

# Briefing Paper: Southport Public Inquiry

## Newcastle Safeguarding Children Partnership (NSCP)

**Date:** 16<sup>th</sup> April 2026

**Audience:** Statutory and relevant safeguarding partners across education, local authority services, health, police, voluntary and community sector

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## Purpose of this briefing

This briefing provides safeguarding partners with a concise summary of the key findings and themes from the Southport Public Inquiry (Volumes 1 and 2). It is intended to support shared understanding of the issues identified, particularly those relevant to multi-agency safeguarding, risk management and system leadership.

## Context and Rationale

The Inquiry examined the circumstances leading up to, and following, the fatal attack on 29 July 2024.

- [Volume 1](#) focuses on the events, impacts and fundamental problems that allowed the attack to occur.
- [Volume 2](#) examines the roles, decisions and actions of individual agencies, including policing, social care, health, education and Prevent.

The Inquiry found that the attack did not result from a single failure, but from multiple, inter-connected systemic weaknesses over several years, despite repeated contact with agencies and clear indicators of escalating risk.

The Inquiry focusses on accountability identifying senior leaders, decision-makers and statutory professionals by name. Members of the public and non-statutory practitioners are also named where their roles are materially relevant to understanding the circumstances under review; the perpetrator is not named and is referred to as AR.

Findings are framed around systemic and leadership failure, not individual fault. The Review Chair consistently distinguishes between individual good faith and wider organisational weaknesses, emphasising culture, governance, information-sharing and risk ownership rather than attributing responsibility to individual practitioners.

Both volumes are intended to be read together to understand how these issues arose and how they were reinforced across agencies and time.

## What This Means in Practice

The Inquiry identified several fundamental problems that repeatedly undermined safeguarding responses:

- **No single organisation or multi-agency arrangement took ownership of the risk posed.**
  - Risk was repeatedly passed between agencies.
  - There was no clearly identified lead responsibility for assessing and managing the risk to others.
- **Parental capacity, obstruction and escalation of risk**
  - The Review Chair concluded that AR's parents were a significant contributory factor in the failure to manage escalating risk.
  - The Review Chair identified parental behaviour as a risk factor in its own right.
  - The failure of AR's parents to share critical information immediately prior to the attack was decisive.
- **Poor information management and information sharing.**
  - Critical risk information was not consistently shared, recorded or retained.
  - The significance of earlier warning signs was lost over time.
  - Later incidents were treated in isolation rather than in the context of cumulative risk
- **Risk to others was repeatedly outweighed by a focus on risk to the individual.**
  - Safeguarding responses focused primarily on protecting the perpetrator as a child, even when there were clear indicators of serious risk to others.
  - When police found AR in possession of a knife on a public bus, the response prioritised his welfare and mental health needs, and he was returned home rather than arrested, despite his stated intent to harm others and known history of serious violence.
  - Existing safeguarding frameworks were not designed to manage situations where a child presented a serious risk of violent harm.
- **Inappropriate use of autism as an explanation for violent behaviour.**
  - Behaviour was frequently excused or minimised on the basis of autism.
  - The Inquiry was clear that this approach was unacceptable, and that autism should not be treated as removing responsibility for violent behaviour.
- **Failure to identify, understand and respond to online harms**
  - There was limited exploration of online behaviour, despite known concerns and offering a crucial perspective on his thinking. This was a missed opportunity to identify intent and escalation of risk, and was not sufficiently explored or integrated into risk assessment at key points, limiting agencies' understanding of the risk he posed to others.
  - AR's online activity and search history,
  - Opportunities to use online activity as an indicator of escalating risk were missed.

These issues meant that clear warning signs were not acted on in a coordinated or sustained way, despite repeated opportunities to intervene.

## Key Messages for Partners

- The Inquiry concluded that the multi-agency system failed to manage known and escalating risk over an extended period.
- Risk was nobody's responsibility, rather than being actively owned, coordinated and reviewed.
- Safeguarding frameworks in place at the time were not equipped to address serious risk to others posed by a child or young person.
- Information was available across agencies, but not brought together in a way that enabled decisive action.
- The Inquiry emphasised that good intentions and professional effort were not sufficient in the absence of clear accountability, leadership and shared risk assessment.

## Safeguarding / Quality Impact

The Inquiry identified significant safeguarding implications, including:

- Public protection gaps when no mechanism exists to manage children or young people who pose a high risk of serious harm to others.
- Inconsistent thresholds and practice across agencies, leading to repeated stepping down or case closure despite unchanged risk.
- Systemic risk of recurrence if responsibilities remain unclear and information sharing remains fragmented.
- Cultural issues where risk is referred on rather than owned, and where safeguarding is narrowly defined.

**The Inquiry was explicit that cultural change, alongside structural reform, is required to prevent similar failures in future.**

## Engagement and Next Steps

The Inquiry made clear that:

- Phase 2 will consider structural and statutory reforms, including:
  - Options for a single agency or structure with responsibility for coordinating and monitoring high-risk cases.
  - Development of a shared multi-agency risk assessment approach.
  - Consideration of powers and mechanisms relating to online safety and monitoring for high-risk children and young people.

Safeguarding partners are encouraged to:

- Reflect on how the Inquiry's findings align with local safeguarding arrangements.
- Consider whether current governance, escalation and information-sharing arrangements provide sufficient clarity and oversight.
- Engage with Phase 2 developments and any national guidance arising from the Inquiry.

*This briefing is intended for professional safeguarding audiences and should be read alongside the [Southport Inquiry Report \(Volumes 1 and 2\)](#) for full detail and context.*