

Southport Inquiry

Witness Name: Samuel Coppard

Exhibits: SC/01 – SC/10

Dated: 4 August 2025

THE SOUTHPORT INQUIRY

FIRST WITNESS STATEMENT OF SAMUEL COPPARD

I, Samuel David Coppard, will say as follows: -

INTRODUCTION

1. I am a Clinical Lead at Alder Hey NHS Children's NHS Foundation Trust ("the **Trust**") Eaton Road, Liverpool, L12 2AP.
2. This witness statement is made to assist the Southport Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 10 July 2025.

BACKGROUND

3. I am a qualified Mental Health Nurse, registered with the Nursing and Midwifery Council (NMC) since 2004. My clinical background spans forensic mental health, substance misuse, eating disorder services, and child and adolescent mental health services (CAMHS).
4. My early career began at Ashworth Hospital (Mersey Care NHS Foundation Trust), where I worked as a staff nurse in a high-secure forensic setting. I transitioned to a

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community psychiatric nursing role within Mersey Care in 2008, working with offenders with suspected or diagnosed personality disorders.

5. In 2011, I joined Knowsley CAMHS (then part of 5 Boroughs Partnership NHS Foundation Trust) in a split post that included youth offending and substance misuse.
6. I initially joined Alder Hey Children's NHS Foundation Trust as a Senior Practitioner for Liverpool CAMHS in 2013, delivering core CAMHS interventions and supporting young people in local authority residential settings and the youth offending service.
7. In 2017, I joined the Wigan and Bolton Community Eating Disorder Service for children and families (then part of North West Boroughs NHS Foundation Trust) in a trainee family therapy role, until qualifying as a family and systemic psychotherapist in 2018. I was subsequently appointed to a substantive family therapy post.
8. In April 2020, I returned to Alder Hey as Assistant Clinical Lead (**ACL**) for Sefton CAMHS, where I supported the Clinical Lead in strategic and operational leadership, managed a multidisciplinary team (**MDT**), and maintained an active clinical caseload.
9. Sefton CAMHS is a specialist NHS service provided by Alder Hey Children's NHS Foundation Trust. It supports children and young people under the age of 18 living in the Sefton area who are experiencing emotional, behavioural, or mental health difficulties. The service also offers guidance and support to parents, carers, and professionals involved in the care of these young people.
10. Since April 2024, I have served as the Clinical Lead for Liverpool Specialist CAMHS. In this role, I hold overarching responsibility for the clinical leadership and governance of the service, ensuring the delivery of safe, effective, and evidence-based care to children, young people, and their families.
11. My role as Assistant Clinical Lead in Sefton CAMHS was part clinical, part supervisory and part managerial. In 2020 there were three MDTs in Sefton CAMHS (there are now four) and I was responsible for the management of MDT3. AR always fell under the care of a case manager within MDT3, although staff members from other MDTs were also involved due to the specific work they provided as part of their job plan.
12. Alder Hey CAMHS utilise structured job plans to ensure that practitioners can effectively manage a diverse range of responsibilities. These job plans are designed

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to enable them to balance clinical duties such as case management, additional therapeutic interventions, leadership tasks, and supervision roles across the service.

13. Requests were made through MDT for specific work such as psychiatry, keywork or psychological therapy that could not be offered by the case manager as part of their core competencies or job plan.
14. The members of staff who were involved in AR's case included Dr Ramasubramanian (Consultant CAMHS Psychiatrist), Dr Molyneux (Consultant CAMHS Psychiatrist), Samantha Steed (CAMHS Case Manager/Social Worker), Kathryn Morris (CAMHS Case Manager/Social Worker), Michelle Warner (CAMHS Keyworker), Dr Aesha Aseri (Core Trainee Psychiatrist), Dr Katrin Russell (Consultant CAMHS Psychiatrist), Dr Keith Ledwidge (Speciality Trainee Doctor, now Consultant CAMHS psychiatrist), Emma Walker-Riley (Alder Hey Safeguarding Practitioner/Social Worker) and Joan Bolger, (Family Therapist). My immediate supervisor was Vicky Killen, Clinical Lead for Sefton CAMHS.
15. As ACL I provided managerial supervision to the CAMHS Case Managers in MDT3. I provided systemic supervision to Michelle Warner for her systemic family practice, but I did not supervise her keywork role during the time of her involvement with AR or provide her managerial supervision as she was in a different MDT. Systemic family practice and keywork were two distinct tasks within Michelle's job plan. Systemic family practice (SFP) is intermediate level training in working with families using systemic theory and is a prerequisite for accessing qualifying level training in family and systemic psychotherapy. Michelle had specific time in her job plan to offer systemic practice under the supervision of a family therapist. The MDT decides which intervention is required and the next available practitioner, able to provide the specific offer, will make contact with the family.
16. Keywork constituted Michelle's core job plan. A Keyworker is also referred to as a mental health engagement practitioner (MHEP) in CAMHS, focusing on engagement and supporting the case manager to promoting attendance through individual sessions, often in the community or home, assisting with establishing therapeutic goals and completing brief interventions such as school observations and graded exposure work for difficulties such as anxiety.
17. The CAMHS Consultant Psychiatrists involved with AR were from MDT1 and MDT2 as the specific work is allocated to the next available Psychiatrist with Sefton

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CAMHS. MDT3 is supported by a Consultant CAMHS Psychiatrist who consulted to the MDT although they did not provide any direct clinical work to AR. I did not have supervisory responsibility for the Psychiatrists within the service.

18. I had two main periods of involvement relating to AR. The first was as CAMHS Case Manager from 7 May 2020 to 11 August 2020 when AR was 14 years old. All children and young people accessing Alder Hey CAMHS are allocated a case manager. Case managers act as a central point of contact for families and professionals, helping to navigate the mental health system and ensuring that interventions are timely, appropriate, and well-integrated across services.
19. The second key period of involvement was as family therapist allocated to provide therapy to AR/his family from May 2022 until 23 April 2024. At this time AR was 16 and 17 years old. As a family therapist, my role was to work systemically with the family with a focus on improving communication, relationships, and emotional understanding within the family.
20. I was also involved in my supervisory/managerial role for MDT3 throughout this period.
21. I think it is important to note that the first period of my involvement was during the height of the COVID-19 pandemic. This impacted the way in which we could provide the service at the time, particularly face to face appointments. Everyone was working in unprecedented circumstances and there was increased pressure on the service.
22. I have completed this statement from my own knowledge, recollection, review of emails that are still available and following a review of the records.

Narrative of involvement

May 2020 to August 2020 – Case Manager

23. I was allocated as AR's CAMHS Case Manager in May 2020. I had only started the role in April 2020 and received a list of children allocated to me from Vicky Killen. I was aware that AR's previous CAMHS Case Manager, Skott Morgan, had left the service and so I did not receive a direct handover. I was aware of the incident in December 2019 when AR had taken a knife into school and also assaulted a fellow pupil. I noted that the contact from CAMHS from the Lancashire Youth Offending

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Team (“YOT”) and the plan was for CAMHS to pick up work on emotional regulation and anxiety.

24. A referral from AR’s GP, dated 5 May 2020, was also received regarding feelings of nervousness and “social anxiety”, informing that AR was only leaving the house when accompanied by a family member and when he does his heart races, and he wants to go back inside. The referral acknowledges the incident in school and carrying of a weapon but indicated there were no safety concerns from the parents’ perspective. The referral states AR had not had any thoughts to harm anyone or himself but feels that his “social anxiety” had become worse since “*quarantine/lock down*”. At the time of the referral, it was reported that AR had no interest in school work but engaged with computer games and TV. AR could show agitation and aggression when asked to do something he did not want to do i.e. school work.
25. Upon review of the records, I am aware that Vicky Killen sent a letter to AR’s parent on the 7 May 2020 to inform that I was allocated to AR.
26. On 7 May 2020 I attempted to call AR’s parents to introduce myself, following discussion with Jill Locke who was the Duty Clinician that day (she was also the CAMHS Case Manager for AR’s brother). This was due to the receipt of the GP referral. There was no answer from either number called. I left a message for AR’s Dad informing him that I had attempted to speak with him to introduce myself as the allocated worker for the family and that I was hoping to make arrangements to discuss the current progress and how CAMHS could be useful to the family at that time. I noted that contact details for CAMHS have been provided to the family by Jill Locke and that they were aware of how to access the service. My plan was to attempt to contact AR’s parents again that day leaving a further message if there was no answer detailing that I would try to contact them again and to provide risk management advice for contacting the service out of hours, if required.
27. Later that day I attempted again to contact AR’s parents. Unfortunately, I was unable to speak with them. As such, I left a message for Dad to contact me at Sefton CAMHS. I did not leave any risk management advice or share any detailed information on the voicemail as I had not established contact with the family at that time. I had not verified this was the contact number with the parent, and I always consider confidentiality when making initial contact. At the time of the call, I was

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aware that the family had already accessed CAMHS to see Jill Locke for AR's brother and would be aware of relevant contact details for the service.

28. On 13 May 2020, I attempted to call Dad again to introduce myself, discuss current progress and the role of CAMHS. Unfortunately, there was again no answer. I left a further message for Dad informing of my attempts to contact the family to arrange appointment. I stated in my message that I would call again on Friday at 10:30 am.
29. On 14 May 2020, I called Dad and was able to speak with him. We discussed AR's current presentation. Dad informed me that AR was generally okay but that he had been experiencing a lot of nervousness when going out. As such, he struggled to go to the shop unless he was accompanied by a parent. This was an ongoing issue and occurred when he was at school as he struggled to cope unless his friends were with him.
30. Dad explained that AR would rub his hands uncontrollably, shake and get easily upset or angry when nervous. This was exacerbated by AR's poor sleep as he often struggled to sleep due to feeling mentally alert and bored. Dad described AR as requiring a lot of mental stimulation but not being very energetic.
31. In relation to mood, dad described AR as someone who would get frustrated if something was said to him that he perceived as judging or offensive. He was described as getting into an argument easily if he disagreed with something and he would stick to his view.
32. Dad and I discussed how AR could become quite rigid in his views and how this could be a characteristic of Autism Spectrum Condition ("**ASC**"). Dad informed me that a referral had been made to the ASC Pathway but at that point in time they had not had an assessment. Dad noted that he would contact the ASC Pathway to find out some more information.
33. I was informed by Dad that AR attended Acorn School ("**Acorn**"), a short-term educational provision designed to support young people temporarily unable to attend mainstream school, but that AR had told him that he would prefer to return to mainstream education. Dad acknowledged that this would be difficult due to an incident whereby another pupil was injured by AR. Dad informed that AR was not doing any schoolwork at home and AR had said that he would do school work at

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school but not at home. Dad explained that he was in regular contact with Acorn and that there was a Skype meeting set up on the Tuesday.

34. I was informed that AR had stated that he wanted to consider medication for his nervousness. However, Dad explained that he had concerns about side effects. I informed that I would discuss the medication with the Multi-disciplinary Team (“MDT”) the following day noting that Talking Therapy is the primary intervention indicated for anxiety. I explained that AR would need to consider participating in some Talking Therapy sessions that focused on education around anxiety and finding ways of learning how to manage and cope with different situations whether or not he was prescribed medication. Dad agreed that Talking Therapy should be considered first.
35. I agreed with Dad that I would call to speak with AR the following day at 12 pm to introduce myself and establish some goals AR would like to work towards in relation to his reported nervousness. I informed Dad about how the family could contact CAMHS either by the main service telephone number or via the crisis line. Dad told me that there were no problems at that time with AR’s mental state or mood but that he had the relevant numbers if they were required. Due to Covid restrictions contact was over the telephone at that time.
36. On 15 May 2020, I made an introductory call to AR as planned. I initially spoke with Dad to get an update regarding our call the previous day. Dad informed that he had not really spoken with AR about our call but that he had been thinking about different schooling options for AR. Dad explained that he had done some research and identified two schools that he thought would be suitable for AR. I stated that these were conversations that would be useful to take place between him, AR and the school as education would be making recommendations about AR’s learning needs and the suitability of the environment. Dad informed that once AR made his mind up that he does not like it, then he would not do it.
37. I asked to speak to AR, and he agreed to speak with me. I asked AR how I could be useful to him as a CAMHS Practitioner and what he felt he needs were that needed to be addressed. AR informed that there was nothing. I checked with AR that he was saying he did not have any difficulties that he wanted to discuss or consider in relation to therapy, and he confirmed that he did not have anything he wanted to discuss.

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38. I spoke to AR about his visit to the GP and the referral letter we had received on 5 May 2020 outlining his nervousness and worry about going out. I asked AR if he thought the worry about going out was something he felt would be worthwhile discussing and he informed that it might be.
39. I agreed with AR to send some information in relation to anxiety for him to read and consider before we spoke and explained to him that the information may provide him with some ideas as to what goals or issues were most important to him.
40. In terms of actions following the call, I planned to email Dad with information regarding anxiety for him and AR to read and consider and to contact AR again by phone on 18 May 2020 to discuss his anxiety and consider goals. I also emailed Dad with a link to a website for "Minds and Hearts" which I thought would be helpful. I exhibit a copy of my emails to Dad, dated 18 May 2020, with four Anxiety Information Sheets attached, as **SDC/01 – AHCH000280**
41. As planned, I called AR on 18 May 2020. I spoke with Dad for the first half of the call and then with AR for the second half. Dad confirmed that he had received my email containing four attachments on anxiety. Dad informed me that he would read and share them with AR. I suggested to Dad that he discuss the content with AR to try to generate ideas and understanding about what anxiety is and how it affects AR and others around him. Dad explained that it was useful receiving information in this way. Dad asked me to recommend to AR that he discuss it with him as AR was more likely to carry out the task if it was advised by me.
42. I spoke with AR and encouraged him to read the documents I had sent. AR agreed to read them and discuss them with his Dad. AR confirmed that this was a relevant issue that he wanted to explore with me.
43. The outcome of the session was that I would contact AR again on 25 May 2020 to ascertain what he had found useful in the papers and what effect it had had on him since reading them both in his understanding of anxiety and his relationships with others.
44. On 27 May 2020, I emailed AR's parents to schedule a telephone call on 29 May 2020 as I was unable to speak with the family on 25 May 2020 as planned due to it being a bank holiday. I had not realised this was the case when making the arrangements.

