

# Southport Inquiry

Witness Name: Lynsey Ann Boggan

Exhibits: LB/01 – LB/02

Dated: 29 July 2025

## THE SOUTHPORT INQUIRY

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### FIRST WITNESS STATEMENT OF LYNSEY ANN BOGGAN

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I, LYNSEY ANN BOGGAN will say as follows: -

#### **INTRODUCTION**

1. I am currently employed as Clinical Lead of Neurodevelopmental Services by Alder Hey Children's NHS Foundation Trust (the Trust), Alder Hey Children's Hospital, Eaton Road, Liverpool, L12 2AP.
2. I have been qualified as a Registered Nurse for Learning Disabilities (RNLD) since April 2004. I have completed a BSc qualification as a Specialist Practitioner for Learning Disability in 2008 at Chester University and have a Post graduate Diploma in Parenting Interventions from Manchester University. I have worked in Child and Adolescent Mental Health Services for over 15 years and have also been Clinical Lead of Halton and St Helens Autism Assessment Team as part of my career history.
3. I commenced working at Alder Hey on 29 June 2020 as a Specialist Practitioner working with children and young people with Learning Disabilities and Autism. This post was within the Liverpool CAMHS team. As I had previously managed and led autism diagnostic services, I was asked to provide clinical support to the ASD diagnostic service two days per week. I commenced as Interim Head of Service for the autism spectrum disorder assessment Team at Alder Hey on 1 November 2020. Following this period of working within a split role, it was agreed by the Director of

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Community and Mental Health Services on 15 March 2021 that a full-time head of service with skills to lead clinically was required. I then gained the post as a secondment for 12 months and this post was eventually made permanent on 1 August 2021.

4. On 1 May 2025 I was appointed as Clinical Lead for Neurodevelopmental Services.
5. This witness statement is made to assist the Southport Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 14 July 2025.
6. I make this statement from review of AR's records held by the Trust, my own recollection, from discussion with colleagues in the service and from my professional knowledge working with Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) Services.

## **BACKGROUND**

7. Since 2020, there have been significant developments in the field of neurodiversity. Research has demonstrated that neurodevelopmental conditions present as complex and overlapping profiles, with a substantial proportion of children and young people meeting diagnostic criteria for both Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) (Simonoff et al., 2008). There has also been a notable shift in societal and clinical perspectives, with services now adopting neuro-affirmative approaches that recognise and value neurodiversity, rather than viewing autism and ADHD as deficits or impairments requiring correction (Kapp, 2020; Department of Health and Social Care, 2021).
8. Current best practice utilises a strengths-based framework, focusing on reasonable adjustments within the child or young person's environment to support their individual needs (NICE, 2021). There has been a significant increase in the number of requests for neurodevelopmental assessments, not only within Sefton, but across the Cheshire and Merseyside area, as well as nationally and globally (NHS Digital, 2023).
9. In response, the Cheshire and Merseyside Integrated Care Board has prioritised neurodiversity within its strategic plans and established a regional recovery

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programme. This initiative aims to reduce assessment waiting times by providing early intervention and support, ensuring that young people can access appropriate services without being solely dependent on a formal diagnosis. As part of this programme, a new clinical model has been developed which recommends the creation of integrated neurodevelopmental services where ADHD and ASD are assessed concurrently, alongside other conditions such as mental health difficulties, Developmental Coordination Disorder, and Developmental Language Disorder, within a multidisciplinary framework (NICE, 2021; NHS England, 2023).

10. I have participated in the regional recovery programme meetings and oversight board and have contributed to the Alder Hey Children's NHS Foundation Trust's transformation programme. As a result, the Trust has agreed to develop an integrated neurodevelopmental service from September 2025. To oversee this work, the role of Clinical Lead for Neurodevelopmental Services was advertised in March 2025, to which I was appointed on 1 May 2025.
11. The Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) services at Alder Hey Children's NHS Foundation Trust have developed significantly over time. Initially, both diagnostic pathways operated under the umbrella of the Community Paediatric Service, with referrals for ASD, ADHD, physical health concerns, and other paediatric issues submitted via a single referral form. I understand that this was the case when AR was referred for assessment in 2019. In March 2021, a Trust-wide programme was launched to restructure these services, resulting in the separation of referral pathways; dedicated referral forms were created for ADHD and ASD respectively and separate waiting lists and waiting times were reported via our business intelligence system dashboards.
12. The primary focus of both services was diagnostic assessment. At that time, the ASD service was commissioned solely to undertake diagnostic assessments and signpost families to relevant support agencies within the community, including voluntary sector organisations and other commissioned services. The ADHD service also operated mainly as a diagnostic pathway but included a treatment arm. Children who met diagnostic criteria for ADHD and presented with significant needs were offered appointments at a medication initiation clinic. Here, the benefits and risks of ADHD medication were discussed with families to support shared decision-making regarding pharmacological intervention and whether this would be adopted as an appropriate treatment option for the child or young person.

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13. Both services functioned independently, each with its own clinical lead. I have served as the clinical lead for the autism diagnostic service. The design and delivery of these services have been closely aligned with evidence-based practice, adhering to National Institute for Health and Care Excellence (NICE) guidelines for ASD and ADHD assessment and treatment (NICE, 2025; NICE, 2021). Multidisciplinary teams with appropriate expertise were established to ensure high-quality and compliant diagnostic assessments.

## **Factual narrative of involvement**

14. I was not employed by the Trust at the time of AR's referral for ASD assessment. My only direct contact with AR was in a virtual appointment on 3 February 2021. This was prior to my formal full time role as Head of Service for the Autism Spectrum Disorder (ASD) team commencing on 15 March 2021. The majority of this narrative is, therefore, taken from review of AR's records held by the Trust.

15. AR was referred to the Community Paediatric Service on 14 August 2019 by his General Practitioner, Dr Emily Arnold, with a request for assessment for both autism spectrum disorder and attention deficit hyperactivity disorder (ADHD).

