they had no oversight of his online activity.[1971]

1967 Witness Statement of Alphonse R IWS000058/§278.

1968 T/S: 34/100/12-101/16; MERP000804.

1969 T/S: 34/49/2-50/13.

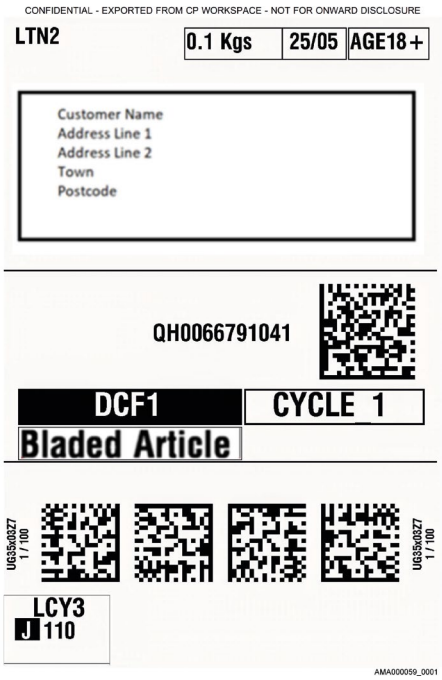
1970 T/S: 34/50/21-25.

1971 See Chapter 5: Weapons and poisons for details of this attempted purchase by AR.

151. However, on 13 July 2024, AR went on to order two chef's knives from Amazon, one of which he used in the attack on 29 July 2024. I have detailed the circumstances of this purchase in Chapter 5: Weapons and poisons but concentrate here on the knowledge and involvement of AR's family.

152. Amazon delivered the two knives on 15 July 2024 through Condor Carriers, an Amazon Delivery Service Partner. The delivery was at 17:40. Laetitia M was at work and Dion R was at university. The delivery driver, Mr Hamza Ali, told the Inquiry that the recipient was over 25 and said they were born in 1978.[1972] Although Alphonse R was born in 1975, he accepted he might have given a year of birth that was close but not exact because he considered it intrusive to be asked to give his correct year of birth. He accepted, moreover, that 1978 could not have matched AR. In these circumstances, Alphonse R agreed it was highly likely that he took delivery of the knives.[1973] For the reasons I have set out in Chapter 5: Weapons and poisons, I find, as a fact, that Alphonse R did accept this delivery.

153. While some retailers had more prominent warnings, the words *"bladed article"* were still set out clearly on the outside of the Amazon package. A sample of the type of delivery label used is set out below:[1974]



154. Alphonse R advanced two alternatives during his evidence as to what happened: either he had probably been half awake and simply took the package, placed it behind the door and went back upstairs to bed or he did not realise it was a knife or machete (he said he had a *"problem"*

1972 T/S: 17/28/1-29/9.

1973 T/S: 34/43/23-45/3.

1974 AMA000059 – this is a mock up provided by Amazon of how the label would have looked.

with the word *"bladed"* which *"to me doesn't mean a knife, necessarily"*). Alphonse R considered it more likely that he simply had not read the label and went back to sleep.[1975]

155. I have the gravest concerns about this evidence from Alphonse R for two reasons. First, I have read a considerable amount written by Alphonse R, most particularly the many emails he sent to the representatives of the various agencies. His grasp of the English language is extremely impressive; indeed, it significantly exceeds that of many people for whom English is their first language. I have no doubt that if Alphonse R had read the label, he would have understood the meaning of the warning *"bladed article"* and that, whether it was a knife or not, it referred to a dangerous item with a blade. Second, Alphonse R was aware of at least the first occasion when a knife/machete had been ordered by AR and delivered to the house. On that occasion, and on 15 July 2024, he was asked for his year of birth before being provided with the package. He would have realised, half asleep or not, that there was an obvious risk that any age verified item being delivered to AR was a knife or other bladed weapon and should then have closely examined the label.

156. As with the second machete delivery, I find that Alphonse R showed – at the very least – a casual disregard for the content of the parcel which was highly blameworthy. Alphonse R himself said that what happened was *"terrible"*.[1976] I appreciate that he had previously intercepted a machete ordered by AR. However, on the balance of probabilities, given the request for a year of birth and labelling, I find that Alphonse R on this occasion understood that the package he was leaving for his son to collect may well have contained a knife, but he turned a blind eye to this possibility, in all likelihood wanting to avoid confrontation. Either way, if Alphonse R had acted more responsibly on 15 July 2024, he could – and should – have intercepted the large knives that AR had ordered, one of which he went on to use in the murders and attempted murders on 29 July 2024.

22 July 2024: the aborted attack on Range High School

157. There was one last occasion when Alphonse R, out of desperation, did intervene and succeeded in temporarily averting a catastrophe. On the morning of 22 July 2024, at about 11:00, AR entered his parents' bedroom. Alphonse R had been asleep because he was working at night. Laetitia M had already left the house for work at around 7:15 and Dion R was at university.[1977,1978] AR asked Alphonse R when Range High School had their morning break.

1975 T/S: 34/45/24-48/25.

1976 T/S: 34/48/19-49/1.

1977 Witness Statement of Laetitia M IWS000056/§220.

1978 Witness Statement of Dion R IWS000060/§108.

Alphonse R checked and noted that it was the final day of the school year. He told AR that they broke up *"today"* and that his former year would have finished their A levels and would then be going to university. AR responded, *"but I'm not going, am I"*.[1979]

158. AR was restless and in Alphonse R's estimation he was experiencing a kind of crisis. He was *"hyper"* and *"breathing heavily"*. AR looked unwell and *"quite depressed"*. Alphonse R said he was scared; he was aware that *"things were wrong […] they were not right […] they weren't normal"*.[1980]

159. AR went downstairs but then returned to the first floor. Alphonse R heard him say that something was missing. When Alphonse R came out of his bedroom, he saw AR pacing between unopened delivery boxes on the landing, which was very untidy. AR seemed to be distressed. Alphonse R went into AR's room where he noticed a bottle containing fluid. When asked, AR said it contained alcohol. There was a small open Tupperware container next to it containing a clear liquid which was spotted with a residue that looked like blue ink. AR permitted his father to pour this down the lavatory. This was undoubtedly the product of AR's attempts to make ricin.[1981]

160. Alphonse R also noticed a bow and arrows under AR's bed, which he had seen on an earlier occasion, probably a few months previously. He understood that this was potentially a weapon, which he was afraid AR would use against him. Otherwise, the bedroom contained a number of unopened delivery boxes *"all over the place"*. Alphonse R did not then or later ask AR about the purpose of the alcohol, the contents of the Tupperware container or the bow and arrows.[1982]

161. AR then asked Alphonse R to buy him petrol. Alphonse R had noticed that AR had purchased a petrol can which he had first seen a couple of days earlier in the living room. Alphonse R had not challenged AR about the petrol can, but he had imagined AR pouring petrol over him (that is Alphonse R) before setting it alight. AR did not respond when Alphonse R asked him why he wanted to buy petrol. Alphonse R concluded that AR wanted to start a fire at Range High School, given AR's earlier query about the school. He refused to make the purchase.[1983]

162. AR then came into his parents' bedroom and produced a knife which he had been hiding behind his back. The Inquiry showed Alphonse R pictures of the type of knife used in the attack on 29 July 2024 and, in his Inquiry witness statement, Alphonse R identified that AR was holding the same type of knife on this occasion. This means that AR was holding one of the two knives that he had ordered on Amazon and had been delivered on 15 July 2024.

1979 Witness Statement of Alphonse R IWS000058/§227.

1980 Witness Statement of Alphonse R IWS000058/§228; T/S: 34/56/25-57/4.

1981 Witness Statement of Alphonse R IWS000058/§229.

1982 Witness Statement of Alphonse R IWS000058/§229; T/S: 34/52/17-55/23.

1983 Witness Statement of Alphonse R IWS000058/§§230-231; T/S: 34/57/13-59/3.

163. AR asked Alphonse R for the knife (machete) that Alphonse R had hidden following its delivery on 14 June 2023. He said, *"[g]ive it to me now"*. Alphonse R was lying on the bed and AR started *"lightly"* to stab the bed, whereupon Alphonse R drew up his legs to avoid being hurt. Clearly AR was attempting to frighten his father into handing over the knife (machete). AR climbed onto the bed. Alphonse R described feeling extremely vulnerable and, as he tried to get off the bed, he fell on the ground next to a chest of drawers. As AR stood over Alphonse R, Alphonse R asked AR to stop and told him that the knife (machete) was downstairs and that he would hand it over. When AR left the bedroom first, Alphonse R closed the door and managed to keep it closed as AR tried to push his way back into the bedroom. After about 30 seconds, AR then went downstairs.[1984]

164. Alphonse R heard AR make a telephone call. Mr Liam Rice, General Manager of One Call Taxis, confirmed that AR made an aborted attempt to book a taxi and then a further call was made which was timed at 12:21. AR made the booking under the false name of 'Simon'.[1985]

165. Alphonse R believed that AR had called for a taxi to go to Range High School. He stated that he rang a local taxi company to find out if they had received a call from AR and that they refused to provide this information.[1986] Alphonse R thought he may also have called One Call Taxis and received a similar response. However, Mr Rice stated that he asked One Call Taxis' telephone provider to check the incoming calls on this date and there was none from Alphonse R's mobile number.[1987]

166. Alphonse R then heard the front door close. He ran outside and saw AR getting into the back seat of the taxi and carrying a bag. Alphonse R believed that AR was carrying the knife that had been used to threaten him in the bag.[1988] The taxi driver, Mr Steven Evason, stated that AR asked to be taken to Range High School.[1989] Alphonse R successfully begged Mr Evason not to take AR as a passenger despite AR stating that he was 18 (he was in fact 17), he wanted to go and he demanded to be taken. Alphonse R paid Mr Evason a small amount of money for his time. Mr Evason provided a warning to One Call Taxis so that further taxis would not go to 10 Old School Close that day, due to the abortive pick-up attempt, but no wider warning was placed on the system. This was understandable given Mr Evason had no reason to suspect a risk of violence or other crime from AR.[1990]

1984 Witness Statement of Alphonse R IWS000058/§§232; T/S: 34/59/3-25.

1985 MERP000730/3; T/S: 13/77/10-24.

1986 Witness Statement of Alphonse R IWS000058/§235. I address the failure of taxi companies to provide information about customers further in Chapter 11: Education.

1987 Witness Statement of Mr Rice OCT000001/§3.

1988 Witness Statement of Alphonse R IWS000058/§237.

1989 MERP000216/1.

1990 T/S: 13/78/17-82/20.

167. AR went back inside the house and Alphonse R remained outside. These moments were captured on the doorbell camera of AR's neighbours, timed at around 12:49.[1991] The doorbell footage shows Alphonse R remaining on the far side of his car from AR while watching AR return to the house. AR was wearing a rucksack, as well as the same hoodie and face mask that he wore on 29 July 2024.

