Witness Name: Dr Oonagh Victoria Killen

Statement No.: 1

Exhibits: VK/01 – VK/05

Dated: 25 July 2025

THE SOUTHPORT INQUIRY

FIRST WITNESS STATEMENT OF DR OONAGH VICTORIA KILLEN

I, Dr. Oonagh Victoria (known as Vicky) Killen will say as follows:-

1. I am employed by Alder Hey Foundation NHS Trust as a Clinical Psychologist and within the role of Clinical Lead of Sefton Child and Adolescent Mental Health Service (CAMHS) based at Burlington House, Crosby Road North, L22 0PJ.

2. I am a qualified Clinical Psychologist HCPC registered (PYL 16495) with BPS Chartered Status. I received my BSc (2:1) in Psychology from the University of Sheffield in 1997. I received a Doctorate in Clinical Psychology (D. Clin. Psychol) from the University of Liverpool in October 2002.

3. I obtained a Post Graduate Certificate in Service Leadership from the University of Manchester in 2017. I am qualified to deliver EMDR, Incredible Years Parenting Groups, Mellow Parenting Groups and Dialectical Behaviour Therapy. I have completed the Level 2 Systems Approach to Patient Safety Incidents through HSSIB in 2023. I am also a qualified supervisor for Clinical Psychology Trainees.

4. From qualification I have worked for Alder Hey. Initially I worked as a clinical psychologist in the newly established Brief Intervention and Consultation Team; progressing to lead of this team in June 2009. At that time I also was promoted into the role of Clinical Lead of the 16-18 Team. In September 2012 I took up the post of Assistant Clinical Lead within the single point of access team, including crisis care. Within this role I continued to lead the Sefton Primary Mental Health Service. From September 2014 I took up the role of Assistant Clinical Lead within locality CAMHS. I was successful in obtaining the clinical lead role within locality CAMHS in 2016 and this is the role I continue to work in.

5. This witness statement is made to assist the Southport Inquiry (the “Inquiry”) with the matters set out in the Rule 9 Request dated 3 July 2025.

6. In making this statement I have relied upon entries made in the Trust's patient record relating to AR, emails that have already been provided to the Inquiry and my own recollection of events.

Background

7. Alder Hey Community Mental Health Services (Sefton Locality) are commissioned to provide an evidence based, effective service to children and young people (0-18), registered with a Sefton GP, who present with significant mental health difficulties.

8. The locality Community Mental Health Service is commissioned to provide assessment and, where indicated, mental health treatment to respond to mental health difficulties which impact significantly on functioning and/or trigger risk to self or other. Alder Hey Community Mental Health Services offer assessment of mental health difficulties and evidenced based treatment when indicated.

9. Sefton CAMHS in 2019 provided mental health treatment delivered by mental health practitioners, working within multi-disciplinary teams (MDTs). Three MDTs were functioning at the point of referral. Each MDT has an Assistant Clinical Lead and Consultant Child and Adolescent Psychiatrist present to provide oversight of clinical delivery. MDTs take place weekly and last between 2 – 3 hours. Children and young people are presented for discussion usually by their case manager, who is their key contact whilst in treatment but can be brought by any practitioner for discussion. Triggers for discussion include new into service, deteriorating patients, patients not improving as planned, safeguarding risk, requests for additional treatment (including psychiatry), transition planning and discharge. MDT meetings were attended on rotation by a safeguarding team practitioner, as well as being attended intermittently by the transition lead.

10. My role as Clinical Lead involves me having oversight of Service delivery and providing assurance with regard to safety and performance of Sefton CAMH service. I am responsible for clinical governance, service delivery and responsiveness (waits). I also practice as a clinical psychologist so provide case management and specific treatment to children and young people assigned to me. The clinical lead is supported by Assistant Clinical Leads, and line management is provided for these roles. In addition, the Service has a Service Manager who is responsible for data reporting and performance and employment metrics. A psychiatry lead position was introduced in 2021 to provide a three at the top leadership model.

11. In December 2019 referrals were received and triaged by the Alder Hey CAMHS Single Point of Access. The Single Point of Access would also offer initial assessment "Choice" appointments. For Children and young people who were already in receipt of mental health treatment or who had been assessed by a mental health team, referrals were automatically pended to a treatment waiting list as a transfer of care. AR's referral was triaged by the Single Point of Access and pended (placed) on the urgent waiting list for treatment "partnership".

12. I became aware of AR on 16th December 2019 and my last direct contact with the family was on 22nd June 2022 when I completed a complaint resolution meeting. I know that AR remained open to Sefton CAMHS until his final family therapy appointment on 23rd April 2024. AR had by that point been discharged from psychiatry, his last appointment was on 25th September 2023. AR's last individual case management appointment that was attended was on 16th January 2023. Indirect case management had continued to the family and professional system, and this ceased after the TAF meeting on 13th September 2023.

13. I did not have any direct contact with AR.

14. I have included some reflection within my narrative of involvement.

Narrative of Involvement

15. Referrals were made by AR's GP to the Single Point of Access Team in April 2019 and by Range High School to CAMHS in October 2019. On both occasions the referrals were rejected as AR did not meet the criteria for CAMHS and feed back was provided to the referrer. On review the response provide by CAMHS was appropriate.

16. A referral for AR was received on 13th December 2019 by Stephanie Hallaron, Criminal Justice Liaison and Diversion Practitioner at the Criminal Justice Liaison and Diversion Team (CJLDT) provided by Mersey Care NHS Trust. CJLDT is an allage service to provide assessment of people arrested by the police. Ms. Hallaron had followed this referral up with a phone contact at 10:15 with Mr. Ricky Zdrenka, Specialist Mental Health Practitioner. It was requested that Mr. Zdrenka make note of a FCAMHS strategy meeting on 21st January 2020 at 2pm and requested the allocated case manager to contact her to discuss their attendance. Contact number left and it was agreed any information from the meeting on 17 December 2019 would be shared.