16. Dr Arnold noted concerns including poor eye contact and marked hyper fixation on specific interests. She also highlighted a family history of ASD, as AR's brother had a confirmed diagnosis. It is recognised in the literature that ASD has a genetic component, and a family history may increase the likelihood of occurrence in siblings (Tick et al., 2016; Sandin et al., 2017). This referral was logged by our referrals team and added to the Meditech system on 18 August 2019.

17. The referral was accepted by the Community Paediatric Department, and AR was added to the waiting list for an initial assessment by a consultant community paediatrician. At that time, referrals were managed chronologically. The average waiting time for a first appointment in the Community Paediatric Department at that time was eleven weeks according to data provided to me from Alex Hird, Senior Information analyst. I am unable to comment on why AR was waiting from 18 August 2019 until 2 July 2020 for this first appointment and can only speculate that the impact of the Covid-19 pandemic influenced this increase in waiting time.

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18. While awaiting assessment, an email was received from AR's school on 22 November 2019 and sent to the community paediatrics inbox. The email reiterated the referral for ASD assessment and provided details of a safeguarding incident, specifically that AR had reportedly contacted ChildLine and disclosed bringing a knife into school on multiple occasions. The deputy headteacher Joanne Hodson, expressed significant safeguarding concerns regarding AR's presentation at that time. She then followed up this email with another on 3 December 2019 requesting that the information she was providing plus the information in the previous e-mail be added to AR Autism referral to be reviewed. This second e-mail contained a timeline of events whereby the school staff had notice of significant difficulties AR was presenting with such as threats to harm himself and others.
19. I am unable to comment on whether a formal clinical response was made to the email by the Community Paediatric Department, or on the specific actions taken regarding AR's autism assessment following this disclosure. However, a review of AR's records indicates that multiple agencies subsequently became involved in providing support at this time, including social care, the police, and Forensic Child and Adolescent Mental Health Services (CAMHS). This multi-agency involvement followed an assessment by Ms Stephanie Hallaron from the Criminal Justice and Liaison Team, who had assessed AR after his arrest for possession of a knife on school premises. Ms Hallaron arranged for AR to be assessed by Forensic CAMHS and requested a referral to the local Sefton CAMHS team for additional support and advice. This referral was signposted to the Targeted Youth Service in order to address AR's forensic presentation at that time.
20. AR was offered a telephone consultation with Dr Acharya, Locum Consultant in Community Paediatrics, on 2 July 2020. AR himself was not present for this appointment, but his father participated in the consultation. The discussion focused on the reason for referral, which was to explore the possibility of ADHD or autism spectrum disorder. During the consultation, 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 Paediatric Team. However, it was concluded that AR's social communication differences and rigidities warranted further assessment, and the decision was made for AR to proceed to an autism assessment at that time.

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21. I am unable to comment on why Dr Acharya did not discuss further, concerns regarding ADHD symptoms with AR's father during this consultation. It should be noted, however, that AR was not present during the initial telephone appointment, and therefore his own views and experiences were not captured as part of this clinical consultation.
  
22. The autism assessment process was then initiated. In accordance with standard practice and NICE guidance, the administrative team contacted AR's school via email to request completion of a questionnaire detailing AR's social communication differences, any rigidities, and any sensory differences observed in the school setting. Obtaining a school report is a required element of the autism diagnostic assessment, as set out in the NICE guidelines (NICE, 2021).
  
23. AR was also placed on the waiting list to be seen by a highly specialist Speech and Language Therapist for a comprehensive social communication assessment, which is likewise a standard component of all autism diagnostic assessments. In addition, AR was scheduled for an appointment with a specialist neurodevelopmental nurse to obtain a thorough developmental history, covering the prenatal period to the present day, including details of social communication differences, rigidities, routines, highly fixed interests, sensory differences, and educational history. These appointments were booked in chronological order based on the original referral date.
  
24. AR's first appointment was with the highly specialist Speech and Language Therapist, Ms Katherine O'Dempsey, on 28 August 2020. The assessment was conducted via video call in light of Covid-19 pandemic restrictions, with both AR and his mother present. The purpose of this appointment was for the Speech and Language Therapist to observe and assess AR's social communication skills. Ms O'Dempsey administered a range of structured tasks, such as picture card activities and conversational exchanges, to elicit and evaluate AR's responses. These observations were systematically recorded and later incorporated into her formal report, which is utilised to identify features consistent with autism spectrum disorder, following the diagnostic criteria outlined in the DSM-5 (American Psychiatric Association, 2013; NICE, 2021). AR participated fully in all aspects of the assessment. The findings were detailed in the report dated 12 October 2020, which also included specific recommendations for AR's parents to implement at home.

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25. AR's second planned appointment was with Ms Kate Murphy, Neurodevelopmental Practitioner and Registered Nurse for Learning Disabilities, on 17 November 2020. This appointment was conducted via telephone with AR's father. During the consultation, Ms Murphy completed the comprehensive developmental history pro forma utilised within our electronic patient record system (Meditech). This assessment gathered detailed information regarding AR's history from pre-natal to the present day. The developmental history interview is designed to ascertain whether AR's differences are pervasive and longstanding, and to evaluate how these impact upon his well-being and daily functioning. The information collected is used as evidence when considering whether AR meets the diagnostic criteria for autism spectrum disorder, in line with the DSM-5 (American Psychiatric Association, 2013; NICE, 2021).
26. Following the completion of the two core assessments, together with supplementary referral information, emails, and school reports, AR's case was scheduled for discussion at the Multidisciplinary Panel Meeting in order to review all available evidence and agree on a diagnostic outcome. This meeting took place on 30 December 2020. Present at the meeting were Dr Sultan, Consultant Paediatrician; Ruth Mitchell, Highly Specialist Speech and Language Therapist; and Ms Dawn Devine, Physician Associate.
27. The professionals present documented within the records the information they had considered and detailed how AR's profile of needs aligned with the diagnostic criteria for autism spectrum disorder. After full consideration of the evidence, the panel concluded that AR met the criteria for a diagnosis of autism spectrum disorder, and this diagnosis was formally confirmed during the meeting, in accordance with NICE guidance (NICE, 2021). The panel also concluded that further assessment of potential ADHD symptoms was warranted.
28. In accordance with standard practice, as set out in the NICE guidance for autism assessment, parents and, where appropriate, the young person are invited to a feedback meeting to discuss the outcome of the assessment and to explore follow-up support services (NICE, 2021). At the time of AR's assessment, he was 14 years old. It is usual practice for parents to decide whether their child should attend the initial feedback meeting as parents and carers often chose to attend the initial feedback meeting themselves to ensure they can access the information given fully and allow time to process and absorb this before discussion with their child or young person. In

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this case, following a telephone call from an administrator, AR's mother agreed that parents would attend the feedback meeting via video call, which was scheduled for 20 January 2021.

