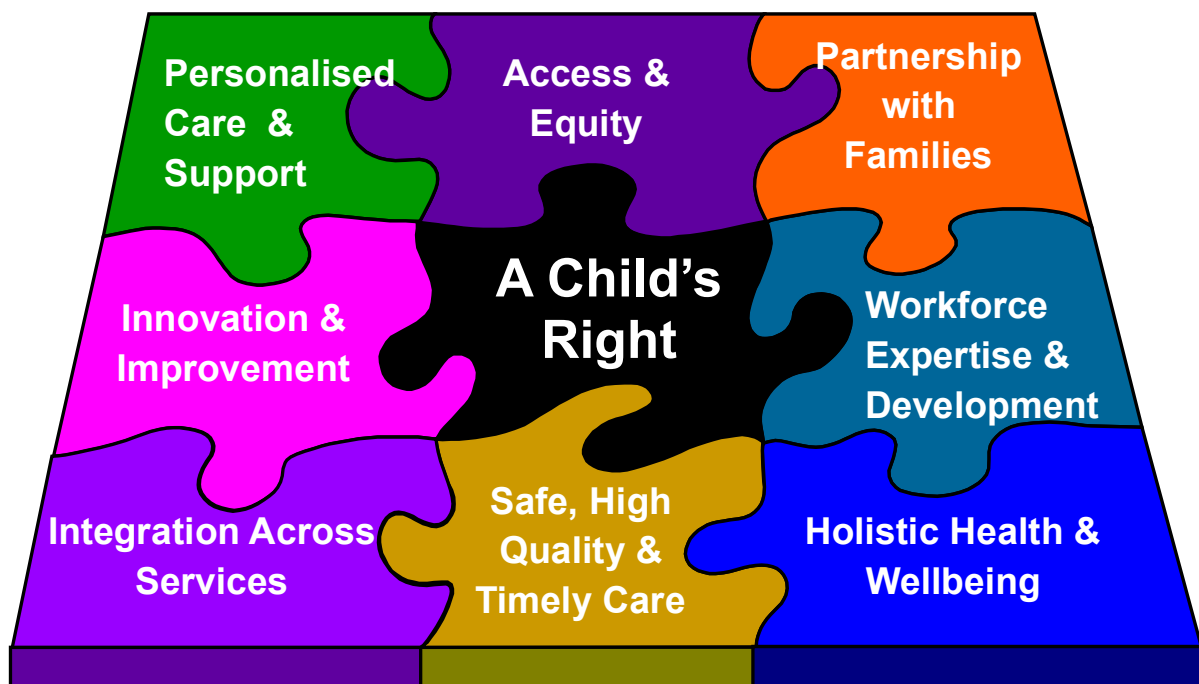


Association of British Paediatric Nurses
Briefing for children's nurses: key
recommendations from the Fulford Inquiry



Acknowledgements

This document has been developed in collaboration with our members, and contains information to assist members in the development of services for children and young people across the UK.

We would like to thank all of those that were involved in this important document.

Purpose

The purpose of this paper is to inform Association of British Paediatric Nurses (ABPN) members of the key recommendations from the [Fulford Inquiry](#) .

Background

The lengthy report - The Southport Inquiry - chaired by Sir Adrian Fulford was published 13 April 2026. The report examined the events of 29th July 2024 when three young girls - Alice, Beba and Elise were murdered and many other children and adults suffered grave physical and/or psychological harm. The [Fulford Inquiry](#) report examined serious failings in care delivery, governance, and safeguarding within children's services. Its findings highlight systemic issues that directly impact children, families, and frontline nursing staff.