168. Alphonse R did not return to the house but stayed outside because he was afraid of AR.[1992] He called Laetitia M, telling her that AR had tried to stab him with a knife but he had managed to escape, and that he had stopped AR from taking a taxi to Range High School.[1993] Laetitia M left work early to return home. She arrived at around 15:44 on foot, having parked her car further away in case AR damaged the car.[1994] Alphonse R and Laetitia M sat in Alphonse R's car for an hour and a quarter. Alphonse R told Laetitia M what had happened, explaining that he was worried that AR had intended to go to Range High School with a knife and carry out an attack and that he thought that AR had a knife in his rucksack when he got into the taxi. Alphonse R accepted that what had occurred indicated a serious escalation in AR's behaviour.[1995]

169. AR had begun to calm down by the time they re-entered the house. Unexpectedly, he allowed his parents to tidy his bedroom and the boxes on the landing. In his police interview, Alphonse R stated that he started cleaning the landing outside AR's room and, initially, Laetitia M cleaned AR's room. He stated that Laetitia M had cleaned the floor and put the boxes to one side. Thereafter, Alphonse R said that he wiped the tables and everywhere else. He stated that they both put AR's things on the side by the wall, around his bunk bed, and that *"everybody was scared. Nobody was talking ab, about it. His mum was more scared tha, than I was … and we were traumatised all of us"*.[1996] In his Inquiry witness statement, Alphonse R stated that Laetitia M helped him to clean and tidy and change the bedding. He stated that, while doing this, he again saw that there was a bow under AR's bed. During this process, Alphonse R moved some of the items that had been used to create ricin, including equipment and the alcohol (which he had already seen) and a funnel. Alphonse R described, in his statement, that the contents of the Tupperware box (now known to contain the crude preparation of ricin) looked disgusting. He saw objects that looked like firecrackers and some matches. He did not see the knife that AR had used against him earlier. He found a sledgehammer in the living room which he moved to the

1991 MERP006462 – Disclosed but not published due to sensitive content.

1992 T/S: 34/64/21-23.

1993 Witness Statement of Laetitia M IWS000056/§220.

1994 T/S: 34/64/24-65/2.

1995 Witness Statement of Alphonse R IWS000058/§§232-241; T/S: 34/59/6-65/16, T/S: 34/154/16-155/6.

1996 MERP001430/21.

airing cupboard in AR's room.[1997] He stated that he was not aware of the bottles with matches, which could have been used to make firebombs or Molotov cocktails.[1998]

170. Notably, when describing the items that he saw in AR's bedroom in his Inquiry witness statement, Alphonse R described Laetitia M as being petrified and she seemed close to having a panic attack. They looked at each other in shock. He went on to say that they knew that they needed to take some action but were not able to have the conversation about calling the police (see below).[1999] In his oral evidence, Alphonse R stated that he cleaned up AR's room with Laetitia M and agreed that the matters set out in his statement were clear recollections.[2000]

171. In her police interview, when asked about the last time she went into AR's room, Laetitia M stated:

> *"… I went to clean in his room … I went once to clean kind of remove the dust … I can't remember when was that, he told me not to go back and when I kind of, things the boxes were moved around things I (inaudible) I dusted as well yeah I can't remember the time."*

She said that this was in 2024 and that she had mopped. She said that she did not notice anything about the room and was interested more in the bedsheets. She said that they were removing empty boxes which were taken to the bin (clarifying in her Inquiry statement that this was done by Alphonse R). She said that she did not look in the boxes because she did not want to be spending time in AR's room, did not want to be in trouble with AR and did not want AR to hit her or anything. She then clarified that the boxes were taken the week before the attack.[2001]

172. In her Inquiry witness statement and in oral evidence, Laetitia M claimed that she had no knowledge of the various items which her husband said he saw in AR's bedroom on 22 July 2024 and that she did not see anything out of the ordinary.[2002] Instead, she stated that she simply entered the bedroom to remove the bed sheets, went in quickly, changed the sheets and went out. She stated that she did not clean the floor; she did not clear or move the boxes; and she was not in AR's bedroom at the same time as Alphonse R. She stated that she did not want to get into trouble with AR, who normally did not allow her into his room, and wanted to act quickly in case the opportunity disappeared. She stated that she remembered some cardboard boxes on the floor but did not spend any time looking and them and did not look inside them or look at the labels because she did not want any trouble.

1997 First Witness Statement of DCI Pye MERP007551/§76(e); MERP000767/6.

1998 Witness Statement of Alphonse R IWS000058/§§244-250.

1999 Witness Statement of Alphonse R IWS000058/§§248-249.

2000 T/S: 34/65/19-67/18.

2001 MERP001432/32-34.

2002 Witness Statement of Laetitia M IWS000056/§§235-240; T/S: 34/157/4-161/10.

173. I found Laetitia M's evidence regarding 22 July 2024 particularly unimpressive. She substantially contradicted the evidence of her husband as to the extent of her actions in AR's bedroom and she implausibly denied that Alphonse R had mentioned them to her (save she said he had previously told her about the bow and arrows). Alphonse R's description of their shared shock was highly convincing, and I find that it was accurate.[2003] Although Alphonse R did not specify that Laetitia M saw the same items that he did, his clear evidence was that they tidied the room together, including moving the boxes in AR's room. Consistent with Alphonse R, in her police interview Laetitia M suggested that she had dusted and mopped in AR's room, although she minimised her involvement in her evidence to the Inquiry. I find that her account in the police interview, given earlier in time and more consistent with the account of Alphonse R, is the accurate one. Laetitia M would have had a significant opportunity to see the concerning items in AR's room given the time she must have spent there cleaning, dusting and changing the sheets. Bearing in mind the number of concerning items in AR's room, the items that Alphonse R himself saw when carrying out the same tidying exercise, the fact that packages appear to have been opened and the appearance of the Tupperware boxes, it is implausible that Laetitia M could have been involved in this process without seeing any items of concern. Moreover, the clear inference from Alphonse R's evidence is that it was **because of** the items that they both saw while tidying AR's room that Laetitia M was petrified and seemed close to having a panic attack.

174. I have recognised above that Laetitia M may suffer from dissociation, that Alphonse R describes Laetitia M as being shocked, and that Laetitia M has said that her memory of this incident was poor. Nevertheless, this event was comparatively close in time to the evidence provided by AR's parents. Given its connection with AR's actions and its significance, it would have been highly memorable. Moreover, Laetitia M's account evolved, and her account to the Inquiry minimised her involvement in cleaning AR's room, compared to her police interview. As a result, I find it more likely than not that Laetitia M was untruthful with the Inquiry in this context.

175. Although AR seemed more stable, he chillingly told his father when he returned to the house, *"[n]ext time, next time if you stop me there will be consequences"*.[2004] Alphonse R agreed with Mr Moss that what this meant was: *"[y]ou stopped me going to do an attack this time, but if you stop me next time there will be consequences"*. Alphonse R accepted that, at the time, he realised that AR had indicated that at some stage in the future he would carry out another attack, although Alphonse R did not realise it would be the following week.[2005] I consider this concession by Alphonse R is of profound significance, given his and Laetitia M's complete failure to warn the authorities of this threat by AR.

2003 Witness Statement of Alphonse R IWS000058/§§244-250; T/S: 34/65/19-66/20.

2004 MERP001430/19.

2005 T/S: 34/68/23-70/24.

176. Any lingering doubt as to Alphonse R's understanding of AR's intention is dispelled by a text message he sent to his wife later that evening when he was on a taxi night shift:

> *"Our child needs to be protected. Imagine how those things [meaning AR's behaviour] have faded away and he could have been killed or imprisoned for good/for life."*[2006]

177. Although slightly oddly worded, the reference to the risk of AR being killed or imprisoned for life makes it plain that he understood that his son was intending to carry out a very serious or fatal attack. I return to the statement that AR *"needs to be protected"* below.

178. Moreover, Alphonse R said in evidence:

> *"Yes, of course. It's obvious that day he was going to attack at Range, but it was confined to Range again and I was relieved that Range was -- had closed for the year -- for the summer."*[2007]

And:

> *"We knew that we needed to take some action but we were not able to have the conversation about calling the police. The situation was just too overwhelming. We thought that AR's target was Range High School and that as the school was now closed until September the immediate danger had passed. We did not think there was a wider public risk because prior to 22 July 2024 AR had not left the house on his own since March 2022. I am desperately sorry to the families of the children, and to everyone that AR harmed for not calling the police at this point."*[2008]

There is no doubt, therefore, that Alphonse R and Laetitia M were fully aware of the high risk posed by AR. However, this attempted justification for their failure to take immediate steps to warn the authorities does not survive the fact that in March 2022 AR had left the house not to travel to Range High School but to stab a random member of the public. The fact that the school was closed until September does not provide any justification for their inaction: AR had made it perfectly clear that his desire to attack another or others with a knife was not confined to Range High School. Additionally, as Mr Moss pointed out in questioning, Range High School was at risk of an arson attack at any time, and AR had asked his father to buy petrol and had purchased a petrol can. Indeed, faced with this background, Alphonse R conceded that the *"risk at this stage was painfully obvious"*. He said he did not at that stage have the courage, and was not ready, to take action. He expressed sorrow for this passivity. Alphonse R accepted that if he had contacted the police, this could have led to AR being taken into care, or, more likely, being placed in custody. He did not want to *"pre-emptively just give him away"*.

2006 Witness Statement of Alphonse R IWS000058/§255; MERP001400/2.

2007 T/S: 34/74/13-21.

2008 Witness Statement of Alphonse R IWS000058/§249.

He said, *"I knew, of course, if I tell the police, they would take him away"* and *"[i]t's a crime, the things we're seeing at home, they're crimes"*.[2009] This explains the wording of Alphonse R's text to Laetitia M on the evening of 22 July 2024 about the need for AR to be *"protected"*.[2010]

179. Similarly, it is incomprehensible that Alphonse R and Laetitia M failed to take any steps to address their knowledge that AR had come into possession of a knife. Mr Moss asked Laetitia M why she and her husband had not done anything about the knife which AR had used to threaten Alphonse R and which he had attempted to take to Range High School on 22 July 2024.[2011] Laetitia M gave a notably unspecific answer:

> *"I would say that we were distressed, broken, the way was our thinking at that time was not the right way of thinking because of what we'd been going through, all those years."*[2012]

She said she did not have a *"clear mind"*.[2013]

180. Laetitia M denied that she had deliberately avoided contacting the police, CAMHS or social services because she wanted to avoid AR being taken into care. Instead, her explanation for the entirely passive stance they adopted was that she was entirely focused on trying to avoid outbursts and for *"everything to calm down"*. She expressed her regret, however, that they had not contacted the police.[2014]

181. Mr Goss, junior counsel to the Inquiry, asked Chief Inspector Andrew Hughes of Merseyside Police, who acted as the Force Incident Manager (FIM) during the attack, what might have happened if Alphonse R had called the police on 22 July 2024 following AR's attempt to get in a taxi.[2015] CI Hughes confirmed that such a call would be handled by Lancashire Constabulary's control room.[2016] However, given the link to Range High School in Merseyside Police's jurisdiction, Lancashire Constabulary would have notified Merseyside Police.[2017] CI Hughes agreed that Merseyside Police would have quickly identified AR's hockey stick attack at Range High School in December 2019, as well as intelligence from Prevent that AR had been actively searching beheading and other extremist material on his computer.[2018] If the information was that AR had returned to his home, CI Hughes considered Merseyside would have deployed to his home address to investigate what was going on.[2019]

2009 T/S: 34/77/17-83/2.
2010 MERP001400/2.
2011 T/S: 34/164/21-165/17.
2012 T/S: 34/165/18-21.
2013 T/S: 34/166/9-10.
2014 Witness Statement of Laetitia M IWS000056/§§230-234; T/S: 34/156/9-17, T/S: 34/166/23-167/7.
2015 T/S: 12/77/20-78/6.
2016 T/S: 12/78/8-11.
2017 T/S: 12/78/12-15.
2018 T/S: 12/78/16-24; MERP000469/20.
2019 T/S: 12/79/9-14.

He would have expected the officers attending to speak to AR's parents, be professionally curious and ask questions. If Alphonse R had mentioned the weapons, CI Hughes confirmed that the police's powers to force action were limited, at that time, because the weapons were legal to keep in a private residence. However, he would have expected the officers to try to encourage Alphonse R to voluntarily surrender any weapons held at Old School Close and to be *"persuasive"* to make sure that happened.[2020] CI Hughes accepted that, if it had become clear that there was ricin at the property, this would have led the police immediately to take action.[2021] CI Hughes also stated that Merseyside Police could activate a Police Protection Order if they held a reasonable belief that AR may be at risk of significant harm and the parents were not able to look after AR.[2022]

182. Alphonse R and Laetitia M should, as they accepted, have called the police on 22 July 2024 and should, then, have been frank and co-operative with the police when they attended 10 Old School Close. This would have involved telling the police about AR's actions on that day but also about the highly concerning weapons and other items AR had been stockpiling. Moreover, it would have involved allowing the police to search the living room and AR's bedroom to view those concerning items, as well as surrendering those items to the police.

183. However painful and difficult it was for Alphonse R and Laetitia M to watch and experience the consequences of their son's deterioration, this total avoidance of responsibility on their part is deeply concerning. It is with the greatest reluctance that I conclude that they bear a very considerable degree of responsibility for the appalling events of 29 July 2024. If they had alerted the authorities following AR's extraordinary behaviour on 22 July 2024, he would have been in custody or in care on 29 July 2024. That would have been the inevitable result because, it should be recalled, a search of AR's bedroom would have revealed the crude preparation of ricin, and a search of his electronic devices would eventually have revealed the academic article containing the Al-Qaeda training manual. The attack, accordingly, would never have occurred.