29. On the day of the planned meeting, Ms Samantha Gaden, Neurodevelopmental Practitioner and Registered Nurse for Learning Disabilities, logged onto the Attend Anywhere platform to facilitate the feedback session. This is a video consultation platform that was approved to be used by the Trust during and following the Covid-19 pandemic. However, AR's parents did not join the video link as planned. Ms Gaden subsequently contacted the parents by telephone using the number provided in AR's records and was able to speak with AR's father. He explained that he was unable to access the video call at that time and agreed to receive the assessment feedback by telephone.
30. During the telephone call, Ms Gaden provided the diagnostic outcome to AR's father. At this point, AR's father expressed concern that AR's emotional well-being might be adversely affected by learning the outcome of the assessment, as AR did not believe he had autism. It was agreed during this conversation that Ms Gaden would consult with her manager to obtain further guidance on how best to support AR in understanding his diagnosis. AR's father agreed not to share the diagnostic outcome with AR until additional support and guidance had been provided by Ms Gaden and the autism team.
31. Ms Gaden then liaised with Mr Aaron Hobson, Modern Matron, myself, and Ms Kelly Dawber, Senior Mental Health Practitioner, a member of the CAMHS duty team, to seek clinical advice on the most appropriate way to proceed. The agreed plan was for the outcome of the assessment to be shared with AR in a sensitive manner by a team member with whom he had previously established rapport. It was further agreed that, if required, an appointment with CAMHS could be arranged to provide additional support for AR's emotional well-being.
32. It is standard practice within the autism assessment team to carefully consider the timing and approach to delivering a diagnosis to a young person who may be vulnerable to mental health difficulties, such as AR. The team takes a risk-informed approach, ensuring that appropriate support and risk management plans are in place before disclosing a diagnosis (NICE, 2021).

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33. The feedback appointment proceeded as planned on 3 February 2021 via video call, with AR and his father present, as well as myself and Katherine O'Dempsey, Highly Specialist Speech and Language Therapist, who had previously conducted AR's assessment. The information below is taken from both the contemporaneous medical notes and my recollection of the meeting.
34. During the appointment, I explained to AR, in a sensitive and supportive manner, the differences we had identified which were consistent with a diagnosis of autism spectrum disorder. I outlined how his profile met the diagnostic criteria, providing examples such as differences engaging with peers, spending considerable time on intense interests, and experiencing sensory differences, particularly in relation to his diet. AR remained quiet and passive during the session but appeared to be listening to the information provided.
35. We emphasised a neuro-affirmative perspective, explaining that autism is not an illness, and that young people with autism can present very differently from one another. AR was reassured that this diagnosis did not make him inferior to others, but reflected a different thinking style, for which support could be provided as needed.
36. We then discussed the content of the final outcome report, which included specific recommendations for support services accessible via parent referral. These included our Integrated Care Board's community partners, Advanced Solutions Community Network, which is commissioned to deliver courses and support for parents of children with neurodiverse conditions. We also discussed the Trust's Sefton Autism and ADHD Children's Service (post diagnosis), a separate support service set apart from the diagnostic team with a different line management structure. This service provides intervention and support for young people and their families following diagnosis and line manager responsible for this team is Helen McCarthy (Specialist Nurse RGN/RSCN Team Leader) This team provides assessment from Specialist Nurses and support staff to assist families in understanding the needs of their child or young person following diagnosis. If further intervention is identified one of the team can support the child/young person and families with personalised strategies. This might include behaviour management support or help to improve the child's emotional wellbeing. The outcome letter, which acts as a referral, was shared with this team, and contact details for parents to opt in to the service were included in the report.

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37. In addition, we discussed the role of voluntary sector organisations, such as Parenting 2000, which offers support, advice, and training to parents. As the autism assessment I was responsible for at that time, was commissioned only to provide diagnostic assessments, we explained that AR's case would now be closed to our service. Further support and advice would be available from our community partners, the Trust ASD/ADHD Children's Service (post diagnosis) (as discussed above) and the voluntary sector, as previously outlined. We also explained that any treatment or support required in relation to comorbid mental health difficulties that AR may be experiencing would be addressed by Child and Adolescent Mental Health Services (CAMHS), which is a separate department from the autism diagnostic team.
38. Due to the limitations of the video format, I was only able to observe AR's head and shoulders, which restricted my ability to complete a full assessment of his physical and emotional presentation. AR was given the opportunity to ask questions about the consultation; however, he chose not to do so and remained quiet and passive throughout the appointment. During this session, AR's father appeared to act appropriately and demonstrated supportive and caring behaviour towards his son. I did not identify any safeguarding risks either to AR or from AR at this time.
39. AR's father expressed concern about AR's level of anxiety and requested a referral to CAMHS to support his emotional well-being. It was agreed by all present that it would be beneficial for AR to receive support for his ongoing anxiety symptoms.
40. AR's father also requested that an assessment for ADHD be undertaken. I agreed to amend the final outcome report to include a recommendation that AR's school should refer him to the ADHD team for assessment, as this was the process in place at that time.
41. Following this discussion, AR's father sent me an email on 3 February 2021, outlining the reasons why he felt a CAMHS review, and an ADHD referral were necessary. Following liaison with the ADHD team I responded on 9 February 2021 to explain that the referral process for ADHD assessments had recently changed. In line with NICE guidance, evidence of ADHD symptoms must be observed in two or more settings, typically at home and at school (NICE, 2025). Therefore, it was new standard practice for the school to complete the referral, as they can provide detailed comments and observations to support the assessment.

