Witness Name: Anthony John Molyneux

Dated: 30/07/2025

THE SOUTHPORT INQUIRY

FIRST WITNESS STATEMENT OF DR ANTHONY JOHN MOLYNEUX

I, Dr Anthony John Molyneux, will say as follows: -

INTRODUCTION

1. I am employed as a Consultant Child and Adolescent Psychiatrist by Alder Hey Children's NHS Foundation Trust, Eaton Road, West Derby, Liverpool, L12 2AP.

2. Having graduated with a degree in biological sciences from the University of Cambridge in June 2001, I studied medicine at the University of Liverpool from September 2004, qualifying as a medical doctor in July 2009. I have been a Member of the Royal College of Psychiatrists since April 2014, and a Consultant Psychiatrist since July 2017. I have worked as a Consultant Child and Adolescent Psychiatrist at Alder Hey – specifically for Sefton Specialist Child and Adolescent Mental Health Service ("Sefton CAMHS"), where I have been the Consultant Psychiatrist attached to Multi-Disciplinary Team No. 1 ("MDT1") – since April 2019. I have held the Neurodevelopmental Lead role for the Alder Hey Psychiatry Consultants' group since July 2019.

3. This witness statement is made to assist the Southport Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 4th July 2025.

BACKGROUND

4. I became involved in the care of AR in July 2022, following the handover to me of his case from his previous Consultant Psychiatrist in Sefton CAMHS, my colleague, Dr Lakshmi Ramasubramanian ("Dr Ram"). The circumstances of the handover were,

as I understood it, a breakdown in the therapeutic relationship between Dr Ram and AR's father. Seemingly the situation, as indicated to me by Dr Ram, was that AR's father appeared to have quite a derogatory attitude towards women in general and towards women of black and minority ethnic ("BAME") backgrounds in particular. I recall that Dr Ram indicated that this attitude had been perceived by AR's hitherto CAMHS case manager, Samantha ("Sam") Steed, also; the sense was that this was a factor in Sam Steed also stepping down as AR's case manager around that time, although I have since discovered that in fact the reason for Sam Steed thus stepping down was that AR's parents had requested this.

5. The key clinical issues, as relayed to me by Dr Ram, were, firstly and most concerningly, AR's recent pattern of weight loss through restrictive eating, and secondly, his longstanding refusal to leave the house, which seemed to be due to symptoms of overwhelming anxiety in the context of an autism diagnosis. A key factor complicating the therapeutic approach to AR was his apparent refusal to engage with Dr Ram, and indeed an email addressed to me, Sam Steed, and our clinical lead Dr Vicky Killen from our then administration manager, Colette Rossiter, dated 19th July 2022, relaying a telephone message apparently from AR's mother, cancelling AR's first scheduled appointment with me due to AR's evident refusal to attend, reported: *"…he doesn't see the point, what else can be offered with Ant [the author, AJM] than he has with Lakshmi [Dr Ram]?"*; Colette also relayed that *"He is not taking meds"*.

6. In my subsequent review of previous correspondence ahead of meeting with AR or at least with his parents in due course, I noted Dr Ram's clinic letter of 7th April 2022 which, in relation to the sertraline medication Dr Ram had initiated for AR's symptomatic anxiety, concluded that: *"…should [AR] not benefit from [increasing the dose up to 100mg once a day, then, after two months,]…we will be able to conclude that medication is not the right approach for [AR] and it will be stopped. I will then be discharging [AR] from my care as [AR] does not present with any evidence of a mental health disorder."*

7. By the time of AR's next face-to-face psychiatric appointment with Dr Ram, on 23rd May 2022, it thus appears to have been the case that, particularly given that by that time AR had stopped taking his sertraline medication *"yet again"*, Dr Ram's foreseen discharge of AR from her psychiatric care at that point was precluded only by the

evident development of a new clinical problem on AR's part – namely, significant weight loss due to restrictive eating. This was thus the core feature of AR's clinical presentation, and the core clinical concern from a risk point of view, that was handed over to me by Dr Ram in the July. Especially given that AR had evidently refused to engage any further with Dr Ram after the 23rd May appointment, I felt that it was imperative that I at least saw him face-to-face, and preferably of course obtained an up-to-date measurement of his weight, that could give me suitable reassurance that his weight had sufficiently improved from the 45.4kg figure obtained on 23rd May, to an extent that would reflect a sufficient amelioration of the pattern of restrictive eating.

8. Following the email sent to me, Sam Steed, and Dr Killen by Colette Rossiter on 19th July 2022 at 9:18am (see para. 5, above), Sam Steed sent a standard "Reply All" message to Colette, me, and Dr Killen, very shortly afterwards, at 9:37am. It said the following: *"[AR] - Before and after being taken off as Case Manager at parents request I tried to escalate this with School - we were supposed to have a MA [I assume this to mean Multi-Agency - AM] mtg but School did not come back - not sure if Lakshmi [Dr Ram] managed to arrange anything. This is a serious safeguarding issue and a new referral needs to be made - I could not make contact with parents at their request to gain their consent or explain that a referral out is needed. Referral was made to Early Help and school were following up to see 'what parents want' (not sure where AR even features in all of this). It's not a matter for Early Help. Bw"*.

9. As there are certain ambiguities in the wording of this email (for example, it appears unclear from the text alone whether *"at parents request"* relates to *"being taken off as case manager"* or to *"I tried to escalate this with school"*; similarly, it appears unclear whether *"at their request"* relates to the parents wanting Sam Steed to make contact with them, or not wanting her to), I think it is fair to say that I did not get a completely clear sense of Sam Steed's thinking here. On the other hand, it did seem clear from the email a) that Sam Steed felt there to be a *"serious safeguarding issue"*, and b) that she felt that the level of concern was above that of "Early Help", but below that of Child Protection – in other words, at the intermediate "Child in Need" level of concern. This is apparent from the fact that Sam Steed refers in the email to the requirement to obtain parental consent for the *"referral out"*, by which she evidently means a referral to Children's Social Care. I knew that, as an experienced social

worker by profession, Sam Steed would know that, if she felt that the degree of concern was at the level of Child Protection, she could (and of course would) bypass the matter of parental consent entirely to make the referral to social care without delay.

10. Sam Steed quickly followed up the 9:37am email with a further message to Colette, me, and Dr Killen at 9:45am, which seemed to be more directed for my attention specifically: *"Sorry, just to add might be one for a home visit if possible"*. I replied to this at 10:36am, copying in our secretaries, confirming receipt, and requesting a visit be arranged for me to review AR at home on the afternoon of 28th July – i.e. within the standard 14-day response time for urgent psychiatric appointments.

CHRONOLOGY

11. I duly attended AR's home address at 3pm on the afternoon of Thursday 28th July 2022, as arranged. On arrival, I was welcomed into the living room area by AR's father; we were soon joined by AR's mother, although AR himself – I was told – was upstairs in his bedroom and was refusing to join the appointment; according to AR's parents, AR had absented himself just prior to my arrival. Though I had reviewed for myself the previous clinical notes and correspondence ahead of the appointment, and had received case handover from Dr Ram as above, I was keen also of course to acquire an up-to-date view of the case history from parents in their own words, including a sense of their present key concerns. Unsurprisingly, and in accordance with Dr Ram's handover, the issue of principal concern for parents appeared to be AR's weight loss due to restrictive eating, and also the background issue of longstanding refusal to leave the house; on the other hand, as regards the former, parents were able to provide me with some reassurance of their sense of an improvement in AR's weight since Dr Ram's last review in May, in line with AR's apparent *"latter embrace of the idea that healthy eating for him at present means eating considerably more than previously"*.

12. I probably spent an hour-and-a-half to two hours or so speaking with AR's parents, making sure I gave plenty of time for AR to put in an appearance, although he did not. I explained to AR's father that the nature of the physical health concerns meant that I would nevertheless need to see AR for myself sooner rather than later, although AR's father was very reluctant for me to go upstairs to AR's bedroom, ostensibly on account of this being likely – in his opinion – to cause AR further undue aggravation. Ultimately we agreed therefore upon an alternative plan (proposed of

course my me) whereby I would prescribe for AR a one-off dose of 5mg of diazepam as a mild sedative to enable him to attend for an appointment at our Southport clinic within the next few days, on 1st August. Such a measure, by the way, was and is no significant departure from standard clinical practice; diazepam as a 5mg "stat" (sole, one off) dose is a standard component of NHS Trust rapid tranquilisation protocols, and is very occasionally (although admittedly not *commonly)* prescribed on this sort of basis by me as well as other psychiatrists. A similar sort of scenario, for example, might be a proposal to prescribe 2 X 5mg "stat" doses of diazepam, one each to facilitate outbound and return holiday flights for a young person struggling with flying anxiety in the context for an autism diagnosis, say. In AR's case, as AR's father had parental responsibility, he was thus of course able to give legal consent for medication on AR's behalf, due to AR being under the age of 18; informed consent was thus duly obtained from AR's father.

13. The morning after the 28th July home visit, I was approached at our offices in Crosby by Sam Steed, who was understandably keen to know how the home visit had gone. In the course of the discussion that ensued, Sam Steed reiterated the fact that, as she had intimated in her email of 19th July (see para. 8, above), she had potential safeguarding concerns in relation to the family. The nature of these concerns appeared to relate to the sense she had obtained from her previous work with AR as his case manager, of past physical abuse of AR from AR's father when AR was a younger child, which appeared to have stopped when AR had progressed into teenage years only on account of the fact that AR was now physically able to fight back. The sense from Sam Steed was that although these allegations were known to social care and all other involved professional parties, the fact that they were evidently disputed by AR's father, plus the fact that they were in any case historic allegations with no ongoing sense of significant risk of physical harm from AR's father to AR, meant that there was little further action that could or would be deemed to be needed to be taken on the basis of the available evidence.

14. Sam Steed furthermore appeared to indicate something of a difference of opinion between herself and her Assistant Clinical Lead (ACL) in MDT3, Sam Coppard, whom I recalled from my review of previous correspondence had a longer view of working with the family; broadly, Sam Steed's suggestion seemed to be that Sam Coppard had experienced AR's parents to be more polite, cooperative, and reliable than she had.

15. Thus, Sam Steed's relaying of these potential safeguarding concerns appeared to me – tempered as they were with the accompanying report of an apparently different perspective on the part of Sam Coppard – to be very much conveying an overall message of "though there's not sufficient evidence to initiate a process in relation to the raising of fresh safeguarding concerns regarding AR's father at present, please be on the lookout for any further such evidence". This of course I resolved to do in my ongoing work with the family.

16. Jumping ahead a little, to 2nd August, some further clarity as to the nature of Sam Steed's potential safeguarding concerns was actually provided in an email reply sent to Dr Ram by Dr Killen, into which I was Cc'd, which mentioned that *"Sam S[teed] has been worried about [AR's] physical wellbeing"*, in the context of a query relating to the timing of AR's forthcoming paediatric appointment in relation to his weight loss (see para. 25, below). Given that AR's presentation with low weight due to restrictive eating was the principal clinical problem pertaining to AR as handed over to me by Dr Ram, my forthcoming clinical work with AR would thus of necessity seek to address these concerns.

17. It is probably worth pausing briefly at this juncture to reflect once again, in light this time of paras. 13-16 above, on Sam Steed's "Reply All" email message to Colette Rossiter, me, and Dr Killen that she sent at 9:37am on 19th July (see para. 8, above), since it might conceivably have been wondered, *prima facie*, if anything was done as a result of the concerns raised by Sam Steed in that email, and in particular if these concerns were escalated to internal or external safeguarding agencies. Naturally I can only answer for my own perspective on Sam Steed's email, and that is to say that, again, I did not find the message in and of itself to be particularly clear, beyond the underlying fact *that* she had safeguarding concerns and that these were evidently at the intermediate "Child in Need" level of concern (see para. 9, above); nor did the email appear to be directed to me specifically; nor did it appear to make any clear requests of me specifically. It would not have been appropriate in the circumstances for *me* to raise or escalate safeguarding concerns on the basis of this email (and, indeed, I don't think Sam Steed would have expected me to), because, beyond all that appeared to me to be clear about the email (essentially: "Sam Steed has safeguarding concerns in relation to this family that would appear to be at the intermediate 'Child in Need' level of concern"), at that stage of my involvement with

the case (I had not even met the family yet) I knew nothing further about the precise nature of these concerns at all.