184. AR's parents had become entirely fatalistic: they chose not to intervene in any way with their son or to warn the authorities; instead, they simply allowed events to unfold. I accept that AR had made their lives extremely difficult but this complete abandonment of responsibility, given the danger they knew their son posed to others, was utterly unconscionable. As Alphonse R described his inertia, in the context of clearing what it later emerged was ricin from AR's

2020 T/S: 12/80/2-81/12.

2021 T/S: 12/80/15-19.

2022 T/S: 12/81/13-19.

room, he stated: *"I was like his obedient servant, I had become servile to [AR]"*.[2023] It is my unhesitating view that the passive stance Alphonse R and Laetitia M adopted constituted a complete moral failure on their part.

185. Dion R returned home from university on 26 July 2024. He was told by his father, in reference to the incident on 22 July 2024, that AR *"has done something bad recently"*. As Dion R set out in his statement to the police, at some stage (although he was unsure precisely when) his father *"told me that recently [AR] had booked a taxi and tried to get in. My dad had stopped him leaving. My brother then threatened my dad and said if you stop me again, there will be consequenses [sic]"*. He warned Dion R not to engage with AR, and to be *"cautious"* and *"careful"* around him. Dion R considered that it was unusual that his father appeared to be worried about provoking AR. On 27 July 2024, Dion sent an electronic message to a friend, which set out that his father had said to him that *"your brother is dangerous, he can kill you"*. What he meant by this was that there was a threat to his (Dion R's) life. Dion R confirmed that he believed that he and his parents were at risk from AR. Nonetheless, Dion R said that he considered that if he did not interact with AR *"things probably would be fine"*. When he arrived at the house, Dion R's impression of AR was that he was withdrawn and subdued, although he had developed a habit of arguing with himself. Dion R registered that there had been an influx of parcels that had been delivered to AR which the other members of the family *"couldn't touch"*.[2024]

29 July 2024: AR's family on the day of the attack

AR's departure from 10 Old School Close

186. In the early hours of 29 July 2024, Alphonse R spoke with AR about YouTubers.[2025] The next morning, at set out at Chapter 4: The attack, AR used his tablet and laptop. At 11:04, AR carried out the search on Twitter/X for *"mar mari Emmanuel stabbing"*.[2026]

187. At around 11:00, Laetitia M was trying to get some rest because she was due to start a block of night shifts that evening. She was in her bedroom lying down but not fully asleep and could hear everyone moving around the house.[2027]

2023 T/S: 34/56/19-20.

2024 MERP001217/4; Witness Statement of Dion R IWS000060/§§107-108, §§111-112; T/S: 33/42/2-48/18, T/S: 33/51/25-52/24.

2025 Witness Statement of Alphonse R IWS000058/§263; T/S: 34/84/2-13.

2026 First Witness Statement of DCI Pye MERP007551/§85 (later corrected to refer to SMG/2. Second Witness Statement of DCI Pye MERP008308/§8).

2027 T/S: 34/167/8-21.

Dion R was meeting friends later that day. He was upstairs and about to have a shower with the help of Alphonse R. Dion R saw AR walk upstairs and go into his (AR's) room. Shortly afterwards, AR went back downstairs, now wearing a face mask. Dion R recalled that AR was pulling at his sleeves in a way that, in retrospect, might have reflected he was hiding something, but this was not uncommon for AR at the time. Nothing was said by AR. AR left the house at 11:10.[2028]

188. Dion R asked his father if AR had done this before and was told he had not done so. This answer made Dion R *"a bit nervous"*. As far as Dion R was concerned, the last time AR had left the house was on 17 March 2022, when he did so in order to stab a member of the public.[2029]

189. Alphonse R heard AR leave the house. His evidence was that he shouted to Laetitia M to alert her. Laetitia M went to look out of Dion R's bedroom window.[2030] She saw AR on foot, turning right into Hoole Lane. AR was not running or walking fast.[2031] Alphonse R states that he asked Laetitia M whether AR was carrying anything, because he was concerned about the events of 22 July 2024. Laetitia M stated that he was not and did not have a bag with him.[2032]

190. Dion R's oral evidence was that his mother suggested – indeed, seemed sure – that AR was going for a walk and because Dion R had been away at university, he accepted this reassurance. However, he told the police in his witness statement that his father was *"more apprehensive"* and that he (Dion R) was *"still worried"*. Alphonse R had told Dion R that AR had been *"a little"* better in the period immediately before Dion R returned home.[2033]

191. Laetitia M's account was that, although she felt nervous for AR, she believed he had simply left home to go for a walk, and she did not consider the possibility he was going to cause harm.[2034] It is an unavoidable conclusion that Laetitia M failed to tell the Inquiry the truth about the events on that day. The text messages she sent to the Pastor at her church at 11:23: *"[w]e don't where he's going"*, and to her cousin at 11:24: *"[t]hat child opened the door and goes; we don't know where he is going"*, reveal a different frame of mind.[2035] Given AR's history, it is simply unbelievable that his parents would not have had in the forefront of their minds that over a number of years AR had only left the house alone when he was intending to use weapons to inflict serious violence (17 March 2022 and 22 July 2024) and that on other occasions he

2028 First Witness Statement of DCI Pye MERP007551/§11.

2029 T/S: 33/27/12-29/17, T/S: 33/54/21-57/4, T/S: 34/85/20-24, T/S: 34/168/6-9.

2030 Witness Statement of Alphonse R IWS000058/§265; T/S:34/84/20-25.

2031 Witness Statement of Laetitia M IWS000056/§247; T/S: 34/167/22-168/5.

2032 Witness Statement of Laetitia M IWS000056/§247; Witness Statement of Alphonse R IWS000058/§267; T/S: 34/85/6-19.

2033 T/S: 33/56/5-59/3.

2034 Witness Statement of Laetitia M IWS000056/§§246-249; T/S: 34/167/18-169/10.

2035 Witness Statement of Laetitia M IWS000056/§§250-251; T/S: 34/169/11-22.

had carried knives in order to kill (October and December 2019). AR's ongoing isolation and the events of less than a week before (22 July 2024) were alone sufficient to cause Laetitia M the gravest alarm as to the reason why AR had left the house without any warning.[2036] In my view, therefore, she did not tell the Inquiry the truth when she said that she was unconcerned that AR would harm someone following his departure. I am reinforced in this view by Laetitia M's wholly implausible evidence concerning the packaging for the knife which AR used on 29 July 2024, which I address below.

The discovery of the knife packaging

192. In my view, the evidence that fundamentally undermines any suggestion that Alphonse R, Laetitia M and Dion R could have seriously and genuinely entertained the notion that AR had simply gone out for a walk was that, according to Dion R, Laetitia M found packaging for the type of knife which AR used during the attack on 29 July 2024 in the washing machine. Dion R stated that Laetitia M found the packaging before he got into the shower, which was very shortly after AR had left the house.[2037] Dion R stated that neither Laetitia M or Alphonse R appeared alarmed and Laetitia M went to bed after this conversation. He took comfort from his parents' reaction.[2038] However, it was, in my view, highly significant that Dion R recalled that nothing was said when they looked at the packaging because he *"didn't think much needed to be said"*, given the three of them had a shared concern. The discovery of the knife packaging so close in time to AR's departure from the house strongly suggested that AR was carrying a knife when he left. The knife was unlocated, no one else in the house had opened the packaging and AR did not use knives for any purpose other than to threaten or harm others. Dion R accepted that it was highly likely that AR had left the house with the knife.[2039]

193. Dion R showered, dressed and went downstairs to leave the house and meet his friends. He left the house at midday, 50 minutes after AR.[2040] While he was waiting to leave, he saw similar knife packaging in one of AR's boxes that was lying open near to the living room door. The thought occurred to him that this was where the packaging he had seen upstairs had originally come from. While Dion R stated that he did not have a visual recollection of the particular knife packaging, he recalled the association made at the time and was able to explain his thought processes at the time.[2041]

2036 Witness Statement of Laetitia M IWS000056/§§225-230; T/S: 34/142/2-145/23.
2037 T/S: 33/59/16-24.
2038 Witness Statement of Dion R IWS000060/§115-117; T/S: 33/61/2-12.
2039 T/S: 33/59/16-67/2 – Disclosed but not published due to sensitive content.
2040 MERP004721.
2041 T/S: 33/61/15-64/6.

194. Dion R's evidence is supported by the fact that Laetitia M's fingerprint was on knife packaging found in a carrier bag on the upstairs landing when Merseyside Police searched the house after the attack.[2042] Merseyside Police found another set of knife packaging in a bin in the garden.[2043] The second knife, matching the knife used in the attack, was found wrapped in a duvet on the sofa in the living room (where AR had been sleeping).[2044]

195. The inconsistencies between Alphonse R, Laetitia M and Dion R as to the packaging for the knife that AR was carrying when he left the house are both profound and troubling.

196. Alphonse R failed to mention the knife packaging being found in his police statement or police interviews. He claimed in evidence to the Inquiry that he was only aware of the packaging in the aftermath of the incident on 22 July 2024 when he tidied up AR's room. He said he did not recall any of the events recounted by Dion R set out above on 29 July 2024, when Laetitia M found the knife packaging in the washing machine shortly after AR departed.[2045] I accept Dion R's detailed evidence on this issue, including importantly the fact that his parents both fully appreciated its potential significance. I have unhesitatingly rejected Alphonse R's suggestion that he had no recollection of the discussion described by Dion R as untruthful. It is inconceivable that he would have forgotten the discovery of the knife packaging given AR had just left the house alone for the first time in over two years and given the events that followed.

197. In Laetitia M's original account to the police on 31 July 2024, she did not mention the packaging at any stage.[2046] When she was interviewed by the police on 4 December 2024, she denied ever having seen any knife packaging, including in AR's bedroom on 22 July 2024.[2047] However, by the time of her statement to the Inquiry, Laetitia M had been told that her fingerprint had been found on the knife packaging. She gave an explanation which explained the fingerprint which was wholly at variance with the account given by Dion R:

> *"We had a plastic carrier bag upstairs on the landing to throw away rubbish before taking it to the big bin downstairs. I saw packaging sticking halfway out of the plastic bag on the floor and I just tidied it up, pushing it fully into the plastic bag. I cannot remember when I saw this, but I believe it was that morning. I do not remember telling Dion I saw it or that it said 'chefs knife' on the package. I do not think I mentioned it to Alphonse because it did not register with me as a*

2042 First Witness Statement of DCI Pye MERP007551/§76(f); MERP000287.
2043 MERP000049.
2044 First Witness Statement of DCI Pye MERP007551/§76g.
2045 T/S: 34/86/12-88/17.
2046 MERP000719.
2047 MERP001432/61-64.

> *problem in that moment. I remember seeing the packaging, but I think I looked at it and put it away. I did not connect this packaging to thoughts of [AR] having a knife or causing harm to others."*[2048]

198. Given Laetitia M's previous account that she had not seen the packaging, I am unable to accept that her account, certainly in this context, was honestly given. This was not an area in which she said she had no memory but instead it involved a highly significant aspect of her evidence that changed over time, including, most particularly, after she became aware that her fingerprint was on the packaging. I do not consider her suggestion that she had more time to think when she prepared her Inquiry statement was a sufficient explanation for this change. The police interview occurred five months after the attack. As with Alphonse R, it would have been concerning to Laetitia M when AR left the house alone for the first time in over two years. The events of that morning, in particular concerning the knife packaging, almost immediately took on very great significance when Laetitia M learned of the attack by AR at the Hart Space. I do not consider that the events around the packaging would have been honestly, but temporarily, forgotten by her at the time of: (a) her police statement two days after the attack; and (b) her police interview five months after the attack.

199. Given Laetitia M's inconsistency, I do not accept her later account insofar as it differs from that of Dion R. In my view, Dion R's evidence, which explains why his mother's fingerprint was found on the knife packaging and was given consistently throughout all of his accounts, including his initial police statement two days after the attack, accurately reflected what occurred.[2049]

200. Additionally, I am also very troubled that, by the time the police arrived to search the house, one of the sets of knife packaging which Dion R had seen had been placed in an outside bin. This must have been done by one of Alphonse R or Laetitia M but neither provided an explanation.[2050]

201. In light of these adverse conclusions, I should repeat once again that I am acutely conscious that AR presented a formidable array of problems for his parents. Alphonse R described how AR *"turned out to be a monster"*, and I entirely accept that he became an overbearing, manipulative, secretive and very violent young man who was permitted successfully to resist all parental control.[2051] While this explains the context in which this erroneous testimony was given, it does not justify providing dishonest evidence to this Inquiry.