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42. I also informed AR's father that I had consulted with the CAMHS manager and, on reviewing AR's records, could see that AR already had an open referral with the Sefton CAMHS service. The CAMHS team agreed to send out a review appointment, which took place on 4 April 2021 with Ms Samantha Steed, CAMHS Practitioner, Social Worker, who was allocated as AR's new case manager within the CAMHS service.
43. I reviewed the final outcome report, dated 12 February 2021 that was shared with family, Sefton ASD/ADHD post diagnostic team and GP and noted it did not include an action for school to complete an ADHD referral for AR. Therefore I completed an amended copy of the final autism outcome report, including the recommendation for the school to complete the ADHD referral. This report was sent out by one of our team administrators on 16 February 2021. Upon reviewing the records, I note that this report does not appear to have been copied to the school as I requested. As a result, I am unable to comment on whether the school received the request to initiate the ADHD referral or whether it was actioned in a timely manner.
44. Upon reviewing the clinical records, I can confirm that Ms Samantha Steed met with AR and his father during her initial CAMHS appointment on 9 April 2021. During this session, AR's father explained that he had requested a referral to the ADHD service for assessment and that AR was currently on the waiting list. I am unable to comment on whether Ms Steed checked the records at that time to confirm if an ADHD referral was active on the system. However, it is possible in my opinion, given that the referral process had changed recently, that Ms Steed noted the active community paediatrics referral open on the system and concluded that the community paediatricians were in the process of considering an ADHD diagnostic assessment. I must clarify that this is a supposition based on the circumstances and available information.
45. Additionally, the records indicate that AR and his father attended a routine Community Paediatrician review appointment with Dr Sultan, Consultant Community Paediatrician, on 7 July 2021. There is no evidence in the notes that either AR or his father raised concerns about ADHD symptoms requiring assessment during this appointment. At this time, treatment and support, including medication for anxiety, had been initiated by the CAMHS team. Consequently, the decision was made to close AR's case to the community paediatrics team.

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46. Dr Sultan wrote to AR's GP with the outcome of the consultation on 10 July 2021. He noted that AR had been started on Propranolol by the CAMHS team on 2 July 2021 but AR said he was not taking the medications due to what he had read on the NHS website. Dr Sultan suggested arranging an appointment with CAMHS to discuss the medications. He noted that AR's general health remained good and his appetite was ok. His sleep pattern of 2 am to 11 am was noted and that he usually watched Youtube until he went to sleep. Dr Sultan set out that he had explained to AR and his father that support for autism comes from support organisations and the education department and as community paediatricians they would have no role in it. He was therefore discharging him from community paediatrics. AR and his father had agreed with this.
47. Dr Sultan has set out his reasoning for discharge from community paediatrics in the letter above. In my professional opinion, it is standard practice for the community paediatrics department (which specialises in the care of children with physical health needs and developmental delays) not to retain cases open solely for the management of autism spectrum disorder. Autism is not a medical condition that requires clinical or pharmacological intervention. Instead, autism in children and young people is managed through early identification, multidisciplinary assessment, and the provision of tailored support, in line with national guidance (NICE 2018, 2021).
48. Best practice for the support of children and young people with autism includes person and family-centred care, psychoeducation, psychosocial interventions, and educational support through Education, Health and Care Plans (EHCPs), as well as reasonable adjustments under the Equality Act 2010 (NICE,2018). The SEND Code of Practice (2015) also provides statutory guidance to ensure appropriate assessment and support for children and young people with autism within the educational setting. Statutory guidance and national organisations also offer resources and support to families.
49. According to the records, neither AR nor his father articulated that he required an ADHD assessment at this time and AR did not present with other developmental delays. Furthermore, by this time, the ASD and ADHD diagnostic services had been restructured to operate independently from the community paediatrics service, in my opinion, further justifying the case closure to the community paediatrics department at that time.

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50. I further note from the records that AR's father expressed concerns regarding AR's attention difficulties and possible symptoms of ADHD during a consultation with the general paediatrician, Dr Elaine Weir, on 31 January 2023. In her clinic letter, Dr Weir requested that either the GP or the CAMHS service investigate these concerns further and initiate an ADHD assessment as appropriate. The clinic letter was copied to the GP practice and to Dr Anthony Molyneux, Consultant Psychiatrist at the Sefton CAMHS Team. However, I am unable to comment on whether this advice was actioned or if an ADHD referral was subsequently made.
51. I also note from the records that a referral was submitted to the ADHD service on 20 June 2023 and was logged on the Meditech system by the referrals team on 10 October 2023. This referral was completed by Ms Hayley Dawson, Teacher at Presfield High School and Specialist College, in what appears to be collaboration with AR's parents as there are two sets of comments within the referral referring to his presentation both at home and at school. Due to AR's limited school attendance at the time, certain sections of the referral form—such as those relating to losing things, distractibility, organisational skills, forgetfulness, leaving his seat, running or climbing inappropriately and whether he takes part in leisure activities—were left incomplete, with the school indicating they were unable to comment on these areas.
52. During the clinical triage process, Ms Donna Hampson, ADHD Nurse Specialist, rejected the referral on 5 February 2024. The reason provided was that there did not appear to be sufficient evidence from both home and school of significant differences in attention, hyperactivity, or impulse control to warrant further assessment. I am unable to comment on whether Ms Hampson reviewed AR's full medical record as part of her decision-making process. However, it is evident from the referral form that Ms Dawson did not include any examples or evidence of previous risk-related incidents involving AR, such as carrying knives or expressions of violence towards himself or others. I was able to review the rejected status of the referral by accessing the Meditech record via referral management desktop and can confirm that via this process autogenerated letters are produced back to original referrer, GP and parents in the form of paper letters to explain the reasons for rejection. However this letter is not visible to all users of the Meditech system. I exhibit a copy of the screenshot as **Exhibit LB/01 – AHCH000250**