17. On 16th December 2019, a phone call was received by a member of the admin team from Anna Jameson, social worker and shared via email at 14.31 with Ms. Julia Dunn, Assistant Clinical Lead and Duty Lead on this day. A call back was requested as there was a strategy meeting (serious in nature) taking place the following day. We advised that the sibling of AR was open already to CAMHS and known to Ms. Jill Locke. Ms. Dunn copied me into replies to this email with one practitioner initially being identified but an update being provided at 15:43 confirming Mr. Skott Morgan would be covering this meeting. I exhibit this email as **VK/01 – AHCH000233**.

18. My understanding from these emails was that we had requested a practitioner to join who had capacity to follow up with further appointments, given that AR was pended for an urgent partnership. From the records I can confirm Mr. Skott Morgan, Mental Health Practitioner, attended the strategy meeting regarding AR on behalf of Sefton CAMHS the following day.

19. Mr. Morgan had capacity to offer follow up appointments should they be needed. Mr. Morgan attended the strategy meeting and completed a follow up appointment and assessment on 20th December 2019. A further strategy meeting was attended on 6th January 2020. Other contacts with AR are referenced specifically in the letter sent by Mr. Morgan which is dated 14th February 2020 "*I have met AR on several occasions*". It does not appear that all of these occasions are documented in the electronic patient record. Skott also liaised with the Criminal Justice and Liaison Team and with Forensic CAMHS (FCAMHS) as evidenced in the FCAMHS consultation letters. I exhibit a copy of the FCAMHS consultation letters as **VK/02 – AHCH000231**.

20. On 12th March 2020 I raised concerns regarding the clinical capacity of Sefton CAMHS as a number of staff were off poorly and staff had left, Mr. Morgan had left abruptly in February 2019. At that time, just as COVID was taking hold, 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.

21. At this point all caseloads of staff who were off poorly or who had left were collated for senior oversight and to manage clinical demands. AR was on this caseload list and I was aware that he was without a case manager.

22. It was within this context that the EHCP was directed to me on 29th April 2020.I exhibit a copy of this email as **VK/03 - AHCH000232**

23. On 14th May 2020 I completed the EHCP health advice form following a clinical review of the notes. AR was at this point without a case manager and the form needed to be returned within statutory timescales. I can confirm I stated:

    "*No Current Diagnosis. Concerns re: social and emotional functioning and referral in for ASC assessment. Concern raised re anxiety and emotional recognition skills (delayed)*".

24. I also wrote "*AR can present as an anxious young person. He struggles to feel comfortable with peers. AR needs support for his emotional understanding (social stories etc). Support for emotional processing. AR presented with rigid behaviour (desire for control). Retribution as emotional management plan*". SMART goals included:

    - Develop emotional vocabulary
    - Use emotional words to describe internal state
    - Medium – to better regulate emotions
    - To use trusted adult to succeed in developing peer relationships.

25. Support suggested to achieve these goals included:

    - Coaching re emotional language (educational provision), Adult support to develop social stories/comic strip conversations to develop social and emotional understanding (educational provision).
    - To be offered adapted CBT and family systemic support to improve emotional processing in the family (CAMHS).
    - To offer system support for parents to gain control over Axel's behaviour (CAMHS).
    - YOT intervention re anger management and offering behaviours (YOT).

26. Sam Coppard, Registered Mental Health Nurse, had been identified as AR's case manager to commence meeting with the family and would be responsible for directing the care plan.

27. On Friday 17th April 2020, I received an email from a colleague in Crisis Care (Mr. Carl Dutton) advising that Anne Simpson from Lancashire YOT had been in contact and

would appreciate a call back. I returned this call. This call is recorded in the notes on 1st May 2020 but I am uncertain as to the precise time and date of the call. The purpose of this conversation was to receive risk information from the Youth Offending Team who would have the primary role in assessing risk of future offending and intervention to mitigate possibility of re-offending. From my recollection of this conversation their concern focused on anxiety management as being a key tool to mitigate future risk. From recollection Anne Simpson, was checking that the anxiety management work being offered by the Youth Offending Team would not clash with any work to be offered by CAMHS. I confirmed AR was without a case manager at this point in time but that he was being picked up by Sam Coppard, Assistant Clinical Lead, who had just started with the Team. During this phone call I recorded the risk assessment shared by Anne Simpson as:

> **"reoffending risk – medium**
> **significant harm risk – medium**
> **risk to children – no**

28. I added a comment at the time that this was unusual and the reason for this, as far as I remember, was because the offence triggering the referral order was one committed against a child. I can only think that this seemed unusual as he had already assaulted another child, and so would potentially pose some level of future risk.

29. In this record I also note that the goals for work would include engaging in education and positive activities out of the house. There was no evidence of radicalisation but concern remained as AR had made reference to school shootings and there were some similarities to the index offence. There was no evidence of disordered thinking or paranoia. The details were shared of Anne Croll, AR's allocated social worker. The plan for CAMHS was recorded as:

> *"VK to do EHCP*
> *Camhs worker to pick up work on emotional regulation and anxiety*
> *VK to check comm paeds referral is in"*

These actions were completed.

30. On the 1st May 2020 at 12:25 hrs, I followed up the phone call with an email to John Hicklin at FCAMHS, Anna Jameson, social worker at Lancashire County Council, and Anna Croll, Social Worker, with a copy to Anne Simpson. I exhibit a copy of this email as **VK/04 - AHCH000234**. In summary, I confirmed that AR was allocated to Sam Coppard as CAMHS Case Manager. I enquired as to whether there had been any additional concerns raised with regard to risk over the past few weeks. I also confirmed that I had not received the FCAMHS assessment/consultation outcome and requested for this to be shared. I apologised for the delay in sharing information with them all.

31. With the benefit of hindsight, I would have recorded the conversation with Anne Simpson in more detail and I would have asked specifically about risk to children and the detail of the risk assessments that have identified a medium risk of 're-offending' and 'significant harm'. Further, I would have enquired about and recorded specific details of any Children's Services involvement and any meetings planned for multi agency communication. The email of 1st May 2020 does not appear in the electronic patient record and this is of course an omission. I can only say that at that time there were multiple competing clinical demands and copying this email across did not happen as it should.