18. Principal responsibility for any internal or external escalation of any safeguarding concerns that was felt to be appropriate on the part of Sam Steed, clearly lay with Sam Steed herself (as Sam, as an experienced and competent professional, would certainly have understood and agreed), and indeed my subsequent discussion with her on the morning after the 28th July home visit (see paras. 13-15) suggested she had already done this. In the circumstances, it was clear that the only appropriate course of action from my point of view following receipt of Sam Steed's email of 9:37am on 19th July was for me to meet the family for myself, discuss the case further with Sam Steed in light of having met them, and proceed from there on the basis of all the evidence before me and in accordance with my clinical judgement – all of which I of course did (see paras. 11-16, above). In hindsight, on the basis of the information that was available to me at the time, I don't see how anything could or should conceivably have been done any differently.

19. The day before Dr Killen's email (see para. 16, above), 1st August 2022, at 4:30pm, AR was accompanied by his father to his scheduled appointment with me at our Southport clinic; evidently he had taken the stat dose of diazepam 5mg I had prescribed, and found it useful in facilitating his attendance at the appointment. Moreover, given that the leading concern had been as regards AR's low weight, I was reassured by the fact that AR presented as overtly physically well, and although very slim certainly did not appear underweight to a pathological degree. It was pleasing that AR cooperated with being weighed in the session, with a measurement of 48.4kg (an increase of 3kg since May) providing further reassurance.

20. Overall he presented as stable in terms of his mental health: He appeared adequately kempt, casually dressed, as I recall, in t-shirt and jogging bottoms or similar; he appeared calm (if a little guarded at the outset, though not unduly so), alert, and oriented; though untalkative, speaking really only when spoken to, he demonstrated no abnormalities of speech or thinking when he did speak; though sullen, giving every impression that he would rather not have to be attending the appointment, he appeared to be essentially both subjectively and objectively euthymic in mood (I recall that he gave a somewhat flippant answer of "fine" or similar, when asked about his mood); there was no evidence of any thoughts of harm

to self or others; there was no subjective or objective evidence of any abnormalities of perception; insight was preserved. In summary he presented much the same as many boys his own age would (and do) in similar circumstances; I did not feel that any sort of meaningful rapport was achieved at this appointment, although this is often a challenge when a parent is also present in the interaction, of course.

21. The only other difficulties alluded to, appeared to relate to the well-known and longstanding symptoms of anxiety that Dr Ram had of course attempted to medicate with sertraline, despite repeated disengagement from the treatment on AR's part. We discussed the option of another Selective Serotonin Reuptake Inhibitor (SSRI) medication, namely fluoxetine, and AR engaged well with this proposal. Given that AR was still of relatively low weight, and given he was not presenting with evidence of depressive illness, I opted for a low initial dose of the fluoxetine (1 ml of fluoxetine liquid of concentration 4mg/ml, once daily), though of course did not foreground it as such in my discussion with AR, as for obvious reasons I did not wish to unnecessarily pre-empt within him any suggestion of sub-therapeutic effectiveness. Relatedly I did not wish to over-activate him with too high a starting dose, which would thus, I felt, have risked scuppering his already demonstrably brittle historic willingness to engage.

22. Overall, however, I was greatly reassured by AR's presentation at this my first face-to-face appointment with him. It had of course been only the matter of weight loss due to restrictive eating that had latterly precluded Dr Ram from being able to discharge AR from her psychiatric care according to her previous intention, on account of his lack of engagement. Now I was in the position of having seen AR for myself and thus been able both to verify his acute physical health stability, and the fact that the pattern of restrictive eating had evidently now resolved, with a healthy observed weight gain of 3kg since Dr Ram's last review in the May.

23. On the other hand, despite the fact that AR was now – following the evident resolution of his restrictive eating – back in the position of no longer presenting with evidence suggestive of a possible mental disorder, the fact that he had also, by virtue of his very attendance at my appointment, thus resumed his engagement with psychiatric input, meant that it was now nevertheless ethically incumbent upon me to work with him insofar as I was able, to attempt to address his evident difficulties as regards anxiety/avoidance symptoms, for as long as he was willing to engage with

me in order to do so. This was the rationale behind the trial now of a low dose of fluoxetine medication.

24. Though a telephone review appointment in four weeks' time would have been perfectly acceptable as a standard follow-up arrangement in the circumstances, as I invariably do, I offered AR the option of a face-to-face follow-up appointment instead, in an attempt opportunistically to capitalise on and promote engagement wherever possible. I was not particularly surprised, however, given his history of tentative engagement at best, that AR declined this and opted instead for just a telephone follow-up in four weeks.

25. In summary, I was greatly reassured both by the clear evident resolution of AR's previous difficulties around restrictive eating, and by his – albeit evidently grumpy and grudging – resumption of therapeutic engagement. A more formal physical health review by way of a paediatric appointment with my colleague at Alder Hey, Dr Elaine Weir, was scheduled for 8th September; AR's father and AR's mother had both struck me as polite and appropriately concerned with AR's wellbeing; notwithstanding Sam Steed's evident concerns (see paras. 13-16, above), nothing I had myself seen or heard in the course of meeting with the family at this point had given me significant cause for any further concerns at all, and I of course remained aware that Sam Steed and Sam Coppard had after all disagreed with one another in relation to their impressions of the parents. Now that the weight/eating issue had evidently resolved, there no longer appeared to be anything from a mental health or otherwise risk point of view that would make this case in particular stand out from any number of other cases on my caseload at the time. I was aware that the standard process of reallocation and handover of AR's case to a new case manager was underway within CAMHS, following Sam Steed's stepping down from this role.

26. Given my impression of this degree of reassurance, and given – as I recall – how particularly busy (even by general current standards) we were as a service around this time, it was inevitable that this case would be one of those cases that would unavoidably and of necessity assume less of a sense of clinical priority compared with other, significantly more overtly risky and complex cases (typically in terms of suicidality, which has over recent years of course sadly reached epidemic proportions amongst young people), when it came to administrative matters such as the timely completion of clinic letters, for example. To give a sense of how particularly busy we

were as a service around that time, I recall an informal conversation that took place between me and Sam Coppard, in which we reflected that another CAMHS service in the region had over the last couple of years got to the point of having to "hold its hands up", so to speak, and actually *close its doors to any further non-urgent referrals* for an extended period of time. It should be remembered, of course, that in 2022 we were still in the period of the COVID-19 pandemic and its aftermath, which had resulted in an ongoing deluge of referrals to CAMHS services across the country; Alder Hey formally recognised the impact of this upon our workloads, by adding the footnote, *"**This patient interaction took place during the Covid-19 pandemic**"* to all clinic letters up to around the end of 2022.

27. For such reasons, my clinic letter relating to the above face-to-face clinic appointment of 1st August was not in fact completed until 2nd September, when it was completed as a composite letter that related the clinical impression and management plan arising from both the 1st August appointment, and the follow-up telephone review appointment of 1st September. Such a delay was and is unusual in terms of my practice, though again was unavoidable and inevitable given the particularly high clinical and related workload facing our service at the time; no aspect of clinical care was compromised by this delay, and indeed, moreover, it was only through this unavoidable delay that clinical care was *not* compromised elsewhere.

28. In terms of the telephone review of 1st September itself, the clinical impression here was unalloyedly positive: AR's father reported a visible improvement in AR's presentation since commencing the fluoxetine medication four weeks previously, with AR reportedly now more willing to talk through his difficulties with his parents. As, furthermore, there were no evident adverse side effects reported from the fluoxetine, and no other significant concerns, it was entirely reasonable and indeed standard practice in the circumstances to arrange our next follow-up appointment for three months' time, again by way of a telephone review, on 1st December. As I standardly do with all of my patients and families, I indicated to AR's father that if in the meantime he were to feel that AR warranted a more timely review, whether again by telephone or face-to-face, I would encourage him to get in touch with me via the case manager or through telephoning the secretaries at our Crosby clinic directly, with a view to us considering arranging such a review; AR's father indicated his agreement with this suggested plan, and indeed in the event no such call was made to me by AR's father between then and 1st December.

29. When that 1st December telephone review came around, I spoke initially with AR's father, who reported positively as regards AR's weight, which was evidently continuing to improve. On the other hand, as regards the fluoxetine, AR had evidently stopped taking this some weeks previously. I spoke with AR himself who confirmed that he had indeed stopped the medication, as he didn't feel that it was having any discernible effect. I tried to get an updated sense from AR as to what he felt was his main difficulty, to which he replied that it lay in *"feeling anxious"*. I wondered perhaps whether he had experienced the fluoxetine (despite the very cautiously low dose) as somewhat over-activating, and – having momentarily overlooked the fact that he had of course been prescribed sertraline previously already – proposed that he might be interested in trying sertraline instead, as sertraline tends to be regarded as less activating than fluoxetine. Interestingly, in retrospect, he replied that he had not tried sertraline medication previously and indicated that he would be interested in a trial of this. On gaining informed consent for the same, I agreed to issue a trial prescription, for which AR thanked me, before ending the call abruptly, leaving me with no opportunity to speak again with AR's father.

30. On a subsequent reflective re-review of the past notes and correspondence from AR's time as Dr Ram's patient, I confirmed that I was correct in my seeming recollection that AR in fact *had* been prescribed sertraline previously, whilst under Dr Ram's care. Though misremembering around the details of past medication regimens is not at all uncommon amongst patients and families, with the benefit of hindsight the definiteness of AR's apparent conviction that he had not previously been prescribed sertraline appears strange in light of the fact that, as I am now aware though was not privy to at the time, discussions around the prescribing of sertraline had evidently occupied quite a bit of AR's time as a patient of Dr Ram's. In retrospect, in light of everything we now know since the tragic events of 29th July 2024 but couldn't have known at the time, I wonder if this wasn't an example of an attempt on AR's part to consciously and deliberatively manipulate professionals.

31. Returning to 1st December 2022, I at least felt that in light of the evident contradiction between AR's reported nonrecollection of having previously been prescribed sertraline, and the demonstrable fact that he *had* previously been prescribed sertraline whilst under the care of Dr Ram, I would need to have a further discussion

with either AR or his parents to gain further clarity before prescribing sertraline again for him. I duly called AR's father on 12th December to explain the situation, although the call connectivity was poor and I found it difficult to get a clear sense of what AR's father was saying. As I thus still did not feel able in the circumstances to reinitiate sertraline for AR as things stood, I arranged for a timely face-to-face review appointment at our Southport clinic over the coming weeks. My recollection, by the way, is that I did not propose a stat dose of diazepam for this appointment and in the end did not need to (see para. 32, below). Of course, if AR had refused to attend the appointment at this stage in my therapeutic relationship with him, and my sense had once again been that anxiety was the barrier to attendance, I would have proposed a further stat dose of diazepam 5mg in order to facilitate attendance.

32. AR's father duly brought AR for his scheduled appointment with me on 29th December. As I was conscious that I had not yet seen AR in clinic alone, I asked to do so, and both AR's father and AR consented to this. AR presented much as he had done when I had met him for the first time face-to-face on 1st August, though his untalkativeness seemed more pronounced now given there was only me and him in the room. I noted that he looked physically healthier again still than when I had last seen him, and that his mental state was again entirely stable. Once again he was appropriately alert and oriented, denied thoughts of harm to self or others, and presented with no evidence of perceptual abnormalities or other such symptoms. Though mood again appeared to be euthymic, equally there remained a clear sense – as had been evident at the 1st August appointment – of sullen impatience, again giving the overriding impression that he did not particularly want to be attending, and was only doing so on the transactional basis that I might be able to provide some assistance as regards his anxiety symptoms, specifically via a pharmacological intervention.