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53. Upon review of the complete medical record, I can confirm that AR did not undergo a formal assessment for ADHD during the period he was under the care of Alder Hey Children's NHS Foundation Trust. Consequently, no treatment or support specifically relating to ADHD symptoms was initiated, as there was no confirmed diagnosis of ADHD. I feel it is important to note that if the referral received by school requesting ADHD assessment on 10 October 2023 had been accepted, the average waiting time for a first appointment in the ADHD Department at that time was fifty-nine weeks due to demand, exceeding the services capacity. This information was provided to me from Alex Hird, Senior Information analyst.
54. In conclusion, I can confirm that AR and his family engaged with all appointments related to his autism diagnostic assessment, including those with all professionals previously listed. Information and signposting advice was provided to AR and his parents both verbally and in writing, as documented in the speech and language therapy assessment report and the final outcome report.
55. As the majority of support services for autism spectrum disorder in this Sefton area are commissioned through the voluntary or community sector, I am unable to comment on whether AR and his family accessed the recommended courses, training, or interventions to which they were signposted.

## **Particular issues relevant to my involvement and improvements**

56. I have attempted to include all details and answers to all questions within the Rule 9 request within the chronology of my involvement and review of the records. I provide further information below to assist.

### ***ASD and ADHD service pathways***

57. As previously discussed, the ASD and ADHD diagnostic services within the Trust have undergone significant restructuring over time. Initially, both services operated under the Community Paediatrics Department until a formal restructure commenced in December 2019, resulting in the development of two separate services: the ADHD service and the ASD service. Each service established its own referral form, waiting list, and performance metrics for waiting times (NICE, 2021; NICE, 2025).
58. The primary function of both services was diagnostic assessment. Within the ADHD service, a limited element of ongoing support was available for children with

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significant symptoms requiring intervention and treatment. In these cases, specialist nurses led on the initiation and prescription of ADHD medications as appropriate, in accordance with NICE guidance (NICE, 2025).

59. However, the autism diagnostic service has made significant improvements over time and on 18 June 2021, the autism diagnostic team, in partnership with ADDvanced Solutions Community Network, applied for funding from the Transforming Care Programme to develop a formal post-diagnostic offer (NHS England, ADASS and Local Government Association 2015). This application was successful, and post-diagnostic services commenced in November 2021.

60. Key components of the post-diagnostic offer included:

- Young People's Feedback Workshop: The autism diagnostic team facilitated sessions for recently or previously diagnosed young people ages 11-19 years to discuss their diagnosis in a safe space, using a neuro-affirmative, strengths-based framework (Kapp, 2020). These workshops were delivered online by experienced clinicians and received positive feedback from attendees.
- Riding the Rapids: Recognising that some parents and carers require additional support to manage behaviours that are perceived to be difficult at home, the team began delivering "Riding the Rapids," an evidence-based, 10-week intervention developed by Manchester University NHS Foundation Trust (Stewart et al., 2020). This programme empowers parents to implement changes in the home setting, with positive evaluations from participants.
- Post-Diagnostic Training: ADDvanced Solutions Community Network provided post-diagnostic training for parents and carers across Sefton and Liverpool, both face-to-face and online. This six-session workshop offers essential information about autism, strategies for support, and ways to nurture strengths and potential in children and young people (NICE, 2013; SEND Code of Practice, 2015). Attendees consistently evaluated the training positively.
- Individualised Coaching: The offer also included individualised, needs-led, goal-based coaching for a small cohort of young people requiring additional support to process their diagnosis and address specific concerns, in line with best practice for personalised care (NICE, 2021).

61. The initial funding supported a 12-month pilot from November 2021 to November 2022. Following a positive evaluation reviewed by the Integrated Care Board (ICB), it

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was agreed that this post-diagnostic offer would be embedded as part of the core service specification for the autism diagnostic team and ADDvanced Solutions Community Network.

## ***Risk Assessment***

62. Within the CAMHS team at Alder Hey Children's NHS Foundation Trust, risk assessment is understood as a dynamic and ongoing process, which is updated in response to any changes in the young person's risk presentation. Review of the records confirms that risk assessments completed by clinicians within the CAMHS service were comprehensive and included AR's history of incidents involving violence and threats, as well as reference to his autism diagnosis as a factor in his emotional dysregulation (NICE, 2018; NHS England, 2019).
  
63. During the period of AR's involvement with the autism diagnostic service, there was no formal Meditech risk assessment pro forma in use for documentation. However, risk was assessed at every appointment, and appropriate action was taken in response to any safeguarding concerns identified. For example, specific consideration was given to the potential impact of AR's autism diagnosis on his emotional well-being, and a plan was implemented to provide support accordingly.
  
64. As part of the wider transformation programme within neurodevelopmental services, a standardised risk pro forma has since been developed. This new document enables clinicians to record all relevant risk factors for young people with neurodevelopmental conditions within a single, accessible form. The risk pro forma is now fully embedded in the neurodevelopmental service pathway and is held on the summary page of the Meditech system. Clinicians are required to review and update this document as part of the clinical triage process and before any and after appointments or consultations take place, ensuring risk factors and safety plans are clearly documented and readily accessible. As explained above, the autism diagnostic service has made significant improvements. The post-diagnostic partnership offer was comprehensive and co-produced with parent carers and young people with neurodiverse needs, reflecting recommendations for collaborative, person- and family-centred care (NICE, 2018; NICE, 2021; SEND Code of Practice, 2015).