32. In response to my email, the FCAMHS consultations were shared via email to the Sefton CAMHS email on 3rd May 2020 and forwarded to me on 6th May 2020. That same day I shared these with Sam Coppard, incoming case manager. In addition, I requested that the reports were sent for scanning. These reports are not scanned on the system and there are some other documents in this month that I understand are recorded as being sent to scanning but have not been scanned. A formal investigation into this is currently being undertaken by the Trust. At the material time, in May 2020 however, I believed the records had been uploaded on ImageNow (record system) and would have been available to future practitioners. Reviewing the records in 2025 I believe the FCAMHS records were not available to practitioners after Mr. Sam Coppard on the basis that they were not uploaded. This is an omission.

33. The FCAMHS consultation letter of 11th February 2020 pertains to a consultation on 21st January 2020 and the letter of 9th March 2020 related to a consultation on 4th March 2020. It is noted that the CAMHS practitioner did not attend the meetings but had contributed to the process via a call to the FCAMHS team.

34. The initial letter includes in its summary the following paragraph relevant to CAMHS *"I also highlighted that AF 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 AF 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. "

35. Interventions linked to reducing risk of offending would be primarily the role of the Youth Offending Team during the course of the referral order, however, as a safeguarding partner we would heed advice as to likely effective interventions that we could offer and we did indeed focus on anxiety and social anxiety and emotional regulation.

36. The letter dated 9th March 2020 concludes:

"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 [AF] 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 naivety*
- *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 [AF])*
- *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*
- *Comorbid mental health diagnosis (although this has been not to be the case by CAMHS in AF'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."*

37. From the information provided by both the YOT team and the FCAMHS Consultation the role of CAMHS would be to improve pro social behaviour, address anxiety that impacts negatively on functioning and support re-integration into education settings. I am confident that over the course of AR's journey with CAMHS that the therapeutic priorities did relate to anxiety management, problem solving and re-engaging in social and particularly educational opportunities.

38. With regard to handover, I will have provided verbal handover to Sam Coppard, I had also shared the FCAMHS letters directly with Mr. Coppard via email. Documented in the file was the conversation with YOT and the EHCP advice was uploaded onto ImageNow.

39. Mr. Coppard attempted to engage with AR and his family until August 2020 when the decision was made that no further appointments were to be offered with Mr. Coppard, however a closure of AR's case on our system was not completed.

40. Following the ASD assessment and diagnosis in early 2021 AR's father requested a re-referral to CAMHS on 3rd February 2021. As AR was still open at this point a new case manager, Ms. Samantha (Sam) Steed was assigned and offered an appointment on 1st April 2021. At this point there was very regular and effective contact with AR and his family. These appointments were largely offered via video or telephone given the COVID restrictions at the time. Engagement with Ms. Steed focussed on anxiety management, graded exposure, problem solving and re-engagement with education. This was all consistent with the outcome of the FCAMHS recommendations.

41. It was during this period of care that Dr. Ramasubramanian met with the family for the first time on 24th June 2021 and a follow up on 1st July 2021. A follow up of the family was completed by Dr. Aseri due to staff sickness and a comprehensive letter followed. Dr.

Ramasubramanian resumed contact on 13th October 2021 and continued with further appointments on 15th November 2021, 24th January 2022, 7th April 2022 and 4th May and a further appointment on 23rd May 2022. The reason for the involvement of the psychiatrists in the team was for the consideration and prescription of medication and to support case managers with risk and care planning.

42. In November 2021 Ms. Steed was working actively with AR to re-engage him in suitable education provision and recommended this intervention would be enhanced via graded exposure keywork sessions. Keywork sessions commenced with Ms. Michelle Warner, On 11th January 2022 and continued regularly until 15th March 2022 when AR requested not to have any more sessions.

43. Following a change of care team (the reasons for which are detailed below), AR did somewhat engage with Dr. Molyneux and Ms. Kate Morris from October 2022 to February 2023. In January 2023 it was clear he did not want access to therapeutic intervention and only wanted to consider medication. During this period of intervention, the family reported challenges with attending school and anxiety going out the house and some positive improvements with AR attending education and conflict at home reducing.

44. On 16th January 2023, AR stated he did not want to engage in therapeutic intervention. A final appointment was offered with Ms. Morris on 1st March 2023. AR did not want to come and no further direct case management appointments were offered. This was shared with the multi agency team around AR at a Team Around the Family (TAF) meeting on 2 March 2023. AR had reported wanting to continue to use medication and contact with AR and his father continued with Dr. Molyneux although this was often via email or telephone at the request of the family.

45. On 27 February 2023, an appointment was attended by AR with Dr. Molyneux and there remained contact via email with the family. On 18th September Dr. Molyneux offered a face to face appointment and when this was not attended he went to the family home to visit AR but AR actively avoided coming into contact with Dr. Molyneux. A further appointment was offered but not attended on 25th September 2023, at this point medication related to melatonin only which AR had reported helped with his sleep routine.

46. Mr. Coppard continued to have some contact with AR's parents for family therapy from 2022 until 23rd April 2024 when it was decided to close the family to therapy.

Particular Issues

Engagement of Young People

47. Sefton CAMHS is a consent based Service so if a young person with capacity refuses to be seen or disengages from the Service their wishes and choices are respected. My understanding is that at no point was AR forced to see a practitioner or accept treatment when he was not consenting. At the same time the Service has a duty of care in line with the Children' Act 1989 to promote the welfare of children and young people who are reluctant to actively engage in treatment, especially in the context of a disability such as ASD. The Service works hard to maintain a relationship and try to identify opportunities to intervene in a helpful and consent based way. The Service also recognises the evidence for parent led intervention such as parent groups and parent or family focussed intervention (family therapy) and these are offered when they are likely to impact positively on the outcomes of the child and where consent by parents is provided.

48. However, Sefton CAMHS has limited ability to treat an individual and impact positive change if someone disengages from treatment. The only option at these times it to offer intervention to parents to effect positive change indirectly. There is evidence that this occurred in AR's journey.

49. AR initially attended appointments with Mr. Skott Morgan. Mr. Sam Coppard was then involved and despite regular contact focussing on AR's goals, engagement was challenging. Poor engagement by AR in initial telephone appointments was proactively responded to by offering Face to Face appointment despite restrictions due to COVID. After the first two appointments AR expressed he did not want these to continue.