33. As I tend to do in such clinical interactions with teenage males, I attempted to focus on engagement through a reasonably light-hearted approach of trying to make the situation feel as safe as possible for the young person; I recall that in response to one such light-hearted comment (a "dad joke" or similar, from what I can remember) towards the end of the session, AR did manage a stifled half-smile that appeared genuine though gave the impression of being conceded only reluctantly through wanting to save face and appear "tough". Again, this is not at all uncommon in therapeutic interactions with teenage males, and indeed I would regard it as entirely

normal in this demographic. Moreover, the presence of appropriate positive reactive affect here, provided still further evidence of course of mental stability.

34. I would like to emphasise here that AR's countenance on the occasion of this clinic appointment – 29th December 2022 – as on each of the other two occasions on which I met him face-to-face, for the first time on 1st August 2022 and for the third and last time on 27th February 2023, was entirely different from the striking and alarming facial expression depicted in the police photograph taken following his arrest for the horrific crimes committed on 29th July 2024, and later broadcast widely across all media. On each of the three occasions in total on which I met AR face-to-face, between mid-2022 and early 2023, he presented, in essence, as an unremarkable, sullen, untalkative, gawky teenage boy.

35. Returning to the clinic appointment of 29th December 2022, it was possible during this appointment, in a way that had not been the case in the context of the telephone appointment of four weeks' previously (see para. 29, above), to have a complete discussion with AR as regards my proposal for a re-titration of sertraline medication. On gaining AR's informed consent for the same, I was content to formalise the *de facto* cessation of fluoxetine that AR himself had implemented many several weeks previously, and commence instead the re-titration of sertraline medication on the basis of 2.5ml of sertraline liquid (25mg of the active medication) once daily for a week, followed by 5ml (50mg) once daily for the following week, followed by 7.5ml (75mg) once daily thereafter. I arranged to review AR's progress again in clinic in a little under six weeks' time, on 6th February 2023.

36. On the day of that next scheduled appointment, I received a message from AR's father via our secretaries, to the effect that AR was refusing to attend the appointment, ostensibly due to feeling unwell. I telephoned AR's father, who told me that following AR's last appointment with the dietician on 28th December, at which his weight had been measured as 60.4kg, he had reduced his food intake by around a half to two thirds; AR's father told me that, based on past experience, he would visually estimate AR's weight now as being around 58kg. AR's father added that AR was now reporting apparent adverse side effects from the sertraline medication in the form of a sensation of numbness in the tongue.

37. I asked to speak with AR himself, and AR's father proceeded to go to AR's bedroom to attempt to engage him in the call, though AR flatly refused to speak to me. I

attempted to clarify with AR's father that AR was taking the prescribed 7.5ml (75mg) once daily dose of sertraline, to which AR's father replied that he believed that to be the case, though he acknowledged that (contrary to my previous advice around best practice) AR was largely being left to his own devices as regards administration of the sertraline medication, evidently on account of AR's father's ostensible fear of riling AR through too close a level of scrutiny.

38. Although AR had turned 16 the previous August (thus bringing him within the legislative remit of the Mental Capacity Act 2005), and at my recent meeting with him had indeed demonstrated capacity to make his own decisions as regards medication, I was nevertheless a little uncomfortable as regards the evident relative lack of parental scrutiny around this. Given these concerns, plus the fact that AR's father's own view – when asked – was that neither the fluoxetine (which he felt had made AR overtalkative) nor the sertraline (which he felt had made AR argumentative) had been helpful for AR, I felt the preferred option at this point was to advise a gradual wean-down of AR's sertraline before then stopping it. Furthermore, on account of these concerns, I scheduled a face-to-face appointment with AR for three weeks' time, adding that if AR were to refuse to attend for this appointment, I would attend for a home visit shortly afterwards.

39. AR's father and AR duly attended the scheduled appointment with me at our Southport clinic on 27th February. Though AR once again appeared well physically (in particular I had no significant concerns relating to his weight) and entirely stable in terms of his mental state, what proceeded to play out in the session in terms of the interpersonal dynamic between him and his father appeared to suggest considered contrarianism from AR, with possibly also a degree of passive-aggressiveness from AR's father. Specifically, AR appeared to me that he might well be stubbornly holding onto the position that he had found the sertraline helpful, simply *because* AR's father was taking the opposite view. Father and son bickered quietly between themselves for a time, in a manner more reminiscent of a family therapy session than a medication review appointment. Interestingly, despite his declared view that he had found the sertraline helpful, AR asked me whether I would be able to prescribe him a monoamine oxidase inhibitor (MAO-I) or a serotonin and noradrenaline reuptake inhibitor (SNRI) for his anxiety symptoms, neither of which – as I made clear to him – would be standard or even permissible practice in CAMHS at all. On the other hand, as I was prepared to make the most of any opportunity to promote AR's engagement,

and as he was once again demonstrating clear capacity to make his own decisions around medication, I was willing to resolve the balance of adjudged attendant risks in favour of another re-titration of sertraline, on the condition that we would of course need to see ongoing engagement with medication reviews etc, which AR ostensibly accepted. AR's father too indicated his agreement with this proposed plan.

40. Though we agreed between us for a further face-to-face follow-up appointment in four weeks' time, in the interim I received a telephone contact from AR's father on 10th March, asking if the sertraline liquid I had once again prescribed for AR's re-titration at the last appointment, could be changed to a tablet preparation, in view of AR's once again reporting altered sensation on his tongue with the liquid preparation. In view of the fact that it was unclear where the previous re-titration was up to, I felt that it would be safest to recommence the re-titration from scratch, this time of course though with the tablet preparation.

41. The next scheduled appointment was the face-to-face session – again at our Southport clinic – that we had arranged for late afternoon, Monday 27th March. As I recall, however, other more urgent, unplanned clinical priorities took hold earlier in the day (as can happen in CAMHS), and it became clear that I would have to postpone the appointment to late afternoon the following Thursday 30th March (an "overbooked" appointment slot); unfortunately however, in the event, AR's parents evidently did not receive the message relaying the postponement in time, and so AR's father and AR evidently ended up attending for Monday's appointment even though it had been cancelled. Obviously as soon as I was made aware, I made sure to pass on my apologies for any inconvenience caused, although the rescheduled appointment on Thursday 30th March was not then attended. I duly arranged another face-to-face appointment in my next available follow-up slot, which was on 15th May.

42. The day before that next scheduled appointment, Sunday 14th May, I was rather surprised to find myself – along with other professionals including my colleague Kate Morris, AR's CAMHS case manager since taking over from the departing Sam Steed the previous September – Cc'd into an email from AR's father to staff at Presfield School where AR was placed. The email said the following: *"Hi Mrs Dawson…[AR] told me that he wants another teacher, not the one he had last time he attended. He said that's when he will come back. Apparently, he is boring that [AR] falls asleep amid his sentence [sic]. He said that others are fine. Thanks, [AR's father]"*. Later

that day, at 4:35pm, I forwarded this email to Kate Morris alone with the simple accompanying message *"!!!"*, which was of course an unspoken expression of my sense of astonishment at the audacity – in relation to both AR and AR's father – that this email from AR's father seemed to reflect.

43. Kate Morris replied to my email the following morning at 9:20am, evidently expressing emphatic agreement with my unspoken sentiments with the simple opening message of *"Seriously!!!"*. She went on to say the following: *"This is more systemic [i.e. relating to problematic family dynamics] than mental health do you think? I feel parents aren't clear on how to manage [AR]'s ASD [autism spectrum disorder]. Everyone has accepted invited [sic] for review meeting on 25th [of May], I know you can't make it, which is a shame but we can have a catch up before the meeting and I can relay your views on your behalf?...This case baffles me!!!"*.

44. I duly replied to Kate's email at 11:34am with the following message: *"Don't know whether it's…Overaccommodation…[, or]…Safeguarding…[, or]…Gaslighting…Or some combination of the above. But [yes] the one thing that's clear is that it's systemic!...Maybe we should introduce them to the* **DPA** *and the* **DPA** *!!!...What time is the meeting again on 25th? I would like to come along if I can; might see if I can re-jig whatever it was that was clashing with it…But [yes] if I can't then I'll [definitely] catch up with you beforehand"*.

45. This email, in the context of this series of email exchanges as a whole, can be seen as an expression of my sense – in agreement with Kate Morris – that, although AR was clearly not presenting with a mental disorder, there nevertheless appeared to be problematic family dynamics at play, the precise nature of which, however, remained unclear. This is by no means an uncommon situation in CAMHS work, as my allusion to two other named families with whom Kate and I were also jointly working at the time (both of whom were lovely, I should add), and who also presented with evidently complex and problematic family dynamics though whose precise nature eluded us, testifies. The comment about introducing these families to one another, though clearly merely rhetorical in this context, is in fact not as unserious as perhaps it may sound: There is a well-established tradition within family therapy discourse, of multi-family therapeutic group work, in which families with evidently problematic

systemic dynamics work through their difficulties together, learning from one another, facilitated by the family therapy team.

46. My suggestions around whether overaccommodation, safeguarding, or gaslighting might be contributory factors to the evidently problematic systemic family dynamics in this case, were clearly more tentative than the recognition of problematic dynamics *per se*, and my mention of them can clearly be seen as attempts to sound out Kate for her thoughts. This is common and indeed standard practice in CAMHS work, where therapeutic hypotheses are often by their very nature hazy and subject to continual revision as new and apparently supportive or contradictory evidence accumulates (or indeed does not) over time, and where the consequences of jumping to conclusions in the absence of sufficient evidence can be extremely counter-productive, not least for the young person in question. Of these three suggestions as to what might be going on in terms of the family dynamics, I regarded the first, parental overaccommodation (which basically refers to parental inability and/or unwillingness to implement and/or enforce requisite behavioural boundaries for their children), as the most likely and evidentially robust: Indeed, this very email exchange had been precipitated by AR's father's apparent expectation that it would be reasonable for the school to just accommodate AR's declaration that he finds a certain teacher "boring", by providing him with an alternative teacher, and moreover that it would be reasonable for AR to just stop attending if this demand was not met. Really, to my mind, so audacious was this "request" from AR's father, that it suggested the secondary question of whether parental overaccommodation might be present to an extent that constituted a safeguarding matter: In other words, was AR's father equipping his son with the requisite skills for life in the education system and wider world of work by apparently reinforcing the message that one has the right to just demand an alternative teacher because one finds the current one boring?

47. The suggestion around potential gaslighting was the most tentative of my suggestions, for obvious reasons: Gaslighting is by its very nature a very subtle interpersonal dynamic; notoriously difficult to prove, easy to deny (in all honesty in fact – it is far from clear that it is entirely or even mostly a conscious process), and easy to misconstrue. What had raised the question in my mind – however tentatively – about potential gaslighting was the very subtle sense I had experienced in the face-to-face appointment with AR's father and AR on 27th February (see para. 39, above) of perhaps a degree of passive-aggressiveness on AR's father's part as the quiet, bickery, obstinate difference of opinion between him and AR played out during that session.

48. The above (paras. 45-47) delineates the extent of my principal concerns at the time in relation to AR and the family circumstances. As I have indicated above, the principal "risk", on the basis of the available evidence, appeared unrelated to AR's mental health – which was evidently stable (stable enough, indeed, to be demanding a replacement teacher at school because the present one was "boring") – and rather appeared to be, in essence, the "risk" of missed life opportunities in relation to education and work, due to parental overaccommodation to demands which would be deemed unacceptable in the adult world.

49. Later that day, 15th May 2023, with literally a minute to go before AR's scheduled face-to-face appointment with me at our Southport clinic, AR's father emailed me to say the following: *"Good afternoon Dr Molyneux…[AR] is not making ready to attend his appointment today for 3:30pm. He has been awake all night reading various topics of interest and chatting with us about it. Maybe it is because of the anxiety pertaining to the idea of attending school. We really don't know. He is asleep at the moment. Regards, [AR's father]"*. I should say at this point, by the way, that my recollection is that this email – as for the email to school into which AR's father had Cc'd me the previous day (see para. 42, above) – was unsolicited; I do not recall having invited AR's father to contact me in this way by providing him with my work email address (though being of the form **I&S** it is of course relatively easy to work out), and indeed doing so tends to be discouraged, even though is not to my knowledge actually *prohibited*, by my employer.