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## ***Assessment/Waiting Times***

65. AR was referred for diagnostic assessment for autism and ADHD on 14 August 2019. His assessment outcome for autism was completed and communicated to AR and his family on 3 February 2021, resulting in a total waiting time of 77 weeks. While this represents a significant duration, it is consistent with national trends, as there has been a substantial increase in requests for diagnostic assessments for both ADHD and autism in recent years, both in the UK and internationally (NHS Digital, 2023). In the UK, waiting times for ASD (autism) and ADHD assessments have reached crisis levels, with over 200,000 people waiting for autism assessments and more than 130,000 for ADHD, and the vast majority of cases exceeding the NICE-recommended 13-week maximum—most wait at least a year, and some areas report waits of two years or more (NHS Digital, 2025, Autism.org.uk, 2024, ADHD UK, 2024).
66. The backlog has grown rapidly, with autism waiting lists almost doubling in two years, and severe regional disparities mean that in some regions, waits stretch up to five years or even longer (Catalyst Group, 2024, The ADHD Clinic, 2024). This mounting pressure on NHS services has led to calls for urgent action, including increased funding, workforce expansion, and better data collection, as delays leave thousands without timely support or diagnosis (Children’s Commissioner, 2024). The potential impact on long waiting times for assessment have been recognised as a key priority by the Cheshire and Merseyside Integrated Care Board, which is why a regional neurodevelopmental recovery programme has been established, as set out earlier.
67. Significant work is underway in this region to ensure that families, children, and young people can access appropriate support for potential neurodevelopmental conditions prior to the completion of a diagnostic assessment. The SEND Code of Practice (2015) supports this approach by introducing the graduated response framework within schools and educational settings. This framework requires that a comprehensive plan of special educational needs (SEN) support is provided for all young people identified as being in need, regardless of diagnostic status. In AR’s case, he had an Education, Health and Care Plan (EHCP) in place and was supported within a specialist school provision. Records also indicate that the family accessed additional support services, including Parenting 2000 and the Targeted Youth Service, both of which are available and do not require a formal diagnosis.

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68. In my view, the waiting time experienced by AR was in line with the current standard across the UK at that time. While I acknowledge that this is a lengthy period for young people and their families, significant improvements have been made within the autism diagnostic service at the Trust since AR's assessment. Since December 2022, we have embedded an Enhanced Fastrack Pathway for Autism Spectrum Disorder (ASD) assessment. This pathway is accessible to children and young people currently open to our Alder Hey CAMHS, eating disorder services, enhanced support teams, sexual assault and rape centre service, and clinical health psychology services. We recognise that the children and young people open to these services often require significant support and that a timely diagnosis can be vital for care planning, adapting suitable intervention and engagement.
69. The Enhanced Fastrack Pathway utilises a partnership approach, in which the referring team contributes to the assessment by providing a developmental history and observations from clinical encounters. Once these documents are shared with the autism diagnostic team, the young person is booked into the next available appointment with a speech and language therapist and consultant psychiatrist for final review and diagnostic outcome. This process has been positively evaluated by both young people and clinical staff, as it allows for prompt integration of diagnostic outcomes into care planning and intervention (NHS England, 2023).
70. Since taking up my role as Clinical Lead for Neurodevelopmental Services in May 2025, I have been working to implement this fast-track model across both the autism and ADHD diagnostic services. I am currently reviewing and updating the standard operating procedures to support this implementation. I exhibit a copy of the current procedure "Enhanced Fastrack Pathway for Autism Spectrum Disorder (ASD) Assessment" dated July 2024 as **Exhibit LB/02 – AHCH000251**.

### ***Post-diagnostic support and treatment for ASD and ADHD***

71. As discussed extensively above, post-diagnostic support for autism is primarily provided within the school environment and through community sector organisations, most of which do not fall under the remit of the Trust. Therefore, I am unable to comment on whether AR and his family engaged with the support services offered by these external providers. However, upon review of the clinical records, it is clear that during AR's involvement with the CAMHS service, his autism diagnosis was a key consideration in clinical consultations and risk assessments, as documented by

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multiple clinicians. Efforts were consistently made by the team to support AR's understanding and acceptance of his autism diagnosis, with evidence in the records of gradual improvement in his acceptance over time.

72. The records further indicate that CAMHS clinicians regularly signposted AR and his family to post-diagnostic services such as the "Riding the Rapids" programme and training/support offered via ADDvanced Solutions Community Network. These post-diagnostic resources were consistently highlighted throughout the case notes as integral to the care provided (NICE, 2018; NICE, 2021). In addition, AR received a period of cognitive behavioural therapy, which was adapted to accommodate his neurodevelopmental profile in line with best practice recommendations.
73. In my professional opinion, the interventions provided by the CAMHS team during the period that AR was open to the service were targeted and supportive of his autism diagnosis. However, as most of the post-diagnostic services referenced are not commissioned in the Trust and are not statutory, they required voluntary engagement by AR and his family.
74. In relation to the email correspondence between Dr Molyneux and Ms Kathryn Morris dated 15 May 2023, I am unable to comment on any specific actions undertaken by these clinicians following concerns that the family may not fully understand AR's autism diagnosis. It should be noted that it is not standard practice for the Clinical Lead for Neurodevelopmental Services to be notified of every young person with an existing autism spectrum disorder (ASD) diagnosis whose family is experiencing difficulties. As previously discussed, the service is primarily commissioned to provide diagnostic assessment, with a limited post-diagnostic offer.
75. I reiterate that, according to the clinical records—particularly following AR's autism diagnosis in February 2021—CAMHS clinicians provided focused intervention and signposting to enable the family to access appropriate community support, in line with national guidance (NICE, 2018; NICE, 2021). Examples from the records include:
- 8 April, 22 April, and 21 May 2021: Ms Samantha Steed met with AR and family to discuss his autism diagnosis, aiming to support him in understanding that no two children with autism are alike. She also suggested the Aiming High service,

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which offers mentoring to children and young people with disabilities to help increase independence in the community.