2048 Witness Statement of Laetitia M IWS000056/§259; T/S: 34/174/10-25.

2049 MERP001217/4.

2050 Witness Statement of Dion R IWS000060/§115; T/S: 34/90/11-17, T/S: 34/177/11-22.

2051 T/S: 34/111/13.

The family's response

202. It is again with regret that I unhesitatingly conclude that Alphonse R and Laetitia M knew they should immediately have called the police when the knife packaging was found in the washing machine, yet they once again failed to take appropriate action. Instead, they reassured Dion R that AR had simply gone out for a walk. This represented deeply concerning inaction on their part, at a time when they should have had an intense concern for the welfare of others, whether at Range High School or elsewhere. They did not attempt to call AR on his mobile telephone, to follow him or to attempt to find out where he had gone. Given the history set out above, Alphonse R's suggestion that he was not seriously concerned that AR was going to carry out an attack is simply unbelievable.

203. Although I considered Dion R to have been an otherwise reliable witness who, over many years, had been placed in an extremely difficult position by his aggressive and domineering brother, I was unable to accept the following assertion that he made in his statement prepared for this Inquiry:

> *"The Inquiry has asked whether, given the concern about AR's prior use of knives, and the finding of any empty knife packet that morning, I (or my parents) considered calling the police that morning. There was no discussion about contacting the police. I thought AR had gone out for a walk, and although I found it unusual (in the sense that he did not usually leave the house), I did not believe he intended to harm anyone and thought, if he was carrying a knife, it was to protect himself, not to harm others."*[2052]

204. Given AR's violent history, once the knife packaging was found it is wholly inconceivable that Dion R or his parents could genuinely have believed that AR had simply left the house to take a walk. The very first question that must have occurred to each of them was *"where is the knife that had been inside the packaging (prior to the latter being hidden in the washing machine)?"* They were fully aware as to why AR, when armed, had gone out on previous occasions, namely to attack others. Although Dion R may have persuaded himself otherwise in the aftermath of these terrible events, I have no doubt that at the time he, along with his parents, must have had the most acute concerns as to why AR, almost definitely armed with a large knife, had silently left home. I am prepared to accept that Dion R cannot be held responsible for his parents' reaction to these events – that of complete inertia – and I understand that Dion R would have been influenced by their reactions. However, I reject without hesitation the contention that the family can justify their inaction on the basis that they believed AR was simply taking a walk in the neighbourhood. The evidence to the contrary was overwhelming. AR's parents had multiple telephone numbers that they could and should have called to alert the police

2052 Witness Statement of Dion R IWS000060/§117.

and social services as to the real risk that AR now posed: he was wearing a face mask, was probably highly armed and, exceptionally for him, had left home. Instead, they simply waited.

205. The following quotation from Dion R's statement to the police is telling in this context:

> *"I was worried that [AR] might do something bad. By the time I got to Specsavers I ran into a friend and someone mentioned there had been stabbings in town. I then started to worry it might be about my brother."*[2053]

206. Notwithstanding Dion R's suggestion that this was not, at the time, a *"particularly strong"* concern on his part, and that part of his concern was that AR might harm his parents, in my view his immediate reaction reveals the risk he understood AR posed when he left the house: to repeat, *"I was worried that [AR] might do something bad"*.[2054] Similarly, Alphonse R stated in his police statement that, very shortly after AR left, he: *"got a message through in my church WhatsApp group informing me that something horrible had just occurred nearby and I felt then that [AR may] be involved"*.[2055] This was telling evidence.

The appropriate response

207. CI Hughes was asked to consider what might have happened if a member of AR's family had called the police on 29 July 2024, just after AR left Old School Close on foot. CI Hughes considered that, if a family member had raised their concerns with the police, then it would have been Lancashire Constabulary who would initially take responsibility.[2056] However, this would have led Merseyside Police to become involved if there was a suspicion that AR was intending to visit Range High School. This suspicion would have arisen if AR's parents had been frank with police on 29 July 2024, as they should have been, about AR's previous actions on 22 July 2024. This would have led to the same considerations of the hypothetical scenario addressed above in relation to 22 July 2024.[2057]

208. There was nothing from AR's history to lead to consideration of the Hart Space as AR's intended destination, as CI Hughes accepted.[2058] However, a 999 call would have led to a patrol car deploying to 10 Old School Close. CI Hughes agreed that it would be graded as an emergency with a 10-minute target

2053 Witness Statement of Dion R IWS000060/§120; MERP001217/4.
2054 T/S: 33/68/19-69/13.
2055 MERP001060/5.
2056 T/S: 12/84/2.
2057 T/S: 12/82/14-83/10.
2058 T/S: 12/83/18-20.

response time.[2059] Moreover, if it was understood that AR had left on foot, CI Hughes would have expected Lancashire Constabulary to deploy to the area on foot to carry out a stop and search.[2060]

209. CI Hughes explained what Merseyside Police would have done if AR had been encountered out of the home. This was in the context of 22 July 2024 but the same principles applied on 29 July 2024. If the police had been able to intercept AR, CI Hughes considered that officers would have been able to effect a stop and search under section 1 of the Police and Criminal Evidence Act 1984 (PACE).[2061] If the stop and search revealed a weapon, CI Hughes explained this would have likely led to a search of 10 Old School Close, pursuant to section 18 PACE, which would have revealed the other weapons and the ricin.[2062]

210. I have set out AR's actions after he left 10 Old School Close in Chapter 4: The attack. In short, AR left the house at 11:10 and walked in the direction of Hoole Lane.[2063] He made a taxi booking to take him to 34A Hart Street via a call timed at 11:14. AR then went back to Old School Close, where he arrived at 11:17. He remained in the vicinity of his home, at number 10, until he was collected at 11:31 by One Call Taxis.[2064] I accept Dion R's evidence, consistent with the accounts of Alphonse R and Laetitia M, that the family were unaware that AR was waiting for the taxi outside their front door during this period.

211. By the time AR got into the taxi on 29 July 2024, it was probably too late to have stopped him carrying out this appalling attack, bearing in mind only the taxi company and AR were aware of his destination. However, if AR's family had called the police when AR left the house, as they should have done, then police would have attended before AR had left. Given the 10 minute response time, this would most probably have been while AR was waiting outside 10 Old School Close from 11:17 to 11:31. This period was around seven to 21 minutes after AR had left the house at 11:10. I have no doubt that the attack would then have been averted, given AR would have been searched, found to be in possession of a knife and arrested, followed by a search of 10 Old School Close.

212. In the alternative, AR's parents could and should have followed AR, watched him, seen him waiting outside 10 Old School Close and stopped the taxi from taking AR to Hart Street, thereafter informing the police. Again, this would have averted the attack for the reasons given in relation to events on 22 July 2024.

2059 T/S: 12/83/12-17.
2060 T/S: 12/84/2-8.
2061 T/S: 12/81/20-25.
2062 T/S: 12/82/4-12.
2063 First Witness Statement of DCI Pye MERP007551/§11.
2064 First Witness Statement of DCI Pye MERP007551/§§11-12.

Conclusions

213. It is important that an Inquiry into events of significant public concern allays rumour and suspicion. Neither Alphonse R nor Laetitia M had extremist views, whether based on religion or otherwise. They did not share AR's fixation on violence. Their background as a couple who had been granted asylum more than 20 years before the dreadful attack of 29 July 2024 is irrelevant to the events that unfolded. They wanted the best for their children and were supportive, to an extent ambitious, about their academic attainment. They moved location to improve their income and family life. They faced the challenge of adjusting life to Dion R's physical disability which (through no fault of their own) caused a degree of resentment on AR's part. I have been critical of how Laetitia M and particularly Alphonse R engaged with the agencies as AR's behaviour deteriorated. That engagement was characterised by significant elements of: downplaying the seriousness of what AR had done; being unrealistic about how AR's education (in particular) should proceed after his exclusion; not trusting or acting upon the valid concerns of The Acorns School and other agencies; and a degree of playing one agency off against others. At times, as with the end stages of Dr Ramasubramanian's involvement, it descended into inappropriate hostility causing her to withdraw from AR's case.

214. Inappropriate though such behaviour was, when set against the significant challenges that AR's worsening behaviour presented, it can to some extent be seen as a misguided and maladjusted way of fighting for what they saw as AR's and the family's interests, combined with significant frustration that AR's behaviour was deteriorating and there was no apparently easy way to stop the decline. AR's parents undoubtedly overaccommodated AR and failed to set boundaries. That had serious consequences in terms of AR's ability to access inappropriate violent material and order weapons online. Even this overaccommodation, however, must be seen in the context of the challenges which the family faced. AR was initially close to his mother. On a human level, it is understandable that she generally chose to try to pacify AR and keep him calm rather than confront his inappropriate behaviours. It is understandable, also, that Alphonse R became, within this dynamic, the subject of AR's aggression, threats and physical violence. The difficulties in communicating with AR effectively and his increasing withdrawal would undoubtedly have been heavily influenced by his autism, and these were great challenges for his parents as I have repeatedly emphasised within this chapter.

215. As I observed in the introduction to this chapter, these factors do not diminish the gravity of the failures by Alphonse R and Laetitia M identified in this chapter and elsewhere in the report, but they are an essential context in which their conduct needs to be understood.

216. Ultimately however, I regret to find that from the time of the delivery of the first machete, Alphonse R and Laetitia M had repeated opportunities over the course of more than a year to warn the authorities that AR had obtained and

sought to obtain weapons. This culminated in the events of 22 July 2024 and the intervention by Alphonse R to prevent a further attack at Range High School on that day. The combination of AR's known intent to carry out an attack that day, the gravity of his intent (evidenced by his desire to get hold of petrol and his purchase of a petrol container), the other weapons seen in his bedroom, and his earlier history can have left Alphonse R and Laetitia M in no doubt that AR was a real risk to others. I do not accept their account that they had simply not yet got round to processing how to deal with this incident. Both on and after 22 July 2024, and then again on 29 July 2024, I consider that they opted not to contact the police or other agencies out of fear of the consequences for AR, including the fear that he might be arrested or taken into care. As I have explained within this chapter, this was a total avoidance of responsibility on their part which means they bear a very considerable degree of responsibility for the appalling events of 29 July 2024. Moreover, regrettably, I have concluded that they have sought in places to justify their actions through dishonest evidence to the Inquiry.

217. Dion R does not bear anything approaching the same level of responsibility as his parents. As AR's brother, he did not have the same level of responsibility for AR's actions as his parents, and he was understandably guided by his parents' behaviour. He was a minor until 2022 and, from autumn of 2022 during the term time, he was away from the family home at university. He was not told that AR had ever tried to buy a knife.[2065] He stated that his parents did not tell him the full detail of AR's actions on 22 July 2024: he was not aware that AR had a knife on that day, nor was he told about the weapons and other concerning items that AR had stockpiled.[2066,2067] I have found that, in general, he has given honest and helpful evidence to the Inquiry. However, as I have indicated, I do consider that he was aware of the risk of a violent attack by his brother when, having seen him depart on 29 July 2024, he shortly afterwards appreciated there was empty packaging for a knife of significant size which AR had hidden in the washing machine. He ought to have raised his concerns with his parents, although, given their inaction, I do not find that they would have taken further action as a result. He was honest about the presence of the knife packaging in his evidence to this Inquiry.

2065 T/S: 33/41/24-42/1.
2066 T/S: 33/44/15-17.
2067 T/S: 33/41/17-23.

Recommendations

218. The challenging question that arises from the facts I have set out in this chapter is how, in future, to minimise the risk that parents of a violence fixated child or young person may choose not to report concerns to social care, healthcare or the police about their child having weapons or taking other steps preparatory to an attack. This case demonstrates that it is not safe to rely on parents having the moral courage and good sense to make such a report. The fear of the child being taken into care and/or facing criminal sanctions is a powerful force, which – in a sense of misguided parental loyalty – can all too easily outweigh the risk of the child going on to commit a crime for which the consequences are far greater.

219. As an immediate step, I make the following recommendation.

> **Recommendation 66:** The Youth Justice Board should ensure that a form of clear practical written guidance is drafted which relevant professionals (social care, healthcare, police, education) can provide to parents of children who have been found with a knife or offensive weapon explaining the importance of informing agencies if they become aware that the child has purchased or obtained a weapon.