50. Nevertheless, on the basis that some engagement is preferential to no engagement, I replied to AR's father's email, requesting an update on the medication situation. AR's father assured me of AR's consistency in taking his sertraline medication at the now fully titrated 75mg once daily dose, adding that this had been able to be verified by AR's mother. Moreover, AR's father reported feeling that AR was now benefiting from the sertraline medication, as demonstrated by the fact that he was now talking to his parents more. The only problematic aspect to AR's current presentation, from AR's father's point of view, was his evidently reversed sleep/wake cycle – a by no means uncommon presentation amongst the teenage population both within and outside of CAMHS services.

51. Mindful that AR's longstanding tendency to disengage from services was now seemingly rearing its head again, and keen to attempt any reasonable means of re-engaging him, I suggested a trial of melatonin medication. This was entirely reasonable in the circumstances, given the much lower index of caution attendant upon initiating a prescription for melatonin compared with an SSRI medication such as sertraline, for example; melatonin is a medication with negligible if any known adverse effects, is readily available over-the-counter in many jurisdictions, and indeed can be readily purchased by the general public over the internet. Relatedly, I was confident that prescribing melatonin on the basis of parental consent alone if necessary was, in the circumstances, both legal and ethical in the sense of it being clearly the "least worst" option on the basis of a risks vs. benefits calculus. Nevertheless, it was clearly good practice to obtain the consent of AR himself if possible, and so, although I had already obtained the informed consent of AR's father (who was clearly very enthusiastic about the suggestion of melatonin), I indicated that I would call the following day – 16th May – to attempt to obtain the consent of AR also, before issuing an initial prescription for melatonin.

52. The following day, 16th May, I duly attempted to call AR to discuss the prescription of melatonin directly with him; however, he flatly refused to speak to me. Though I was content to nevertheless issue an initial prescription for melatonin on the basis of doing so being evidently the "least worst" option in the circumstances (see para. 51, above), on the other hand I felt increasingly uncomfortable, given AR's apparent and seemingly not easily remediable latest fall-off in engagement, as regards ongoing prescribing in relation to the sertraline; I duly explained to AR's father that although – given his report of recent apparent therapeutic success as a result of the sertraline (see para. 50, above) – I was prepared to concede to it continuing in the interim, I would however have to insist that my next appointment with AR would need to be face-to-face in order for me to be able to continue prescribing it thereafter. The next reasonably available follow-up date for me to see AR in clinic was 3rd July.

53. On 25th May I joined Kate Morris in attending the scheduled online multi-agency meeting to review AR's progress (see paras. 43-44, above), at which parents were also present. The overall feeling expressed by school representatives at this meeting in relation to AR's mental health was evidently positive. On the other hand, there also appeared to be plenty of further evidence (see para. 42, above, for context) of AR involving himself in the school programme very sporadically on the basis simply

of whether he felt like it or not; this seemed to provide further indication that the overarching problem was essentially systemic and related to parental overaccommodation.

54. I should say at this point that I do not recollect how frequently these multi-agency meetings were held at this point, but my sense, looking back, is that they were not held particularly frequently or regularly and that they were convened more on an "as required" basis, though I may be wrong about this. I am aware that Kate Morris certainly attended more multi-agency meetings relating to AR than I did, over the course of our involvement. Though it is not standardly incumbent upon a consultant psychiatrist to necessarily *have to* attend such multi-agency meetings, this is of course – as can probably be imagined – increasingly desirable, the more risky and/or complex and/or mental health-/psychiatry-related the case in question is. Though this case, by this time, was considered neither particularly risky nor particularly mental health-/psychiatry-related, it is fair to say that it did have a degree of systemic complexity in terms of our understanding of it that made me want to support Kate in her attendance at the meeting, as regards communicating our sense of the case to the wider professional network, and in turn getting the perspectives of others in the network.

55. My recollection, incidentally, is that this 25th May 2023 meeting was the first of only two references I ever heard to the Prevent programme in relation to AR prior to the tragic events of 29th July 2024. My recollection is that at this 25th May 2023 meeting, there was a passing reference by one of the professionals in attendance, to a Prevent referral that had been submitted by school at some point in relation to something AR had said, though evidently no further action had been deemed necessary, and he had been discharged from the programme.

56. The "TAF [Team Around the Family] Meeting Outcomes" document in relation to the 25th May 2023 meeting, notes the following in relation to some of my contributions in the meeting: *"engagement from [AR] has been patchy…Anthony stated that he would like to see [AR] for a face to face conversation as he has not been seen by CAHMS since march"*. In fact, as the preceding paragraphs bear out, I had not seen AR since late February (see para. 39). A face-to-face appointment had been offered for late March, though AR had then not attended this (see para. 41). The next available face-to-face appointment slot was then offered for 15th May; there was no clinical

indication to insist upon a more timely review appointment than this. Given other clinical priorities within the service, and AR's longstanding history of patchy, non-committal engagement, it was not – in view of the now relatively low sense of attendant risk – an appropriate use of clinician time to be continually, actively, attempting to actively re-engage AR in attending more timely appointments, when the next scheduled appointment slot of 15th May was perfectly acceptable in the circumstances; again, AR's father was aware that I was always amenable to being approached with a request for a more timely review for AR if that were ever felt to be indicated.

57. As a related aside from the main narrative, it might reasonably be wondered, given AR's disengagement with and refusal of treatment, and his failure to take his prescribed medication correctly, how I might in general be able to treat an individual who disengages/refuses treatment/does not take prescribed medication correctly. The simple answer to such a question is to consider a few simple, interrelated points: the age of the individual; whether they have a diagnosable mental disorder; whether they have the capacity to refuse treatment; and whether they are adjudged to pose a significant risk of harm to themselves or others. If an individual is over the age of 16, does not have a diagnosable mental disorder, has the capacity to refuse treatment, and is not adjudged to pose a significant risk of harm to self or others by virtue of refusing such a treatment, then neither I nor any other psychiatrist would insist upon treating them, as to do so would be illegal (as well as being unethical and unnecessary).

58. It should be remembered that since the resolution of the issue of significant weight loss due to restrictive eating, AR – presenting once again with symptomatic anxiety and avoidance symptoms in the context of autism only – no longer met criteria for a mental disorder (note that autism is conventionally considered a *neurodevelopmental* as opposed to a mental disorder); he also was no longer adjudged – on the basis of the evidence available to us at the time – to pose a significant risk of harm to self or others; finally, he was over 16 and clearly had the capacity to refuse treatment (for his symptomatic anxiety). Therefore he was adjudged to have every right to refuse or disengage from any treatment we suggested, for as long as these conditions obtained. In these prevailing conditions, we as a service were keeping his case open to us, continuing to try to engage him, through our goodwill to him and his parents.

59. Re-engagement strategies available to myself and to Alder Hey Children's NHS Foundation Trust more generally essentially amount to reasonable attempts to persuade a young person to attend for appointments, but they have to be proportionate to the sense of adjudged risk of not doing so. There simply is not clinician time or resources to try repeatedly to engage every single young person who persistently refuses to engage. In the case of my own continual efforts to repeatedly engage AR, this essentially centred around my "open door" policy in relation to AR's father, who was aware he could contact me with any concerns to request a timely review, and indeed on a number of occasions did so (though, as it later became evident only in retrospect, on his own terms), throughout my time as AR's psychiatrist.

60. Of course, if adjudged risk of harm to self or others on AR's part were to significantly increase, in the context of a deterioration in his mental health to the point where he met criteria for a diagnosable mental disorder, we could consider use of the Mental Health Act to compel compulsory treatment. These conditions, however, were never fulfilled by AR during my time working with him as his psychiatrist, with the arguable exception of when he presented with low weight in the context of restricted eating, between approximately May 2022 (when Dr Ram was his psychiatrist) and approximately September 2022 (shortly after I had taken over as his psychiatrist); on the other hand, during this time he was engaging sufficiently with our outpatient treatment plan for us not to have had to consider resorting to use of the Mental Health Act, which states that the least restrictive means of administering treatment should always be utilised if possible. All in all, in hindsight, I am 100% confident that nothing could have been done more or differently in order to attempt to re-engage AR in the treatment we were offering him; on the contrary, we continually "bent over backwards", so to speak, in our efforts to accommodate AR and his family.

61. At 3:19pm on 3rd July 2023, 11 minutes prior to AR's scheduled appointment with me, I received an email from AR's father to say that AR was refusing to attend. As the overall impression of the professional network in relation to AR's mental health was now evidently one of stability (I had heard no evidence to the contrary since the multi-agency meeting of 25th May, including from AR's father), and mindful of AR's father's reported positive therapeutic response to the sertraline back in May (see para. 50, above), I resolved to authorise one final round of sertraline prescription before I really would need to insist on a face-to-face review of AR as a precondition of continuing to prescribe. In the meantime, as there was now, all things considered, no apparent

indication for an urgent follow-up appointment in AR's case, and as of course urgent appointment slots are at a premium in CAMHS, and need to be given priority allocation to young people where there *is* a sense of significant attendant risk, invariably in the context of a mental disorder, I in due course booked a non-urgent face-to-face follow-up slot for AR for 18th September, having in the meantime unfortunately had to cancel a face-to-face appointment on 7th August due to sickness. From previous discussions with AR's father, I knew that he knew that he was always free and welcome to approach me in the interim, whether directly or via the case manager, to request a more timely review for AR if he felt this to be indicated.

62. In the event I was not altogether surprised when, as 18th September came around, AR's father emailed me at 1:44pm to say that *"It looks like AR will not attend the appointment at 2pm today"*. Although time and work constraints at such short notice precluded me from insisting upon a home visit that same day, I initially proposed a further face-to-face appointment at our Southport clinic for a week's time, on 25th September, at 5pm, with the caveat that if AR did not attend, then I would be having to insist upon a home visit there and then, to review AR in person. Again, the principal concern was the safety and ethics of continuing to prescribe sertraline for a 16-year-old who, in virtue of refusing to engage directly, was not providing good evidence of his own consent; although relying on AR's father's consent on AR's behalf was strictly speaking legal given that AR was under 18, the matter was in my view nevertheless at risk of becoming medically and ethically questionable. Ultimately, on reflection, with the full expectation now that AR would just refuse once again to attend another scheduled clinic appointment, I simply scheduled the appointment for the following week as a home visit.

63. At 5pm on 25th September, I attended AR's home address. As had been the case for my first home visit over a year previously, I was welcomed into the living room area by AR's father, and as had been the case for my first home visit over a year previously, AR was in his bedroom, evidently refusing to meet with me. Moreover, this time, it was clear that AR had been in the living room area just prior to my arrival: there were foodstuffs (I seem to recall a box of cream crackers or similar and houmous type dips as well as an aroma of celery), crockery, and cutlery on the couch; AR's father cheerily confirmed that AR had seen me walking up the driveway and had promptly departed to his bedroom to avoid me.

64. As I sat down to speak with AR's father, I felt a distinct sense of exasperation at how relaxed he seemed to be in relation to the clear lack of parental authority he seemed to be able or willing to exert over his son. *"I can't make [AR] do anything he doesn't want to do!"*, he smiled, literally holding his hands up. It is of course not unusual for parents to understandably struggle in relation to exerting their own authority over their teenage children in practice, but it was AR's father's seemingly quite blithe, passive attitude towards this that was unusual and rankled with me. Parental overaccommodation did indeed clearly appear to be the essential problem in terms of the family dynamics, as we had by now come to suspect, to the extent, in my judgment, of constituting a safeguarding matter at the "Child in Need" level of concern; the principal "risk" here indeed appeared to be in relation to the missed life opportunities as regards education, vocational training, and work, that such an evident lack of parental guidance around the need to adhere to the adult world's expectations, would presumably, quite likely, engender.