50. When trying to re-engage a young person the Service accesses their wishes and feelings usually via their parents/carers and ideas from them or their family of activities that might engage them and the Service takes a problem solving approach to engagement issues. For example, where is their preferred venue to be seen, would modality of delivery impact and characteristics of their healthcare professional. There is evidence that appointments were offered at the venue preferred by AR. This is evidenced in the records of Mr. Coppard, Ms. Steed, Ms. Warner and Ms. Morris. Dr. Molyneux, a Consultant Psychiatrist was also very flexible offering home visits. All practitioners demonstrated an attempt to make appointments at a convenient time.

51. For AR a female case manager had been allocated as this preference had been shared by his parents. Appointments were offered at a local health care base and later were offered at home. Appointments were offered on the phone and by video, as well as face to face to try to hear AR's voice. Young people who are struggling to access the Service are reviewed in MDT meetings and this occurred for AR on (26th May 2021, 16th June 2021, 18th and 25th August 2021, on 22nd September 2021 and on 12th January 2022, 23rd March 2022 and 18th and 25th May 2022, 29th July 2022, 8th March 2023, 10th April 2023, 31st May 2023, 4th October 2023 and 10th January 2024. MDT meetings enable multiple professionals from different backgrounds to share their views on what might help to engage a young person and when discharge is appropriate.

52. Even with the benefit of hindsight, I cannot see that any more could have been done to re-engage AR in the Service. If anything, there is challenge whether the Service should have closed him sooner on the basis of his reluctance to engage and the limited impact that parental work was seeming to have on AR's presentation.

Risk

53. My understanding from reviewing the records was that the primary risk through these contacts related to AR's functioning and prognosis for future functioning. AR was presenting as unwilling to go out or attend school and was anxious in social situations. AR was not at this point referencing any thoughts or plans to hurt himself or others and these concerns were not being raised by the family. The reason for referral in 2019 followed an assault on a peer, this poses a risk to others and was appropriately included in risk assessment. There are no reports that there had been aggressive acts outside of the house through the multiple multi agency contacts. In addition, there was concern about physical wellbeing when on 23rd May 2022 when AR was perceived to be physically compromised due to restrictive eating patterns. Risk of not going out and not engaging in social or educational activities remained a risk and remains a pressing concern throughout ARs journey with Sefton CAMHS.

54. Sefton CAMHS practitioners undertake bio-psycho-social assessments of risk. These risk assessments are holistic in nature and include reference to contextual risks, as well as risk to self, to others and from others. Risk assessments are documented on the system formally as "Risk Management Tool". In addition, 'Risk' is reviewed and monitored at every contact and should changes in 'Risk' be identified, clarification of the 'Risk' is

expected with a clear plan of how the 'Risk' can be mitigated. Support options for the practitioner recording increased 'Risk' include:

Clinical Supervision - this occurs on a monthly basis.
MDT – this occurs weekly
Consultant of the Day (consultant on base and providing cover each day)
Assistant Clinical Lead or Clinical Lead (physical presence each day)

55. With regard to safeguarding risks they can be escalated for supervision via the trust safeguarding team and contact with multi agency partners is also available.

56. On reflection we can see that the formal risk tool was not completed regularly enough, this should be completed every 3 months or when 'Risk' changes. The risk assessments on the file did include historic and recent risks and reference harm to others from the initial referral. Harm to others was not featured as a significant concern from February 2021. There were some concerns regarding aggression in the family home but the parents often minimised these incidents and were reluctant to seek formal help. In October and November 2021 there were concerns raised by his family regarding aggression in the home and the police were called. However, his parents were unwilling for this to be a focus of intervention, they believed this pertained only to within the home setting and conflict with parents and they felt they could keep themselves safe. There are reports of AR going missing on 17 March 2022 and possibly having a small knife on his person. It is reported the police returned AR home after this event but a multi agency review was not triggered. From CAMHS the missing episode was addressed in a face to face appointment the following day (18 March 2022). Although, AR refused to answer specifically with regard to carrying a knife, risk to others was reviewed as part of this appointment and no increased risk was recorded.

57. My direct involvement in the conversation with Anne Simpson, Lancashire Youth Offending Team re AR and 'Risk' has been set out in the narrative above.

Informal Complaint and Change of Care Team

58. On 25th May 2022, Ms. Steed took AR's case to the MDT meeting for consultation. This followed a joint appointment on 23rd May with Ms. Steed and Dr. Ramasubramanian. The following notes were recorded:

> *"Previously discussed at MDT on 26th May, 16th June, 18th August, 25th August, 15th September and 22nd September 21 and 23rd March and 18th May 22.*
>
> *15 years old with ASD and non-attendance at school for 2 years. AR currently has a placement at Presfield School but doesn't attend.*
>
> *He came in to see Lakshmi and Sam on Monday and has lost a lot of weight and looks poorly. His current measurements are weight 45.4kg height 172cm, so is significantly underweight. No pulse or BP was taken during the session. Sam is very concerned. A dietician prescribed him shakes / juices, but he didn't like the taste / sensation. AR is also complaining of chest pain and indigestion so has stopped taking his Sertraline.*
>
> *Sam feels that the family have a poor understanding of AR's autism and don't provide home cooked meals. Dad continues to request more medication for AR. Sam has advised the family to make a referral to Early Help. The school have also done a referral.*
>
> *AR has attended Presfield today and Sam is to ring them for an update later*
>
> *Dad asked for another Case Manager again."*

59. A prompt in the minutes for safeguarding concerns was completed as follows "*Sam Coppard to join Sam Steed in conversation with parents regarding current concerns for AR. Sam to discuss AR with Emma Walker-Riley today*." Actions were recorded as:

> "*Sam to request as urgent that the GP do bloods / physical assessment and ECG as AR is now high risk due to weight loss. (ask GP to assess if Axel needs to attend AED). If AR doesn't attend GP appointment, then Sam will contact Social Care.*
>
> *MASH referral to be done by Sam*".