220. There is, however, a still wider issue that I consider merits consideration. AR's parents knew that he had ordered at least one large knife. They knew that on 22 July 2024 he had planned to attack Range High School and believed that he had a knife. They then saw that he had other weapons hidden in his room and a suspicious substance. They saw at least one empty knife package when AR had left the house on the day of the attack. They reported none of this. The concern at AR's parents' lack of action is far greater than of the taxi driver Mr Poland delaying so long before contacting the police. But both instances are deeply troubling. It is trite that difficult cases make bad law. To introduce a bystander's and/or parental legal duty to warn or report criminality (whether by way of a tortious duty or a criminal offence for failing to make such a report) would be a major legal development, the implications of which are wider than a public Inquiry into a single event can properly consider. However a change to the law does warrant serious consideration and therefore my further recommendation in this area is as follows.

> **Recommendation 67:** The Law Commission should be asked to review the merits of legal reform concerning whether specified categories of persons ought to be under a legal duty to warn about, or a duty to report, the criminality of another.

Chapter 13

Recommendations

Introduction

1. In this chapter, I bring together the various recommendations made in earlier parts of this report.
2. The recommendations fall into two categories:
    a. Matters on which I consider immediate action can and should be taken; and
    b. Matters on which it would not be safe or appropriate to make recommendations at this stage, but which I flag for the government's consideration in determining the scope of Phase 2 of this Inquiry.
3. Regarding the recommendations for immediate action, it is for the government to decide whether to accept them, reject them, or adopt an alternative course. I make clear, however, that in Phase 2 of the Inquiry I will expect detailed updates on the progress of all accepted recommendations, and on any alternative measures the government chooses to pursue. A consistent concern raised by the victims of the attack has been that recommendations from past reviews and inquiries have not led to meaningful change. It is therefore essential that they are informed, in concrete terms, of the action to be taken in response to the Phase 1 recommendations.
4. As for the matters I propose for further consideration in Phase 2, the Home Secretary will ultimately determine the Terms of Reference. I nonetheless encourage her to include these issues within its scope. I am aware that work is already underway in several relevant areas. If ongoing or proposed changes to guidance or legislation make detailed examination by this Inquiry unnecessary, the Phase 2 evidence will reflect this.
5. I have also made a small number of formal observations. These are intended to draw attention to issues or concerns relevant to particular bodies, but which, for various reasons - often because they fall outside the scope of this Inquiry – do not warrant a formal recommendation. These are set out in the individual chapters and I do not repeat them here.

The recommendations

Fundamental problems

Recommendation 1: Phase 2 should consider what single agency or structure should be appointed or established to record, monitor and co-ordinate interventions for children and young people who present a high risk of serious harm. This must be matched with cultural change so that agencies are prepared to own and manage risk appropriately not just refer it on to others.

Recommendation 2: Phase 2 should consider the development of a shared multi-agency risk-assessment tool that is clear, accessible and suitable for use across public sector services.

Recommendation 3: Phase 2 should consider whether there should be a further ability to restrict or monitor access to the internet on the part of children and young people, if a significant threshold is passed concerning the risk they pose to others.

The attack

Recommendation 4: The Department for Transport should require local authorities to ensure that all licensed taxi drivers have a clear duty promptly to report any significant criminal activity they witness while working. This duty should form part of mandatory training, and a failure to report such activity, subject to individual circumstances, should place the driver's licence at risk. Local authorities should implement practical measures to ensure that drivers have read, understood and acknowledged this requirement.

Recommendation 5: The Department for Transport should ensure that local authorities establish effective arrangements between licensed taxi companies and schools. These should enable school safeguarding teams to access taxi booking information where relevant to a legitimate safeguarding or risk concern relating to a child who should be at school.

Recommendation 6: All police forces should ensure that their policies, guidance and training address taking on a calculated degree of risk in recognition of the immediate need to protect the public from an obvious risk to life. This may involve the decision to deploy unarmed officers with caution.

Recommendation 7: All police forces that have not implemented a model providing immediate and direct support to Force Incident Managers, ideally through a second Force Incident Manager, should consider adopting such arrangements to strengthen decision-making during critical incidents.

Recommendation 8: NHS England should review funding, and consider providing additional resources, to enable all emergency response ambulance staff to participate in appropriate training exercises.

Recommendation 9: North West Ambulance Service should review its procedures for declaring a Major Incident or Major Incident (Standby) to ensure clarity in how declarations are made and how they are communicated internally and to other emergency services.

Recommendation 10: Merseyside Police and North West Ambulance Service should review the terminology used in their systems and procedures to ensure shared understanding and interoperability. The College of Policing and the National Ambulance Resilience Unit should undertake a national review to ensure that police and ambulance services across the country operate with consistent terminology and mutual understanding.

Recommendation 11: The Department for Education should update the out-of-school settings guidance by reviewing the health and safety section to ensure terminology is clear and consistent, particularly regarding emergency plans and fire/evacuation plans for smaller providers. The guidance should also be updated to include a non-binding cross-reference to school entrance security guidance, emphasising that while out-of-school settings may differ from schools in terms of what is necessary, appropriate or proportionate, providers should still consider appropriate entrance and exit security measures.

Weapons and poisons

Recommendation 12: Phase 2 should consider systems to detect and report concerning online behaviour and suspicious combinations of purchases. This should include consideration of:

1. Concerning patterns of online browsing and purchasing (e.g. change of names and addresses, use of Virtual Private Networks).
2. Concerning purchases of dangerous but legal items (e.g. sledgehammers, bow and arrows and smoke grenades).
3. Concerning combinations of purchases (e.g. castor beans, alcohol and laboratory equipment).

Recommendation 13: The Home Office's ongoing review of the sale of castor beans should consider regulation of the number of castor beans that can be sold in a single transaction.

Recommendation 14: Phase 2 should consider whether conventional archery bows should be subject to age-verification prior to sale, delivery restrictions including ID checks, mandatory labelling for deliveries, and industry or trading standards to prevent the use of military-style imagery in marketing.

Recommendation 15: Phase 2 should consider, in parallel with the government's consultation where possible, a prohibition on the sale of crossbows, a licensing scheme similar to firearms, tighter controls on purchasing such as restricting sales to age-verified in-store transactions, and Trading Standards measures to prevent military-style marketing.

Recommendation 16: The Home Office should provide clear guidance to all UK retailers of archery bows and crossbows on identifying and reporting suspicious behaviour, including underage purchasers or those who appear to be interested in criminal use of the equipment, and should consider placing retailers under defined obligations to report material suspicions.

Recommendation 17: The Commissioner of Police of the Metropolis should consider an investigation, with input from the Crown Prosecution Service if appropriate, as to whether Ageo Wholesale UK Ltd committed criminal offences in relation to how it marketed knives/machetes or sold them without required age verification or labelling.

Recommendation 18: The Home Office should take immediate action to ensure that online knife retailers are complying with the Knives Act 1997, particularly regarding the marketing of knives, machetes, swords and similar bladed articles.

Recommendation 19: Amazon should:

1. Improve its measures to prevent children from making purchases, including making the conditions of use and sale more prominent.
2. Improve the labelling on packaging of bladed articles so that the warning is more prominent.
3. Ensure drivers inform recipients whenever deliveries contain a bladed article (I recognise the closing statement on behalf of Amazon that this is in train).
4. Review its systems for recording details of the recipient to ensure that an accurate record of the recipient is obtained.
5. Audit its training of age verified deliveries for drivers, in particular for Amazon Flex drivers. This should include training on the labelling of packaging so that, where appropriate, delivery drivers know what they are delivering.

Recommendation 20: Phase 2 should consider further measures relating to knives/bladed items sales, including:

1. Restrictions on sharp-tipped knives.
2. Prohibiting some online sales (such as machetes).
3. Strengthening online age-verification and age verified delivery standards.
4. Mandatory reporting and information-sharing about suspicious behaviour.
5. The risks surrounding importation of bladed items.
6. The risks surrounding multiple sub-contractors in a supply chain delivering bladed articles.

Online harms

Recommendation 21: The Department for Education should review and strengthen its guidance to schools on monitoring and filtering systems, including ensuring that the systems used are appropriate and adequate from a technical perspective. The department should ensure schools understand these requirements and consider whether inspections by Ofsted should play a greater role in monitoring compliance.

Recommendation 22: Lancashire County Council should undertake a comprehensive review of how its children's services and Early Help teams (i.e. Children and Family Wellbeing Service) assess and manage risk and online harms to children. This review should ensure that all frontline staff have a consistent and up-to-date understanding of online risks, and that they have access to effective tools and guidance to identify and respond to these risks. It should specifically include consideration of the risks associated with the use of Virtual Private Networks, which can enable children to bypass the safeguards established under the Online Safety Act 2023. The Department of Health and Social Care should consider whether reforms to national guidance, policy or training are required.

Recommendation 23: The Department for Science, Innovation and Technology should consider extending the powers under the Online Safety Act 2023 to enable Senior Coroners to make a notification to Ofcom to obtain access to social media accounts of perpetrators (not just of a child who has died), and for statutory Inquiries to be able to make a notification to Ofcom to obtain access to the social media accounts of both a child who has died and also a perpetrator.

Recommendation 24: Phase 2 should consider age verification for the use of Virtual Private Network (VPN) software and other options to avoid VPNs being used to circumvent the age-related protections in the Online Safety Act 2023.

Policing

Recommendation 25: Lancashire Constabulary should consider extending Operation Encompass to share automatically relevant information with schools in bordering areas. The Department for Education should consider national implementation. This is because children will not necessarily attend school in the same police force area as they live.

Recommendation 26: Lancashire Constabulary, and the College of Policing nationally, should ensure that forms and training emphasise the importance of recording, as precisely as possible, the words and behaviour of individuals who may pose a significant risk to others.

Recommendation 27: Lancashire Constabulary and Merseyside Police should review the effectiveness of their information-sharing systems and consider whether a more robust process is required. Findings should be shared with the National Police Chiefs' Council and College of Policing for consideration as to whether national level guidance is appropriate.

Recommendation 28: Lancashire Constabulary should ensure its training and systems address the risks associated with failing to record case information on police systems so it is readily available to others. The National Police Chiefs' Council and College of Policing should consider whether further national guidance is required.

Recommendation 29: Lancashire Constabulary should ensure its procedures and training sufficiently addresses the risks children and young people may pose to others and the options for addressing that risk. The College of Policing, with national partners, should review legislation and guidance on how police respond to children and young people who present a risk of serious harm to others.

Recommendation 30:

1. Lancashire Constabulary should strengthen its autism spectrum disorder-related training for new officers and through continuous development.
2. National policing bodies, with input from the Department of Health and Social Care, should consider whether reforms to guidance or training are required.

Recommendation 31:

1. Lancashire Constabulary should ensure response officers have access to effective technology providing clear, essential case information.
2. The National Police Chiefs' Council, College of Policing and Home Office should review whether current policing information systems, particularly the limitations on cross-force access, are suitable for modern policing needs.

Prevent and Counter Terrorism Policing

Recommendation 32: While training for Counter Terrorism Policing, staff involved in Prevent currently cover the importance of understanding a referred individual's online activity and the practical steps required to assess it, the Home Office and Counter Terrorism Policing Headquarters should review and strengthen this training to ensure that officers fully understand both the importance of investigating online activity and that where online behaviour is a factor in a referral, cases should not ordinarily be closed until proportionate steps have been taken to access and assess the individual's online activity. Counter Terrorism Policing Headquarters should ensure that this remains a consistent priority across all regions. Counter Terrorism Policing North West should review its own processes in this regard.

Recommendation 33: Counter Terrorism Policing's capability to access and analyse data relating to a referred person's online activity should be reviewed in the context of Prevent referrals, to determine whether staff have the technical tools required to undertake this assessment. The Home Office and Counter Terrorism Policing Headquarters should ensure this review is conducted.

Recommendation 34: Counter Terrorism Policing Headquarters should review its neurodiversity training for Prevent practitioners (including, where appropriate, drawing in wider healthcare advice) to ensure that they sufficiently equip practitioners with a proper understanding of:

1. How autism may influence risk in the context of a Prevent referral.
2. The importance of timely referrals to the Clinical Consultancy Service to obtain advice on how neurodiversity, including autism, may affect the risks in any individual case.

Counter Terrorism Policing Headquarters should ensure that this remains a consistent priority across regions. Counter Terrorism Policing North West should review its own processes in this regard.