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45. On 29 May 2020, I attempted to call AR's Dad. Unfortunately, there was no answer. I subsequently sent an email to AR's parent apprising them of my attempt to make contact by telephone and to offer another call on 1 June 2020 at 1 pm. I cannot now locate a copy of that email.
46. On 1 June 2020, I called Dad and AR. The call was split into two parts to discuss directly with Dad and AR. I initially spoke with Dad who informed me that he had shared the anxiety information sheets but AR had told him that he had not read them. AR did not give Dad a reason as to why he had not read them. I asked about whether Dad had spoken to AR about the information and Dad said that had not happened as AR did not want to talk about it.
47. I acknowledged the difficulty in communication between Dad and AR and asked how I could continue to provide a level of intervention to AR. Dad explained that he felt that it was probably more likely to happen when AR was able to have a face-to-face appointment in the future.
48. I then spoke with AR as Dad informed that he was in a good mood that morning and AR was aware that I would be calling. AR told me that he had not been experiencing much anxiety, and I asked him how he had managed to achieve that. AR informed me that he was not sure. I encouraged AR to consider what had made the difference for him. I asked AR about the anxiety information sheets and he confirmed to me that he had not read them. I also encouraged him to read them so that we could consider them together.
49. I asked AR if he would be able to chart or make a note of some of his worries and rate them in different situations. AR informed me that he was unlikely to do this. I asked him how we might go about understanding the anxiety and its influence. AR again informed me that he was not sure. I suggested that we try to examine the anxiety together in our telephone conversations. AR agreed to this. AR explained that he often had worry around but that he was not sure what it was, it was different things. No risk issues were identified by either Dad or AR during the conversation. I agreed to confirm the date and time of our next appointment with Dad and to send some additional information to Dad and AR relating to anxiety and its management. Following the call, I sent an email to Dad on 4 June 2020 offering and appointment on 12 June 2020 at 1 pm and sending two additional Anxiety Information Sheets. I

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exhibit a copy of this email and the attached Anxiety Information Sheets as **SDC/02 –**

AHCH000281

50. On 12 June 2020, I called Dad and AR. I spoke with Dad who informed me that AR was in bed. Dad agreed to try and wake AR, but he declined to speak with me. AR did not give an explanation.
51. I spoke with Dad about how we can overcome the difficulties in engagement as AR is not keen on speaking with me. Dad stated that he thought it might be better if we consider a face-to-face appointment. I agreed to offer AR another appointment on 15 June 2020 at 4:45 pm as it was in the afternoon and hoped that AR would be awake and out of bed.
52. I encouraged Dad to speak with AR about the appointments and to talk about what AR would like to gain from them. Dad informed me that he had read the anxiety management materials I had sent and that they had been useful. I suggested that Dad try and speak with AR about the information sheets and to consider how they each might show bias in different situations and how noticing these biases might influence the way they experience each other and the situation.
53. On 15 June 2020, I called Dad and AR as planned in the afternoon as it was hoped this would provide me with a better opportunity to speak with AR as he had been in bed sleeping a lot through the day. I began by speaking with Dad who informed me that he not seen or spoken to AR as he had been in bed. I asked Dad if he and AR had spoken about my previous calls and the information I had sent. Dad informed me that he and AR had not spoken about my contacts as AR did not want to talk with him about it.
54. Dad attempted to wake AR and passed the phone to him. The phone call ended. I called back and Dad informed me that AR had pressed the button to end the call rather than speak with me.
55. I spoke at length with Dad about how it would not be appropriate to continue to persist in offering appointments with AR that he did not want. Dad requested an appointment in September at it was likely that when AR was asked to go back to school, he would become distressed. I informed that I had offered anxiety management to AR that would also address anticipatory anxiety and what preparations could be made to support AR during any times of transition, but AR was

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not showing any willingness or readiness. Dad explained that he worried about getting back into CAMHS if AR was discharged. I noted that AR would be re-allocated a Case Manager if he was re-referred within three months.

56. I explained that I would discuss AR with the MDT as I had reservations about a young person being open to CAMHS who was declining any treatment or intervention. My view on this was informed by ethical practice for respecting the rights of individuals with capacity to make decisions about their care. In the absence of risk or mental disorder, overriding AR's refusal could be considered unethical. I informed that I had offered both telephone and online consultation to AR, but he was declining. Dad suggested that I offer a face-to-face appointment. I agreed to offer a conditional face-to-face appointment on 2 July 2020 at 3 pm at Burlington House, subject to approval from the MDT. Dad asked if the appointment could be offered in August and when I asked why he wanted August Dad informed me that he wanted to try to get it as close to September as possible.
57. I reiterated to Dad that I would offer a face-to-face appointment on 2 July 2020, again subject to approval from the MDT. I explained to Dad that all requests for face-to-face contacts needed to be considered due to the restrictions in relation to COVID-19. I agreed to confirm whether a face-to-face appointment was able to take place by email. Dad was in agreement. Dad informed me that AR had been receiving therapy from Claudia at Parenting 2000 but that this was due to end. Prior to this, Dad explained that he had been paying for therapy privately which was also why he was wanting to maintain involvement with CAMHS.
58. I attended the MDT on 17 June 2020. The relevant extract from the Minutes (which relate to a number of patients) is as follows:

Recording of MDT Discussion/agenda

MDT 3 – Wednesday 17th June 2020

Present:

Admin:

<u>Name/AH</u>	<u>Case presentation (embed)</u>	<u>Purpose of bringing case?</u> 1. Share formulation and care	<u>Outcome of themes Specific Work – Change to Care plan</u>	<u>Task to be completed</u>	<u>Need to bring back? When?</u>

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		plan for review 2. Risk 3. Stuck case 4. Additional therapy requested	Risk Plan		
AR <div style="border: 1px dashed black; padding: 2px; display: inline-block;">DPA</div>	Sam Coppard	Not engaging or participating in therapeutic work.	Offer a face to face then review. ?Social care referral. Understanding ASC.	Liaise with Jill regarding family functioning	

59. On 23 June 2020, I emailed Dad to inform him that the MDT had agreed that the next CAMHS appointment for AR could be face-to-face.

60. On 25 June 2020 I received an email from Sharon Kirkby (CAMHS Admin) informing Ramon Niemiec from Lancashire Youth Offending Team had called and left contact details for me to call or email him back. I responded to the message by email to acknowledge the call and confirm it would be useful to link up with John Fitzpatrick (Social Worker, Lancashire County Council) and the West Lancashire CAMHS Practitioner to think about care planning and treatment opportunities. I recall that I also spoke with Ramon although I did not document the conversation.

61. On 26 June 2020 I received an email from Ramon stating he was going to email John Fitzpatrick (Social Worker, Lancashire County Council) after our conversation the previous day. He informed he had also spoken with Jeannette Jennings (West Lancashire CAMHS/YOT) and Jo Welch (YOT Health Lead) and he would cc them into his email to John and suggest a group discussion, possibly on Skype.

62. On 1 July 2020, I received an email from Ramon Niemiec informing he had spoken with John Fitzpatrick on Monday of that week and had given him verbal feedback following our liaison. He informed that John Fitzpatrick and Jeanette Jennings were cc'd into the email and John had suggested we arrange a skype call. I responded by email to apprise them I was unable to use Skype but I could join a call if invited by email and requested their available dates and times.

63. On 2 July 2020 I received an email from Jeanette Jennings suggesting a potential day (Thursdays) and times. John Fitzpatrick responded by email to request 10 July 2020. Ramon asked if this would be suitable for me and Jeanette. Jeanette clarified that it was 9 July 2020 and not 10 July as she did not work Fridays. I replied by email

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to confirm I could meet at 12.30 pm on Thursday 9 July. This arrangement was confirmed by John by email. I exhibit a copy of these emails as **SDC/03 –**

AHCH000282

64. On 2 July 2020, Dad and AR attended a face-to-face appointment at Burlington House as planned. They were late in arriving as Dad had taken AR to the Southport Hub instead of Burlington House. Dad informed that he could be at Burlington House at 3.30 pm; however, they arrived at 4 pm. I agreed to see them, and we completed an hour session. Dad remained with AR throughout the meeting, although we agreed that it may be useful for AR to be seen alone for part of the meeting.
65. AR informed me that nerves were his main problem and that he had experienced anxiety since he was in Year 5 at school, noting that it had been worse in Year 7, particularly in relation to social situations and eating in social situations. AR informed that the difficulties occurred mostly in school and at home sometimes. We discussed how AR was able to find ways of managing at home that meant he did not encounter situations that made him anxious. We discussed how this may be part of a pattern of avoidance that temporarily removed the anxiety but disabled him from tolerating it in the future. AR described experiencing thoughts that he was being judged by others when in school. Dad explained that he believed AR had encountered a lot of bullying and difficulties in relationships in school which had possibly made the nerves worse for him. AR denied this and stated that his Dad was wrong. AR frequently rejected Dad's ideas about what was contributing to the nervousness and said that what he was saying was stupid.
66. Dad also commented on the possibility of AR having ASC. AR informed that he did not think he had autism and said that he could normally tell if someone had ASC. I shared that it was often difficult for professionals to determine a diagnosis of ASC and therefore I asked how he was able to know who had ASC. AR informed me that he did not know. I also asked AR if he had done any reading on research on ASC to help him understand what it was, and he told me that he had not.
67. I talked about 'mind reading' and bias as possible factors in generating worry. AR stated that he had received 20 sessions from a psychologist. His Dad clarified that it was a Counsellor, and I confirmed that it was through Parenting 2000. Dad highlighted that AR was wanting medication. I informed that medication was not the first line treatment, and that Talking Therapy was indicated. AR explained that he felt that people did not think the anxiety was serious. I responded to inform that the

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purpose of our conversation was to talk about the anxiety and that it was one of the most prevalent problems both children and adults experience. I spoke with AR about the need to be motivated and active in tackling anxiety through talking and behavioural experiments. I used the imagery of a football player encouraging AR to think about how much training they undertake in order to perform on the pitch under stress. I suggested that it would be difficult for someone to play in a football team if they had never played before and had not spent any time preparing or learning. I linked this to anxiety management and the requirement of persistence and perseverance in overcoming the obstacles.

68. I recommended AR re-visit the educational material about anxiety I had sent him as he had not read any of it. I shared some diagrams about the effects of anxiety on the brain and arousal. I asked AR what had been useful to him in the meeting, and he informed me that he was not sure. Dad explained that it may be helpful if AR had some time alone in future meetings as it may help him to talk more without him being present.
69. The outcome of the meeting was that I agreed to meet with AR face-to-face on 9 July 2020, 3 pm, at Burlington House. Dad agreed to bring AR to the meeting and accompany him for part of the session. I agreed to continue to explore anxiety and its management with AR. I also informed AR that I had arranged a meeting with his Youth Offending Team ("YOT") Worker, John Fitzpatrick and the West Lancashire CAMHS Practitioner assigned to YOT on 9 July 2020.
70. On 6 July 2020 I received an email from AR dad stating Thank you for the meeting (2 July) and it was nice to meet you. I am checking whether the next appointment is Thursday 9 July. I responded by email on 7 July to confirm the details were correct.
71. On 9 July 2020 I received an email from John Fitzpatrick requesting my telephone number for them to call me into the professionals meeting later in the day. I replied to provide my telephone number. The meeting took place as planned to share information, attended by me, John Fitzpatrick, Jeanette Jennings and Ramon Niemiec. John emailed me after the meeting to provide me with the email address for Maggie Allred at AR's school. I replied by email to acknowledge the message. I advised I would contact the school to update them on my involvement and that AR's dad had called to cancel the meeting today as AR had been sick. I stated I was not sure if it would have an impact on any of their appointments, but I would offer another

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appointment to AR. These emails are included within **Exhibit SDC/03 – AHCH000282**

Unfortunately, I have not documented the details of the meeting. I recall sharing information about AR's ambivalence about engagement and possible ASC which had not yet been diagnosed. I do not recall any concerns being shared within the meeting in relation to risk of harm to self or others. I cannot see that I actioned contacting the school.

72. Dad and AR did not attend the appointment on 9 July 2020 as planned. I received an email from Dad at 3 pm informing that he had left a message with reception informing that AR became sick and threw up on their way to school that afternoon but was otherwise okay. Dad did not think it was COVID-19. As a precaution, Dad informed that AR would not be attending the session. Dad asked if the appointment could be re-arranged for the same time the following week. I responded to thank Dad for letting me know and to confirm I would book the appointment for 16 July 2020, 3 pm, at Burlington House. AR's Dad responded to thank me for my understanding.
73. On 16 July 2020, it was noted that a face to face appointment took place with AR and parent, which lasted one hour. Unfortunately, I have not documented the details of this discussion. A further face-to-face appointment was arranged for 23 July 2020.
74. On 23 July 2020, I received an email from Dad informing me that AR had decided not to attend the session as the experience was stressful for him. Dad explained that AR had made up his mind the previous week, but he hoped AR would have changed his mind. Dad informed that he was happy with his first therapist, Claudia, at Parenting 2000. Dad noted that at the time AR was in a terrible place and sought counselling. He then met psychologists and officers from different agencies who asked him questions and got him to talk. Dad explained that it seemed to him that AR had had enough of Talking Therapy from different people whilst he had an established working and emotional relationship with Claudia. Dad explained that it appeared to him that Claudia was the preferred therapist that AR was used to and comfortable with; however, they would need to pay £40 per session or wait roughly two years via the NHS funded route. Dad informed me that he had tried to persuade AR into giving it another go but was unsuccessful. I responded to AR's Dad's email that I would call him at the time I was sending my email. I exhibit a copy of this email as **SDC/04 – AHCH000283**
- Unfortunately, I have not recorded the details of this call. I recall speaking with AR dad about his hope that AR could stay open to CAMHS in case he may want to talk more but at the time he did not want to.

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75. On 29 July 2020 there was an MDT meeting. I discussed AR's nervousness and social anxiety and how I had tried a CBT informed approach, but AR had chosen not to receive a service from CAMHS. Discharge was the agreed action by the team.

76. The relevant extract from the Minutes (which relate to a number of patients) is as follows:

Recording of MDT Discussion/agenda

MDT 3 – Wednesday 29th July 2020

Present: Claire, Leanne, Hassan, Sam, Sarah

Apologies: Sharon Kirby, Demi, Russ, Vicky, Linny

Admin:

<u>Name/AH</u>	<u>Case presentation (embed)</u>	<u>Purpose of bringing case?</u>	<u>Outcome of themes</u>	<u>Task to be completed</u>	<u>Need to bring back? When?</u>
AR DPA	Sam	5. Share formulation and care plan for review 6. Risk 7. Stuck case 8. Additional therapy requested	Specific Work – Change to Care plan Risk Plan	Discharge	
		?Discharge	Age 13.?ASC. Nervousness and social anxiety. CBT informed.		