60. Two patient safety incidents were recorded in relation to this meeting by both Dr. Ramasubramanian and Ms. Sam Steed. Incident 57912 was recorded by Dr. Ramasubramanian and referenced anger by AR's father and a disrespectful manner which left the professionals feeling distressed "*by both the neglectful attitude and the disrespectful manner of the Child's father*". Incident 57916 was entered by Ms. Sam Steed highlighting the difficult conversation that had taken place with multiple

complexities. When Ms. Steed had appropriately tried to address this with the family the parents requested a new case manager.

61. On 26th May 2022, I was informed by Mr. Sam Coppard that an incident was to be reported with regard to the parent behaviour of AR by Dr. Ramasubramanian and Ms. Sam Steed. It was my understanding that Dr. Ramasubramanian and Ms. Steed felt intimidated by the behaviour of AR's father during what was reported later by all parties as an emotional and difficult session. The Care Team had requested that this behaviour be addressed by me as Clinical Lead.

62. On 1st June 2022, I was made aware via email that an email had been sent by the father of AR challenging the outcome of the appointment on 23rd May 2022 and specifically the contents of the letter written by Dr. Ramasubramanian on 23rd May 2022. The content of the email has been shared but for ease the concerns raised by the family were as follows:

"Dear Sam and Dr Ram,

It was good for A and I to meet you on Monday 23/05/2022.

I am writing to you because I received your letter/report about the meeting. I was astonished by some of the content of the letter.

The following are some corrections to the statements made in your letter.

1. A eats breakfast. He makes himself cereals with milk and juice or smoothie. In addition, mum makes him egg toasts when A is awake, which is most mornings. A makes himself a butter toast when he wants.

2. I don't know what you mean by "A does not have a fixed meal time..." As far as I know, A eats breakfast if he wants to, lunch, dinner, tea, cookies and sweets, and our fridge always has lots of ready made foods and sandwiches that A eats when he wants to.

3. When A took Sertraline the second time, I made sure that he ate his breakfast before I gave him the tablet. He didn't take it "in empty stomach." On the third day, he complained again of the heartburn. I said this in our meeting.

4. I was not there when A discussed alcohol with you but this is what he told his parents of what he meant. He told us that he asked you that if A reduces anxiety/fear in people who take it, how come there is no medication which is as effective. May I advise that when A makes an unusual statement, you should ask him to explain or what he means?

5. We (the parents) don't agree with "There were significant concerns around an adult monitoring his medication. Unfortunately A wants to take it himself and there is no consistent adult monitoring it due to work related commitments." If this what A said when I was away from the meeting, you should at least have given me the opportunity to explain or to respond. You should also mention the source of such incorrect statement.
I would like to confirm that we, as responsible parents, did not have any concerns or difficulty managing A's medication. Especially when both of you explained to him that a parent will keep and give him the required daily dose of Sertraline. I took over that responsibility when A was advised to resume his medication and have it after food intake. Since the beginning of the prescription of the anti anxiety medication, A had insisted that he wanted to manage the medication himself that he was not a baby. He was careful enough for us to accept his decision and so far there haven't been any problem that we weren't aware of.

6. The following statement is false: "...there is no consistent adult monitoring it due to work commitments." How do you possibly know? Since I came from doing a school run a few months ago and found A was missing, I have alway been available and I am with A at all times. I only go to work when A's mum is at home. That's the truth.

Having said that, it is safe for A to manage 1 strip of Sertraline at a time as instructed. We also make sure that he takes his daily dose.

7. On physical health, I don't know if you heard me. I explained that the dietician has issued shakes and (enriched) juices as well as tips for A, such as trying various ready-made foods, taking supplements. A doesn't take the drinks but can change from time to time, therefore, we keep them in the house just in case. There is nothing else the dietician can do and we understand this, so there is no follow up to do. We have vitamin supplements as well. I told you that A is not regarded as having eating disorder for his GP to refer him to the eating disorder clinic. I said that A has a small frame just like I

was, and is not as unhealthy as you perceive him to be. However, he is likely to be low on vitamin D for staying inside the house and we are thankful to you that you ordered his bloods to be tested.

I hope this helps 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.

I look forward to hearing from you.

Many thanks,

[AR's Father]

PS: Sam please forward this email to Dr Ram. Thanks"

63. I was on annual leave from Friday 27th May 2022 returning to work on Monday 6th June 2022. I was copied into an email from Ms. Sam Steed (08.06.2022 18:52) outlining her concerns regarding AR and the family. I had requested updated information prior to contacting the family.

64. My role as Clinical Lead was to address the distress reported by Ms. Sam Steed and Dr. Ramasubramanian via incidents reported, verbal and email contact. In line with the preventing violence and harassment at work policy a conversation would involve, in the first instance, resolving any concerns from the parents or family that had been raised. I had been made aware that the family had raised concerns. My role at this point was to resolve the complaint from the family, to re-engage the family and AR in therapeutic work AND to ensure that the family were aware of expected behaviours when engaging with health care professionals in Alder Hey and specifically Sefton CAMHS.

65. On 9th June 2022, I contacted the family and spoke to parents of AR, the Father was clearer on the phone with Mother being present in the background of the call. I recorded the conversation as best as I could contemporaneously and understand this document has been submitted. This is not recorded on the EPR as it pertains to a complaint and incident reporting rather than the Child's record per se.

66. The purpose of this call was to understand the parental position but to be clear regarding the Service responsibilities to clinical delivery. I was clear that medical opinion cannot be changed, so its unlikely that that the letter will be amended and that the Service wanted to continue to work with AR and the family at this time.