- 9 July 2021: Ms Steed discussed post-diagnostic support and training with AR's parents, including the ADDvanced Solutions Community Network and the Isabella Trust, a voluntary organisation supporting families of children with ASD. AR's father agreed to consider accessing these support services.
- 12 August 2021: Ms Steed discussed AR's case within the CAMHS multidisciplinary team, stating that following her adapted approach, AR was *"now more accepting as this has been reframed in terms of embracing and understanding his characteristics."*
- 15 October 2021: Ms Steed documented a Team Around the Family meeting, noting that "Riding the Rapids" parenting training would commence in January 2022. While I am unable to comment on Ms Steed's intent, it is reasonable to assume she wished the family to consider attending. However, it is documented that AR's father felt he had sufficient training, stating he was *"trained in"* managing AR's behaviours and did not perceive a problem with his parenting. There is a record of a referral to the Riding the Rapids programme dated 9 August 2022, but there is no evidence that AR's parents attended the course.
- 22 March 2022: Ms Steed discussed intervention options with AR and his family, noting that AR was on the waiting list for family therapy. However, AR himself did not wish to attend, so he was referred for adapted cognitive behavioural therapy (i.e, CBT tailored to his neurodevelopmental profile).

76. These examples demonstrate that post-diagnostic advice and signposting were provided in accordance with NICE recommendations (NICE, 2018; NICE, 2021). However, as engagement with most community and voluntary sector services is voluntary, it is not possible to confirm whether AR and his family accessed all recommended support.

## **ADHD diagnosis and support**

77. As explained above, I have confirmed that AR was never formally assessed for ADHD and did not have a confirmed diagnosis of this condition during the period he was supported by the Trust. Standard practice, should a young person receive an ADHD diagnosis, is for parents or carers to attend training courses to gain a better understanding of the condition and to implement reasonable adjustments within the home environment to help manage symptoms. NICE guidelines suggest that children

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with significant ADHD symptoms can be considered for medication if deemed clinically appropriate. Before commencing ADHD medication, standard protocol includes a thorough medical assessment—including a cardiac history—and, in some cases, an ECG and/or referral to a cardiologist if indicated. Only when a young person is declared fit following these assessments can medication be considered (NICE,2025).

78. ADHD medication in children is primarily designed to reduce core symptoms—namely inattention, hyperactivity, and impulsivity—by modulating neurotransmitter activity in the brain, particularly dopamine and norepinephrine pathways. Stimulant medications (such as methylphenidate and amphetamines) are most commonly prescribed and have been shown to improve concentration, decrease disruptive behaviours, and enhance overall functioning at home and school. Non-stimulant medications, such as atomoxetine, are considered when stimulants are ineffective or contraindicated. The aim is to support better academic performance, social relationships, and daily functioning, while minimizing side effects and optimising quality of life (Cortese et al., 2018; NICE 2025; Faraone et al., 2021).
79. As I am not currently a practising nurse prescriber, I do not feel it would be appropriate for me to comment on whether AR would have been prescribed ADHD treatment if he had received a confirmed diagnosis. However, a review of his records highlights significant risks related to dietary restrictions and periods of notable weight loss, which required monitoring and support from dietetic services. Stimulant medications—the first-line treatment for ADHD—are known to have side effects such as appetite suppression, which can lead to further weight loss in children and young people. Therefore, in AR’s case, stimulant medication may not have been appropriate due to these potential risks (Cortese et al., 2020; NICE 2025; Bolea-Alamanac et al., 2014).
80. Upon review of the complete clinical record, including disclosures from AR and his parents regarding concerns about AR’s attention, hyperactivity, and impulse control, it is evident that these issues were raised on multiple occasions during AR’s involvement with the Trust. In my professional opinion, there were some missed opportunities where an assessment for ADHD could have been considered and potentially undertaken. Completion of such an assessment may have been beneficial for the professionals involved in AR’s care, as it could have helped to better understand his needs and inform the interventions offered. However, it is not possible

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to conclude, retrospectively, whether a confirmed diagnosis of ADHD would have resulted had the assessment been completed.

## Involvement with other agencies

81. The ASD diagnostic service relies on information from the school setting to complete a thorough diagnostic assessment. In AR's case, the service's relationship with the school was positive, as the school report was submitted in a timely manner. The school also raised concerns via email to the Community Paediatrics Department to ensure relevant information was considered during the Autism Diagnostic Team panel conclusion meeting.

82. Upon review of the records, it is evident that multiple multidisciplinary meetings took place, including the diagnostic outcome panel meeting, as well as case discussions and professional forums regarding AR's presentation. His difficulties and needs appeared to be considered sensitively across the partnership agencies in Sefton.

83. Records show that AR accessed a wide range of services over time, including Children's Social Care, the Early Help Team, Targeted Youth Services, Parenting 2000, and CAMHS. There is evidence of effective communication and collaboration between these teams, as demonstrated by email correspondence and attendance at multidisciplinary meetings.

84. Overall, I consider that information was shared appropriately in AR's case. Safeguarding referrals were made at times when risk increased, in line with the Trust's safeguarding procedures and national statutory obligations (Children Act 1989, Working Together to Safeguard Children, 2018). On reflection, there is evidence of positive multi-agency working.

## Reflection on events

85. The only gap I have identified, as discussed in previous sections, is that clinicians involved in AR's care do not appear to have checked whether an ADHD assessment had been commenced, nor is there any evidence in the records of email correspondence with the relevant department to confirm the status of any ongoing

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assessment. In my view, this represents a potential missed opportunity for further assessment and support.