77. On 6 August 2020, I attended a safeguarding supervision session between me and Emma Walker-Riley, Safeguarding Specialist Practitioner at the Trust. I was due to record the details of the discussion; however, I unfortunately did not. I recall that I had requested the meeting with Emma to discuss my intention to close to CAMHS based on AR having capacity, not presenting with a mental disorder, not presenting with risk to self for others and not consenting to receive a service from CAMHS. I recall Emma agreeing with this decision with no further action. I exhibit a copy of the

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Safeguarding Children Clinical Supervision Agreement that governs these sessions, dated 4 August 2020, as **SDC/05 – AHCH000284**

78. On 11 August 2020, AR did not attend a CAMHS appointment. I documented “*no further appointment*”. I do not recall requesting this appointment to be booked but it may have been a final appointment I had scheduled if AR changed his mind, based on the conversation with his Dad in July. On review of the records, it appears that AR was not formally closed on the CAMHS system at that time, although he should have been.
79. On review of the records, I note that I did not update AR’s risk assessment whilst I was his CAMHS Case Manager. However, there was no increase in risk that I was aware of during that period that would have caused me to alter the risk assessment on file. He was not prescribed any medication by CAMHS during that period and I was not aware of any compliance issues relating to any other prescribed medication.

February 2021 to June 2022 – Managerial/Supervisory role

80. On 9 February 2021, I received an email from Lynsey Boggan, Specialist Practitioner/Interim Clinical Lead ASD Pathway, informing me that AR had received a diagnosis of ASD and Dad had requested a new CAMHS appointment due to increasing levels of anxiety. I agreed to plan for AR to be seen.
81. On 1 April 2021, Samantha Steed was allocated as Case Manager for AR. I recall, I did not have capacity to provide additional case management and there was limited availability across the service. However, Samantha did have capacity to meet with AR as a new practitioner within the team.
82. On 12 August 2021, a CAMHS Professional Meeting took place in which I attended in my team and managerial role. The meeting was also attended by Dr Lakshmi Ramasubramanian, Consultant Psychiatrist at the Trust, Samantha Steed, CAMHS Case Manager at the Trust and Jill Locke, CAMHS Case Manager at the Trust for AR’s sibling.
83. I note from the record that Dr Ramasubramanian expressed concerns regarding her interactions to date with the family. Samantha Steed made a full note of the meeting. My contribution was noted as explaining that when I was the Case Manager, I had felt that AR did not want to engage in therapeutic sessions to address feelings of anxiety.

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There were no specific actions for me as a result of the meeting, although I note that the plan included for Samantha Steed and Dr Ramasubramanian to offer family therapy. I note that Samantha Steed updated AR's risk assessment on this date.

84. On 19 August 2021, I was copied into correspondence between Michelle Warner (CAMHS Keyworker) and Samantha Steed. Samantha had contacted Michelle to ascertain when AR may be seen for Keywork. Michelle responded and informed Samantha that AR was not on the list, but she was meeting about allocations the following week and would update Samantha after this meeting. Samantha responded to Michelle to confirm the date AR had been discussed in MDT and requested he be added to the Keywork list. Samantha informed that Social Care may be offering something similar in the context of the family difficulties so it may end up not being a service CAMHS provides but to add to the keywork list anyway.
85. On 25 August 2021, AR was discussed by Samantha Steed at the MDT. I was not present. Vicky Killen was present in my absence. Minutes were shared with me by email. It is recorded that Social Care had seen the family and a family support worker had been offered. Use of lone working risk assessment and keywork to be offered by CAMHS and backdated on list to 25 June 2021 when original referral was made. Vicky Killen discussed whether a violence reduction worker would be able to support the family and agreed to look at the geographical jurisdiction of the workers.
86. I was copied into email correspondence from 1 September and 13 September 2021 between Samantha Steed, Dr Ramasubramanian, Dr Katrin Russell and Dr Aesha Aseri about arranging a joint review between a psychiatrist and Samantha Steed with a view to starting medication. Aesha Aseri (Trainee Psychiatrist) agreed to see AR on 15 September 2021 with Samantha. Dr Ramasubramanian stated that AR was keen on starting antidepressant medication and there was over reporting of his symptoms by his father who believed that there is a major mental illness in AR. Dr Ramasubramanian noted that there was no objective evidence for it and there were systemic factors. It had been agreed for a trial of Sertraline with the proviso that he was unlikely to improve unless he engaged in behavioural intervention as well.
87. On 15 September 2021, an MDT Meeting took place. Samantha Steed had had a discussion with Dr Ramasubramanian and Jill Locke about AR's case, and particularly Dad's responses. An action from the meeting was for Samantha Steed and me to consider co-work to systemically work with the family. However, AR's dad was not

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consenting to family work which included systemic family practice (SFP) and family therapy. Therefore, my direct involvement did not progress. AR's dad had agreed to keywork involvement and this was actioned.

88. On 22 September 2021, AR was discussed in MDT by Samantha Steed. It was agreed in the MDT meeting for a referral to family therapy be actioned as AR's Dad had agreed to be referred for Family Therapy and Riding the Rapids.

89. On 12 January 2022 AR was discussed in MDT by Samantha Steed. I was not present, but the meeting was chaired by Dr Katrin Russell in my absence. I received the minutes of the meeting by email. Samantha stated that AR was not attending school, and she had revised his EHCP as she did not feel it accurately reflected his needs. Samantha explained that she did not feel AR's concerns were being heard and that she queried a CETR process with West Lancashire Social Care. CETR is a "Care, Education and Treatment Review" which is a formal review process including a number of agencies. Samantha felt there was a safeguarding concern as AR had no respect for his Dad and had made allegations of abuse from his Dad against him and his brother. The Police had been called to the family home by Dad due to concerns about AR's behaviour. Samantha was meeting with AR face to face on 17 January 2023, which Sally Williams (CBT Therapist) was also due to attend. AR was to remain on the family therapy waitlist, to continue keywork with Michelle Warner, to consider psychiatric review with Dr Ramasubramanian. Samantha Steed was also to arrange a professionals' meeting to highlight concerns about Social Care closing AR's case, with Social Care, Education and Psychiatry (Dr Ramasubramanian) to attend. Samantha was to check with Adele Smith (Family Therapist) where AR was on the family therapy list and Samantha was to discuss possibility of CPA (Care Programme Approach) with Dr Katrin Russell.

90. On 2 March 2022 I received an email from Samantha Steed sharing a compliment received from AR's Dad to her and Gayle Lavelle stating "*Dear Gayle and Sam, On behalf of my family, I would like to thank you for loving and helping [AR] from the beginning to until him receiving a place at Presfield. I was touched by how Sam took upon herself rewriting his ECHP to better represent how she knows him. As for Gayle, you were by our side since [AR] was allocated to you and were patient and effective when putting my incoherent thoughts in the written form. I am sure [AR] will still need your service Sam as his CAMHS practitioner, so we will still be in touch. As for you Gayle, my family and I are so grateful for your help throughout the last two and half years. We will not hesitate to contact you for advice in the future. I hope that's ok with*

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you. Therefore, from the bottom of our hearts, Thank you". I forwarded this to Christine Pope, CAMHS Service Manager to be added to the CAMHS Compliments and Complaints System.

91. Between 17 March 2022 and 22 March 2022, a number of emails were exchanged between Samantha Steed and Michelle Warner, CAMHS Key Worker at the Trust which I was copied into. The emails discussed AR's wishes to cease to work with Michelle Warner, AR starting Presfield School ("**Presfield**") on 19 April 2022, AR going missing from home on 17 March 2022 and the plan to present AR to the MDT to consider preparation for discharge planning from CAMHS as he was reintegrating into school.
92. On 23 March 2022 there was an MDT meeting that I did not attend. The meeting was chaired by Dr Katrin Russell (Consultant CAMHS Psychiatrist) in my absence. The minutes were shared with me by email and I note that the extract relevant to AR has been copied into his records. Reviewing the minutes, AR was discussed by Samantha Steed and Dr Ramasubramanian. An update was provided regarding AR's difficult relationship with his dad, the anticipated start at Presfield Special School, the episode of AR going missing, and keywork sessions with Michelle coming to an end at AR's request. It was noted that AR was on the list for family therapy, but AR would not want to attend. An action from this meeting was for AR to be referred within the service for autism adapted CBT for anxiety.
93. On 18 May 2022, an MDT professional meeting took place and the relevant extract from the minutes is recorded in AR's records. I was not present for the MDT meeting, but minutes were shared with me by email. The meeting was chaired by Dr Katrin Russell and attended by Emma Walker-Riley (Safeguarding Lead). It is noted that AR had not attended his placement at Presfield School. AR has stopped taking his medication and a psychiatric review had been completed by Dr Ramasubramanian. It is recorded that there was an incident with Dad at the weekend whereby the police were called. The details of the incident are not specified. It is noted that there was no parental control over AR. Actions from the meeting were for Samantha to seek a family therapy consultation and Samantha to arrange a joint review meeting with Dr Ramasubramanian.
94. On the 25 May 2022, an MDT meeting took place, which I attended. It is recorded that AR came in to see Dr Ramasubramanian and Samantha Steed and was reported to

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have lost a lot of weight and looked poorly. Samantha Steed was very concerned. It is noted that a dietician had prescribed him shakes/juices, but he did not like the taste/sensation. AR was also complaining of chest pain and indigestion and therefore had stopped taking his Sertraline.

95. It is documented that Samantha Steed felt that the family had a poor understanding of AR's autism and did not provide home cooked meals. Dad was also noted to be continuing to request more medication for AR. Samantha Steed advised the family to make a referral to Early Help and it is noted that the school had also completed a referral. I understand that Early Help is a system of support for families with children of all ages that aims to improve outcomes and prevent problems from escalating, where they do not meet the criteria for statutory intervention from Social Care. It is recorded that AR had attended Presfield school that day and Samantha Steed was going to call them for an update. It is noted that Dad asked for another Case Manager. An action was for me to join Samantha Steed in conversations with AR's parents regarding the concerns at that time for AR. Additional actions were for Samantha to discuss AR with Emma Walker-Riley that day, to request his GP complete urgent physical investigations and ECG due to weight loss and to request the GP to assess whether AR needed to attend the Accident and Emergency Department. If AR did not attend his GP, Samantha was to contact Social Care. A MASH referral to be completed by Samantha Steed. MASH stands for Multi-Agency Safeguarding Hub.
96. On 25 May 2022, I sent an email to Samantha Steed and Dr Keith Ledwidge (Trainee Psychiatrist) in response to her request for advice regarding what physical investigations and bloods to request from the GP in the context of concern about weight loss and malnutrition. I detailed the relevant information. I exhibit a copy of this email as **SDC/06 – AHCH000285**
97. Later on the 25 May 2022 I received an email from Samantha Steed requesting I meet with her and Dr Ramasubramanian. Samantha Steed informed me that she wanted to raise welfare concerns regarding AR and his significant weight loss alongside concerns that his presentation had changed. A further concern Samantha Steed wanted to raise was in relation to Dad's presentation towards her during a joint meeting with her, Dad and Dr Ramasubramanian the previous day. Samantha Steed informed me that Dad was requesting a female Psychotherapist for AR and asking for her not to be involved. She explained to me that she had previously brought the concerns regarding AR's wellbeing and Dad's presentation to the MDT to ensure the concerns were logged.

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Samantha Steed noted that school and Dad had asked for Early Help to become involved again and the outcome of the referral was awaited. Samantha noted that there would likely be a requirement for Social Care to become involved. I exhibit a copy of the email correspondence as **SDC/07 – AHCH000286**

98. I responded to Samantha Steed's email to inform her I was unable to see AR's name on the waitlist for family therapy, but I had verified that reviewing the records SFP/family therapy had been requested in the MDT meeting on 22 September 2021. I confirmed that AR had now been added to the waitlist following liaison with the CAMHS admin. I informed Samantha that I would back date it to the original date and there had been no disadvantage as AR would not have been seen yet.
99. I offered a systemic consultation to Samantha Steed on 31 March (this was a typing error and should read 31 May), but she informed me she was on leave and requested an alternate date. Samantha confirmed she felt family therapy intervention was needed and that AR had a GP appointment the following day at 2 pm.
100. On 26 May 2022, I received an email from Katie Donovan, a member of the CAMHS Admin team. She informed me that she had received a call from Dad requesting re-allocation of AR's Case Manager. Dad requested a female if possible. Dad informed Katie Donovan that the family worked well with Samantha Steed and that she went out of her way to get an Educational Health Care Plan ("EHCP") and helped a lot. Dad explained that they felt the sessions focused on what the parents were doing as opposed to AR. Dad stated that they had tried to explain themselves on email and phone but that their explanations were not being accepted. Dad said that the parent focused questions had caused friction at home and that AR was threatening them by saying he would tell Samantha Steed.
101. Dad stated that he was being told he was not feeding AR and to make him proper meals. Dad explained that he had purchased a number of recipe books and cooked sometimes for two to three hours for AR to then not eat the food. Dad noted that the problem with AR was that he said untruthful things. Dad highlighted that there was a lack of trust between Samantha Steed and him and Mum. Dad expressed that previous CAMHS workers had never spoken to Dad like his mother, and they deal with AR and then call Dad in and give a summary. Dad was of the view it went beyond the realms of professionalism and there was no respect or trust which undermined Mum and Dad. As such, Dad found it offensive at times and wanted another therapist.

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102. Dad reported that they referred AR to get him looked after but now they are all shouting at each other at home which had not happened previously with AR blaming Dad for everything that went wrong. Dad explained that he was an open book, but that Samantha Steed did not believe him and Mum. Dad did not want the situation to get out of control and mentioned about going to the Council and school. Dad mentioned at the end of the call that there had been a police incident that he had not yet discussed with Samantha Steed. Katie Donovan requested at the end of her email that I give Dad a call to discuss. I did not call AR's dad back immediately as I wanted to seek advice from my Clinical Lead Vicky Killen. She then took over dealing with the request.