Recommendation 35: Counter Terrorism Policing Headquarters should review and where necessary strengthen the training that Counter Terrorism Policing officers involved in Prevent already receive to ensure that they understand the importance of balancing concern for an individual's vulnerability with appropriate professional curiosity and awareness of disguised compliance. The training should:

1. Address cases involving children or individuals with mental health conditions or neurodivergence, where concern for vulnerability may obscure the potential for dangerousness;
2. Equip officers to test and verify accounts, including probing explanations when necessary and comparing accounts with other available evidence, including that provided by the referrer.

Counter Terrorism Policing North West should review its own processes in this regard.

Recommendation 36: Counter Terrorism Policing Headquarters and the Home Office should assess and issue clear guidance on best practice for sharing appropriate information about closed Prevent referrals. This guidance should ensure that relevant professional agencies outside Counter Terrorism Policing, including local police and referring bodies, are notified of a closure and provided with relevant feedback, unless strong legal or other case specific risk grounds justify non-disclosure.

Recommendation 37: Prevent Supervisors should receive improved role specific training, including training on supervising decisions to close Prevent referrals and ensuring that all outstanding actions have been completed. This may be achieved by work currently underway but the effectiveness of new training in this area should be audited.

Recommendation 38: Building on the Key Principles of Prevent issued on 23 February 2026, the Home Office should ensure that accessible information and appropriate training materials should be made available to organisations which are likely to make Prevent referrals (particularly those subject to the Prevent Duty) to strengthen understanding that a fixed ideology is not required for a referral to be made or accepted. The development of a Prevent practitioner portal should be prioritised.

Social care

Recommendation 39: The Department for Education should update Working Together to Safeguard Children and the Children's Social Care National Framework. These documents should highlight that safeguarding and child protection assessments, when considering what support to put in place and planned multi-agency working, must consider the risks posed by children to others.

Recommendation 40: Lancashire County Council should ensure that by 13 October 2026 all its frontline staff have received suitable training, or refresher training, on Prevent.

Recommendation 41: Lancashire County Council should ensure that its arrangements for social workers provide appropriate support and supervision for family support workers handling Level 3 cases on the Continuum of Need.

Recommendation 42: Lancashire County Council should review its processes and training to ensure decisions regarding children and families are made on the basis of assessed need rather than inflexible criteria such as duration or ease of arranging services.

Recommendation 43: Lancashire County Council should ensure that its policies and training emphasise the significance of multiple referrals when considering the relevant risks relating to a child (including the risk to others).

Recommendation 44:

1. Lancashire County Council should ensure that frontline staff are required to familiarise themselves with full case information, with this being embedded through training and performance review.
2. Lancashire County Council should review its IT systems to ensure that there are adequate mechanisms to bring all relevant information speedily to someone's attention. The warning markers visible on the front page should include markers relevant to risk of harm to others and use of or access to weapons, as well as factors relating to risk of harm to a child.
3. Lancashire County Council should conduct sampling audits to monitor record-keeping practices.

Recommendation 45: Lancashire County Council should ensure frontline staff receive appropriate training on autism spectrum disorder, emphasising that autism does not necessarily explain or excuse behaviour. The Department for Education should ensure this approach is applied nationally.

Recommendation 46:

1. Lancashire County Council should consider how to address repeated lack of consent or manipulation of consent within existing legislation.
2. Phase 2 should consider whether legal reforms are needed to permit agencies, when considering children and young people who pose a risk of violence to others, to override parental consent to share information, access a child or young person, or obtain information about their online activity.

Recommendation 47: Lancashire County Council, in consultation with the Youth Justice Board, should arrange for a comprehensive and independent audit to be undertaken of the Lancashire County Council Child and Youth Justice Service to report by 13 October 2026. This should include assurance that the service is holding young offenders to sufficient standards and boundaries in referral orders, and that interventions are focussed and appropriate.

Recommendation 48:

1. Lancashire County Council should ensure that staff within Children and Family Wellbeing Service, and Children's Social Care receive training on the services available through the Child and Youth Justice Service, including prior to any court or out of court disposals such as Prevention and Diversion.
2. Lancashire County Council should offer input on this topic to Lancashire Constabulary, Counter Terrorism Policing North West, and any relevant Child and Adolescent Mental Health Service.

Recommendation 49: Lancashire County Council, with the Care Quality Commission, should commission an independent audit of the Young Adults Team to ensure assessments for transition to adult care are timely, properly reasoned and take full account of the individual's history. This should report by 13 October 2026.

AR's healthcare

Recommendation 50: The Department of Health and Social Care / NHS England should ensure that all healthcare trusts involved in the care of children and young people who are at risk of acts of violence against others have systems that ensure that:

1. Key information regarding current and historic risk information is readily visible to treating clinicians in a summarised form, where appropriate with suitable warning flags.
2. Where information comes in from other agencies that is relevant to the risk of violence to others, there are robust systems to ensure that the material is uploaded to or available on their own electronic patient records. Single points of failure leading to risk-relevant communications failing to be scanned need to be designed out.

Recommendation 51: At the local level, Greater Manchester Mental Health NHS Foundation Trust should liaise with all of the relevant community healthcare organisations (including Child and Adolescent Mental Health Services and Criminal Justice Liaison Services) to ensure that there is clarity about who is responsible for conducting complex structured risk assessments for children and young people who present a risk of violence to others.

Recommendation 52: Nationally, the Department of Health and Social Care and NHS England should review:

1. Whether there is a need for further development and guidance including on the thresholds for when complex structured risk assessments (such as the Structured Assessment of Violence Risk in Youth) are required for children and young people who present a risk of violence to others. A balance may need to be struck between sufficient provision of guidance to assist as to when the more complex type of structured risk assessment may be justified and retaining the case-specific judgements by professionals that are inevitably required.
2. Whether national guidance is required to ensure clarity about who is responsible for conducting complex structured risk assessments (where they are appropriate) for children and young people who present a risk of violence to others. Consideration should also be given to the roles of children and young people's mental health services and wider children's services in conducting or referring for appropriate risk assessments.

Recommendation 53: At the local level, Greater Manchester Mental Health NHS Foundation Trust and Alder Hey Children's NHS Foundation Trust should by no later than 13 October 2026 carry out and report on a joint audit to ensure that for cases involving both Trusts, the action points from multi agency meetings, healthcare meetings, discharge plans and management plans after risk assessments are being recorded in a SMART-compliant (specific, measurable, achievable, relevant and time-bound) way.

Recommendation 54: Nationally, the Department of Health and Social Care and NHS England should consider whether nationwide guidance should be issued on the importance of action points from all relevant meetings involving healthcare agencies, discharge plans and management plans after risk assessments being recorded in a SMART-compliant (specific, measurable, achievable, relevant and time-bound) way.

Recommendation 55: Phase 2 should consider the ability of community and forensic mental health services to deliver clinical interventions to mitigate the risk from violence fixated children and young people.

Recommendation 56: Phase 2 should consider whether further legislative change is required to allow mental health clinicians to assess children and young people who are isolated from professional support and may pose a risk of violence, particularly where powers under the Mental Health Act 1983, as amended by the Mental Health Act 2025, do not permit assessment or detention.

Education

Recommendation 57: The Home Office (for police forces nationwide) Counter Terrorism Police Headquarters (for Prevent), Department of Health and Social Care (for all healthcare providers) and Ministry of Housing, Communities and Local Government (for all local authorities regarding their social care functions) should issue a nationwide reminder to all agencies considering the risk that children pose to others of the importance of respecting the insight offered by the child's school if they raise concern about the severity of risk that the child poses to others. As was the case with AR at The Acorns School, teachers will often spend more time observing the child (and their interaction with peers) than is available to other professionals. Warnings from teachers and/or schools with particular expertise (including but not limited to Pupil Referral Units) should be given particular weight.

Recommendation 58: The Department for Education, in finalising the Keeping Children Safe in Education guidance 2026, and in any necessary amendments to other policy and guidance, should ensure that:

1. In cases where a child leaves a school because of permanent exclusion, there is absolute clarity concerning the relative responsibilities of the excluding school and the local authority over the transfer of (i) the Common Transfer File and (ii) safeguarding information to the next school.
2. Better guidance is given of the circumstances in which safeguarding information is to be shared in advance of: (i) an offer of a placement; and (ii) the transfer of a pupil. This should include, in particular, where this would aid arrangements that may be necessary for the safety of other pupils or staff because there is relevant information concerning the child's risk to others.
3. There is absolute clarity over the extent to which risk to others information is expected to be covered in an Education, Health and Care Plan. There should be consistency (which is currently lacking) about whether risk to others is addressed in an Education, Health and Care Plan. However, it must be made clear that an Education, Health and Care Plan (even if one is in place) is not a substitute for the proper exchange of information between schools on the risk that a student may pose to others.
4. The arrangements for the exchange of safeguarding information are not prone to a single point of failure (such as a Designated Safeguarding Lead who is absent or unwell and does not read an incoming email). While the current guidance refers to obtaining confirmation of receipt, there is a case for strengthening the guidance with a clear mechanism at a fixed time to ensure the exchange of information has been effected. There is also a case for the introduction of a formal 'sign-off' by the Designated Safeguarding Lead (with appropriate contingencies in place) to confirm that safeguarding information has been received, reviewed and acted upon prior to a pupil being offered a place and prior to the pupil moving to the school.
5. Ensuring that appropriate safeguarding information about a pupil joining a school is shared with relevant staff at the school (e.g. form tutors) before the pupil begins at school.
6. Ensuring that incidents of serious concern, particularly including the use of weapons and intent to seriously harm other pupils, are given appropriate prominence when safeguarding information is shared.
7. Ensuring, where a pupil has a history of possession of a knife or other offensive weapon, that the Designated Safeguarding Lead of the receiving school carries out a risk assessment and implements a safety plan prior to their transfer.

Recommendation 59: The Department for Education should carry out an audit to ensure that safeguarding information is reliably being passed between schools and should consider what further role Ofsted may play to strengthen protection in this area.

Recommendation 60: The Department for Education should ensure (either by direct guidance or through Ofsted) that all schools are required to record safeguarding information in a system that is fit for purpose.

Recommendation 61: Lancashire County Council should, by no later than 13 October 2026, carry out and report on an audit (preferably involving an experienced independent external member) to review:

1. The speed of response to cases where a need for alternative education provision is raised including for those over 16 with an Education, Health and Care Plan.
2. The effectiveness of its monitoring of (and action in response to) school attendance with particular attention being given to (i) children who live in Lancashire but attend school in neighbouring counties; (ii) the resourcing of home visits in appropriate cases; (iii) whether appropriate action is being taken where parents refuse to allow school attendance workers to see a child who is not attending school.
3. The effectiveness of the Education, Health and Care Plan portal approach which has been put in place.

Recommendation 62: The Department for Education and the Home Office should review whether further guidance and/or minimum guidance is required in relation to local education authority and police visits to children not attending their place of education.

Recommendation 63: The Department for Education should ensure that (i) its own policy guidance for teachers and schools (outside the Statutory Guidance for which the Home Office is responsible) is strengthened; and (ii) schools put in place improved Prevent training (including refresher training). This must ensure that staff are not just aware of when to make a Prevent referral but are also aware of (i) what happens once a Prevent referral is made; and (ii) the importance of ongoing dialogue, feedback and assessment between the referrer and the Prevent officer.

Recommendation 64: The Department for Education should undertake a targeted review, engaging with a representative sample of local authorities, to check both that the current (improved) guidance is now sufficient and understood and that the system for monitoring school attendance is being followed in practice and meets the need in cross border cases.

Recommendation 65: The Department for Education should consider what remedial steps can be put in place to assist in circumstances where, whether through underfunding or underperformance, local education authorities are failing to respond adequately to the need for alternative education provision for children who may pose a risk to others. Reforms currently being developed to Special Education Needs and Disabilities (SEND) and alternative provision may be part of the necessary solution.

AR's family

Recommendation 66: The Youth Justice Board should ensure that a form of clear practical written guidance is drafted which relevant professionals (social care, healthcare, police, education) can provide to parents of children who have been found with a knife or offensive weapon, explaining the importance of informing agencies if they become aware that the child has purchased or obtained a weapon.

Recommendation 67: The Law Commission should be asked to review the merits of legal reform concerning whether specified categories of persons ought to be under a legal duty to warn about, or a duty to report, the criminality of another.