86. It is also my opinion that the Meditech Expanse system may have contributed to this gap. As noted, when AR's referral for ADHD assessment was rejected in 2023, the outcome letter was automatically generated and a physical paper letter sent to the GP, referrer and parents. However, this letter was not made visible within AR's clinical record for other clinicians involved in his care to review, or to enable a timely re-referral if required. This digital system limitation may have contributed to AR not receiving the ADHD assessment that was requested.
87. In conclusion, I have reflected on the events and processes described throughout this statement. It is important to note that, due to the nature of neurodiversity, young people in the UK with conditions such as autism spectrum disorder are at an increased risk of experiencing comorbid mental health difficulties including emotional dysregulation, anxiety and social isolation (National Autistic Society and Mind, 2021; NICE, 2018). AR disclosed that he struggled with anxiety and required support to go out independently, which is consistent with the elevated prevalence of mental health challenges in the neurodiverse population.
88. Although this is a key area of need, current CAMHS provision in the United Kingdom is not universally designed to support young people with neurodevelopmental conditions, and clinician experience with autism spectrum disorder presentations may vary significantly between teams. In my opinion, AR received a supportive service during his time with Sefton CAMHS. However, I believe that embedding more dedicated training and specific interventions—such as adapted cognitive behavioural therapy (CBT), and acceptance and commitment therapy (ACT) tailored for children with autism — within all CAMHS services will be essential for creating positive change. Ensuring that all neurodiverse young people who access CAMHS receive support from professionals with expertise in autism spectrum disorder is vital.
89. Positive steps have been taken within the Trust, including staff participation in the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) course for autism spectrum disorder and learning disabilities. This evidence-based programme enables practitioners to develop the skills required to adapt interventions and support families (Health Education England, 2022). Additionally, the implementation of the Enhanced Fast Track Assessment Pathway has enabled

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practitioners within CAMHS to more rapidly identify neurodivergent profiles and incorporate these into their clinical formulations.

90. Furthermore, the Cheshire and Mersey Integrated Care Board has established a dedicated workstream within its recovery programme, focusing on the creation of a standardised CAMHS pathway for young people with neurodiversity. This aims to ensure consistent access to intervention and support, with completion targeted for April 2026.

## Improvements

91. In summary, throughout this statement I have sought to highlight the improvements implemented across the Trust. However, I have added some further comments below which may assist:

- The introduction of the new Neurodevelopmental Assessment and Treatment Service from September 2025 will ensure that all children and young people are assessed holistically for possible diagnoses of ADHD, autism spectrum disorder, and other neurodevelopmental conditions. This integrated approach will eliminate the need for separate diagnostic pathways and waiting lists, enabling neurodevelopmental conditions to be identified, monitored, and managed in a timely manner. It is anticipated that this will support children and young people to better understand their own needs, reach their potential, and access all available support and training.
- We now have a comprehensive post-diagnostic offer for children and young people diagnosed with autism spectrum disorder, as detailed earlier in this report. This support is available to all children, young people and their families in receipt of an ASD diagnosis and includes interventions delivered in partnership with ADDvanced Solutions Community Network. Additionally, the Trust has established a partnership with the ADHD Foundation, which provides post-diagnostic support and training for parents and carers to help them understand and manage ADHD symptoms within the home environment (NICE, 2025).
- The ADHD treatment care pathway is fully embedded, and, following appropriate physical examination and assessment of symptom severity, children and young people who meet criteria can be offered medication, which is closely monitored and supported by our specialist prescribing nursing team. The introduction of a

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new risk assessment document on our Meditech electronic record system ensures that all risk-related behaviours are clearly documented and visible to all practitioners involved in a young person's care, enabling appropriate and timely clinical responses. Planned improvements to the Expanse system are expected to resolve existing issues with referral rejection documentation, although I am unaware of the specific timescales for completion. Improvements to CAMHS digital records now also include a new risk stratification process, enabling the classification and identification of young people requiring a higher level of support.

- The enhanced Fast Track Assessment Pathway will be embedded across the neurodevelopmental team, ensuring that children and young people referred for ADHD assessment are also able to access timely diagnostic appointments when appropriate. This pathway will incorporate a multidisciplinary team meeting approach, whereby clinicians from both the neurodevelopmental team and CAMHS will convene to discuss cases that are currently at risk, require expedited assessment, or are undergoing treatment and need a collaborative approach to support and intervention. This change is scheduled for implementation in September 2025 and, in my opinion, will further strengthen partnership working between neurodevelopmental and CAMHS services, enhancing the quality and coordination of care provided to children and young people across the partnership.
- Other ongoing work with the Cheshire and Mersey Recovery Programme includes the development of a neurodevelopmental profiling tool, similar to those implemented in Portsmouth and Cornwall, which will be completed collaboratively with the young person and their family. This tool will help identify strengths and differences in a neuro-affirmative and person-centred way and will generate a co-produced plan of support services tailored to each family's needs (SEND Code of Practice, 2015; Kapp, 2020).
- Also, following application process and agreed funding from NHS England, the neurodevelopmental team has recruited seven autism spectrum disorder peer support workers, all of whom have lived experience of neurodiversity. These peer support workers are embedded within the diagnostic team and have received additional training to support families who may face barriers in accessing appointments or require reasonable adjustments. The aim is to ensure that children and young people at risk of missing appointments or disengaging from the assessment process can receive tailored support from someone with lived

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experience, promoting greater understanding, engagement, and improved outcomes.

92. In conclusion, I believe that since my personal involvement with AR's diagnostic assessment in February 2021, both ASD and ADHD services have improved significantly. With the forthcoming internal merger to establish an integrated neurodevelopmental team in September 2025, I am confident that we will be able to provide a fully inclusive and supportive service that meets the needs of children and young people with neurodiverse profiles. This integrated approach will enable the delivery of a safe, efficient, and comprehensive service for all children and young people requiring neurodevelopmental assessment and support.

## Other matters

93. I can confirm that I have no other matters in relation to the inquiry to raise within my statement at this time.

## 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: ... SIGNATURE .....

Date: .....29 July 2025.....

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## Annex 1

Index to the Witness Statement of Lynsey Boggan:

<b>Exhibit No.</b>	<b>Inquiry reference No.</b>	<b>Document description</b>
1	INQ- AHCH000250	Meditech Screenshot of 5 February 2024
2	INQ- AHCH000251	Enhanced Fastrack Pathway for Autism Spectrum Disorder (ASD) Assessment dated July 2024