June 2022 to April 2024 – family therapy

103. On 1 June 2022, Dr Ramasubramanian emailed me, Samantha Steed and Vicky Killen, Clinical Lead for CAMHS Sefton at the Trust regarding an email from Dad received by Samantha Steed on 31 May 2022, raising concerns regarding the contents of her letter produced following a meeting with her, Dad and Samantha Steed on 23 May 2022. Dr Ramasubramanian informed that her letter was based on the clinical impression at the face-to-face meeting and previous interactions with the family. Dr Ramasubramanian appreciated that Dad wanted the letter to be amended but she expressed that she could not amend a clinic letter based on what the parents wanted to be on it unless there was clear evidence for it. Dr Ramasubramanian highlighted that her concerns about AR's medication compliance and monitoring pre-dated the face-to-face meeting and Dad contradicted what he said. Dr Ramasubramanian asked for me or Vicky Killen to share her response with Dad as she did not want her email address to be shared with Dad. Dr Ramasubramanian noted that she was happy to attend a meeting with Dad and a Senior Manager if he wished to pursue his concerns any further. Dr Ramasubramanian queried whether AR's GP and address made him a patient for West Lancashire CAMHS. Vicky Killen followed this up with Dr Ramasubramanian.

104. On 1 June 2022, I emailed Dr Ramasubramanian, Samantha Steed and Vicky Killen to confirm that I would be offering a family therapy appointment to AR in either June or July as we had discharged a family the previous day in the family therapy clinic and AR was next on the list to be seen. I informed that I would arrange a family therapy appointment but to provide family therapy another ACL or Vicky in her role as Clinical Lead would need to cover the managerial tasks and complaints that had been raised.

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105. Samantha Steed responded to the email later on 1 June 2022, informing me that Dad may be reluctant to engage in Family Therapy as he felt AR required treatment, not him. She explained that Dad was reluctant when she first offered Family Therapy but then came around. Samantha Steed informed that Dad was also referred to Riding the Rapids; a group for parents and carers of children with autism, learning disability or complex needs, aimed at improving parental confidence and reducing problem behaviours. However, the group did not take place. She noted that it may be worth someone else having the conversation with Dad before an offer was made to establish what his thinking was regarding care planning and risk management for AR.
106. On 1 June 2022, I requested CAMHS Admin schedule a family therapy appointment for 28 June, face to face in Southport and send a letter. I understand a letter was sent.
107. On 8 June 2022, I was copied into an email from Samantha Steed to Vicky Killen and Dr Ramasubramanian clarifying whether a meeting in the afternoon was about AR and if Dr Ramasubramanian could be involved. Samantha Steed informed me that she was not sure if there was a meeting booked in to discuss AR with SLT (Senior Leadership Team). Dr Ramasubramanian responded to the email adding that she had been advised to cancel the appointment for AR the next day until she and Samantha Steed had met with a member of the senior leadership team. Dr Ramasubramanian stated it was imperative that the meeting took place as AR needed a review. Dr Ramasubramanian also stated that she believed I would be offering FT (family therapy), so it would have to be another ACL or CL who should be involved from management.
108. In a separate email, Dr Ramasubramanian informed Vicky Killen and me that a professionals' meeting had been booked with school for 14 June at 11 am.
109. Vicky Killen responded to the emails from Samantha Steed. I was copied in with Dr Ramasubramanian. Vicky confirmed the meeting was for her and Samantha Steed to meet – not specifically about AR, but she would arrange a separate meeting to discuss AR.
110. In the afternoon of 8 June an email was sent by Marie Disley (CAMHS Admin) to me, Samantha Steed and Vicky Killen informing AR's Dad had called about upcoming appointments and he had said he did not think they should go ahead until someone had rung him back to discuss a new case manager.

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111. Later on 8 June 2022, I received an email from Julie Royle, CAMHS Admin, stating that AR's Mum had called this morning and had called again requesting a call back.
112. Samantha Steed responded and explained that she was not aware that Mum had called that morning and noted that Vicky Killen was due to call Dad. I was unaware of a call being received from AR's Mum in the morning. Samantha Steed explained that regarding AR's physical health, she had had a consultation with Eating Disorder Young People Service ("**EDYS**") and they recommended a referral to his GP and to make contact with Dietician to see if he was still open. She noted that she had asked Dr Ramasubramanian to lead on the referrals as parents were explicit in not wanting her to be involved further.
113. Samantha Steed highlighted that we needed to be sure AR was taking his Sertraline noting that Dr Ramasubramanian was due to offer a review once a professionals' meeting had taken place.
114. Samantha Steed updated that school and Dad had referred for Early Help in Lancashire and the school had been advised to visit at home so that they could find out what he wanted. She explained that via safeguarding supervision the advice was to refer to Social Care; however, she was not in a position to do this as parents did not want her involved, particularly in relation to her sharing information with other agencies. Samantha Steed noted that she was unable to gain consent and that someone else would need to lead. She raised that it should not be a case of what Dad wants, and we needed to consider AR's voice.
115. Samantha Steed highlighted that I had offered an appointment for Family Therapy and that her worry was that Dad would not be happy for the offer to go ahead due to him not wishing to work on himself. She raised that Dad had previously become quite threatening towards her in relation to the suggestion parents attend sessions and a Family Therapy referral be made. She stated that it may be Dad now thought differently but that was his initial message.
116. In terms of risk, Samantha Steed noted that she had spoken with Adele Smith, CAMHS Specialist Practitioner regarding Dynamic Support Database ("**DSD**") but that there was some uncertainty regarding their Lancashire address. Adele is a family therapist and link worker for the DSD. Samantha Steed noted that Adele Smith was going to

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check this out but that she had not completed that tool due to not being able to ask Mum or Dad for consent.

117. Regarding ASC, Samantha Steed stated that Dad was supposed to be attending Riding the Rapids but the referral she made may have been lost. She explained that the family were Lancashire residents but that their GP was Sefton and therefore it may be that they could attend via Venus. Venus is a Sefton based charity that offers a service to assist families in understanding the needs of their child following diagnosis, which may include personalised behaviour management strategies or help to improve the child's emotional wellbeing. Samantha Steed stated that AR had been referred for ASC Post Diagnostic Support.
118. In relation to education, Samantha Steed stated that she had learnt that if young people were accessing Venus they could attend Pinefield, a complementary education service in Sefton supporting children who are unable to attend mainstream school due to medical, emotional or other complex needs. She wondered whether this was AR's best hope to try and help him back to Presfield. She explained that the GP in Sefton may allow AR to access Venus although his home address may be the issue noting that she had explored this previously and advised that the home address precluded him for Pinefield.
119. Samantha Steed explained that school staff had visited home, but that AR took himself off to his room and refused to speak with them. He went to school once after the joint meeting with Dr Ramasubramanian on 25 May 2022 and has not returned since. She noted that AR did not present well when he did attend, head on the table, not engaging and declining food.
120. In terms of therapeutic support for AR, Samantha Steed stated that AR was on the waiting list for CBT adapted for ASC. She was unsure how effective it would be and suggested it may be that the specialist ASC support Camille Hayward was offering in her role as a mental health engagement practitioner could be extended to family as parents had limited understanding of AR's needs and how best to manage them. She also highlighted that AR had limited tolerance for Dad.
121. Samantha Steed went on to request that she been removed from the case as the parents' response was having a negative impact on her and she was unable to practice in a safe way. She explained that if AR was brought to Clinic and wished to speak with her, she would, albeit she would prefer to do it jointly with someone else. She

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requested that Dad be made aware that his behaviour was inappropriate and that he could not continue to state what clinicians allow AR to talk about if he wanted a service from CAMHS.

122. On 8 June 2022, Vicky Killen responded to Samantha Steed's email, informing that she did not get chance to call AR's dad before her leave and she wanted to touch base before calling in case there was an update. Vicky stated that she would follow up and update the following day.
123. On 27 June 2022, I received an email from Julie Royle, CAMHS Admin, informing parent of AR had called to say they cannot attend face to face appointment tomorrow and there was a request from the parent for me to do this on Teams. I responded to state that I had actioned this.
124. The initial family therapy appointment with me on 28 June 2022 was attended by both parents online. I was due to record the session. Unfortunately, I did not. I recall talking about my previous involvement and AR's Dad spoke about his hope that family therapy could be useful. AR's Dad said he would find it helpful to talk about AR and get some information and strategies for helping AR. When asking about what kind of strategies and information would be useful, Dad said that AR needed to be in education, not spending as much time in his room, staying healthy and talking more. I asked why it had not been possible to meet face to face. AR's Dad informed me that he had to remain at home with AR and they could not leave him on his own in the house after being advised by Social Care. I asked why Social Care had made this recommendation and he stated that it was because they had been told as parents, they were neglecting AR. Dad said they did not want to leave AR on his own in case they were judged negatively. Dad said both he and AR's Mum had been judged by professionals, and they had been made to feel like bad parents. We spoke about who would attend the sessions and AR's Dad said he did not think AR would attend.
125. AR's Dad stated that AR did not want to participate. I suggested that the meetings were open for him to join at any time and Dad could talk with him about what we had discussed together. I enquired about AR's brother and Dad said that he was accessing higher education and would not be able to join as he would not be at home. I also spoke about the importance of AR's Mum attending and hearing her views. There were some connection issues, so although present she was not on camera, and she did not speak. Dad said that AR's Mum was working shifts and may find it difficult to join,

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especially as the clinic appointments were on set days and times. I spoke about the challenge of offering family therapy if the family were not present. I recall Dad informing that he would speak with AR to encourage him to join. I arranged the next appointment with Dad in the meeting.

126. On 12 July 2022, I received an email from AR dad asking if we were meeting on Teams. I replied stating that I was having difficulty accessing MS Teams due to connectivity and stated that I would call him by telephone with my colleague Joan Bolger, another Family Therapist present. Handwritten notes were taken. I do not have these available. They were forwarded for scanning. I emailed AR's Dad after the meeting as I was unable to access the diary due to connectivity issues. In my email I acknowledge the meeting that had taken place and requested dates for their availability over August and September.
127. I received a reply from AR's Dad on 19 July 2022 stating that he had dates for August only and that he would provide the dates for September availability as soon as he could. He requested an afternoon appointment if possible.
128. On 16 August 2022, AR's Dad and Mum attended a family therapy appointment online with me, Joan Bolger and Michelle Warner (Trainee Family Therapist). I exhibit a copy of the notes made by Michelle Warner, which were emailed to me, as **SDC/08 – INQ-AHCH000287**. The clinical record for this appointment was written by Michelle Warner. AR's Dad spoke about losing his authority in the home, the lack of respect from AR and the gender reversal of staying at home to care for AR. AR's Mum was online but not showing on screen nor responding to attempts to engage her in conversation. Dad spoke about AR becoming aggressive towards him when speaking to him and asking him to do things. AR's Mum was described as having a very different experience of AR and able to encourage him to do things. We spoke about adapting communication with ASC in mind. Dad had reflected on his approach to communication with AR as being one of understanding, that he is not okay, and not well, so he treated him as a person that did not understand and cannot be blamed for his temper. AR's Dad spoke about getting punished by AR. This was explored in the session and Dad reflected that AR would not speak to him as punishment after an argument. Dad reflected on how he often felt like he had to give in a lot.
129. AR entered the room during the meeting. AR wanted to spend time in the lounge area where Dad was sitting, and he asked him to go upstairs so he could use the room. I recall asking if AR would consider joining the meeting while he was present but there

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was no response and Dad moved rooms. Dad asked Mum to take over talking, but the family therapy team were unable to see or hear her. When dad had relocated, I took the opportunity to check how he was feeling and how safe it was to talk about different issues. I queried whether there had been any tension when AR had entered the room, but Dad said it was okay.

130. Themes of control, mistrust, talking therapy not meeting the need for understanding what is going on and whether there were other services to get to the bottom of what is going on with AR, parents fear of AR being sectioned and AR's anger management problems, parents adapting parenting style, staying safe. The next family therapy appointment was arranged in the meeting for 22 September 2022. On 23 August I requested CAMHS Admin book this appointment and I received confirmation my request had been actioned.
131. On 2 September 2022, Dr Anthony Molyneux, Consultant Psychiatrist at the Trust, sent a letter to AR's GP and a copy was sent to me. The letter stated that Dr Molyneux had taken over as AR's Consultant Psychiatrist in July 2022. Dr Molyneux explained that there were concerns around AR's weight and restricted eating coupled with his significant reluctance to engage with professionals. He noted that part of AR's reluctance was to leave the house, and that AR tended to spend long periods of time in his bedroom. As such, Dr Molyneux noted that it was clear a face-to-face appointment was needed.
132. Dr Molyneux explained that AR cancelled his first scheduled appointment with him on 19 July 2022 and that he thereafter carried out a home visit on 28 July 2022. Dr Molyneux explained that during the visit on 28 July 2022, AR had retired to his room prior to arrival and refused to come out or let him in. As such, Dr Molyneux received an update from parents. They provided reassurance that there had been an uptick in AR's eating since May.
133. Dr Molyneux noted that with the assistance of a one-off dose of Diazepam 5mg, he was able to arrange to see AR face-to-face at the Southport Centre for Health and Wellbeing on 1 August 2022. At the appointment on 1 August 2022, Dr Molyneux explained that he was reassured that AR looked physically stable as well as improved weight. He noted that AR engaged really well during the session and demonstrated acute stability in his mental state. Dr Molyneux stated that a discussion of a further trial with a Selective Serotonin Reuptake Inhibitor ("SSRI") medication took place as Sertraline had not suited him and therefore Fluoxetine was suggested. Dr Molyneux

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concluded by stating that he had arranged to review AR's progress again over the phone on 1 December 2022 at 11:30am.