65. As regards the sertraline medication – the principal rationale for my having had to insist upon a home visit with a view to speaking to AR himself – AR's father informed me that in fact AR had stopped taking it around two months previously. Though somewhat annoyed that it was only now that I was finding out about this, on the other hand I was relieved that the matter of prescribing a medication such as sertraline in the midst of patchy engagement *at best* from the young person, was now resolved definitively in favour of being able to formalise its cessation. AR had never – according to my understanding – presented with a conclusively diagnosable mental disorder, instead demonstrating only fluctuating symptoms of anxiety and related avoidance, with occasional and transient forays into problematic patterns of coping behaviour such as weight loss through restrictive eating; there had certainly never been any sense of severe and enduring mental illness that could conceivably indicate compulsory treatment.

66. As such, though we had been prepared to prescribe a medication such as sertraline for AR to do what we could to try to help him with his evident anxiety and related symptoms, such assistance was of course predicated upon his compliance with the medication itself as prescribed, and engagement with our review process. AR had repeatedly, whether working with myself or Dr Ram before me as his psychiatrist, disengaged from treatment in an unpredictable and thus potentially unsafe manner; furthermore, there had never been a clear and consistent sense from AR himself that

he had even found the SSRI medications helpful (if he had, then he would presumably have continued to take them consistently); thus it had become increasingly clear that to continue to prescribe sertraline in the circumstances would be neither safe, nor helpful, nor ethical. By far the best and indeed the *only* option available to me now in the circumstances, therefore, was to formalise the cessation of sertraline that had evidently been *de facto* discontinued by AR himself two months previously.

67. As to whether, and how, AR stopping his sertraline may have impacted his mental health, there are a number of points to be made in response to this question. The first thing to realise is that sertraline, along with other SSRI medications, is not a direct treatment of a known pathological process in the same way that, say, insulin for type 1 diabetes mellitus is in the domain of physical health. In other words, SSRIs do not work by restoring pathological deficits of neurochemicals to "normal" baseline levels; they do not "work" by virtue of "correcting a serotonin deficiency" in the brain, any more than alcohol "works" by virtue of "correcting an alcohol deficiency" in the brain. Rather, SSRIs are purely *symptomatic* treatments – psychotropic substances that, in their case, cause a slight increase in serotonin levels in the brain in a way that people may find helpful for the particular emotional problems they may be struggling with. Though they are not generally considered pleasant to take (hence they have little or no street value as illicit substances), they are often described as either providing some sense of inner activation, which can be useful in obtunded depressive states, and/or providing a sense of emotional blunting, which can be useful in anxious states.

68. Of course, the flip side of these therapeutic effects is that too much inner activation and/or emotional blunting can be perceived as unpleasant, and thus as adverse effects; to complicate this, different people seem to have different sensitivities to these medications, and moreover (like any psychotropic) perceived effect is very much context-dependent. The long and short of all this is that prescribing requires careful monitoring, and must always be done according to a careful risk/benefit calculus; furthermore, for these medications to have the desired therapeutic effect, prescribing should invariably have to be in the context of a meaningful therapeutic relationship between patient and prescriber; if there's no such relationship, there's next to no point in taking the medication. In the case of AR, the very fact that he disengaged so many times from taking an SSRI medication (fluoxetine as well as sertraline) by itself gave plenty of indication that to go on trying to prescribe it in any

case would *ipso facto* inevitably be worse for his mental health, not better; thus the least worst option from the point of view of his mental health on 25th September 2023 was absolutely to formalise the cessation of the medication that he had himself evidently enacted anyway two months previously.

69. As the principal rationale for ongoing psychiatric involvement in AR's care was thus now removed, and as AR continued evidently to demonstrate neither significant evidence suggestive of mental illness, nor any inclination to engage with CAMHS in any case, the question that inevitably now suggested itself was whether there was any benefit served by AR's case continuing to remain open to CAMHS at all. Not infrequently in the course of CAMHS work, a situation will arise such that a young person whose case comes to the attention of the service, is experiencing difficulties that primarily fall within the remit of social services, with issues relating to mental health only a relatively minor and secondary factor. In such situations, in my experience, CAMHS will often actually tend to become involved in helping to support the young person, even though such involvement is strictly speaking over and above their expected remit; sometimes however, especially in cases where ongoing involvement from CAMHS is manifestly serving no useful purpose, consideration needs to be given for CAMHS to "step back", precisely so that the message that the essential nature of the presenting problem is primarily a matter for social care, can be underscored.

70. This was very much the situation as it appeared to me as I raised with AR's father the question of AR's therapeutic direction within CAMHS. In essence we had a situation whereby a young person was not only refusing to engage with CAMHS (I was aware that AR had by now also disengaged from working with Kate Morris), but was also now – since the start of the new academic term – once again refusing to attend school; in AR's father's own words (I paraphrase…), *"he would attend if all he had to do there was have a chat with the teachers; as soon as they tried to introduce English and maths he disengaged"*. More to the point, this essentially demand-avoidant presentation was evidently being facilitated by parental overaccommodation, with AR's father not only openly admitting that he *"…can't make [AR] do anything he doesn't want to do!"* (see para. 64, above), but moreover appearing to come across as fairly relaxed about this.

71. To be clear: Parental overaccommodation now appeared to be the central problem that was driving the dysfunctional family dynamics; CAMHS' attempts at direct support to AR himself had seemingly failed conclusively due to his persistent non-engagement, and there was no evidence to support any indication for compulsory treatment as regards his mental health, given the level of adjudged risk (which was felt to be relatively low and, such as it was, related primarily to the "risk" of lost life opportunities); crucially, precisely due to the very centrality of the problem of parental overaccommodation, parents seemed to be either unable or unwilling to implement upon AR an expectation of attendance at CAMHS appointments, and furthermore, as all the evidence shows, it is clinically pointless in any case to try to enforce psychological therapeutic engagement upon someone who clearly and capacitously expresses that they do not want it.

72. Unquestionably and inevitably therefore, according to the available evidence, the situation would need to fall principally within the remit of social care. Given this, it was at least reassuring in the circumstances to note from my conversation with AR's father that not only was there a social worker already now involved in supporting AR, but moreover that there were evidently plans in place for AR to come under the care of the social care "transition team" that covered the 17-19 age bracket, so that the requisite support for AR and the wider family would not just stop when AR turned 18.

73. As I have already intimated above, my conversation with AR's father yielded no clear evidence suggestive of a significant deterioration in AR's mental health beyond the baseline presentation with which we felt we were now very familiar. More specifically, AR's father related that (again, I paraphrase) *"[AR] seems happy just doing what he wants to do"*. The only factor of note over the course of a general review of AR's reported presentation in relation to his mental health – which was all otherwise evidently unremarkable – was the report from AR's father that AR had evidently not had a bath or shower for a month or so, although he was apparently continuing to brush his teeth regularly as normal. AR's father felt that this recent aversion to baths and showers on AR's part might be to do with the presence of limescale in the bath, though wasn't sure. Though this report struck me as very much consistent with AR's historic presentation, with transient anxieties, quirks, aversions, and rigidities very much to be expected in the context of an autism diagnosis (not least in AR's case, judging from his historic presentation), the avoidance of bathing for the past month or

so was nevertheless of course a matter of some concern, and something we would – via parents – need to keep an eye on, so to speak, in the meantime.

74. In addition to the fact that social care were evidently now due to be involved in supporting AR and the family until he was 19 (see para. 72, above), still more of a sense of reassurance was provided by the fact that our CAMHS ACL Sam Coppard had now been back involved with supporting the family by way of regular family therapy sessions for the last several months, although of course these were being attended by parents only due to AR's refusal to attend. Thus there would inevitably be something of a "run-out" period whilst Sam Coppard completed his family therapy work, which would give us an opportunity to continue to link in with parents as regards AR's ongoing presentation ahead of discharge from CAMHS.

75. I thus suggested to AR's father that in the circumstances of AR's persistent non-engagement, and, relatedly, the fact that I would now be formalising the discontinuation of sertraline (see para. 68, above), we would therefore now likely be needing to consider moving towards a situation whereby AR would be discharged from further psychiatric input, and ultimately, in due course, from CAMHS as a whole, once – of course – Sam Coppard had completed his course of family therapy input. AR's father appeared philosophical about this proposal. I of course reiterated the obvious caveat (particularly in view of the residual concerns around AR not having bathed for the past month) that if AR were in the meantime to show evidence of significant deterioration in terms of his mental health, we would of course encourage parents to report such concerns to us, and psychiatry input could always thus be reinstated if indicated, and/or – of course – if AR were to indicate a willingness to engage with this. Similarly, post-discharge, a re-referral could always be made to CAMHS up until AR turned 18, and due consideration would always be given to accepting such a re-referral, if circumstances were deemed to have changed either in terms of a significant perceived deterioration in AR's mental health, and/or an improvement in his willingness to engage with our service, which we would of course welcome with open arms. Again I reiterated the standard advice around the availability of the Alder Hey CAMHS Crisis Team in situations of due urgency, including outside of working hours.

76. The plan that inevitably began to suggest itself therefore, was of necessity one that envisaged reasonable, appropriate, and proportionate multi-agency support

measures for AR and his parents going forward, in view of the persistent non-engagement of AR himself. Reflecting on the visit itself, and subsequently, I am confident that there was absolutely nothing further that could conceivably have been done to facilitate a face-to-face assessment of AR, based on a proportionate response to the adjudged attendant risk at the time of not doing so. His point-blank refusal to see me had been as stubborn as ever, and his father's unwillingness or inability to place this expectation upon him for fear of aggravating him appeared to be as ineffectual as ever.

77. Of course, if the adjudged risk had been high, based on the information available to us at the time, in the context of a suspected mental health disorder, we could and of course would have considered arranging an assessment under the Mental Health Act 1983 (as amended) that would have imposed a formal face-to-face psychiatric review upon AR, whether he liked it or not. I should add that I have had no hesitation to take such steps on a number of occasions during my career when the adjudged risk situation according to the available information has impelled this; indeed, this would of course have been exactly the situation that would likely have had to play out back in July/August 2022, had AR refused to attend my appointment even with the assistance of mild sedation with diazepam, as the adjudged risk of him not being seen at the time was of course that of high risk to his physical health via significant weight loss through restrictive eating.

78. In relation to the home visit of 25th September 2023 itself, it might conceivably be wondered as to whether indeed I was satisfied that the information provided to me by AR's father was reliable, particularly given that I had been unable in the course of the visit to examine AR himself in person. The answer to such a question would of course be Yes: At the time, I had no reason to doubt AR's father's reliability or honesty (subsequent to the horrific events of 29th July 2024 of course is quite a different matter); by September 2023 I doubted his effectiveness as a parent, but that is quite a different matter to doubting someone's reliability or honesty.

79. I fed back my findings and impression from the home visit to Kate Morris – and by extension to Sam Coppard, her supervisor – by way of an email sent more or less immediately following the home visit, at 7:03pm on the evening of 25th September. The email began by saying that I was *"struggling to see if there's any further role for*

psychiatry (or CAMHS as a whole)", and then set out my findings from the home visit that, in the context of the overall clinical situation, had led me to this conclusion (see paras. 63-78, above).

80. Kate replied to my email the following morning, 26th September, at 9:30am, expressing unequivocal agreement with my impression of the essential nature of the clinical situation in relation to AR's case and suggested way forward; specifically, Kate said the following: *"Morning Ant…Yes totally agree with what you have said below. I have discussed this case several times in MDT as I don't think I have a clear role with [AR] and to be [honest] parents are the barrier to interventions and work would be around parenting skills (in my opinion). I have my 1-2-1 with Sam [Coppard] on Thursday so I will discuss again and share your views of psychiatry. Let you know the outcome. Kate"*.

81. As a brief aside from the main narrative, one point that I do feel probably ought to be addressed explicitly at this juncture, lies in the comparison between AR's presentation as reported at the multi-agency review meeting of 25th May (see para. 53, above), and his evident presentation from my home visit of 25th September as described in detail in paras. 63-78, above. On the face of it, it might conceivably be wondered if it wasn't in fact the case that AR was "better" in terms of his presentation in May, compared with the following September: it was after all the case that AR was indeed attending school (albeit very sporadically) in the May, whereas from the start of the new term in September, he evidently reverted to old habits of outright school refusal.