67. During this phone call the parents praised Ms. Steed for her support of AR and for writing reports to get AR the right school place. They shared school had been a difficult situation for AR as his friends had gone to Christ the King but parents chose Range High School for AR as AR's older sibling attended there after having a difficult time in AR's preferred school. AR's father shared he regretted this decision, "many regrets". AR's father shared that AR reported being bullied in school, a culture of bullying and that he felt scared attending, felt that they were fighting many battles looking at assessment for ADHD and ASD. The parents reported that before they could resolve the issues, AR took matters into his own hands and things fell apart. With regard to the current relationship with Ms. Steed, AR's father referred to it as a "bad marriage". Specifically, AR's father said that he felt Ms. Steed was prejudiced against the parents revisiting the point about cooking, parents reported that they were told what to cook for AR but did not feel that this was the correct diet for him, was too much oil and too much spice. AR's father reported they had taken advice on board and had cooked different meals but often AR would only eat a few spoonfuls and as this food was not eaten by the rest of the family it was often thrown away so they felt it was not working. AR's father stated he felt criticised by Ms. Steed.

68. AR's father stated he was told to attend courses eg Riding the Rapids course, AR's father reported he had resisted this as they had previously attended Parenting 2000 and accessed a parenting group of 2 hours per week. AR's father reported he did not agree Riding the Rapids would be helpful. AR's father stated that he felt threatened with social care and felt the family were being threatened to be broken up. AR's father reported he was open and wanted to help AR. He reiterated there was nothing personal about Ms. Steed, he wanted to thank her for all she has done for the family. Reference was made in the meeting to AR sharing concerns to professionals to get Dad into trouble. I asked about concerns regarding physical assault, AR's father was open that this had happened historically and had been due to physical chastisement and there had been no recent concerns.

69. The outcome of this call was that parents were reporting that AR had said he did not want to meet Ms. Steed again and wanted Mr. Sam Coppard to call the family. A preference for a female case manager was shared. A meeting was arranged with the parents, myself

and Dr. Ramasubramanian to discuss the letter. A discussion re family therapy was also recommended.

70. On 14th June 2022, I was copied into an email Dr. Ramasubramanian had written to Dr. Russell (Psychiatry Lead) to request reallocation to a new psychiatrist in view of the behaviour of his father and the tone of emails received. I also understood that on this date there was to be a professionals meeting regarding the family. I note from the records that a meeting did take place between the school, Sam Steed and Dr Ramasubramanian. It was noted that a referral to Lancashire Children's Social Care would be considered by the school regarding his non-attendance at school and the difficulty in getting to see him. An Early Help referral had already been completed.

71. A follow up meeting was arranged via video and this took place on 22nd June 2022 from 11.30-12.45 hrs. I made a note of this meeting in the records on 24 June 2022. Dr. Ramasubramanian and I met with AR's parents. During this meeting safeguarding concerns were again revisited and there was no evidence that new concerns regarding physical chastisement were being raised. There was concern regarding AR's weight and medication compliance, the parents shared that they were trying to provide food for AR to eat but did not think buying him takeaways when he wanted them was always the answer. The 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.

72. In June 2022, in my view the relationship with Ms. Steed as AR's case manager had broken down and this could not be retrieved. This was my understanding from both parties. On 25th May 2022 during safeguarding group supervision it is stated "*Sam Steed feels unable to continue as case manager due to Dad's response to her practice and work with AR*"; this was consistent with themes raised in the incident. AR's parents had shared that they felt it would be difficult to continue working with Ms. Steed after feeling so judged and they did report AR wanted a change of case manager.

73. There was of course a risk that AR would experience a set back in engagement in meeting a new team especially as he had built trust with Ms. Steed. However, on review, since January 2022 AR had attended one face to face appointment with Ms. Steed, had attended on the telephone on one occasion and on video on one occasion and had experienced the joint appointment. That said it was clear that the period of engagement under Ms. Sam Steed was the best period of engagement the Service had experienced. I was also aware that there were concerns regarding medication compliance and physical wellbeing which would require regular face to face appointments this would be difficult to achieve if the parents are actively not wanting contact with their case manager.

74. On balance, it was my view that continuing to offer appointments with Ms. Steed would be ineffective and reduce the likelihood of monitoring any risks. In addition, a lack of attended appointments with a case manager where the relationship had broken down would limit the Service's chance to hear AR's voice and to monitor his physical and emotional wellbeing. It was on this basis that I recommended a new case manager, Kate Morris, should be assigned. This new case manager had been present in MDT meetings so was aware of the historical concerns pertaining to AR's engagement and parental views. The new case manager had space to see children at Southport Hub so could offer face to face appointments. It was also relevant that during the complaint resolution meetings AR was 15 years old and it is appropriate to make decisions with parents under the zone of parental responsibility.

75. With regard to changes in case manager I am aware that AR experienced multiple changes in case managers during his journey with CAMHS. Initially he was seen by Mr. Morgan, who left, he was reassigned to Mr. Coppard when Mr. Coppard joined the Service and then direct work was offered by Ms. Steed (alongside keywork by Ms. Warner and Psychiatry input from Dr. Ramasubramanian) and then by Ms. Morris who became the case manager for AR with Dr. Molyneux providing psychiatric oversight. With respect to the impact of this on AR it was my understanding that AR had previously engaged in sessions with Ms. Warner and had been able to share his views with her on keyworker visits. AR had also talked in sessions with Ms. Coppard. Although a change in case manager is never ideal, I had limited options at this point in AR's journey.

76. AR attended a face to face appointment between September and December 2022 and four telephone contacts were completed. There is evidence in the notes of Ms. Morris working hard to build trust and develop a working relationship with AR, for example she

accommodated specific and contradictory requests for face to face and clinic appointments.

77. The decision to change AR's consultant psychiatrist followed an incident raised by Dr. Ramasubramanian (incident number 57912) and a further communication by Dr. Ramasubramanian that she did not feel comfortable continuing to work with the parents, due to the parents' (particularly the behaviour of AR's father) at the appointment on 23rd May 2022. The parents did engage in a resolution meeting with Dr. Ramasubramanian and were able to take on board the points raised during that meeting. However, on balance it was felt that a fresh start to work with another Consultant Psychiatrist was the best course of action to maintain a functional clinical relationship whilst discharging a duty of care to health professionals. On that basis, a change of Consultant was facilitated. Dr. Molyneux who had clinic space in Southport (so easier to access by the family) was allocated to see AR and their first completed meeting took place on 1st August 2022. Although an earlier appointment on 19th July 2022 had not been attended and a home visit was completed by Dr. Molyneux as a consequence. AR came to clinic on 1st August 2022 to commence appointments with Dr. Molyneux.