134. On 16 September 2022, I received an email from Dad requesting a meeting on Tuesday 20 September 2022 rather than 22 September 2022 as they would be extremely busy away from home on 22 September. I later received an email from Sarah Maguire CAMHS Admin informing me that AR's Mum had called to cancel the appointment of 22 September, and she had emailed me to request an alternative date.
135. On 20 September, I received an email from AR parent stating they were available that day and the next. Unfortunately, there is no record of my response.
136. On 11 October 2022, I received an email from CAMHS Admin Sarah Maguire stating that Mum had asked me to call prior to the scheduled appointment that day. Unfortunately, I have no record of the appointment or of any contact with AR's parents for that day.
137. On 1 November 2022, I emailed AR's parents stating I was contacting them to arrange another Family Therapy appointment. Dad responded to me by email on the same day to say that they could make a meeting on 29 November 2022, preferably in the afternoon. I emailed CAMHS Admin to request they book an online appointment for me and Joan Bolger to meet with AR family.
138. On 29 November 2022, a family therapy appointment was scheduled with me and Joan Bolger. Handwritten notes were completed and sent for scanning. I do not have a record of this meeting available. Another online family therapy appointment was scheduled in the diary for 24 January 2023.
139. On 5 December 2022, I was copied into an email from Sally Williams to Kathryn (Kate) Morris. Sally stated that she was able to take another case off the CBT waiting list and may be able to offer CBT to AR. She stated that she had checked back through the notes and could see that attendance was an issue for AR. Sally noted that she could offer him a face-to-face at Southport Centre for Health and asked for confirmation if AR was still awaiting CBT.
140. On 12 December 2022, I was copied into a further email from Sally Williams. Sally Williams saying that she had not heard back from Kate regarding a CBT appointment for AR and noted that she was able to offer him an appointment on 9 January, 11 am at the Southport Centre for Health and Wellbeing. Sally Williams explained that she

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was happy to go ahead and offer this; however, if he did not attend then she would close him to the CBT list, and he would have to be re-referred.

141. On 13 December 2022, I was copied into an email from Kate Morris responding to Sally Williams. Kate Morris stated that she was struggling to engage AR with CAMHS sessions and that she had met with him once to date after a lot of "Did Not Attends". She explained that she was waiting to hear from Dad to see if she could arrange a home visit, in the hope she could start to build engagement with AR. She stated that she would contact Dad that week and discuss CBT; however, she was not hopeful AR would engage.
142. On 24 January 2023, AR parents did not attend family therapy. I sent an email querying if they had received the link inviting them to the meeting and offered 21 February 2023 as the date of the next appointment. A letter was sent to AR's parents offering an appointment for Family Therapy on 21 February 2023 at 12.45pm via video link.
143. On 21 February 2023 the family therapy appointment took place with me and Michelle Warner present. Handwritten notes were completed on the day of the appointment. They were sent for scanning but unfortunately there is no electronic patient record available.
144. On 5 March 2023, I was copied into an email with Kate Morris, sent by CAMHS Admin Laura Thornton to Dr Molyneux. Attached was a letter received from Marianne Croft, Community Paediatric Dietitian, stating that AR did not attend the dietetic review on 20 February 2023, but she had spoken to his parents on the phone while AR was in the background. Marianne reported that she was really impressed with AR as he had done everything suggested and is reported to feel more confident in his ability to achieve nutritional stability. AR was discharged from the Dietetic service as he was nutritionally stable. Advice was given to follow the prescribed care plan.
145. On 28 March 2023, a Family Therapy session took place with me, Mum and Dad all online. Michelle Warner was also present. There were connection issues for AR Mum and Dad was driving which delayed the meeting. I made notes of the session in AR's records the following day. Mum expressed that she felt the Family Therapy was pointless and that she did not Trust CAMHS. Both parents explained their experience of what had been written about them by the ASC Pathway and CAMHS had led them to feel that reports were prejudiced against them and that CAMHS was very powerful and had the power to remove children. Mum then spoke about being offended and

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wounded by the comments made to them about not feeding AR in the context of concerns about his weight loss and dietary intake. They stated that these comments were not in Family Therapy but prior to coming.

146. Mum went on to speak about being referred to Family Therapy and not being in agreement with this. I shared that we had spoken at length during our first meeting, after being referred, about Family Therapy and that it was started through agreement and consent. Both parents queried why they would need to talk about aspects of their history or relationships within the family. I shared my thoughts about the nature of Family Therapy exploring the connection and understanding between people in different contexts across time. Dad said that he anticipated meeting each month to share what had happened over the month and we would offer practical suggestions about what to do.
147. I shared my concern about trying to offer Family Therapy when family members are saying that they did not trust CAMHS and did not want to talk. I suggested that we explore how trust could be established and that it may be that would be through talking despite their hesitation. I did explain that if they felt strongly that it was not possible to talk and meet due to feeling so mistrustful then it may be that we would reconsider whether Family Therapy was the right intervention at that time and undertake a review with the Case Manager about different options that felt more possible and more useful to them.
148. Both parents spoke about observing the frustration of professionals working with them and how they felt that in a recent meeting the CAMHS Case Manager had thrown AR under the bus. Dad expressed his concern that because we had focused a lot on the above issues, he had not been able to talk about what he wanted to talk about over the month. I acknowledged that what Dad wanted to contribute was also important but difficult to attend to when we had started late (due to parents' connectivity issues) and Mum having expressed such strong views on Family Therapy being pointless and she did not think it would be useful. Dad had other ideas about how Family Therapy could be useful to him and that he would have a conversation with Mum outside of the meeting.
149. In essence, the theme of the meeting focused on engagement, establishing trust and contracting. I agreed to send a date and time to meet again in the future as we did not have time to arrange this during the meeting. I subsequently sent an appointment offer for 18 April, 4 pm online but Dad responded and requested an appointment take place

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w/c 24 April. I therefore offered an appointment on 25 April 2023 at 12.45 pm via MS Teams and a letter was sent to parents on 30 March 2023 to confirm this.

150. On 10 April 2023, I received an email from Dr Molyneux, which was also addressed to Kate Morris. He requested a joint catch-up regarding AR. He stated that he was supposed to see AR again in person on 27 March 2023, but the meeting was postponed to 30 March 2023 and not attended. Dr Molyneux expressed that he felt he was not progressing with AR's case, and it felt that AR, to the extent that he did engage, had unrealistic expectations of a medical solution. He also raised concerns about the reliability of the medication monitoring and consistency of dose given the extent of parental over-accommodation as regard to leaving AR to his own devices on demand. I note that AR was discussed in MDT on 31 May 2023 although I was not present.
151. On 19 April 2023, I received an email from AR's Dad stating that he had received an in-person appointment letter for 25 April 2023. He wanted to say that both he and AR's Mum would be attending online by Teams because one of them had to be home with AR. I responded on 20 April 2023 to state the appointment would be online.
152. On 25 April 2023, a family therapy appointment took place online with me, Joan Bolger and Michelle Warner. Handwritten notes were made and sent for scanning. A record of the appointment is not available on the patient record.
153. On 23 May 2023, a family therapy appointment took place online with me, Joan Bolger and Michelle Warner. Handwritten notes were made and sent for scanning. Unfortunately, there is no record of the appointment on the patient record. I sent an email to AR's Dad at the start of the appointment as we could neither see nor hear them, but they were showing as present.
154. On 30 May 2023, I received an email from AR's Dad sharing their availability for the next appointments in June and July. I responded on 1 June 2023 to confirm the date for 18 July 2023 and that I had sent a Teams link. I stated that we did not have appointments in June available on the dates they had specified and offered alternate dates however, I do not recall receiving a response.
155. On 7 June 2023, I was informed of a TAF Meeting (Team Around Family) by email from Kate Morris. The meeting was due to take place on 22 June 2023 and was organised by Ashleigh Williams (Lancashire County Council), inviting Kate Morris, Dr Molyneux,

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AR's Dad and Mum, H Dawson from Presfield School and Sharon Rowland. I did not attend this meeting.

156. On 8 June 2023, I received an email from Kate Morris informing me that she had completed the DSD Rating Tool for my perusal and comments. I did not provide any additional comments to the completed tool.
157. On 22 June 2023, I emailed AR's Dad and Mum to explain that I would not be able to attend the arranged TAF as I had another meeting to attend. I confirmed that Kate Morris would be attending and that I would next meet with them on 18 July 2023.
158. On 18 July 2023, a family therapy meeting took place online with me and Michelle Warner. Handwritten notes were made during the meeting. Unfortunately, there is no record of the appointment on the patient record.
159. On 30 July 2023, I received an email from AR's Mum providing dates of her availability for forthcoming family therapy meetings in August and September. I responded on 29 August 2023 to inform AR's parents and Michelle Warner that I would be on leave in September, but Joan Bolger and Michelle Warner would be able to meet with them online on 5 September. AR's Dad responded by email on 29 August to confirm attendance on 5 September 2023.
160. On 5 September 2023, I received an email from AR's Dad requesting the link for the meeting but as I was on leave and did not have access to emails, I was unable to respond. On 6 September 2023, I received an email from AR's Dad stating they had not met yesterday because maybe I was not there, and they had tried to connect unsuccessfully with the link they had used. AR's Dad requested to meet on 12 September or 26 September 2023 as they were both available.
161. On 8 September 2023, I sent an email to AR Dad advising him I had sent a Teams link for 12 September to meet with Joan Bolger and Katie Williams (Trainee Clinical Psychologist). I informed them I was on leave as was Michelle Warner. AR's Dad responded asking that I ensure Michelle had the correct credentials to let them into Teams as they did not know what happened last time. I replied to reiterate that Michelle would be on leave, but Katie would be able to access Teams. Dad requested that Katie send them the link rather than me. I explained that Katie was on leave until 11 September, but I had copied her into the previous email, and she would send an invitation when she returned from leave.

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162. On 15 September 2023, a family therapy meeting took place online with Joan Bolger and Katie Williams. I was not present. My understanding is that Handwritten notes were made on the day. Unfortunately, there is no record of the meeting in the patient record.
163. On 4 October 2023, AR was discussed in the MDT. During the meeting I noted that the family had not engaged well in Family Therapy with me, and that AR did not want to work with CAMHS. I recorded that Social Care had also closed with the family. In terms of actions, I was to have a review meeting with Kathryn Morris, Dr Molyneux and the family. This is recorded as a professional discussion by Marie Disley on that date.
164. On 10 October 2023, I was copied into an email between Dr Molyneux and CAMHS Admin Laura Thornton. Kate Morris was also copied in. Dr Molyneux wanted to apprise us of a letter dated 3 October 2023, from Marianne Croft (Community Paediatric Dietitian) updating the GP of her involvement. In the letter she stated that she had not seen AR for several months due to appointment cancellation and AR's anxiety. Weight and growth had not been reviewed as AR had not been seen since May 2023. A care plan was detailed and follow up was to be arranged by her.
165. On 26 October 2023, an email was received from AR's Dad providing dates of their availability for family therapy appointments. They were available on 31 October 2023, 7 November 2023 and 2 January 2024. I responded on 3 November 2023 confirming a date of 7 November for the next family therapy appointment and sending the Teams link.
166. On 7 November 2023, AR's Dad sent an email at 2.18am asking for clarification of the time of the meeting as the smartphones were not displaying the date and time. I do not recall responding to this email as I would not have been aware of it until their appointment later in the day.
167. On 7 November 2023, a Family Therapy session was held online with me, Joan Bolger, Lead Family Therapist at the Trust, AR's Mum and Dad. Dad stated that family life was going okay. He explained that Presfield were bringing their involvement to an end as AR was not attending and that he was not accessing any tutoring or learning from them. As such, the EHCP would come to an end too. The parents noted that they were still waiting to meet with the Local Authority Transitions Worker and a meeting was arranged for the following week. Joan and I asked what AR would want in relation

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to school, learning or work. Dad stated that he did not feel AR was ready for any sort of work or college. Joan and I asserted the value of the EHCP being available until age 25 as AR's ideas about attending college could change.

168. Joan and I explored the impact of lots of professionals and what outcomes they have achieved. Mum stated that she felt some workers who visited and spoke to them were rude. We spoke about the importance speaking with respect. Joan and I shared ideas about parental presence and how they were always striving to do the best for AR, noting that they were currently trying to sort out benefits for him. Dad requested a vacation from therapy in December. It was agreed that the next meeting would take place on 9 January 2024 at 12.45pm online.
169. On 9 January 2024, a family therapy meeting took place online with me, Joan Bolger and Michelle Warner (Trainee Family Therapist). AR dad attended. I exhibit a handwritten copy of the notes of the meeting as **SDC/09 – AHCH000288** The meeting themes were endings, school and the role of therapy. Dad had been informed by the local authority that if place at Presfield remains or AR returns to college the EHCP would be re-instated. Dad stated that a member of safeguarding staff had attended to see AR and they discussed college. Dad stated AR had informed the staff member he was unsure what he would like to do. Dad reported he had requested school keep AR's 6th Form placement open.
170. We discussed what arrangements might be in place for AR to contribute to the house such as rent as he approached 18. AR's Dad said he thought this might be a conversation for AR to have with professionals. Culture was explored in relation to differences between UK and Rwanda. Dad informed they would not ask children to contribute, unless people are older, when the children take over. Dad said that if AR was working, he would ask for a contribution, but he was not sure Mum would support this view. Dad said Mum sees a child as learning and she would not take stuff from her babies and would encourage him to save.
171. Dad voiced his view that with AR's autism he needs to be supported and understood. Dad reported that AR has said that when he is 18, he will start his own company. Dad said that they would help him save although AR doesn't want parental involvement.
172. We talked about AR in terms of Achieving, Happy, Healthy, Alive (AHHA). Dad stated that he considered AR to be happy and healthy, but Dad said he was finding the achieving bit a struggle. Dad said AR didn't understand stuff and he had to strike a

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balance between health and happiness. Dad reflected on when AR had to attend a dietitian appointment, he was up all night and then didn't attend. Dad said he felt AR feared going out so wouldn't attend appointments.

173. Dad spoke about how AR had increased his weight through ready meals and drinks which now included milk. Dad spoke about trying to re-connect his son with his primary school friends, but AR was not interested. Michelle asked about how parents let AR be exposed to natural consequences. Dad said that if you didn't intervene it could result in calling the police and things escalating. Dad said they worried AR would not eat and would starve to death. Dad said at that moment they did things for AR in the hope he would learn things like managing money but at that time he was not ready. Dad spoke about taking things slowly, he knew when to have a shower and change his clothes.
174. The meeting was brought to a close with consideration of parents keeping things safe, parents being on standby and exploring transition to adulthood and adult services. Additional services AR could access as well as his parents were considered. The next appointment was agreed for 6 February 2024 although Dad was unsure if Mum could join due to her work commitments.
175. On 10 January 2024, AR was discussed in MDT by Kate Morris. It was discussed that Dad wanted AR to remain with CAMHS until he could transition to adult services. AR did not engage with CAMHS and did not attend Presfield. Action was for Kate to consult with Jenny Balmer (Mersey Care Transitions Lead). This entry is in the records as a professional discussion.
176. On 10 January 2024 I received an email from AR's Dad informing me that Tuesdays in February (20 February and 27 February) were when he and Mum could attend a further family therapy session. On 2 February 2024 I responded by email to explain that the clinic was already booked on the dates they had specified and to request we still meet on 6 February 2024 as previously arranged. I stated that Joan Bolger and Michelle Warner were also on leave, but I could still meet with him. AR Dad responded saying that he really wanted AR's Mum to be there to benefit from the therapy as a family. He asked to cancel the meeting in February and find a suitable date in March. He said that he would update me with their availability. I replied by email to apprise him that I would be in contact if we got a cancellation on either of the dates they had specified. Dad responded to say that AR was no longer attending school which meant they were available all day on Tuesday 20 and 27 February. The family therapy appointment for 6 February was cancelled at AR parents' request.

