7 Minute Briefing: Southport Inquiry and Future Practice

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Background- what happened?

On 29 July 2024, Axel Rudakubana (17 years old) carried out a knife attack at a children's dance class in Southport. Three children, Elsie Dot Stancombe, Alice da Silva Aguiar and Bebe King, were murdered and multiple children and adults were seriously injured.

Prior to the attack, he had been known to a range of agencies, including education, police, children's social care, mental health services and Prevent, due to concerns relating to violent behaviour, school incidents, social isolation, mental health needs and potential risk to others

The Southport Public Inquiry was established to understand how the attack was able to happen, identify missed opportunities for intervention, and determine what lessons must be learned to reduce the risk of similar incidents in the future.

Phase 1 of the Inquiry was published in April 2026 and examined the perpetrator's history, agency involvement, decision-making and information sharing prior to the attack.

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Why is this important?

The Inquiry concluded that the attack was both **foreseeable and avoidable**.
Despite repeated contact with police, education, health, social care and Prevent services over several years, no agency effectively coordinated the assessment and management of the significant risk posed.
The findings highlight important lessons for safeguarding professionals, particularly around:

- Recognising and responding to risks posed by children and young people.
- Information sharing.
- Professional curiosity.
- Multi-agency decision making.
- Understanding online behaviour and radicalisation pathways.
- Avoiding assumptions when assessing risk.

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The 7 Key Messages

1. Nobody took ownership of the risk

Multiple agencies were involved with Axel, but no individual service or multi-agency arrangement accepted overall responsibility for assessing and managing the risk he posed.
Cases that do not fit neatly into existing pathways can become everyone's concern but nobody's responsibility.
Practice Point: Ensure there is clarity about lead professional responsibility, escalation routes and risk ownership.

2. Information sharing was inconsistent and ineffective

Important information was frequently lost, diluted, misunderstood or not brought together across agencies.
Individual incidents were assessed in isolation rather than being viewed as part of an escalating pattern of concerning behaviour.
Practice Point: Always consider cumulative risk and seek the full safeguarding history before making assessments.

3. Professional curiosity was insufficient

Professionals often accepted explanations at face value and did not fully explore the significance of behaviours, incidents or emerging risks.
Opportunities to understand the seriousness of concerns were missed.
Practice Point: Be professionally curious, triangulate information and challenge gaps, inconsistencies or minimisation.

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4. Risk to others was overshadowed by concern for the child
Services focused heavily on Axel's vulnerabilities and support needs.
While safeguarding a child remains essential, the Inquiry found insufficient attention was given to the risk he posed to other children and the wider public.
Practice Point: Assess both vulnerability and potential harm to others.

5. Assumptions about autism influenced decision making
The Inquiry found that behaviours were frequently attributed to Axel's diagnosed autism spectrum disorder (ASD), resulting in some concerns being minimised or explained away. The report stresses that autism should never be viewed as being inherently linked to violence. However, professionals must still assess presenting behaviours and risks objectively.
Practice Point: Avoid diagnostic overshadowing and focus on behaviour, impact and risk.

6. Online activity was not effectively explored
Axel accessed extensive violent, disturbing and extremist-related material online. Professionals and parents did not sufficiently understand, monitor or investigate his online world. The Inquiry highlighted that online behaviour can provide important indicators of offline risk.
Practice Point: Routinely explore online activity as part of safeguarding and risk assessments.

7. Parents can both support and hinder safeguarding
The Inquiry found that parental actions sometimes concealed risks and obstructed professional understanding of the level of concern.
Professionals did not always fully consider the impact of parental non-engagement, minimisation or lack of cooperation when assessing risk.
Practice Point: Consider the effect of parental behaviour on risk assessment and safety planning.

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Key Recommendations

The Inquiry recommends that Phase 2 considers:

1. Establishing a single agency or structure with responsibility for coordinating the management of children and young people who present a high risk of serious harm.
2. Developing a shared multi-agency risk assessment framework that can be used consistently across services.
3. Exploring additional powers and mechanisms to restrict or monitor internet access where a child or young person presents a significant risk of serious harm.

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What does this mean for practice?

All Partnership professionals should:

- Take responsibility for escalating risk concerns.
- Share information promptly and effectively.
- Look at the whole picture, not isolated incidents.
- Be professionally curious.
- Consider both vulnerability and risk posed to others.
- Explore online behaviour routinely.
- Challenge minimisation and assumptions.
- Ensure clear leadership and accountability in complex multi-agency cases.

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Reflection Time

Ask yourself:

- Who owns the risk in complex cases within our service?
- How well do we understand a child's online life?
- Are we assessing cumulative risk effectively?
- Do we challenge assumptions that may minimise risk?
- Would we recognise when a child presents a serious risk to others?
- How do we hold our service and partner services accountable for agreed decisions about risk?
- How do I understand neurodivergent strengths/ needs/behaviours/vulnerabilities?

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Further Reading

- Southport Inquiry Reports (Volumes 1 & 2)
- NSPCC CASPAR Briefing: Summary of the Southport Inquiry – Phase 1 Report

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