82. To claim on the basis of this, though, that AR was straightforwardly "better" in terms of his presentation in the May than in the September, in a way that might challenge the albeit tentative conclusion that I posed to my colleagues following the September home visit, to the effect that I was *"struggling to see if there's any further role for psychiatry (or CAMHS as a whole)"*, in my opinion gives undue precedence to superficial appearances over underlying realities. The clear emerging impression by the time of the May meeting was that parental overaccommodation was the essence of the dysfunctional dynamic at play in AR's family; this can be seen, for example, when one considers that AR's reported sporadic engagement with school was nevertheless evidently very much on his own terms (see para. 42, above). Considered in this context, the clinical picture as revealed by my home visit of 25th

September did not, in my opinion, appear to represent a new qualitative deterioration in AR's presentation but merely a continuation of the same evident, longstanding, underlying problem of parental overaccommodation, now simply seen more clearly, at first hand: This was not a boy confined to isolation in his bedroom; he had been in the living room, eating there as he pleased, literally seconds prior to my arrival. AR's father, cheerfully unable or unwilling even to attempt to place upon AR the reasonable expectation that he at least speak to me, spoke of AR *"seem[ing] happy just doing what he wants to do"* (see para. 73, above).

83. To be clear: My hypothesis that I was *"struggling to see if there's any role for psychiatry (or CAMHS as a whole)"*, was far from a call for all professionals involved in the multi-agency support network around the family to just walk away; on the contrary, my point was that given that AR was refusing to take medication, given that he was refusing to engage with direct case management or psychiatry sessions, and given – crucially – that the essence of the whole problematic family dynamic appeared to be his parents' inability or unwillingness to place the expectation (along with other such reasonable expectations) upon him to do so, it seemed pointless to be continuing to waste our energies in this way, and moreover in so doing to divert requisite focus away from the principal task: Put simply, given that the central problem appeared to be one of parental overaccommodation, and given that this appeared to be putting AR at increased "risk" of lost life opportunities in relation to education, training, and work, the key agency quite clearly needed to be social care.

84. My sense of this as the key "risk" at the time, on the basis of the information then available to me, can be seen in my clinical documentation specifically in relation to adjudged risk, following the home visit of 25th September, thus: *"potential social care/safeguarding type risk in relation to AR not evidently engaging with education or other similar life functioning…unclear that there is any specific mental health related risk however, and AR continues evidently to be clear by his actions and what we know of his statements that he does not wish to engage with CAMHS"*. My sense of attendant risk as documented here was dealt with in the appropriate manner by virtue of the central message of this information being passed on, in essence, to Kate Morris as case manager, in the first instance by way of my email to Kate of 25th September at 7:03pm (see para. 79, above), and through subsequent conversations we had in relation to the case over the ensuing weeks and months. Specifically, my original email to Kate concluded with the message, *"…would welcome your thoughts*

re how to proceed. Feels to me [definitely] like social care, but [probably] not for us [i.e. CAMHS]…([Especially] after all this time)". I knew that as an experienced and highly capable clinician, and social worker herself by profession, Kate would be aware that my sense of "social care risk as opposed to mental health risk", in the context of the detailed findings of my home visit as relayed to her in the initial email, and of course what we both already understood of the case, would give her the sense of my thinking around principal risk being in relation to lost life opportunities (an impression with which, indeed, Kate was clearly already in agreement on the basis of her email reply to me of 26th September at 9:30am); and as I have already intimated above, this sense was further communicated and clarified in subsequent discussions of the case between the two of us over the weeks and months that followed.

85. As regards whether in view of this sense of adjudged risk in relation to lost life opportunities, I would consider, with the benefit of hindsight, that a discussion should have taken place with the Safeguarding Team and/or safeguarding supervision, the simple answer to that question is No. Throughout my career as a consultant psychiatrist I have worked on a great many cases with a safeguarding element to them, with a much greater sense of attendant risk – both in nature and extent – than appeared to be the case in relation to AR; in some of those cases, I have had cause to seek formal advice from colleagues in the Safeguarding Team. But the simple truth of the matter is that the nature and extent of attendant risk as it appeared to us in relation to the AR case at the time, was relatively low compared to many other cases on which we were working. Not only did it appear to me, on the basis of the information available to me at the time, that there was no indication for consulting with the Safeguarding Team, but the fact of the matter is that there are simply not the available resources in terms of clinician time for seeking Safeguarding consultations in relation to what would appear to be relatively low risk cases.

86. Thus, in hindsight, and in light of all the information that was available to me at the time, I still absolutely consider that it was entirely appropriate to conclude that I was *"struggling to see if there's any role for psychiatry (or CAMHS as a whole)"*. Moreover, the face validity of this conclusion – which, it ought to be remembered, was only a tentative and provisional one in any case – can be seen in the unequivocal endorsement given to it straight away by such an experienced practitioner as Kate Morris.

87. My email to Kate Morris recording my clinical findings and impression from the home visit of 25th September had been fairly detailed. As I recall, our employer, Alder Hey Children's NHS Foundation Trust, at this time was undergoing a digital transition from its old clinical record system – "Meditech 6" – to a new system (which is much better in my opinion, by the way), "Meditech Expanse". As a consequence there was a brief period of time over the course of a couple of days or so when it was not possible to upload clinical notes directly to the system as the old system transitioned over to the new one. By the time it became possible to upload clinical notes to the new "Expanse" system, as I recall, a couple of days had passed and so I knew that the most reliable contemporaneous transcription of notes in this case would simply be to "copy and paste" the detailed notes I had documented in the email to Kate Morris of 25th September, indicating – of course – in the notes the fact that I had done this. I recognise that this is not standard documentation practice, but I hope it will be recognised that this was an exceptional situation given the digital clinical record transition process that was taking place at the time. Clinical care was not, of course, compromised in any way at any point.

88. Regarding my request for the parental monitoring of AR's personal hygiene, two days after my home visit, on 27th September, AR's father emailed me with the following message: *"Hi Dr Molyneux, It's good news here, [AR] has had a shower today. Kind regards, [AR's father]"*. I duly replied to AR's father with the following: *"Hi [AR's father]…That's really good news! [thumbs-up emoji] I can appreciate how challenging it must feel for him, so that's good progress. Thanks for letting me know. All the best…Anthony"*, and also of course forwarded the email to Kate Morris as case manager.

89. The following day, 28th September, Kate contacted me to let me know that, following her "one-to-one" supervision with Sam Coppard, Sam was in agreement in the circumstances with the suggested plan to aim towards AR's discharge from CAMHS, with ongoing input from social care. In terms of the timescale in relation to remaining family therapy sessions, discharge was envisioned for December. In the meantime, Kate proposed bringing AR's case for discussion at the next MDT3 meeting on 4th October, with a view to then convening a multi-agency professionals' meeting to discuss and clarify next steps. Unfortunately however I was not able to join the MDT3 meeting on 4th October myself due to annual leave. As an aside, though it does occasionally happen in our service that when two clinicians jointly working on a

case are in different MDTs, one clinician will briefly join the other MDT meeting in which the case discussion is happening, this is the exception rather than the rule. Nevertheless, if a case is felt to present with high risk or complexity such that the presence of the other clinician is felt to be warranted for the purposes of the case discussion at the MDT meeting, clinicians will do their best to facilitate this.

90. Later that day, 28th September, Kate Morris emailed me and Sam Coppard with a suggestion of an organisation called "Talent Match" that she felt might be a good fit for AR. I replied to Kate to the effect that I agreed it was a good suggestion and certainly worth a try, but pointed out that the obvious stumbling block – on the evidence of the history of AR's involvement with our service proper – would almost certainly be his unwillingness to engage, a point with which Kate could only agree. I mention this however to demonstrate the extent to which all of us involved in the care of AR from a CAMHS point of view – and Kate in particular – were constantly trying to think outside the box, so to speak, for creative ways of trying to engage AR. This was by no means something that was specific to the care of AR, but something we are always trying to do as clinicians in relation to those young people whom we experience as for whatever reason "hard to reach".

91. As AR's sertraline medication had now been formally discontinued (see para. 68, above), thus meaning I had no further reason – in the absence of any reported mental health deterioration – to insist upon psychiatry appointments for AR despite his unwillingness to engage, no further appointments were booked in for me to review AR at this point. Nevertheless, following discussion with Kate Morris, I had agreed to hold off from formally discharging AR from my psychiatric caseload for the time being "just in case"; as the principal therapeutic link with the service was now Sam Coppard's remaining family therapy sessions with parents, I was open to the possibility that Sam through his regular meetings with parents during which AR's presentation and progress would be discussed, might conceivably request a resumption of my active involvement with the case, which I was of course prepared to reinstate if necessary. I should point out that standard psychiatric practice in the service is typically to discharge patients from one's caseload at the point at which there is no longer any active involvement; I feel therefore that this represents yet further evidence of the way in which, as a service, we continually went "out of our way" in our attempts to engage AR – again, as we would do for all "hard to reach" young people.

92. It remained the case, of course, that I was aware that AR's father was aware that I essentially maintained "an open" door policy that encouraged him to contact me to arrange a review in the event of any sign of deterioration in mental health on the part of AR, and/or any evidence of increased willingness to engage with CAMHS input. With the benefit of hindsight, I am thus 100% confident that everything that could possibly and reasonably have been done, on the basis of our sense of attendant risk at the time, in relation to our ongoing offer of engagement to AR, that remained open, was done.

93. And so indeed, my next contact with the case came from AR's father himself. On 11th December he emailed me to request a repeat prescription of melatonin, relating that *"AR is well but is struggling with sleeping"*. Evidently the request had been initiated by AR himself. Noting AR's father's message of general reassurance (*"AR is well"*) alongside the report of a specific – though eminently manageable – difficulty, I replied promptly, indicating my readiness to help through the issue of a repeat prescription for melatonin as requested. It is worth noting once again, at this juncture, the quite different index of caution in relation to prescribing melatonin when compared with a medication such as sertraline, for example; put simply, if it had been sertraline that AR's father was requesting on AR's behalf, I would not now have felt able to prescribe this in the absence of direct consent from AR himself. As for melatonin, the fact that this is a much safer medication etc meant that I felt I could prescribe safely and ethically via parental consent alone, and moreover make the most of this opportunity to respond to AR's own prescription request, as another means of attempting to creatively engage him. Furthermore, in my email reply to AR's father, I took the opportunity to remind him once again of the online reference for the standard Royal College of Paediatrics and Child Health (RCPCH) information leaflet in respect of melatonin, for which he thanked me.

94. AR's father contacting me to request a prescription for melatonin on AR's behalf, prompted me not only to share this information with Kate Morris as case manager, but also to check in with Kate as regards where things were up to in terms of discharge arrangements, given that, as I recalled, we had been envisaging discharge in December. Kate duly replied that she would bring the case to her MDT meeting for discussion and also catch up with Sam Coppard as regards where things were up to in terms of the family therapy.

95. On 22nd February 2024, the clinical record shows that Kate Morris, as case manager, formally reviewed the risk management tool on our Meditech Expanse system. This gives a formalised sense of our assessment of attendant risks at the time, according to the information available to us at the time. I think it is fair to summarise Kate's notes as giving our sense of risk of harm to self or others in AR's case as being low, and general risk in relation to mental health overall as being low; again, the principal "risk", according to our evidence-based judgement at the time, was the – so to speak – "social care risk" attendant upon the central evident fact of parental overaccommodation leading to lost life opportunities.

96. In terms of formal responsibility for updating the risk management tool and CAMHS care plan, by the way, my understanding is that these tasks are ordinarily completed by the case manager (and indeed, I might add, Kate Morris – like Sam Steed who occupied the role before her – to my knowledge, fulfilled these and all other such process-related tasks to the full extent, and more, of what would be reasonably expected in the fulfilment of the case manager role, throughout our time together working on the AR case). That is not to say, by the way, that a psychiatrist or other specific therapist working on a case *could not* contribute to the process of formally updating the risk management tool or care plan, though, again, my understanding is that responsibility for ensuring that minimum formal requirements in relation to this process are met, belongs to the case manager; certainly I as a psychiatrist have never found myself upbraided for not formally updating a patient's risk management tool or care plan, and, as far as I am aware, management expectations of psychiatry as regards formal documentation of updated adjudged risk status, have been content with the standard historic contribution of clinic letters and session notes.