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177. On 20 February I sent an email to AR's Dad informing him that there had been a cancellation in the family therapy clinic, and I could meet with them online with Michelle Warner. I apologised for the short notice.
178. On 20 February 2024, a Family Therapy Session was held online with me, Michelle Warner, Trainee Family Therapist, Mum and Dad. I have made a note of this session in AR's records. AR did not join but this was not unusual as AR had chosen not to join any Family Therapy appointments. Mum chose not to be on camera but was listening and contributing to the conversation. Dad remembered that we had spoken about AHHA during our last meeting which led on to a conversation about gratitude and faith. We spoke about progress and there had been no change in relation to AR going out or accessing learning.
179. Both parents spoke about AR being calmer now without professionals visiting the home. They spoke about visits leaving AR unsettled in the home, which they had to manage. Dad said AR was happy doing what he did as long as no one bothered him. They said that AR would speak to them in different ways, sometimes late at night, often at great length about geo-politics or other things he had been researching. Dad spoke about how bad things had been in the past with AR sharing some examples whereby he threw things, tipped over tables, hit Dad and shouted. Dad noted that these things did not happen anymore.
180. The conversation continued to consider what could be offered by the Family Therapy team. Dad said that he benefitted from Family Therapy as it gave him a space to talk about things. Mum shared a different opinion in that there was nothing she felt Family Therapy could do for AR or them as a family. Given that Dad wanted to continue with Family Therapy, we agreed to offer another appointment. We originally offered an appointment in March but for Mum to be present we agreed to meet on 23 April 2024, at 12.45 pm online (a letter was sent to parents on 26 February 2024 to confirm this) but also suggested we could meet with Dad in March as he found the meetings useful. Unfortunately, Mum felt that this was a way of trying to split up the family. She made other comments and remarks which were accusatory in nature which I cannot recall. I provided an apology for any misunderstanding and reiterated that Dad had found the sessions useful, and we always offer appointments to families both together and on their own.

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181. On 26 March 2024, I had an email exchange with AR's parents to explain that I was leaving the Sefton service at the end of March but that I would still attend the meeting as planned on 23 April 2024. I said that I wanted to let them know in advance rather than for it to be a surprise. Dad responded to say that he was sad I was leaving, and it had never crossed his mind. Dad stated that he would like the planned meeting on 23 April to be the final Family Therapy session. Dad commented that we would bring our involvement to an end leaving them stronger, more self-aware, and therefore more resilient than before family therapy began. Dad took the opportunity to thank me and the family therapy team, notably Michelle and Joan for their patience and support.
182. On 16 April 2024, Dr Molyneux sent a letter to AR's GP of which I received a copy. The letter advised that AR had been discharged from CAMHS Psychiatry but remained open to me. He stated that it had been challenging to engage AR and that his parents had been much more open to engaging with Family Therapy.
183. Dr Molyneux highlighted that Sertraline medication had been tried for AR in the past but that the lack of consistency in the taking of this medication led to Dr Molyneux feeling he could not continue to prescribe it safely until or unless AR engaged in a consistent manner with follow-up appointments, which he did not.
184. Dr Molyneux explained that AR had responded well to Melatonin medication with it being a much safer and uncomplicated medication to prescribe. Dr Molyneux did not see any reason why it could not continue although he did have an expectation of 6 – 12 monthly appointments going forward if AR wished to remain on the medication.
185. On 23 April 2024, the final Family Therapy session took place online with me, Joan Bolger, Michelle Warner, Mum and Dad. I have made a note of the meeting in AR's records. We discussed AR's Mum and Dad's experience of Family Therapy and CAMHS. Mum and Dad reflected on how it had been a difficult journey at times with professionals. Dad stated that the sessions had been helpful in terms of having space and time to think about his own family and in areas around parenting a child with enhanced needs.
186. Other parental feedback included parents advising that they felt issues around power and status made them feel disempowered and misunderstood at times. They expressed that very personal aspects of family life are explored, with the process sometimes feeling undermining of their parental confidence and competence. Mum

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and Dad advised professionals charged with their care should embrace issues around ethnicity and cultural identity to allow the family to feel valued and understood.

187. AR's Mum and Dad spoke about their acceptance of their sons' enhanced needs and unique personality with them feeling they need to celebrate this news of difference. They advised that their other son was doing well at college, playing multiple instruments and wanted to be an opera singer.
188. Both parents suggested we should ask a family permission before inviting students or new team members to join meetings and to let the family know they have a choice and an opportunity to be prepared when sharing aspects of their family life with others.
189. The family therapy team gave feedback about the parents' commitment to Family Therapy despite their struggle to trust mental health services. We agreed that Family Therapy would come to an end, a closure letter would be shared, and AR would continue under the care of the Case Manager, Kathryn Morris, who would review the plan and decide next steps with them as AR was turning 18 soon.
190. I had no further involvement in relation to AR or his family.

My involvement in assessment, diagnosis and treatment

As CAMHS Case Manager (May–August 2020)

191. I was allocated to AR by Vicky Killen (Clinical Lead). Previous Case Manager was Skott Morgan (CAMHS Practitioner) who had left the service before I started in post. At the time of my commencement in post in May 2020, an additional GP referral was received by the service citing social anxiety and nervousness. My role included initial engagement, assessment of presenting issues, and offering psychoeducation and therapeutic input. I attempted multiple telephone contacts and held two direct conversations with AR. I provided anxiety management materials and explored therapeutic goals. Despite these efforts, AR demonstrated limited engagement and ultimately declined further involvement. AR was on the ASD Pathway waiting for assessment.

As Family Therapist (May 2022–April 2024)

192. I was allocated to provide systemic family therapy. Sessions were held online at parents request due to being advised they had to remain at home with AR. AR did not

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attend any sessions, but his parents participated. The therapy focused on family dynamics, communication, and understanding AR's needs in the context of his autism diagnosis. Sessions explored themes such as parental authority, cultural expectations, and emotional regulation. The therapy concluded in April 2024 with mutual agreement.

Particular issues relevant to my involvement

Family Therapy

193. Family therapy at Alder Hey NHS Foundation Trust is provided as a systemic intervention for a range of relational and interpersonal difficulties being experienced by a family accessing CAMHS. The Association for Family Therapy and Systemic Practice defines the practice of family therapy, as an evidence-based intervention that *“can help those in close relationships to better understand and support each other. It enables family members to express and explore difficult thoughts and emotions safely, understand each other's experiences and views, appreciate each other's needs, build on family strengths, and work together to make useful changes in their relationships and their lives”*. The therapy is collaborative, inclusive, and culturally sensitive, and it seeks to empower families to find their own solutions and strengthen their resilience.
194. Family therapy can be offered either by a single practitioner or as a team intervention. AR's family were provided a team approach, staffed by three core family therapy team members, comprised of two family therapists and one trainee family therapist. Working as a team with a family allows multiple perspectives to be considered through the use of a reflecting team method and live supervision. Family members respond differently to different therapists, supporting flexibility in engagement, which can be useful when working with neurodivergence or reluctance. Appointments are offered every three to four weeks. Some families attend over a twelve-month period, but this can be extended when families need longer to find solutions that work for them.
195. Family therapy was provided from May 2022 to April 2024, using a family therapy team approach, with my colleagues Joan Bolger and Michelle Warner. Meetings were conducted online. AR did not provide his informed consent to participate and did not attend any meetings. AR's parents participated in family therapy meetings. The therapy focused on: exploring family dynamics and communication styles; understanding AR's autism diagnosis and its impact on relationships; addressing parental concerns around authority, trust, and cultural expectations; Supporting parents in adapting their

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parenting approaches and managing stress; and facilitating reflection on emotional responses and family roles.

196. Themes such as mistrust of services, parental roles and responsibilities, and AR's independence were recurrent.
197. Concerns were raised regarding parental mistrust of CAMHS, particularly from AR's mother, who consistently expressed feeling judged, misunderstood, and unsupported by professionals. This mistrust appeared to impact engagement with services and contributed to a guarded approach during clinical interactions. The perception of being scrutinised by professionals may have exacerbated existing stress within the family system and hindered collaborative care planning.
198. Parental stress and intra-familial conflict were also evident, with reports of frequent shouting, emotional dysregulation, and breakdowns in communication both within the home and in interactions with professionals. These dynamics were explored in family therapy sessions and discussed in multi-disciplinary team (MDT) meetings and safeguarding forums, where appropriate. The case managers maintained oversight of these concerns, ensuring that risk assessments and support strategies were regularly reviewed.
199. In response to these challenges, we maintained an open and transparent dialogue with the family, validating their lived experiences and concerns. The therapeutic approach was adapted to accommodate the parents' emotional readiness and different preferences, with an emphasis on building trust, reducing negativity and blame, particularly in relation to perceived professional authority, and promoting psychological safety. This included pacing interventions appropriately, offering psychoeducation, and facilitating space for reflective conversations aimed at improving relational functioning as a family and engagement with services
200. In instances where a child or young person does not attend family therapy sessions, therapeutic work can continue with parents or carers to address systemic issues and promote a more supportive home environment. This approach is grounded in systemic practice principles, which recognise that meaningful change can occur through shifts in family dynamics, even in the absence of the child.
201. In AR's case, although he declined to participate in family therapy, sessions proceeded with his parents to explore relational patterns, communication difficulties, and sources

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of stress within the family system. The therapeutic focus included empowering parents to better understand AR's emotional needs, reduce environmental triggers, and implement strategies to support his well-being indirectly. This work aimed to enhance parental attunement and reduce conflict, thereby creating conditions more conducive to AR's engagement and emotional regulation.

202. The invitation for AR to join therapy remained open throughout, and this was communicated clearly to both AR and his parents. His autonomy and right to decline participation were respected, in line with CAMHS' consent-based model and legal standards regarding competence.
203. In parallel, the case was regularly reviewed in multi-disciplinary team (MDT) meetings, where alternative or adjunctive interventions were considered. These included keywork support, psychiatric review, and adapted psychological interventions such as low-demand cognitive behavioural strategies. The clinical team remained responsive to AR's evolving needs and continued to explore engagement opportunities through indirect means, while maintaining safeguarding oversight and open communication with the family.
204. In response to his non-attendance, several actions were taken to promote inclusion and maintain therapeutic momentum: Parents were encouraged to invite AR to sessions and to share relevant content with him, fostering transparency and keeping the door open for future engagement. The service offered flexible formats and scheduling options, including the possibility of shorter sessions, remote access, or informal check-ins, to accommodate AR's preferences and reduce perceived pressure. Therapeutic work continued with AR's parents, focusing on improving communication, reducing conflict, and enhancing their capacity to support AR's emotional needs within the home environment. This systemic approach aimed to create a more stable and responsive family context, which could indirectly benefit AR.
205. AR's non-attendance and its implications were regularly documented and discussed in multi-disciplinary team (MDT) meetings. These discussions informed ongoing care planning, risk assessment, and consideration of alternative or adjunctive interventions, such as keywork, psychiatric input, or adapted psychological strategies. The clinical team remained committed to a relational and trauma-informed approach, ensuring that AR's voice and preferences were respected while continuing to support the family system.

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206. Risk management in AR's case was approached through a structured, multi-agency framework, with a focus on early identification, collaborative planning, and responsive intervention. Although no acute risk was identified during the assessment period, AR's presentation and the family dynamics warranted ongoing monitoring and professional oversight.
207. The following measures were implemented to ensure that potential risks were appropriately managed: AR's case was discussed routinely in multi-disciplinary team (MDT) meetings, where new information, parental reports, and engagement patterns were reviewed. These forums enabled shared decision-making, risk formulation, and the coordination of care across disciplines.
208. Where concerns arose, particularly in relation to parental stress, communication breakdowns, or AR's social withdrawal, safeguarding consultations were held with designated professionals. These discussions ensured that any emerging risks were assessed in line with local safeguarding protocols and thresholds.
209. Parental feedback was actively sought and monitored for changes in AR's mood, behaviour, eating patterns, and engagement. This information was used to inform clinical judgement and guide the pace and focus of intervention.
210. Ongoing communication was maintained with other professionals involved in AR's care, including psychiatry, dietetics, education, and social care. This ensured a coordinated approach and allowed for the triangulation of information to support ongoing assessment.
211. Parents were offered psychoeducation regarding anxiety, neurodivergence, and demand avoidance, alongside emotional support to help them manage stress and respond to AR's needs more effectively. This work aimed to reduce family conflict and promote a safer, more regulated home environment.
212. Clear escalation pathways were in place should AR's presentation deteriorate, or safeguarding concerns escalate. These included access to urgent psychiatric review, 24 hour Crisis Care Services, and referral to statutory safeguarding agencies if required.

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213. Overall, care was managed proactively and proportionately, with a focus on relational safety, family support, and inter-agency collaboration.
214. Despite sustained efforts to engage AR in therapeutic work, he consistently declined to attend sessions, including family therapy. Several factors may have contributed to his refusal to engage. These include the autism-related traits, such as heightened demand avoidance, cognitive rigidity, and a strong preference for routine and predictability, which may have made the therapeutic setting feel overwhelming or intrusive. Previous negative experiences with professionals, which may have led to mistrust or scepticism about the value of mental health services and a clear preference for privacy and autonomy, which AR expressed through his behaviour, suggesting that direct engagement may have felt threatening to his sense of control.
215. In response, the clinical team employed a range of strategies to encourage engagement, including offering flexible scheduling, adapting the format of sessions, and maintaining indirect therapeutic support through work with his parents. These efforts were designed to reduce perceived pressure, build trust, and keep the door open for future participation.
216. While AR remained resistant to direct involvement, the approach taken was proportionate, ethically sound, and consistent with CAMHS' consent-based model. It is acknowledged that a different modality, timing, or practitioner may have yielded a different outcome. However, given AR's consistent stance, presentation, and the legal requirement to respect his autonomy and capacity, the clinical decisions made were appropriate and in line with best practice. The team remained committed to supporting AR indirectly, maintaining open channels of communication with his parents, while continuing to contribute to multi-disciplinary forums to ensure that all reasonable avenues for engagement were explored.