Safeguarding

78. With regard to the safeguarding concerns raised to me locally, these included concern re physical assault/chastisement by dad and concern that the family were neglecting AR's physical needs by not providing enough of his preferred food for him to eat contributing to weight loss. There was also some concern regarding medication monitoring. Ms. Steed shared a concern about how the parents had presented on 23rd May 2022 and questioned whether the parents were engaging in an open way with Sefton CAMHS. Ms. Steed had heard AR share views that this brother was in a wheelchair because of his parents and that he had hit him before; he had also shared he was not being given food he liked or wanted to eat at home so was not eating and had lost weight. I was also aware of the initial referral of safeguarding concerns regarding risk to others in 2019 although that was not raised as a concern at this point.

79. With regard to the allegations of physical chastisement of AR, these were documented in the records and had been shared with the social worker at the time during a phone call on 18th August 2021. Further follow up for these allegations had taken place with a home visit and it is recorded in the notes on 1 October 2021 that social care had closed. With no new information and with the knowledge that the concerns raised had been previously

investigated, I did not feel there was enough evidence for me to raise a safeguarding concern.

80. In addition, with regard to the low weight, the parents had been raising this as concern for over a year and had been seeking help to make changes to encourage AR to eat more. At the complaint resolution although the parents did not consent to adding eating onto the care plan they did consent to physical monitoring and were aware that should concerns remain and weight was not restored this would have to be a focus of CAMHS work and would increase safeguarding risks.

81. My understanding was that there was a professionals meeting planned for 14th June 2022 and this would be an opportunity to review risks from the multi agency partnership supporting the family. I was also clear with Ms. Steed that should she have concerns regarding safeguarding, it would be appropriate for her to raise this directly. I understood these concerns were already being raised in MDT meetings and indeed they were logged on 25th May 2022; further to which safeguarding supervision was accessed to guide next steps. My understanding was that if a referral was deemed appropriate this would be completed. From my direct contact with the family and in my capacity as resolving the complaint I did not think the threshold for child protection was met so I did not make the referral. I was aware of the risks within this family outlined above and was confident that following the complaint meeting a care team was in place in a timely way to review risks recorded and to raise concern should there been any change in presentation.

82. On 19th July 2022 I was sent an email by Ms. Steed, which also included Dr Molyneux and Colette Rossiter, Operational Support Manager. She was frustrated that the school had not come back to her. She felt there was a serious safeguarding issue and that a new referral needed to be made. She was concerned that Early Help was not the right resource. I cannot recall if I had any direct discussions regarding this at the time but I note that Dr Molyneux picked this up and suggested a home visit and was involved in further emails and meetings.

83. To further follow up, I requested an update regarding AR's physical presentation on 19 July 2022, which was kindly provided by Dr. Molyneux and provided some reassurance. A further email confirmed AR had regained some of this lost weight. I exhibit the email chain as **VK/05 –** AHCH000230 .It was clear as part of the outcome of the complaint resolution that should physical health be compromised and should the family not be responding to this in an appropriate manner then this should be escalated.

84. In summary, I think that the explicit safeguarding concerns were properly managed. Allegations of physical assault had been previously investigated, with no new concern raised and there was a plan in place for how the risk could be managed (with respect to physical wellbeing). With hindsight, there remains a concern that the parents were not being fully open with Services and were opting to share only information that they felt was relevant: This can be a feature of ‘disguised compliance’. At the time, the parents of AR did reach out for support and share their concerns and appeared to be a strong advocates for AR which is not usually consistent with ‘disguised compliance’. In addition, they had accessed parental only support and continued to engage in family therapy past the point of AR not actively being in treatment. It is also true that the parents felt quickly threatened by services and could become defensive. On occasion, it is noted that the parents reacted in an aggressive or intimidating manner to professionals when challenged and with hindsight this is a cause for concern. However, at the time, I was assured that this was not consistent across all practitioners and my view as clinical lead was the safest way to support the family and AR was to continue with active engagement when possible and try to effect change with whoever would work with us- which was largely the parents.

85. With regard to Ms. Steed’s view of safeguarding referrals, I was confident Ms. Steed knew that a referral could be made without parental consent, Ms. Steed is an experienced social worker and the Trust safeguarding training is clear that concerns can be raised without parental consent when we are concerned regarding imminent harm.

Involvement With Other Agencies

86. My direct involvement with other agencies is limited to the EHCP advice submitted , a conversation with Anne Simpson from YOT and an email to YOT (copying in FCAMHS). However, even from that limited involvement, I acknowledge there was greater opportunity to link and work together more robustly.

87. There is evidence of multi agency communication on multiple dates by members of the CAMHS team (17th Dec 2019, 6th Jan 2020, link with YOT July 2020, 17th Aug 2021, 19th August 2021, 15th October 2021, 18th November 2021, 7th December 2021, 23rd December 2021, 11th January 2022, 23rd May 2022, 2nd March 2023, 11th April 2023, 10th May 2023, 14th May 2023, 25th May 2023, 13th September 2023). There is also

evidence that when concerns were highlighted they were followed up with contact to school, to family or social care professionals.

Reflection on Events and Learning

88. On reflection, I think Sefton CAMHS were able to show a commitment to AR and his family over a long period time, including multi agency working and linking with other professionals to provide support despite his reluctance to engage at times. I recognise that despite this active engagement, AR made patchy and limited progress. AR had timely access to Consultant Psychiatry to support case management. This involvement included assertive outreach including home visits.

89. The questions that remain are how and by whom should the risk concerns related to the index offence have been identified and monitored, in circumstances were neither PREVENT nor MAPPA were deemed appropriate frameworks. For future learning, and with hindsight, further guidance about this would be invaluable. I acknowledge FCAMHS provided consultation but did not complete a direct assessment at the time of AR's initial offence. FCAMHS recommended a re-referral should risks arise in the future but it is not clear what the threshold for a re-referral would be. A potential trigger for re-referral would have been the aggression reported in the home. However, this level of aggression for children with complex needs is not significantly out of the ordinary and his parents reported feeling confident to manage risks. In addition, there was an incident reported when AR might have left home with a knife. It might be that an actuarial risk assessment should be better embedded in multi-agency systems so when risk arises, the historic risk is also taken into account to recognise if further concern should be flagged.