97. Risk assessment, of course, is something that all psychiatrists and mental health practitioners do *all of the time* in our work, simply as a matter of course. This is something that is instilled in us from Day 1 of commencing in training in mental health (whatever our own individual professional discipline happens to be), and applies as much to the theory and practice of mental health work at Alder Hey Children's NHS Foundation Trust, as it does anywhere. In each and every moment of each and every clinical interaction to which we contribute professionally, we are assessing and adjudging risk on the basis of the available evidence, and, as soon as is practicable, taking appropriate action where necessary or desirable to mitigate such risks. Broadly speaking, risks fall into the conceptual categories of risk of harm to self, risk of harm *to* others, and risk of harm *from* others; further subcategorisations can of

course be applied to aid clarity of thinking, such as risk of deliberate versus inadvertent harm, for example.

98. Though in a sense it is mental health-related risks that are the principal business of mental health services, in another very real and overriding sense of course, we are well versed in Safeguarding culture, which quite rightly teaches that safeguarding is *everyone's* responsibility; as such, if we were to encounter in the course of our practice – as we very commonly do – evidence of risks that are significant but not strictly speaking or primarily related to mental health, we would and do nevertheless take appropriate action to mitigate such risks, which may well – and frequently does – involve liaison with colleagues in other agencies such as social care or police, or with colleagues closer to home in our own Safeguarding Team. In Sefton CAMHS, clinicians have regular access to Safeguarding supervision, and our colleagues from the Safeguarding Team regularly rotate through our MDTs to help address any relevant concerns or queries clinicians may bring from their work.

99. Returning to the main narrative then: Although, after September 2023, there was no longer any initiation of appointment contacts from my side (see para. 91, above), AR's father contacting me regarding the matter of issuing a repeat prescription for melatonin for AR in the December, and my prompt agreement to issue such a prescription (see para. 93, above), underscored not only that AR's father was evidently aware that he was still able to contact me with any psychiatric queries or concerns in relation to AR, but moreover that I maintained a "low bar", so to speak, for responding to such queries. Notwithstanding this, it was not until 26th March 2024 that I heard from AR's father again, when he emailed me at 12:50pm that day; he said the following: *"Good afternoon Dr Molyneux, [AR] needs more melatonin tablets to help with his sleep. Please could you make it a repeat prescription (with an open end date) and inform our GP? [AR] takes up to 2 tablets at once when he has difficulty sleeping. He found 1 tablet useless. Please advise the maximum dose for him. I spoke to our GP and was told that they would not prescribe melatonin to [AR] without your permission. A repeat prescription from yourself would help us avoid the headache of getting melatonin post his 18th birthday, which is not far. I look forward to hearing from you. [AR's father]"*.

100. Looking back, this email is remarkable only in terms of how unremarkable it is: There is no reporting of any significant concerns in relation to any aspect of AR's

presentation, other than a very standard, very everyday, request for a further repeat prescription of melatonin for refractory difficulty in sleeping. There is a sense of AR's own agency and personality coming through too, in the reported description of him having found one melatonin tablet alone *"useless"*. In the context of the email as a whole, in that essentially it makes a polite, uncomplicated request for a transfer of medication prescribing and monitoring responsibility over to the GP – something we standardly facilitate on a regular basis for our young people when they reach the age of 16 though do not require ongoing psychiatric input – the overall impression conveyed is very much in keeping with our by then longstanding impression of AR as essentially a grumpy, indulged, demand-avoidant, though mentally stable, teenage boy.

101. In the event, on account of annual leave, I did not receive AR's father's email until at least the second week of April 2024. Prior to replying to AR's father, as I recall, I made sure to catch up with Kate Morris to check in as regards where things were up to in terms of other aspects of AR's CAMHS input, in particular as regards whether Sam Coppard's family therapy input was completed or approaching completion. My purpose, of course, especially in light of AR's father's email of 26th March (see para. 99, above) was to make sure my colleagues were in agreement with me now proceeding with AR's formal discharge from CAMHS psychiatry ahead of his subsequent discharge from CAMHS as a whole in due course. As would be standard practice for any young person on our caseload for whom we were considering discharge in such circumstances, Kate and I conducted a broad review of our understanding of the case in the context of an informal but thorough catch-up conversation.

102. It was in the course of this final review conversation that I heard only the second reference to the "Prevent" process that I ever came across in the course of my involvement with AR's case, as Kate mentioned the fact of AR having previously been referred to the "Prevent" programme, though nothing of substance had evidently been found in relation to risk of radicalisation etc, and so he had been discharged from the programme with no further action deemed to be required. This chimed with my understanding of the case already in that regard, from my recollection of the mention of the "Prevent" aspect only in passing, and in relation to the "no further action" conclusion, at the multi-agency meeting of 25th May 2023 (see para. 55, above). The conclusion that the "Prevent" aspect was something that had

been looked into via the appropriate channels and nothing further of substance discovered on further investigation, was clearly also Kate Morris' sense of this aspect of the case, and by extension Sam Coppard's too. Hence it took up relatively little of our conversational review of the case.

103. As a brief aside from the main narrative, this is probably the appropriate juncture to mention the fact that, since the launch of this Inquiry process, I have been asked whether I was aware of *"the community dietetics appointment which took place on 20/02/24 and in which it was reported that AR had not left the house for 4-5 months and had erratic eating patterns".* The simple answer to this is that I was not aware of such an appointment; if a letter relating to such an appointment was addressed to me I do not appear to have received it. In any case, if that was the extent of the significance of the information conveyed in that letter, I do not see how that by itself would necessarily have had any bearing on my ultimate decision to discharge AR from CAMHS psychiatry: The pattern of AR not leaving the house for long periods at a time was longstanding, known to us (note also that a report of him having not left the house for 4-5 months as of 20th February 2024, implies that he *did* leave the house in September or October 2023, which would likely have been *after* my home visit of 25th September 2023, especially as the strong sense from AR's father at that time was that it already been quite some time since AR had left the house), and predated my involvement with his case. Moreover, "erratic eating patterns" by itself would not ordinarily be an indication for a psychiatrist to become involved with the care of a young person who flatly refused to engage with them, unless such behaviour was complicated by risk of significant harm to self through significant weight loss, say.

104. Returning then to the situation arising from the final review conversation that took place between me and Kate Morris in early-to-mid-April 2024 (see paras. 101-102, above): All in all, as Sam Coppard's family therapy input was evidently now approaching its conclusion, there was no objection from Sam or Kate as regards my proceeding with my formal discharge of AR from CAMHS psychiatry, ahead of discharge from the service as a whole, with ongoing input from social care as we had envisioned (see para. 89, above), in due course. The only residual psychiatric input aspect, in relation to the prescribing of the melatonin as per AR's father's email of 26th March (see para. 99, above), would be handed over to the GP by way of a formal psychiatry discharge/medication handover letter, as standard.

105. The way was now clear, therefore, for me to respond to AR' father's email of 26th March (I had heard nothing further from him in the meantime); I duly replied, on 16th April, at 9:45am, as follows: *"Hi [AR's father]…Sincere apologies for the delay in my reply; i'm afraid I was away on leave and so have had to play catch-up since my return…Of course – am happy to do a letter handing over to GP to continue the melatonin…Wishing you and the family all the very best for the future…Anthony"*. Having thus replied to AR's father's email, I was now able – on the same day, 16th April – to complete the discharge letter in relation to CAMHS psychiatry, in which I formally handed over prescribing and monitoring responsibility in relation to AR's melatonin, to his GP as standard. I also of course mentioned in this letter that AR remained open to CAMHS family therapy input, though that this would *"shortly be concluding in due course"*.

106. Although the only direct contact I had with AR's case following the home visit of 25th September 2023 was to issue prescriptions for melatonin the following December and April, this was most certainly not a question of me being "under-involved". On the contrary, the fact that I *kept the case open to CAMHS psychiatry at all* in the circumstances after 25th September 2023, if anything constitutes a case of me being *over-involved* – in the sense of continuing to do absolutely everything I could to keep open the channels of engagement for a young person who had demonstrated time and time again, evidently, that he was not willing to engage with me or the wider service. I had indicated to AR's father at the 25th September 2023 home visit that in the event of a perceived deterioration in AR's mental health, and/or a new willingness to engage on the part of AR, I and the wider service would of course be appropriately responsive to this (see para. 75, above); AR's father contacted me directly by email in the following December and March in order to request the melatonin prescriptions, giving implicit *and explicit* confirmation that *"AR is well"* (see para. 93, above) as he did so. In parallel with this, Sam Coppard's persistent provision of family therapy support to both parents, long after it was clear that AR himself was never going to put in an appearance, and Kate Morris' tireless dredging of every conceivable means of trying to engage AR (see para. 90, above), demonstrate the lengths we went to, to do everything we could to support this family as best we could – even though our sense of attendant risk at the time, such as it was, was much lower than for many of the young people and families we work with. On reflection, I can't conceive of how it would even have been possible in the

circumstances, given our sense of attendant risk at the time, to have had greater involvement with AR during this period.

107. I hope the reader will see that the above paragraphs give a clear sense of why AR was discharged from CAMHS psychiatry on 16th April 2024. In summary: I had accepted AR onto my caseload in July 2022 as a young person whose already highly inconsistent and reluctant engagement with the care provided by my colleague Dr Ram, had by April 2022 led her to the point of discharging him from CAMHS psychiatry. This foreseen discharge was forestalled only on account of the fact that, "at the last minute", so to speak, AR developed a problem of significant weight loss through restrictive eating. I shortly afterwards agreed to take over from Dr Ram as AR's psychiatrist, due to Dr Ram's understandable discomfort with the attitudes and behaviours of AR's father.

108. Thus my principal "remit", so to speak, was to assess and address the adjudged risk of harm to self due to the weight loss resulting from AR's restrictive eating; this task was by its very nature made more difficult by AR's reluctant engagement. The nature and potential extent of this adjudged risk, though, meant that I could and would, if necessary, need to insist on seeing him at least once – whether he wanted to see me or not – in order to assess and if necessary address this risk. This I managed to do, and fortunately the eating problem very soon resolved of its own accord as his weight began to improve considerably. We were thus in effect now back in the situation that had pertained in April 2022: happy to work with the young person to help him with his residual difficulties in terms of anxiety and related avoidance behaviours in the context of his autism diagnosis, though with no medical, ethical, or legal indication to insist on doing so if he did not wish us to.

109. Following eight months of the same sort of patchy, inconsistent, and on-his-own-terms engagement that he had demonstrated *at best* with Dr Ram, despite my best efforts too to creatively engage him, AR disengaged outright with me also after March 2023. Nevertheless, though I could have (and many no doubt *would* have) advised and implemented a wean-down and cessation of his CAMHS medication there and then prior to promptly discharging him, instead, for approaching six months, I maintained an active involvement with his care, offering multiple appointments, considering and implementing creative attempts at medication

solutions via the consent of his father insofar as it was safe, legal, and ethical to do so, and inputting to wider professional discussions involved in supporting him, including external agencies; all this at a time when what we were hearing from his side was that he was demanding another teacher as a precondition of attending school because he found the present one *"boring"*.

110. Finally, by late September 2023, having stretched the bounds of safe and ethical prescribing via parental consent alone to their limit, I had to insist upon seeing AR for myself by way of a home visit as a precondition for continuing to be able to safely prescribe sertraline medication. What the home visit appeared to confirm to me was the centrality of the problem of parental overaccommodation to the whole situation. This was not a matter primarily for CAMHS – still less for CAMHS psychiatry – but for *children's social care*, the principal attendant risk being not in relation to AR's mental health but to lost life opportunities in relation to education, training, and work in the context of a situation whereby parents not only appeared unable or unwilling to place reasonable life expectations upon their son, but moreover appeared to be intensely relaxed about this.