Final Family Therapy Session 23 April 2024 and closure on 23 July 2024

217. The CAMHS clinical record dated 23 April 2024 refers to the final family therapy session conducted with AR's parents. This session was attended by me (clinician), Joan Bolger (Family Therapist), and Michelle Warner (Case Manager). AR did not attend the session, consistent with his previous pattern of non-engagement.
218. The focus of the session was to reflect on the family's therapeutic journey and their broader experience with CAMHS. Both parents contributed openly, sharing their

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perspectives on the challenges they had encountered, their evolving understanding of AR's emotional and developmental needs, and their appreciation for the support provided by the family therapy team. The session also served as a space to acknowledge the progress made in terms of parental insight and systemic understanding, despite AR's absence from direct therapeutic work.

219. At the conclusion of the session, it was mutually agreed that family therapy would come to an end. It was confirmed that the Case Manager would also be bringing their involvement to a close in CAMHS, with a view to discharge from the service.

220. There was no family therapy session on 26 June 2024. Kate Morris has made a closure entry in the clinical documentation on 23 July 2024. She refers to the last session being on 26 June 2024. Based on the available evidence, it is likely that this date represents a typographical error due to the fact that I did not upload the entry relating to the session on 23 April 2024 on the system until 26 June 2024. This clarification is provided to ensure accuracy in the Inquiry's review of the therapeutic timeline and case chronology.

221. As set out in the chronology and clarified above, the final family therapy session took place on 23 April 2024 and was conducted online. It was attended by AR's parents, me, Joan Bolger (Family Therapist), and Michelle Warner (Case Manager). AR did not attend this session, consistent with his established pattern of non-engagement throughout the therapeutic process. The clinical record for this session was formally updated on 26 June 2024 by me.

222. The session provided a structured opportunity for AR's parents to reflect on their experience of family therapy and their broader involvement with CAMHS. Both parents engaged meaningfully in the discussion and shared the following:

- Acknowledgement that the therapeutic process had been emotionally challenging but ultimately beneficial, particularly in offering space for reflection, validation, and support in the difficulty of parenting AR.
- Concerns regarding perceived power imbalances and professional judgement from health and social care agencies, which at times left them feeling disempowered and misunderstood. These reflections were explored sensitively and acknowledged as part of the therapeutic process within family therapy.

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- Emphasis on the importance of cultural understanding and sensitivity in therapeutic work, particularly in relation to how their family's values and experiences were interpreted by professionals. The parents informed we had attended to this in family therapy.
- A growing sense of acceptance of AR's unique neurodevelopmental profile, including his preferences, sensitivities, and strengths. The parents expressed a desire to celebrate AR's individuality rather than pathologize his differences.

223. From a team perspective, the view at the time was that AR remained disengaged from direct therapeutic input, despite multiple efforts to encourage participation. However, his parents had reported increased insight, emotional resilience, and a more nuanced understanding of AR's needs. There were no immediate safeguarding concerns at the time of the session. AR had shown improvements in his nutritional intake, and the family environment appeared stable, with reduced conflict and improved communication.

224. The decision to conclude family therapy was mutual and clinically appropriate, reflecting both the natural closure of the therapeutic process and the family's readiness to move forward.

225. The decision to conclude family therapy was based on a combination of clinical, relational, and developmental factors, and was made collaboratively with AR's parents and the wider CAMHS team. The rationale included the following considerations:

- Despite repeated invitations and efforts to accommodate his preferences, AR did not attend any family therapy sessions. His stance remained unchanged throughout the intervention period, and his autonomy and capacity to decline participation were respected in accordance with CAMHS' consent-based model and legal standards.
- AR's parents expressed that they had gained meaningful insight and support through the therapeutic process. They reported feeling more confident in their ability to understand and respond to AR's needs and indicated that they were ready to move forward independently. The final session provided a space for reflection and closure, and the parents acknowledged the value of the work undertaken.

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- The sessions facilitated reflection on family dynamics, with reported improvement in parental understanding of AR's neurodevelopmental profile and strengthened coping strategies. With AR approaching adulthood, the therapeutic focus shifted toward transition planning and parenting to prepare for such change.

226. The decision to end family therapy was made with careful consideration of AR's presentation, the progress achieved through indirect work, and the family's expressed needs. It was deemed clinically appropriate, ethically sound, and aligned with best practice in systemic and consent-based care.

227. In my professional judgement, the decision to conclude family therapy was both clinically appropriate and ethically sound, based on the family's level of engagement, the therapeutic progress achieved, and the broader context of AR's ongoing non-participation.

228. The family had engaged with the therapeutic process to the extent they were able, given the emotional and relational complexities involved. While AR consistently declined to attend sessions, his parents, particularly his father, demonstrated a sustained commitment to the work, attending regularly and participating openly. Over time, they reported developing greater insight into AR's needs, improving their emotional resilience, and feeling more confident in their ability to support him within the home environment.

229. During the final session, both parents expressed appreciation for the support they had received and acknowledged the value of the space provided for reflection, validation, and growth. They also indicated that they had reached a point of readiness to move forward independently, without the need for continued therapeutic input.

230. Given AR's continued non-engagement, despite multiple invitations and adaptations to the therapeutic offer, and the parents' expressed sense of closure, it was agreed that the therapeutic process had reached a natural and meaningful conclusion. The decision to end family therapy was made collaboratively, with consideration of the family's progress, the absence of immediate safeguarding concerns, and the transition planning already underway with AR's Case Manager as he approached adulthood.

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Assessment of risks

231. At Alder Hey NHS Foundation Trust, risk assessment is embedded as a core component of clinical practice and is conducted in a manner that is continuous, collaborative, and contextually informed. The process is designed to ensure that potential risks to the young person, their family, and others are identified, monitored, and managed in a timely and proportionate way.
232. Risk is assessed involving the young person (where appropriate), their family, and the wider multidisciplinary team (MDT). This approach ensures that risk formulation is informed by multiple perspectives and remains responsive to changes in presentation or context.
233. CAMHS Practitioners use a structured clinical judgement model, which incorporates clinical interviews, behavioural observations, collateral information from parents, schools, and other agencies to evaluate risk.
234. Where risk is identified, risk management plans are developed in collaboration with the MDT and the family and reviewed regularly in MDT meetings and safeguarding supervision.
235. In AR's case, although no acute risk was identified during the period of involvement, risk was monitored proactively through ongoing liaison with parents and professionals, regular MDT discussions, safeguarding consultations where appropriate, and escalation pathways were in place should AR's presentation deteriorate, including access to urgent psychiatric review, crisis services, and referral to statutory safeguarding agencies if required.
236. Risk assessment was completed by Skott Morgan, Samantha Steed, and Kate Morris, using the risk management tools available to ensure that risk was appropriately evaluated and managed. Each clinician contributed to a continued assessment of the presenting concern, with documentation reflecting a consistent and structured approach. The absence of acute risk indicated a stable risk profile and supported the appropriateness of the ongoing care plan.

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237. Risk assessment was conducted through direct clinical contact during my involvement as both Case Manager and Family Therapist. This included regular communication with AR's parents and their view of AR's presentation and family dynamics. My involvement with Multidisciplinary Team (MDT) discussions allowed for shared clinical formulation and planning, ensuring that risk was considered from multiple professional perspectives. Safeguarding supervision was accessed by the case managers, particularly in response to disclosures regarding family conflict and concerns about AR's physical health. Appropriate actions and escalation pathways were followed.
238. Liaison with psychiatrists, and external professionals such as dietitians, and social care, was used to triangulate information and ensure a broader understanding of AR's needs and risks.
239. While AR did not present with acute risk to self or others during my direct involvement, several areas of concern were identified and monitored. These included weight loss and refusal to eat, which prompted medical investigations and liaison with paediatric and dietetic services. Although AR's nutritional intake later improved, this period of physical health concern was treated with clinical seriousness.
240. Family conflict and allegations of aggression were escalated to safeguarding by the case manager for further review. Concerns were explored in family therapy and discussed in MDT. The case manager was supported to access safeguarding supervision to assess risk and support relational safety.
241. AR's non-engagement with services, which limited the ability to fully assess AR's mental state, posed a challenge to risk formulation. This was recognised as a potential vulnerability, particularly in the context of social withdrawal and demand avoidance. In response to these concerns, referrals to Safeguarding and Social Care were completed to ensure that the family received appropriate support and oversight. Medical referrals were supported to investigate AR's physical health and nutritional status. There was ongoing monitoring through MDT reviews and parental updates, with escalation pathways in place should AR's presentation deteriorate.
242. Throughout the period of CAMHS involvement, the clinical team remained vigilant and responsive, balancing the need to respect AR's autonomy with the duty to safeguard his wellbeing. Risk was managed proportionately and collaboratively, based on the information available to the service.

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CAMHS Session Note 25 September 2023

243. The session note was made by Dr Molyneux and refers to a plan to discuss the future role of psychiatry and CAMHS with Kate Morris and myself. While I do not have a specific standalone record of this discussion, I was actively involved in ongoing multidisciplinary team (MDT) meetings and case discussions during this period. It is likely that the conversation referenced in the note took place either informally or within the context of one of these MDT forums, contributing to the broader care planning process.

244. From memory, these discussions focused on several key areas:

- AR's continued non-engagement with CAMHS, despite repeated efforts to offer flexible, low-demand, and relationship-based interventions. His refusal to engage limited the scope of direct psychiatric assessment and intervention.
- The appropriateness of ongoing psychiatric input, particularly in the absence of acute mental health risk or a clear diagnostic formulation that would benefit from medical treatment. The team considered whether continued psychiatric oversight was proportionate and clinically justified, given AR's presentation and preferences.
- Transition planning, as AR was approaching the age of 18. Discussions included the need to prepare for potential transfer to adult services, the importance of maintaining continuity of care, and the role of the Case Manager in coordinating this process. Consideration was also given to whether AR would meet the threshold for adult mental health services, given his non-engagement and the absence of acute risk.

245. These conversations were part of a broader systemic and collaborative approach to care planning, ensuring that decisions were made in the best interests of the young person while respecting his autonomy and legal rights. The absence of a formal record of the specific conversation does not reflect a lack of clinical oversight, but rather the integrated nature of MDT working, where decisions are often shaped through cumulative dialogue and shared professional judgement

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Involvement with other agencies

246. In my role as case manager, I liaised with Lancashire Youth Offending Team (YOT) and West Lancashire CAMHS in relation to engagement, information sharing and aligning care planning. I recall my experience being positive and responsive.
247. I am also aware that subsequent case managers in CAMHS were required to liaise with Social Care in response to safeguarding concerns, particularly around family conflict and allegations of aggression. These discussions informed risk assessments and contributed to safeguarding supervision. They also liaised with education providers to support AR's educational engagement and learning profile and ensure that his emotional and behavioural needs were considered within the school environment.
248. Dietetic Services and General Practitioners (GPs) were essential in monitoring AR's physical health, particularly during periods of weight loss and nutritional concern. Medical investigations were coordinated to ensure appropriate follow-up and support. It is worthy to note the dietetics service encountered similar difficulty in evaluating AR's needs due to non-attendance and engagement difficulties.
249. Reflecting on the effectiveness of multi-agency collaboration, my view would be that CAMHS was proactive in requesting multi-agency support for information sharing, coordinated planning, and a shared understanding of AR's needs.
250. However, the differing thresholds for risk and intervention sometimes led to inconsistencies in response, particularly between health and social care, with varying interpretations of risk severity, eligibility for services, and urgency of action. This has been especially evident in relation to the concerns about family conflict and non-engagement, where thresholds for statutory intervention were not always aligned with clinical concerns raised by CAMHS. The absence of a shared framework for understanding neurodevelopmental vulnerability may have led to misalignment in interpretation and response. This is particularly relevant for discussions around safeguarding thresholds and behavioural presentations that may be misunderstood outside of a clinical context.

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251. The review process, has identified an emerging concern regarding limitations on information sharing by Prevent and the Police, highlighting broader systemic issues in how they interface with mental health services. Specifically, the restricted flow of information to CAMHS, limiting the ability of CAMHS professionals to fully understand the scope of external concerns or to contribute meaningfully to joint safeguarding decisions. This lack of transparency can hinder risk formulation and delay appropriate intervention, particularly in complex cases involving neurodivergence, social withdrawal, or oppositional behaviours, where there is a risk of harm to others.

252. During AR's care, limitations in the provision of appropriate education were a significant concern, particularly in relation to his neurodevelopmental needs and the impact on wellbeing and engagement. Education providers have a statutory responsibility to ensure access to suitable education for all children, including those with complex health and developmental needs. Despite efforts to escalate these concerns through multi-agency meetings and formal communication with education providers, progress was slow. This highlights the need for clearer escalation pathways and stronger accountability mechanisms across Social Care and Education sectors for improved collaboration and responsiveness, particularly where specialist input and flexible provision are required.

253. My reflections have focused on the importance of continued inter-agency training, improved protocols for information sharing, and a shared understanding of neurodevelopmental needs across all safeguarding partners.

Reflection on events

254. At the time of my involvement in AR's care, I acted in accordance with clinical guidance, ethical standards, and the information available to me. I made repeated efforts to engage AR, adapted my approach to their presentation and preferences, and escalated concerns through appropriate channels. However, with the benefit of hindsight and reflection, several key learning points have emerged:

- While AR's autonomy and right to disengage were respected, earlier and more assertive multi-agency planning may have helped address systemic barriers to engagement. This could have included convening professionals sooner to

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explore alternative approaches, clarify roles, and ensure that AR's voice was heard in a more structured and supported way. Earlier escalation may also have prompted more timely interventions from education and social care partners.