Key findings

The Report opens with a chapter 'Fundamental problems' and concludes that the attack was foreseeable and avoidable, highlighting five major areas of systemic failure:

- 1. Absence of risk ownership Critical:** No agency or multi-agency structure accepted responsibility for assessing and managing the grave risk posed by the perpetrator.
- 2. Critical failures in information sharing:** Essential information was repeatedly lost, diluted or poorly managed across agencies.
- 3. Misunderstanding of autism:** AR's conduct was wrongly attributed to his autism spectrum disorder, leading to inaction and a failure to address dangerous behaviours.
- 4. Lack of oversight of online activity:** AR's online behaviour, which provided the clearest indications of his violent preoccupations, was never meaningfully examined.
- 5. Significant parental failures:** AR's parents did not provide boundaries, permitted knives and weapons to be delivered to the home, and failed to report crucial information in the days leading up to the attack.

Recommendations

Recommendation 1 - 3: Issues which should be considered during Phase 2 of the Inquiry.

Recommendation 4 - 5: Safeguarding considerations for taxi services.

Recommendation 6 - 10: Issues relating to emergency response (police and ambulance).

Recommendation 11: Out of school settings.

Recommendation 12 – 20: Online purchasing/marketing/restrictions.

Recommendation 21 – 24: Online access/filtering and monitoring; Age verification.

Recommendation 25 – 38: Policing issues including counter-terrorism and Prevent training.

Recommendation 39: Updating of Working Together.

Recommendation 40 – 45: Lancashire County Council staff training, support and supervision.

Recommendation 46: Consent issues.

Recommendation 47 – 48: Youth Justice Services.

Recommendation 49: Young Adults Service.

Recommendation 50: System requirement relating to the care of children and young people who are at risk of acts of violence.

Recommendation 51: Conducting complex structured risk assessments for children and young people who present a risk of violence to others.

Recommendation 52: National review of complex structured risk assessments.

Recommendation 53 – 54: Regional and National consideration of the issues relating to action points from multi agency meetings, healthcare meetings, discharge plans and management plans after risk assessments are being recorded in a SMART-compliant way.

Recommendation 55: 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: Is 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?

Recommendation 57: 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.

Recommendation 58 – 60, 62 and 64 – 65: Department for Education considerations and reference to Keeping Children Safe in Education guidance.

Recommendation 61: Education Health Care Plan considerations for Lancashire County Council.

Recommendation 63: Prevent training.

Recommendation 66: Youth Justice Board guidance for parents of children who have been found with a knife or offensive weapon.

Recommendation 67: Review the merits of legal reform.

Implications for Children's Nurses

Children's nurses play a critical role in working with multi-agency partners in implementing these recommendations:

- **Advocacy:** Actively advocate for children and families, especially when concerns arise.
- **Vigilance:** Maintain high awareness of safeguarding risks and clinical deterioration.
- **Communication:** Engage clearly with colleagues and families, documenting concerns accurately.
- **Professional Development:** Participate in ongoing training and reflective practice.
- **Speaking Up:** Use established channels to report unsafe care or organisational issues.

Children's nurses are expected to be:

- proactive safeguarding practitioners
- key contributors to multi-agency decision-making
- advocates for the child's voice and wellbeing.

Actions for Practice

Members are encouraged to:

- Be aware of local safeguarding & escalation and Prevent policies.
- Participate in team discussions about lessons learned from the Inquiry.
- Identify gaps in training or staffing and raise these with leadership.
- Support a positive workplace culture where concerns are welcomed and acted upon.

Support from the ABPN

- The Association has a number of free resources available from the website www.abpn-uk.com aligned with the Inquiry (e.g. safeguarding and workforce issues).
- Offer webinars for members to share learning and best practice.

Conclusion

Children's nurses play a key role in early identification (e.g., developmental concerns, neglect indicators) and ongoing support and should consider the whole family system, not just presenting symptoms. Timely escalation is essential to protect children.

The Fulford Inquiry underscores the importance of safe systems, strong leadership, and empowered nursing staff and effective multi-agency working. Children's nurses are central to driving these improvements and ensuring high-quality, compassionate care for every baby, child and young person. Safeguarding is everyone's responsibility (including health). In practice: nurses should be fully involved in multi-agency meetings, child protection plans, and ongoing support, for children's nurses: collaboration and professional curiosity are critical.

16th April 2026

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