Annex 1

Terms of Reference

1. On 29 July 2024, [AR] carried out a brutal knife attack at a children's dance club in Southport. He murdered three young girls, Elsie Dot Stancombe, Alice da Silva Aguiar and Bebe King, and injured 10 other people. Sixteen others survived the attack but live with the emotional scars.
2. It is of vital importance that there is a clear understanding of how this was able to happen, and the lessons identified, so that we can take appropriate steps to minimise the risk of a future tragedy. This statutory Inquiry has been established to achieve this.
3. Phase 1 will examine evidence, including considering the findings of any parallel locally led investigations, to:
    a. Establish a definitive account of the events leading up to the Southport attack and the attack itself, including an overall timeline of [AR]'s history and interactions with various state systems including criminal justice, education, social care and healthcare. The account of the attack will include the facts and circumstances of each individual death to reflect the purposes of section 5(1) of the Coroners and Justice Act 2009. The inquiry will consider the accounts of all those directly impacted by the attack;
    b. Review the decision making and information sharing by local services and agencies which interacted with [AR] prior to the attack to examine whether there were opportunities to manage the risk he posed to the public, making any required recommendations for improvements.
4. The findings of Phase 1 will inform the Secretary of State for the Home Department's consideration of the focus of Phase 2 of the inquiry. This is expected to consider the adequacy of multi-agency systems to address the risk posed by young people whose fixation or obsession with, and desire to commit, acts of extreme violence presents a significant risk to public safety.
5. The Inquiry will examine all evidence as the Chair shall judge appropriate, including, but not limited to, interviews with relevant witnesses and disclosure by the following organisations:
    a. Merseyside Police
    b. Lancashire Constabulary
    c. Counter Terrorism Policing
    d. Lancashire County Council
    e. Lancashire and South Cumbria Integrated Care Board
    f. Department of Health and Social Care
    g. Department for Education
    h. Ministry of Housing, Communities and Local Government
    i. Home Office
    j. Ministry of Justice
    k. Department for Science, Innovation and Technology

l. MI5

m. NHS England

n. Youth Justice Board

o. Alder Hey Children's NHS Foundation Trust

6. The Inquiry will receive such oral and written evidence, as the Inquiry Chair shall judge appropriate and follow such procedures as are appropriate to ensure that the Inquiry is effective.

7. The Inquiry should aim to provide a final report on Phase 1 to the Secretary of State for the Home Department by the end of 2025 or early 2026, subject to reasonable progress on matters outside the Inquiry's control. The Inquiry should make pragmatic choices as to its methods and procedure to deliver within this timeframe. The report may include recommendations for local and national authorities to address any issues arising from this work. In making recommendations, the Inquiry should engage with relevant practitioners to ensure they are practicable.

Annex 2

Witnesses

Witnesses who gave oral evidence and written statements to the Inquiry (in alphabetical order). The evidence of those who gave commemorative and impact evidence to the Inquiry is considered in Chapter 3: Victims and the impact of the attack.

Witness	**Title** (as of 29 July 2024, unless otherwise stated)	**Date of oral evidence**
Daniel Ainsworth	Director of Operations, North West Ambulance Service	24 September 2025
Hamza Ali	Delivery Driver, Condor Carriers	2 October 2025
Louise Anderson	Director of Children's Social Care, Lancashire County Council	3 November 2025
Christopher Ashworth	Chief Customer Officer, Evri Limited	1 October 2025
Katherine Ashworth	Head of the Children and Family Wellbeing Service, Lancashire County Council	3 November 2025
Sharon Barrett	Senior Family Support Worker, Lancashire County Council	29 October 2025
Andrew Bramhall	Sergeant, Lancashire Constabulary (between 1992 and 2020)	6 October 2025
Philip Blundell	Detective Constable, Fixed Intelligence Management Unit, Counter Terrorism Policing North West	8 October 2025
Lynsey Boggan	Head of Service for Autism Spectrum Disorder Assessment Team, Alder Hey Children's Hospital NHS Foundation Trust	21 October 2025

Witness	**Title** (as of 29 July 2024, unless otherwise stated)	**Date of oral evidence**
John Boumphrey	UK and Ireland Country Manager, Amazon	2 October 2025
Amanda Brown	Head of Operations for CAMHS Division, Greater Manchester Mental NHS Foundation Trust (GMMH)	21 October 2025
Luke Bullock	Director, Springfields of Burton Limited	30 September 2025
Sarah Callon	Senior Manager, Child and Youth Justice Service Department, Lancashire County Council	27 and 28 October 2025
Amanda Chapman	Missing from Home Support Worker, Lancashire County Council (between March 2021 and August 2024)	28 October 2025
Daniel Clarke	Police Sergeant, Lancashire Constabulary (between October 2016 and December 2022)	7 October 2025
Sarah Connolly	Interim Director General for Digital, Technology Infrastructure at the Department for Science, Innovation and Technology (appointed August 2025)	3 November 2025
Helen Coombes	Executive Director of Adult Social Services, Lancashire County Council (since December 2024)	3 November 2025

Witness	**Title** (as of 29 July 2024, unless otherwise stated)	**Date of oral evidence**
Robert Correy	Police Staff, Lancashire Constabulary	7 October 2025
Carl Coughlan	Team Leader, Targeted Youth Support, Lancashire County Council	28 October 2025
David Cregeen	Assistant Headteacher and Designated Safeguarding Lead, Range High School (between 2002 and 2022)	22 and 23 October 2025
Kate Dixon	Director of Strategy and Safer Streets, Department for Education	27 October 2025
Cathryn Ellsmore	Prevent Director, Home Office (at time of evidence)	13 October 2025
Victoria Evans	Senior National Coordinator for Prevent and Pursue, Counter Terrorism Policing Headquarters	14 October 2025
David Fairclough	Police Constable, Lancashire Constabulary	6 and 7 October 2025
Andrea Fontaine-Smith	Family Support Worker, Children and Family and Wellbeing Service, Lancashire County Council (between 2019 and 2021)	29 October 2025
Stephen Henderson	Director and CEO, Genesis Group Enterprises	1 October 2025

Witness	**Title** (as of 29 July 2024, unless otherwise stated)	**Date of oral evidence**
John Hicklin	Clinical Nurse Specialist, FCAMHS, Greater Manchester NHS Foundation Trust (GMMH) (between 2017 and May 2022)	21 October 2025
Andrew Hughes	Chief Inspector, Merseyside Police	24 September 2025
Joanne Hodson	Headteacher, The Acorns School	23 October 2025
Nick Hunt	Deputy Director, Head of Firearms and Weapons Unit, Home Office	14 October 2025
Dr Tina Irani	Consultant in Child and Adolescent Forensic Psychology	22 October 2025
Anna Jameson	Social Worker, Lancashire County Council (between 2015 and 2020)	27 October 2025
Benjamin Jones	Managing Director, Merlin Archery	1 October 2025
Sarah Kenwright	Detective Chief Superintendent, Head of Counter Terrorism Policing North West	13 October 2025
Deanna Romina Khananisho	Head of Global Government Affairs, X Corporation	4 November 2025
Dr Vicky Killen	Clinical Lead / Clinical Psychologist, Sefton Specialist CAMHS, Alder Hey Children's NHS Foundation Trust	20 October 2025

Witness	**Title** (as of 29 July 2024, unless otherwise stated)	**Date of oral evidence**
Janet Lewis	Designated Safeguarding Lead and Attendance Manager, The Acorns School (between March 2019 and August 2023)	23 October 2025
Louise Lewis	Family Support Worker, Lancashire County Council	28 October 2025
Laetitia M	Parent	6 November 2025
Juan Martinez	Director of Ageo Wholesale UK Limited, trading name of huntingandknives.co.uk	30 September 2025
Michael McGarry	Headteacher, Range High School	22 October 2025
Lucy McLoughlin	Headteacher, Presfield High School	23 October 2025
Alexander McNamee	Police Response Officer, Lancashire Constabulary	2 October 2025
Dr Anthony Molyneux	Consultant Child and Adolescent Psychologist, Alder Hey Children's NHS Foundation Trust	20 October 2025
Kathryn Morris	Senior Mental Health Practitioner, Alder Hey Children's NHS Foundation Trust	23 October 2025
Paula Murphy	Detective Constable, Merseyside Police	6 October 2025
Officer B	Counter Terrorism Policing North West	8 October 2025
Gary Poland	Taxi Driver, One Call Taxis	25 September 2025

Witness	**Title** **(as of 29 July 2024, unless otherwise stated)**	**Date of oral evidence**
Nigel Polglass	Chief Operating Officer, Whistl	1 October 2025
Jason Pye	Detective Chief Inspector, Merseyside Police	22 and 23 September
Dr Lakshmi Ramasubramanian	Consultant Child and Adolescent Psychiatrist and Paediatric Neuropsychiatrist at Alder Hey Children's NHS Foundation Trust	20 October 2025
Alphonse R	Parent	5 and 6 November 2025
Dion R	Sibling	4 and 5 November 2025
Eve Rhodes	Police Constable, Lancashire Constabulary	7 October 2025
Liam Rice	General Manager, One Call Taxis	25 September 2025
Stephanie Roberts-Bibby	Chief Executive Officer, Youth Justice Board	4 November 2025
Jenie Scholes	Owner of Empowered Bumps, tenant of The Hart Space	29 September 2025
Cheryl Smith	Deputy Headteacher and Designated Safeguarding Lead, Presfield High School	23 October 2025
Bradley Sutherland	Director of MB Outdoors, owner of Tactical Archery	1 October 2025
Carmen Thompson	Prevent, Counter Terrorism Policing North West (between December 2018 and July 2021)	9 October 2025

Witness	**Title** (as of 29 July 2024, unless otherwise stated)	**Date of oral evidence**
Mark Toohey	Principal Trading Standards Officer, Sefton Council	25 September 2025
Rachael Treharne	Prevent, Counter Terrorism Policing North West (between 2018 and 2022)	9 October 2025
Paul Turner	Director of Education, Skills and Culture, Lancashire County Council	22 October 2025
Ashleigh Williams	Family Support Worker, Lancashire County Council	29 October 2025
Mark Winstanley	Assistant Chief Constable, Lancashire Constabulary	8 October 2025
Joseph Wheeler	Managing Director of Artemis Web Limited, trading name of Knife Warehouse	30 September 2025

Witnesses who gave only written statements to the Inquiry (in alphabetical order).

Witness	**Title (as of 29 July 2024, unless otherwise stated)**
Claudia Aldersley	Therapeutic Counsellor, Parenting 2000 (between 2019 and 2020)
Maggie Allred	High Support Teacher, The Acorns School (between 2014 and 2022)
Paul Ainsworth	Consultant General Surgeon, Southport Hospital, Mersey and West Lancashire Teaching Hospitals NHS Trust
Peter Andrews	Police Constable, Lancashire Constabulary
Jamuna Acharya	Doctor, Alder Hey Children's NHS Foundation Trust
Timothy Aspinall	Detective Constable, Lancashire Fixed Intelligence Management Unit, Counter Terrorism Policing North West (between September 2018 and December 2022)
Stephen Baker	Police Constable, Merseyside Police
James Berry	Teacher, Presfield High School
Paul Brennan	Advanced Paramedic, North West Ambulance Service
Simon Boardman	Senior Paramedic Team Leader, North West Ambulance Service
Matt Bousfield	Paramedic, North West Ambulance Service
Ian Carville	Emergency Medical Technician, North West Ambulance Service
Mark Charles-Pass	Director and Owner of Condor Carriers
John Clarke	Police Constable, Merseyside Police
Helen Connaughton	Detective Constable, Lancashire Constabulary
Lisa Cooper	Director of Community and Mental Health Services, Alder Hey Children's NHS Foundation Trust
Samuel Coppard	Clinical Lead for Liverpool Specialist CAMHS, Alder Hey Children's NHS Foundation Trust
Hayley Dawson	Assistant Headteacher, Presfield High School
Liam Dodd	Police Constable, Merseyside Police