- The complexity of family relationships, including mistrust of services and differing perspectives on AR's needs, presented significant challenges. In retrospect, earlier systemic intervention, such as a coordinated family support plan, jointly held between Social Care and Health, may have helped to build trust, reduce conflict, and improve engagement. These dynamics required a more proactive and relational approach across agencies.
- Due to competing clinical demands, some sessions and decisions were not fully documented, both by myself and other members of the team. There were also issues with the scanning in of documents which meant that they were not always available to the wider team. While this did not compromise immediate safety, more consistent and detailed record-keeping would have strengthened continuity, accountability, and the ability to track progress over time. This reflection aligns with recent service improvements, including the implementation of a strengthened record-keeping policy and enhanced electronic documentation systems.
- AR's care involved coordination between services in Sefton and Lancashire, which created ambiguity around responsibilities and pathways. The absence of a clear protocol for managing cross-border cases contributed to delays and confusion. A more defined framework for inter-authority collaboration would have supported smoother transitions and more consistent care planning.
- The impact of the Covid-19 pandemic on CAMHS was, and continues to be, significant. This led to huge shifts in our practice, for example to telephone and video consultations, but also a lot of fear at the time amongst practitioners, families, children and young people. There was a great deal of pressure within the service, not only due to the number of referrals but due to the inevitable levels of staff sickness. This meant staff prioritised seeing children, and particularly those with the most concerning mental health presentations, over documentation. The impact upon children cannot be underestimated. There have always been a small number of children stuck at home but now we have

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many. They see that all their needs can be met at home. This has knock on effects for education and I have noted that the tolerance for non-attendance is higher. We now see children much further down the line, for example not having attended school for two years.

255. While the care provided was thoughtful, collaborative, and grounded in clinical best practice, this case illustrates the inherent challenges of working with non-engaging young people and families with complex needs. It also underscores the importance of early escalation, systemic thinking, and robust inter-agency coordination. These reflections have informed my ongoing practice and reinforce the value of continuous learning, service development, and shared responsibility across systems.

256. At the time of my involvement, the guidance and training available were generally adequate for my role as Case Manager and Family Therapist. I had access to regular clinical supervision and safeguarding supervision, which supported reflective practice and risk management. I also had access to Multidisciplinary team (MDT) discussions, offering peer support and shared decision-making. I have received training as a mental health nurse and advanced training in systemic practice, which informed my approach to working with AR and his family.

257. However, CAMHS often functions as the sole provider for children and young people presenting with a complex range of emotional, behavioural, and neurodevelopmental difficulties. While the service is increasingly neurodiversity-informed, incorporating principles of autism-informed and trauma-informed care, it is important to note that CAMHS is not a specialist Autism Spectrum Condition (ASC) service.

258. In AR's case, his presentation involved traits consistent with autism, significant anxiety, and possible demand avoidance. While CAMHS staff were able to adapt their approach using autism-informed strategies, the absence of a dedicated ASC pathway or specialist provision limited the scope of intervention. This reflects a broader systemic gap in service provision. Children with complex neurodevelopmental profiles often fall between service thresholds, particularly when they do not meet criteria for learning disability services.

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259. The result is that CAMHS is frequently left to hold clinical responsibility for young people whose needs extend beyond its core remit, without access to the specialist input, resources, or multi-agency infrastructure required to deliver comprehensive care. This can lead to fragmented support, delayed intervention, and increased pressure on families and frontline clinicians.
260. Addressing this gap requires investment in specialist neurodevelopmental services, improved cross-agency pathways, and greater recognition of the complexity and diversity of presentations within the autism spectrum — particularly where co-occurring mental health needs and service disengagement are present.
261. Resources for cross-border working, especially between Sefton and Lancashire services, were limited. Differences in service structures, referral pathways, and communication protocols occasionally created delays and confusion in care coordination. Improved guidance and shared frameworks for inter-authority collaboration would support more seamless transitions and joint planning.
262. Administrative support for documentation and coordination was stretched. This impacted the ability to maintain comprehensive records, track multi-agency input, and ensure timely updates to care plans. In complex cases like AR's, where multiple agencies are involved and engagement is limited, robust administrative systems that support practitioners are essential to ensure continuity and accountability.
263. These reflections underscore the importance of ongoing professional development, investment in inter-agency infrastructure, and the need for tailored training to meet the evolving demands of clinical practice—particularly in cases involving neurodivergence, safeguarding complexity, and systemic disengagement.

Improvements

Improvements already made

264. Since my direct involvement in AR's care, I have observed several significant improvements within CAMHS at Alder Hey NHS Foundation Trust that have strengthened clinical governance, communication, and care coordination.
265. The service has adopted a more robust record-keeping policy with improvements to the Meditech electronic patient record system. This includes

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improved risk stratification and management at point of referral, clearer risk and care planning documentation, and improved scanning and uploading of documents. All staff have received training in the improvements which reinforces expectations around timely, accurate, and comprehensive documentation. The changes have enhanced transparency, ensured continuity of care, and improved information accessibility across teams within the Trust.

266. To support clinical efficiency and reduce documentation delays, the service has strengthened administrative support through investment in Ambient AI tools to enable clinicians to focus on direct care. AI-powered transcription tools allow for real-time notetaking and streamlined record entry, improving the timeliness, accuracy, and consistency of clinical documentation. These developments reflect a commitment to reducing workload pressures while maintaining high standards of record-keeping and follow-up.
267. Safeguarding reporting and escalation pathway within the Trust has been improved. This includes strengthened procedures for safeguarding alerts and Prevent monitoring, ensuring that concerns related to radicalisation, extremism and risk to others are identified and addressed in a timely and coordinated manner. These enhancements have supported more responsive and joined-up approaches to managing risk. These changes reflect the commitment to service development and learning from complex cases.
268. The service has taken a proactive stance in enhancing staff capability through targeted cultural competence training with the Anthony Walker Foundation, recognising the importance of equitable and sensitive care for families from diverse backgrounds. This initiative reflects a broader commitment to inclusive practice and acknowledges the impact of cultural identity, language, and lived experience on engagement, communication, and therapeutic outcomes.
269. This training has been embedded into the induction programme and ongoing professional development, with feedback mechanisms to ensure relevance and responsiveness to emerging needs. In cases such as AR's, where cultural and relational factors may influence engagement, this investment in staff development is essential to building trust, improving outcomes, and delivering care that is both clinically effective and culturally attuned.

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Improvements that could be made

270. Child and Adolescent Mental Health Services (CAMHS) are increasingly being pulled away from their core purpose: delivering specialist psychological assessment and therapy to young people with moderate to severe mental health needs. Over time, the role of CAMHS has expanded, often by necessity, into areas traditionally covered by social care, education, or early help services. This shift has led to a dilution of clinical expertise, confusion around professional roles, and growing pressure on a workforce already stretched by rising demand.
271. A particularly concerning trend is the way mental health is being leveraged by other services to justify decisions that may not be clinically appropriate. In education, mental health is frequently cited as the primary reason for school non-attendance, often without a formal assessment or diagnosis. This can lead to inappropriate referrals to CAMHS, or the use of mental health language to secure specialist placements or justify exclusions. Similarly, in social care, emotional wellbeing concerns are sometimes used to escalate cases or justify statutory thresholds, placing further pressure on CAMHS to validate or manage these concerns.
272. This systemic dependency on CAMHS to legitimise or resolve non-clinical issues not only misrepresents the nature of mental health need, it also diverts clinical resources away from those who require therapeutic intervention, and risks pathologizing normal distress or social adversity.
273. Psychological assessment, formulation, and evidence-based therapy must remain at the heart of CAMHS. While care coordination may be necessary in some complex cases, it should not become the default role of clinicians whose primary expertise lies in therapeutic intervention.
274. Referral pathways and thresholds must also be reviewed and clarified within the Trust. CAMHS should be accessed for mental health need, not as a substitute for Early Help, SEND support, or social care. Strengthening alternative pathways for behavioural, social, or educational concerns will help ensure that young people are supported by the right service at the right time.
275. At the same time, the interface between CAMHS and other services must be strengthened. Clear protocols for joint working with social care, education, and early help are essential, but these must not result in CAMHS becoming the lead agency by

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default. Instead, shared responsibility and mutual accountability should underpin all multi-agency collaboration.

276. To support this, investment is needed in system navigation roles outside of CAMHS. Commissioning additional support within Early Help or SEND services would reduce the pressure on CAMHS clinicians to coordinate complex plans, allowing them to focus on delivering therapy.
277. Internally, CAMHS must also protect time for clinical supervision, reflective practice, and continuing professional development. These are not luxuries - they are essential to maintaining safe, effective, and ethical therapeutic work.
278. Finally, CAMHS should continue to play a leadership role in promoting psychologically informed practice across the wider system. However, this should not mean delivering all psychological input. Instead, CAMHS can support other services to embed psychological thinking into their own practice, helping to build a more resilient and responsive system overall.
279. Refocusing CAMHS on its core therapeutic mission is not about doing less, it is about doing what it does best. By restoring clarity of purpose, protecting clinical expertise, and challenging the inappropriate medicalisation of social and educational issues, CAMHS can continue to provide high-quality, specialist mental health care to the children and young people who need it most.
280. Young people with Autism Spectrum Conditions (ASC), particularly those presenting with demand avoidance traits — including those consistent with Pathological Demand Avoidance (PDA) — often face significant barriers in accessing and engaging with traditional services. These individuals may experience heightened anxiety, sensory sensitivities, and extreme avoidance of everyday demands, which can lead to school refusal, social isolation, and family breakdown.
281. Mainstream pathways across education, health, and social care are frequently ill-equipped to meet the needs of this cohort. As a result, families often reach crisis point before receiving appropriate support, and young people may become disengaged from education, misdiagnosed, or inappropriately escalated into mental health or safeguarding pathways.
282. There is a growing recognition of the need for tailored, flexible, and relationship-based approaches that reflect the unique presentation of young people with autism

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and demand avoidance traits. A dedicated service is required to bridge the gap between existing provision and the complex, often misunderstood needs of this group.

283. A dedicated, commissioned ASC service designed specifically for young people with autism and significant demand avoidance traits would offer a blend of community outreach and intensive home-based interventions, delivered by a multidisciplinary team with specialist training in autism, demand avoidance, trauma-informed practice, and neurodiversity-affirming approaches, capable of reducing the need for clinic-based appointments, enabling engagement in safe familiar environments. Fundamental to this service will be the ability to assess and manage risk, with strong collaboration between SEND, Education and Social Care ensuring a coordination response to the needs of this group.

284. This dedicated ASC service would fill a critical gap in current provision, offering early, specialist, and relationship-based support to a highly vulnerable group of young people. By intervening earlier and more effectively, the model aims to reduce crisis presentations, prevent family breakdowns, and improve long-term outcomes for young people and their families where there is neurodiversity.

285. Children and young people with complex and overlapping needs—such as mental health difficulties, school disengagement, risk of exploitation, and vulnerability to radicalisation, are often supported by multiple services. However, these services frequently operate in isolation. Despite the best efforts of professionals across Social Care, Education, Targeted Youth Support, CAMHS, and Prevent/Channel Panels, the lack of integration between systems results in fragmented care, delayed responses, and missed opportunities for early intervention.

286. This disjointed approach can lead to escalation of risk, with young people entering high-cost, high-intensity services such as residential care, in-patient mental health settings, or the youth justice system. Families, meanwhile, are often left navigating a complex web of services, receiving inconsistent messages and support that can erode trust and reduce engagement.

287. There is a clear and pressing need for a more joined-up, preventative model of support — one that brings together the full range of services around the child and family, and delivers intensive, coordinated interventions at the point of need. A dedicated Intensive Multi-Systemic Therapy (MST) model offers a proven, evidence-based approach to meeting this challenge.

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288. An MST model could integrate Social Care, Targeted Youth Support, Education, CAMHS, and Prevent/Channel Panels into a single, multidisciplinary team. Whether co-located or virtually connected, this team would work collaboratively to deliver intensive, home-based interventions that are tailored to the unique needs of each young person and their family.
289. At the heart of the model is a commitment to systemic, family-focused practice. Interventions would be grounded in evidence-based frameworks and delivered with the intensity and flexibility required to address entrenched and overlapping needs. A joint referral and triage process would ensure timely identification of young people at risk, including those referred through Channel Panels, enabling swift and coordinated responses.
290. Robust governance is essential to the success of this model. Oversight would be provided by a multi-agency strategic board, chaired the Local Authority. This board would include representation from all key partners, including CAMHS, Education, Youth Justice, Prevent/Channel Panels, Police and Community Safety, and the Voluntary and Community Sector.
291. The board would be responsible for monitoring outcomes, managing risk, and ensuring alignment with statutory duties, including those set out in the Counter-Terrorism and Security Act 2015 and Working Together to Safeguard Children. It would also oversee the use of pooled budgets and shared outcomes frameworks, ensuring that the model is both accountable and sustainable.
292. The current CAMHS model in the Trust is structured around planned appointments and performance targets (KPIs), which support the delivery of therapy when there is a clinical rationale for intervention but can limit the flexibility needed to engage young people who are not yet ready for intervention. While this model facilitates structured care, it does not always allow for the time and responsiveness required to build therapeutic rapport or adapt to fluctuating levels of readiness. Additional services that offer flexible therapy models, including hybrid or asynchronous options, to accommodate young people who struggle with traditional formats could be considered.

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Other matters

293. There are no other matters that I wish to draw to the Chair' attention.

Further disclosure

294. I have exhibited any emails/documents referred to in my statement which have not already been disclosed to the Inquiry as and when they are mentioned. In addition, I exhibit a bundle of further emails located when preparing this statement as **SDC/10**

— **AHCH000291** —

Statement of Truth

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

Signed:

Signature

Date: 4 August 2025

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Annex 1

Index to the Witness Statement of Samuel David Coppard:

Exhibit No.	Inquiry reference No.	Document description
1	SDC/01 - AHCH000280	Email to Dad with four Anxiety Information Sheets dated 18 May 2020
2	SDC/02 - AHCH000281	Email to Dad with two Anxiety Information Sheets dated 4 June 2020
3	SDC/03 - AHCH000282	Emails between 25.06.2020 - 09.07.2020 including Sharon Kirby, Ramon Niemiec, John Fitzpatrick, Jeannette Jennings and Sam Coppard
4	SDC/04 - AHCH000283	Email from Sam Coppard to Dad regarding call on 23 July 2020
5	SDC/05 - AHCH000284	Safeguarding Children Clinical Supervision Agreement dated 4 June 2020
6	SDC/06 - AHCH000285	Email's between Sam Coppard and Samantha Steed with Keith Ledwidge included on 25 May 2022
7	SDC/07 - AHCH000286	Emails between Samantha Steed, Samuel Coppard and Dr Lakshmi Ramasubramanian re AR concerns dated 25 May 2022
8	SDC/08 - AHCH000287	AR Family Therapy Session Noted dated 16 August 2022
9	SDC/09 - AHCH000288	AR Family Therapy Session Noted dated 9 January 2024
10	SDC/10 - AHCH000291	Bundle of emails