111. As it turned out that AR had stopped taking the sertraline medication two months previously in any case, the matter of my needing to see AR for myself to obtain his own consent for the medication was obviously now moot. In the circumstances therefore, this was merely the latest juncture at which a perfectly reasonable decision from the point of view of psychiatry would have been to discharge forthwith back to case management alone, ahead of a timely planned discharge from CAMHS as a whole with ongoing input from social care; as AR was over the age of 16, responsibility for the ongoing prescribing and monitoring of melatonin – were this requested – could easily have been passed over to the GP there and then. Still though, instead, Kate Morris, Sam Coppard, and I all maintained our involvement over the ensuing several months whilst Sam completed his course of family therapy support to the parents. Over that time I was responsive to any concerns and queries raised with me by direct contact from AR's father, which never extended beyond requests for repeat prescriptions for melatonin alongside, as I have already stated, implicit and explicit assurances right up to the point of final discharge from CAMHS psychiatry in April 2024, that AR was well.

112. Given then that discharge from CAMHS psychiatry could legitimately have taken place, on the basis of the information available to us at the time, as early as September 2023, or March 2023, or even the latter months of 2022, on reflection what is shown by the fact that it was not until April 2024 that he was discharged from CAMHS psychiatry, is that not only was this discharge at this time entirely appropriate, but moreover that it provides yet more evidence of how our service, in every conceivable respect, went way over and above the bounds of reasonable expectations in our efforts to support this family. That is not to say, by the way, that we were affording AR and his parents any special treatment; this is merely what we try to do – as best we can – for every family we work with.

113. My closing of AR's case to CAMHS psychiatry ahead of our planned discharge from Sefton CAMHS as a whole, was of course flagged clearly not only by way of my discharge letter to GP of 16th April (parents of course being standardly copied into such letters), but also via email directly to AR's father that same day, that signed off with, *"am happy to do a letter handing over to GP to continue the melatonin…Wishing you and the family all the very best for the future…Anthony"*. Nevertheless, over two months after I had thus discharged AR from CAMHS psychiatry, and whilst I happened to be away on annual leave, on 19th June I was emailed by AR's mother with the following message: *"Dear Dr.molyneux, I am [AR's Mother], ……I would like to speak to you asap to discuss about sertraline medicine for him. I hope you speak to me or [AR's father] in the morning. Kind regards…[AR's mother]"*.

114. Given that I was away on annual leave at the time this email was sent, it would have triggered my standard out-of-office reply, which (at the time) read: *"Hi, I am currently on annual leave. I will be back in work on Monday 1st July. In the meantime, for any urgent queries, please consider contacting the relevant case manager or Sefton CAMHS duty clinician via* DPA *; or the Alder Hey CAMHS Crisis Team on* DPA *. Many thanks. [additionally:] Our service is currently experiencing unprecedented levels of demand. Given this, it is simply not possible to respond to each and every email in as timely a manner as I would like. If your email is urgent, and I do not get back to you as soon as you feel is necessary, please do send me another email; alternatively, please do consider giving me a call via our secretaries on* DPA *. Many thanks, Anthony Molyneux"*.

115. On receiving the email from AR's mother on my return from leave, I of course did not respond to it, seeing as I had now long since formally discharged AR from CAMHS psychiatry input, and that parents were aware of this. I also knew that parents had long been aware of standard procedure as regards contacting the CAMHS Crisis Team etc if necessary outside of planned care and working hours, and moreover that my out-of-office reply email would have explicitly prompted them to consider exactly these sorts of measures. Finally, AR's mother's email did not appear to be reporting any particular problem as such – still less any *urgent* problem, evidently – as much as attempting to direct me towards a proposed "solution" on the family's own terms in the form of sertraline, despite the fact that I had made clear to AR's father the previous September how it would be inappropriate and unsafe to continue to prescribe sertraline for AR in the absence of his own consent, and AR's father had evidently understood and accepted this. Since AR's mother had sent me this email there had in the meantime been no further attempts by either her or AR's father (or indeed AR) to contact me, and nor were there subsequently.

INVOLVEMENT WITH OTHER AGENCIES

116. Insofar as I was involved with other relevant agencies during my time as AR's psychiatrist within Sefton CAMHS, I can only say that my own experience of working with professionals from such agencies in relation to the events under investigation was unremarkably positive. As consultant psychiatrists working in CAMHS, we do not typically find ourselves at the hub, so to speak, of the nexus of professionals working between services; though we do have large caseloads, we would standardly case-manage only a relatively small number of cases ourselves (and for me this was not one of them).

117. As I have intimated in the main narrative (see para. 53, above), I can recall attending only one multi-agency meeting myself in relation to this case, which really is a reflection of the sense of relatively low priority in terms of attendant risk that we and seemingly other professionals from other agencies too, attached to this case on the basis of the available evidence at the time. To my mind, matters such as joint working arrangements, information sharing, effectiveness of communication, and degree of openness between agencies did not appear to be especially problematic at the time (no more so than for any other case anyway), although this may have been a consequence of Kate Morris' particularly effective and tireless case management making such aspects appear outwardly less problematical than they were from her point of view.

REFLECTION ON EVENTS

118. On reflection, as the above narrative chronology strongly bears out, I am 100% confident that not only did I and my organisation do everything we possibly could and should have done to correctly and appropriately assess, treat (where relevant), support, and engage with AR and his parents, at every turn, during our period of working with them, but moreover we quite clearly went way above and beyond the bounds of what would ordinarily be expected of a CAMHS service in order to do so.

119. Looking back there was simply no conceivable way we could or should have done any more or differently, at any point, on the basis of our understanding of the attendant risks at the time, which – with the exception of the period of significant weight loss due to restrictive eating between approximately May and September 2022 – appeared to be relatively low. During that relatively brief period (May – September 2022), as I have explained in the main narrative chronology above, resort to the Mental Health Act was present as a background consideration if necessary, though almost straight away actually in terms of the period of my own involvement in AR's care, weight – and, for a time, engagement – began to improve, and so the question of resort to the Mental Health Act was then rightly thereafter rendered moot.

120. In terms of my wider understanding of events now, with the benefit of hindsight, the obvious and significant shift in my perspective has been in relation to the reliability and veracity of parental testimony in this case. In the course of working in the field of children's mental health, I have always operated according to the baseline assumption that parents and carers are acting in good faith, and this is no doubt true for the overwhelming majority of parents and carers. But it is no exaggeration to say that looking back over this case, with the benefit of hindsight, in my opinion, my sense is that experienced professionals trying their best to involve themselves in the creative provision of care and support to AR, were likely subjected to a sustained and deeply cynical exercise in manipulation of clinical perspective, in a manner that, by its very nature, only became visible in retrospect.

121. In answer to the question that might conceivably be asked, as to whether I would consider that the guidance, training, and resources available to me were adequate for the nature of the involvement I had in the events under investigation, I would say,

emphatically, Yes (in fact they were more than adequate). For the avoidance of doubt: What happened, happened not because of any lack of guidance, training, resources, or anything of that nature on our part at all. What happened, happened *despite* the best efforts of professionals who, again, did absolutely everything right in our provision of care and support to AR, in accordance with our understanding of the situation at the time, according to the information we had available to us at the time; moreover we went way over and above standard service expectations, time and time again, in our attempts to find creative ways to support AR in the face of his persistent lack of engagement and, seemingly, in hindsight, the stage-management of our clinical perspectives throughout on the part of AR's father. Furthermore, for by far the most part of AR's journey of care with Sefton CAMHS, *he did not even meet diagnostic criteria for a mental disorder*; our service was quite literally *going outside of its remit* to try to provide *any support it could* for AR and his parents – support that, with the benefit of hindsight, however, can seemingly be seen to have, for whatever reason, only been deemed by the family to be acceptable to them within a relatively narrow range of possible interventions (typically in relation to medication).

IMPROVEMENTS

122. Though, as can be seen throughout my narrative chronology above, it is my absolute and unyielding view that there was no element of fault *whatsoever* in *any* aspect of Alder Hey Children's NHS Foundation Trust's involvement with the provision of care to AR, in such a way as had any bearing whatsoever on the horrific events of 29th July 2024, it is nevertheless the nature of all public bodies that they will inevitably want to implement any learning they can in order to mitigate insofar as possible any potential future risks in any way they can. Thus I am aware of a number of improvements that Alder Hey have implemented recently, in relation to our electronic clinical records system, Meditech Expanse.

123. Most conspicuously, referrals are now easily visible on a new "front screen"; details relating to risk assessment, any information relating to Mental Health Act assessments, etc are similarly all easily visible in the one place, making the system now much more user-friendly. There are also now highly visible markers for key features of cases with an obvious bearing on risk and complexity, such as Safeguarding, Learning Disability, etc. My colleagues and I have all received training regarding the above, and all in all the layout of the system does feel much more intuitive now, with a palpable "everything in one place" feel to it. I understand that

steps have also been taken to facilitate better communication between the various clinical teams.

124. I understand there is now also regular data collection as regards staff completion of session notes, so that incomplete session notes can easily be flagged up and addressed. Furthermore, I am pleased to report that there is now a regular programme of in-house training on legal aspects of capacity and consent in under-18-year-olds.

125. Finally, it is probably worth mentioning at this juncture that, understandably, in relation to the wider investigation process across agencies in the aftermath of the tragic events relating to the AR case, all Alder Hey CAMHS services – including Sefton CAMHS – were subject to an impromptu inspection by the Care Quality Commission (CQC) in March of this year. I am pleased to report that we have recently received the outcome of that report, which was an overall award of Outstanding, with an Outstanding grading also in the specific domains of Well-Led and Care – truly an outstanding achievement and testament to the relentless dedication of our staff.

RECOMMENDATIONS

126. I hope the Inquiry Chair will not take it amiss if I make just one recommendation, though I do think it is a crucial one.

127. A key distinction in medicine is of course the distinction between treating the symptoms of a clinical problem and treating the cause, and though the treatment of symptoms is important and indeed crucial, the overriding aim should always be to treat the cause.

128. We live in a society today that has transformed beyond all recognition from the safe, plodding, mundanity of the society those of us old enough to remember knew 30 years ago. There are untold benefits of the new technologies relating to the internet, smartphones, etc, but equally there is the strong sense that the pace of the new technology has outstripped our readiness as a society to cope with the negative aspects. The internet has come to operate, unchecked, as a kind of Wild West, and the malleable, impressionable, developing minds of our young people are incredibly vulnerable to its unprecedented and frighteningly underrecognised dangers. I thank

God every day that I was born in 1980, and knew a childhood and adolescence without the internet (or at least without the internet in its present form).

129. Something as horrific as what happened in Southport on 29th July 2024 could only have happened, I think, in a society where every kind of unspeakable horror is now accessible to anyone and everyone, anytime, everywhere, literally at their fingertips. Why is this allowed? The UK government have the power to shut down any website they want to, if they want to; they have the power to criminally prosecute people for uploading such material to the internet, if they want to. So why don't they? When I was a medical student I spent five weeks on a clinical attachment – called an elective – in Havana, Cuba. I saw there how the internet operates in that country in the form of a kind of national *intranet*: no extreme violent content, no extreme pornography, no organised crime. Just safe, normal, educational or entertainment content – not dissimilar, in fact, to how television was in this country just 30 years ago. So it can be done. Without exception the children I saw in Cuba appeared happy, healthy, and carefree.

130. In the UK we have become used to public inquiries over recent years in the aftermath of several major national traumas. What tends to happen is that all the agencies whose job it is to protect and care for the public – health, social care, police, education, armed forces, fire service, and the rest – are subjected to intense scrutiny as the government asks what could and should have been done differently. It is of course right and proper that this happens, but I wonder if to restrict the necessary learning process to this approach alone, risks focusing on treating the symptoms, but ignoring the causes? With regard to Southport, I wonder if the most valuable learning of all, might be to rethink our entire approach to how we regulate the internet in this country, and set about building a nation that provides psychological safety and security for our children.

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 

Dated 30/07/25