Witness	**Title** (as of 29 July 2024, unless otherwise stated)
Tony Fay	Headteacher, Presfield High School (between Jan 2016 and April 2023)
Gary Fitzpatrick	Advanced Paramedic, North West Ambulance Service
Dr Darren Gates	Consultant Paediatric Intensivist, Alder Hey Children's NHS Foundation Trust
Dr Jessica Green	Paediatric Intensive Care Consultant, Alder Hey Children's NHS Foundation Trust
Michael Gregory	Regional Medical Director, NHS England
Stephanie Hallaron	Social Worker, Mersey Care NHS Trust
Guy Halsall	Paramedic, North West Ambulance Service
Risthardh Hare	Executive Director of Children Services, Sefton Council
Stacey Haydock	Social Worker, Lancashire County Council (between 2019 and 2021)
Helen Hayes	Director of JGH Developments and Legal Secretary of Calculus Costs Holdings
Stephanie Heaton	Special Educational Needs Coordinator, The Acorns School
Iain Hennessey	Consultant Paediatric Surgeon and Director of Innovation, Alder Hey Children's NHS Foundation Trust
Dr Jon Higham	Director of Policy Development, Online Safety Group, Ofcom
Dame Annie Hudson	Chair of the Child Safeguarding Practice Review Panel
Dr Shermin Imran	Consultant Child and Adolescent Psychiatrist and Lead Consultant for FCAMHSNW, Greater Manchester NHS Foundation Trust (GMMH)
Glyn Johnson	Head of Security, DPD Group UK Limited
Catherine Jones	Paramedic, North West Ambulance Service
Sakthi Karunanithi	Director for Public Health, Wellbeing and Communities, Lancashire County Council (since October 2024)

Witness	**Title (as of 29 July 2024, unless otherwise stated)**
Melissa Kelly	Detective Inspector, Operational Lead for Lancashire Constabulary Multi-Agency Safeguarding Hub, Lancashire Constabulary
Professor Simon Kenny	Consultant Paediatric General Surgeon, Alder Hey Children's NHS Foundation Trust
Richard Krcmar	Paramedic, North West Ambulance Service
Ramesh Kutty	Consultant Congenital Cardiac Surgeon, Alder Hey Children's NHS Foundation Trust
Richard Lappin	Content Policy Director, Meta Platforms Ireland Limited
Heidi Liddle	Teaching Assistant and qualified dance teacher (Also gave impact evidence)
Jill Locke	Mental Health Practitioner, Sefton CAMHS, Alder Hey Children's NHS Foundation Trust
Janine Lloyd	Chief Executive, Parenting 2000
John Lloyd	Police Constable, Merseyside Police
Leanne Lucas[2068]	Self-employed Primary School Teacher and yoga teacher (Also gave impact evidence)
Professor Richard Lyon MBE	Consultant in Emergency Medicine and Pre-hospital Care, Royal Infirmary of Edinburgh
Andrew Marston	Detective Inspector, Op Encompass, Lancashire Constabulary
Martin Mayne	Sergeant, Merseyside Police
Heloise McAndrew	Director of Law and Governance, Lancashire County Council
Ricky McAulay	UK Operations Director, Royal Mail Group Limited
Neil McDowall	Operations Manager, Cheshire and Mersey Mental Health and Community Services, Care Quality Commission (since September 2024)

2068 A summary of Ms Lucas' Witness Statement was read during the Inquiry hearings. T/S:14/73/5-86/2.

Witness	**Title** (as of 29 July 2024, unless otherwise stated)
Dr Bimal Mehta	Consultant Paediatric Emergency Medicine, Alder Hey Children's NHS Foundation Trust
Joanne Minford	Consultant Paediatric Surgeon, Alder Hey Children's NHS Foundation Trust
Skott Morgan	Senior Mental Health Practitioner, Sefton Specialist CAMHS (between November 2019 and March 2020)
Fiona Murphy	Consultant Paediatric Surgeon, Alder Hey Children's NHS Foundation Trust
James Neale	Sergeant, Prevent Team, Counter Terrorism Policing North West (between April 2018 and July 2020)
Michelle O'Brien	Owner and Sole Trader, Inevitable
Officer A	Lancashire Fixed Intelligence Management Unit, Counter Terrorism Policing North West
Jacqui Old	Executive Director Education and Children's Services, Lancashire County Council
Roland Partridge	Consultant Neonatal and Paediatric Surgeon, Alder Hey Children's NHS Foundation Trust
Sam Proffitt	Acting Chief Executive of NHS Lancashire and South Cumbria Integrated Care Board (between May and November 2025)
Alexander Rawle	Head of Public Policy, YouTube UK (since March 2025)
Philip Redman	Majority owner and Managing Director, Premier Seeds Direct Limited
Mark Rigby	Deputy Designated Safeguarding Lead, Presfield High School
Erica Saunders	Chief Corporate Affairs Officer, Alder Hey Children's NHS Foundation Trust
Jane Scattergood	Acting Chief Nurse NHS Lancashire and South Cumbria Integrated Care Board (since August 2025)
Robert Shaw	Director of Jimbobs Limited
Paul Smith	Senior Paramedic Team Leader, North West Ambulance Service

Witness	**Title (as of 29 July 2024, unless otherwise stated)**
Samantha Steed	Senior Mental Health Practitioner and CAMHS Case Manager for Sefton, Alder Hey Children's NHS Foundation Trust
Martin Storey	Temporary Superintendent, Lancashire Constabulary (since November 2025)
Emma Walker-Riley	Safeguarding Specialist Practitioner, Alder Hey Children's NHS Foundation Trust
Suzanne Walmsley	Social Worker, Lancashire County Council
Keith Ward	Police Sergeant, Lancashire Constabulary
Michelle Warner	Keyworker and Youth Worker, Alder Hey Children's NHS Foundation Trust
Alan Wood	Detective Inspector, Merseyside Police

Annex 3

Inquiry personnel

Legal team	
Role	**Name**
Counsel to the Inquiry	Nicholas Moss KC
Counsel	Richard Boyle
Counsel	John Goss
Counsel	Harriet Wakeman
Solicitor to the Inquiry	Caroline Featherstone
Deputy Solicitor	Ross Howarth
Solicitors' team	Hanna Joseph
Solicitors' team	Agnes Horton
Solicitors' team	Jennifer Forrest
Solicitors' team	Leona Reid

Secretariat	
Role	**Name**
Secretary to the Inquiry	Kate Anderson
Deputy Secretary	Anna Jones
Secretariat team	Sophie Vandermeer
Secretariat team	Lax Kuganeethan
Secretariat team	Sue Curran
Secretariat team	Yasmin Janespar
Secretariat team	Cyrus Kay
Secretariat team	Vicky Lubwama

Experts	
Role	**Name**
Expert	Professor Richard Lyon MBE
Expert	Dr Tina Irani

Service providers	
Role	**Name**
Document management services and digital platform provider	Epiq
Legal document review	DWF
Witness and attendee support services	Hestia and Coroners' Court Support Services
Hearing premises and support	Liverpool Town Hall
Media support	Crest Limited
Hearing technology and transcription services	RTS
Report typesetting and proofreading	Design102

Security and ushers	
Role	**Name**
Security	Naomi Gledhill
Security	Kevin Dupree
Security	Simon Clarke
Security	Andrew Bareham
Security	Josephine Garcia-Ortin
Security	Frances Chambers
Security	Stephen Gibbs
Security	Eric Watson
Usher	Rachel Kelleher
Usher	Liz Reeves
Usher	Sadie Knightley

Annex 4

Acronyms

Acronym	Meaning
ACC	Assistant Chief Constable
ADD	Attention deficit disorder
ADHD	Attention deficit hyperactivity disorder
A/PS	Acting Police Sergeant
ASC	Autism spectrum condition
ASD	Autism spectrum disorder
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Services
CANW	Child Action Northwest
CBT	Cognitive Behavioural Therapy
CFW/CFWS	Children and Family Wellbeing/Service
CI	Chief Inspector
CJA	Criminal Justice Act 1988
CJLDT	Criminal Justice Liaison and Diversion Team
CMIS	Channel Management Information System
CON	Continuum of Need
CONTEST	Counter Terrorism Strategy
CPOMS	Child Protection Online Management System
CPTSD	Complex post-traumatic stress disorder
CSC	Children's Social Care
CSSH	Children's Services Support Hub
CTCO	Counter Terrorism Case Officer
CTF	Common Transfer File
CT/DE	Counter terrorism or domestic extremism
CTP	Counter Terrorism Police
CTPHQ	Counter Terrorism Police Headquarters

Acronym	Meaning
CTPNW	Counter Terrorism Police North West
CTSA	Counter Terrorism and Security Act 2015
CYJS	Child and Youth Justice Service
DAC	Deputy Assistant Commissioner
DBS	Disclosure and Barring Service
DC	Detective Constable
DCI	Detective Chief Inspector
DfE	Department for Education
DHSC	Department of Health and Social Care
DS	Detective Sergeant
DSIT	Department for Science, Innovation and Technology
DSL	Designated safeguarding lead
DSP	Delivery Service Provider
EHCP	Education, Health and Care Plan
EMT	Emergency Medical Technician
EPR	Electronic Patient Record
ESICTRL	Emergency Services Interoperability Control Channel
ETHANE	Exact location/Type of incident/Hazards/Access/ Number of casualties/Emergency services
FCAMHS	Forensic Child and Adolescent Mental Health Services
FIM	Force Incident Manager
FIMU	Fixed Intelligence Management Unit
GMMH	Greater Manchester Mental Health (GMMH) Foundation Trust
GP	General Practitioner
HEMS	Helicopter Emergency Medical Service

Acronym	Meaning
ICT	Information Communication Technology
JAT	Joint Assessment Team
JESIP	Joint Emergency Services Interoperability Programme
LA	Local authority
LACC	Local Authority Channel Coordinator
LADO	Local Authority Designated Officer
LCC	Lancashire County Council
LEA	Local Education Authority
MAPPA	Multi-agency public protection arrangements
MASPs	Multi-agency Safeguarding Partnerships
MASH	Multi-agency Safeguarding Hub
MBC	Metropolitan Borough Council
MDT	Multi-disciplinary teams
M/ETHANE	Major Incident/Exact Location/Type of Incident/ Hazards/Access/Number of Casualties/Emergency Services
MHCLG	Ministry of Housing, Communities and Local Government
NARU	National Ambulance Resilience Unit
NBCC	National Business Crime Centre
NFA	No further action
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NPCC	National Police Chiefs' Council
NSPCC	National Society for the Prevention of Cruelty to Children
NWAS	North West Ambulance Service

Acronym	Meaning
Ofcom	Office of Communications
Ofsted	Office for Standards in Education, Children's Services and Skills
OIC	Officer in the Case
OOSS	Out-of-school settings
OSA	Online Safety Act 2023
OWA	Offensive Weapons Act 2019
PASS	Proof of Age Standard Scheme
PC	Police Constable
PCE	Police and Criminal Evidence Act 1984
PCM	Prevent Case Management
PCMT	Prevent Case Management Tracker
PCSO	Police Community Support Officer
PGA	Police Gateway Assessment
PLP	Police Led Partnership
PRU	Pupil Referral Unit
PS	Police Sergeant
PTSD	Post-traumatic stress disorder
PVP	Protecting vulnerable persons
RCRP	Right Care, Right Person
RP	Responsible person
RVP	Rendezvous point
SAVRY	Structured Assessment of Violence Risk in Youth
SENCO	Special educational needs co-ordinator
SEND	Special Educational Needs and Disabilities

Acronym	Meaning
SMART	Specific, measurable, achievable, relevant and time-bound
SSRI	Selective Serotonin Reuptake Inhibitor
TAF	Team Around the Family
VPN	Virtual Private Network
YOT	Youth Offending Team

Annex 5

Guide to references

This annex is a guide to the references contained in the Inquiry report. It sets out the conventions adopted in footnotes and in references contained within the text. The documents which are referenced in the Inquiry report have been disclosed to Core Participants and published on the Inquiry website: www.southport.public-inquiry.uk

Documents

[Inquiry reference number/page number/§paragraph number]

Example reference	Meaning
INQ123456/7	Document reference INQ123456 at page 7
INQ123456/7/§8	Document reference INQ123456 at page 7, paragraph 8

Witness Statements

[Inquiry reference number/§paragraph number]

Example reference	Meaning
Witness Statement of Joe Bloggs INQ123456	Joe Bloggs' Witness Statement
Witness Statement of Joe Bloggs INQ123456/§7	Paragraph 7 of Joe Bloggs' Witness Statement

Transcripts

Transcript references [day/[page number/line number(s)]

Example reference	Meaning
T/S: 24/62/15-18	Lines 15 to 18 on page 62 of the oral evidence heard on day 24
T/S: 24/62/5-64/10	Line 5 on page 62 to line 10 on page 64 of the oral evidence heard on day 24

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