90. In terms of learning, I recognise that the quality of documentation throughout AR's record is not to the standard that is expected of CAMHS practitioners. Improvements have already taken place so the Electronic Patient Record BI dashboard can monitor session note completion. This is monitored on a weekly basis and assurance is provided to Trust board that all appointments have a corresponding session note completed. A different dashboard is present to support case management form completion during monthly 1:1s with practitioners.

91. Timeliness and quality of care plans is part of the Service's improvement journey, and we are working with our service users to co-produce meaningful care plans that can be

uploaded into the electronic patient record and shared with families who use our Service. At present care plans are still shared in a variety of formats which makes compliance harder to review.

92. With regard to uploaded documents, it is a concern that the process in place at the time of AR's journey with CAMHS has resulted in missing documents. It has also been a concern historically that scanned documents were recorded on a separate part of the system without automatic notification. Over the past 12 months, a thorough review of scanning has taken place. A new process for scanning documents from external systems has been rolled out. This means that across the Trust practitioners and services are able to upload external documents within the record and these are stored within the care note window providing awareness that they are there and also easy access to read the records. As a Trust/Service we have appropriately invested time in reviewing the care delivered to AR and his family and a leaning review has taken place which will outline further improvements.

93. Uploading of electronic communication remains a challenge with the EPR. This has followed a rapid shift in delivery to virtual delivery including use of emails and mobile phones to complete calls. Calls are not recorded directly into the EPR so almost by default need entering after the call is completed, this is a challenge when competing demands are present. The same is true for email correspondence. Whilst it provides a quick and efficient way to communicate with colleagues, lack of clarity about when and by whom emails should be uploaded means that there remains a risk emails are missing from the EPR.

94. With hindsight, my view is that there is a gap in Service provision for young people (and possibly adults) where there is a risk of offending outside the context of a diagnosable mental health difficulty. It is also true that the risk of extreme violence can exist without linking to an ideology and whether the current legal and service framework for public protection are adequate. Sefton CAMHS do not use a validated actuarial risk assessment system. I recognise the resource implications of adopting and implementing such a system, however it is essential that the events of 29th July 2024 are never repeated and to this end across Services we need to adopt a multi-agency system designed to identify children and young people who pose a risk others but do not have a mental health difficulty.

95. In March 2020 the Service was under significant pressure due to staff changes and staff sickness. In addition, at this time COVID impacted significantly moving care to virtual

delivery, although if risks required face to face appointments these were still offered. During 2020, there were multiple competing demands which impacted on documentation and oversight of documentation. Clinical time was directed by NHSE to clinical delivery which meant there was a reduction in the completion of service audits. For business continuity purposes clinical activity was prioritised for children and young people at immediate risk of harm. For AR there was some drift in his journey due to Service demands (March 2020 - May 2020 and again August 2020 - February 2020).

96. AR has never been diagnosed with a mental illness; he was also reported to be low risk of harm to self. There were no further incidents that increased his risk to others over and above the risks that were being managed as part of his referral order so during this period of unprecedented Service challenges there were times care was delayed. With regard to the potential impact of any such delay, I am confident that AR went on to develop key relationships with health care professionals through 2021, 2022 and into 2023. AR and his family accessed case management, medication oversight, key work and family therapy through which key interventions were offered. It is, however, also true that these interventions did not consistently make the impact we would want and were not always consistently attended.

Learning already implemented

97. A new Standard Operating Procedure (SOP) providing clear standards of documentation for CAMHS practitioners has been written and shared with staff members. Colleagues are aware of having to complete session notes in a timely manner and this is monitored on a weekly basis.

98. Improvements to the CAMHS front screen have also been completed providing easier access to key mental health difficulties and a visual prompt to complete documents such as risk screens and care plans. There has been an extensive training schedule for the new screens and staff in work within the Service have attended this training.

99. For scanning of documents, there has been a significant improvement to the functionality of the EPR to allow uploading of documents directly to the patient record. In addition, the admin team has developed an in-house scanning system which has significant improved confidence that external documents are uploaded in a timely manner and are available to see for other practitioners working with the young person.

100. With regard to risk screen updates, the care plan and risk screens have been merged in the new Expanse update to Electronic Patient Record to ensure more timely completion of both these key documents. The care plan and risk plan screens have recently been improved further in terms of coding risk and colour coding the open caseload so 'high risk' young people are much easier to identify. The BI dashboard has been improved so this information is more easily available during management one to ones and so assurance can be provided.

Recommendations

101. I have set out some suggestions below which may be of assistance to the Chair in relation to recommendations:

- Consideration of whether email functionality can be linked with EPR so emails and email conversations can be uploaded in real time to the patient record.

- Consideration of whether phone calls can be recorded onto the system to provide a contemporaneous and full record of what was discussed.

- The use of ambient AI – Lyrebird will be a useful improvement partner. Documenting lengthy contacts and spontaneous phone contacts takes a lot of clinical time. The use of AI note keeping will reduce this time and provide more capacity and time to upload emails and other documents in a timely way.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: ___Vicky Killen ______________________________

SIGNATURE

Dated: ______25.07.2025____________________________

ANNEX 1

Index to the Witness Statement of: Oonagh Victoria Killen

Exhibit No.	Inquiry reference No.	Document description
1	VK/01 – AHCH000233	Emails between Julia Dunn and Sefton Specialist CAMHS Administrator dated 16 December 2019
2	VK/02 – AHCH000231	FCAMHS Consultation Letters dated 11 February 2020 and 9 March 2020
3	VK/03 – AHCH000232	Emails regarding AR not having a Case Manager
4	VK/04 – AHCH000234	Email from Vicky Killen to John Hicklin, Anna Jameson and Anna Croll dated 1 May 2020
5	VK/05 – AHCH000230	Email chain between Vicky Killen, Dr Molyneux and Dr Ramasubramanian regarding AR's physical health between 19 July 2022 and 2 August 2022