Witness Name: Lakshmi Prabha Ramasubramanian

Exhibits: LPR/01 - LPR/04

Dated: 24/07/2025

THE SOUTHPORT INQUIRY

FIRST WITNESS STATEMENT OF LAKSHMI PRABHA RAMASUBRAMANIAN

I, Lakshmi Prabha Ramasubramanian, will say as follows: -

Introduction

1. I am an experienced Consultant Child and Adolescent Psychiatrist. I have worked in Psychiatry for over 20 years and have been a Consultant Child and Adolescent Psychiatrist in the NHS for 14 years. I work as a Consultant Child Psychiatrist and Paediatric Neuropsychiatrist at Alder Hey Children's NHS Foundation Trust since 2011. I work in Sefton Child and Adolescent Mental Health Services (CAMHS) and am based at Burlington House, Crosby Road North, Waterloo, Liverpool L22 0PJ. I graduated from Madurai Medical College in 1998 and completed higher specialist training in Child and Adolescent Psychiatry in Merseyside before taking up the current post in 2011.

2. I have extensive clinical knowledge and skills in treating mental health difficulties in children and young people with Neurodevelopmental Disorders such as ASD, ADHD alongside anxieties including OCD, specific phobias, school attendance problems and mood difficulties.

3. I have specialist clinical interest in Paediatric neuropsychiatry and management of co-morbid mental health difficulties in children with neurodiversity. I have a particular interest in mental health of children with drug resistant epilepsy and offer Neuropsychiatric

evaluations for children on the Nor CESS pathway. I lead on the Tics and Tourette's pathway at Alder Hey and set up evidence based, needs led multi-disciplinary interventions for children and young people presenting with Tics and Tic like presentations in 2021.

4. I maintain an active interest in, and have published on Learning Disabilities, Mental Capacity Act, Autism focusing on children's rights, decision-making and concerning behaviours in Children with Autism. I have also presented my work at many local, regional, national, and international conferences and have been part of regional and national research collaborations.

5. I obtained a Postgraduate Certificate in Teaching and Learning in Clinical Practice and Fellowship of the Higher Education Academy in 2010.

6. As a senior educator, I supervise post graduate doctors in training since 2012. I have been Training Programme Director, Child and Adolescent Training scheme at Mersey Deanery for over five years until 2020 and subsequently took up the role as Associate Director of Medical Education at Alder Hey Children's NHS Foundation Trust.

7. I started private practice in Child Psychiatry from August 2024 and offer appointments on Saturdays at The Therapy Company, Preston and for Psychiatry-UK.

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

9. I make this statement from review of AR's patient record held by the Trust and my recollection of events.

Background

10. I was involved in the care of AR as Consultant Child and Adolescent Psychiatrist from 1/7/21 to 23/6/22. I first became involved in ARAR's care following an internal referral to psychiatry by his then Case Manager Mrs Samantha Steed on 25/5/21. The referral was discussed in the MDT on 26/5/21 where it was indicated that AR presented with anxiety in relation to leaving the house and refusing to attend school. AR had previously requested medication and requested to be seen by a psychiatrist. It was noted that all therapeutic options should be tried first but he was placed on the routine medication waiting list. so that he had the option to access medication, if needed, in the future.

11. However, AR was discussed at the CAMHS Multi-Disciplinary Team meeting on 16/6/21. It was noted at this meeting that AR *"was making progress and had a successful EHCP, but is now stepping backwards with increased paranoia. His relationship with Dad has deteriorated and he is not speaking to him at all. He is beginning to consider medication as his only option*." The outcome was that the referral to psychiatry was escalated from routine to urgent waiting list.

Factual narrative of involvement and particular issues

12. I offered my first appointment to AR on 01/07/2021. Prior to the appointment, I familiarised myself with AR's background history by reviewing information that was available on the Alder Hey Electronic Patient Records. I understood from the available records that AR was referred to PREVENT and to FCAMHS (Forensic CAMHS which is a service provided by another Trust) and was closed to these services and deemed to be not at risk of radicalisation, counter terrorism or risk to others. So, AR's presentation during this episode of care was not to do with risks to others but due to reported anxiety, school refusal and difficulties leaving the house. Due to AR's difficulties in relation to leaving the house, this appointment was offered as a telephone appointment to enable him to attend. During this appointment, I was informed that AR has been struggling with chronic anxiety since primary school and that this has now become quite entrenched. I heard that AR's anxiety was impacting on his daily living and was also affecting his overall functioning. AR eloquently described physiological symptoms of anxiety when social demands were placed on him such as dizziness, palpitations, sweating and said that he resorted to avoidance of activities as a result. The way AR articulated (in a fluent and clear way) a list of symptoms of anxiety was unusual and it felt that AR had researched into symptoms of anxiety prior to the appointment.

13. At this appointment, AR denied having any symptoms of depression. I did not find anything to suggest that AR was a risk to himself or to others. AR appeared keen to consider medication to treat his anxiety and said that he is not too keen on talking therapies for anxiety. I discussed the benefits of a Beta-blocker – Propranolol - to help reduce the physiological effects of anxiety, but AR was not too keen on this. He was argumentative and said that he had researched about medications and would like to be prescribed an SSRI (Selective Serotonin Reuptake Inhibitor such as Sertraline) medication. I clarified that his presentation would not warrant treatment with an SSRI medication and that we

should proceed with a trial with Propranolol. I offered psychoeducation and information on Propranolol.

14. I discussed the benefits of a Beta blocker - Propranolol - on the Flight Fright Fight reaction that one experiences from anxiety and how Propranolol will help reduce the physiological effects of anxiety and thereby help him to deal with anxiety better. I started AR on Propranolol tablets 10 mg twice a day.

15. My professional opinion following this assessment was that AR has researched symptoms of anxiety and about medications and insisted that I start him on an SSRI medication which was not clinically indicated at the time of the assessment.

16. Unfortunately, AR did not take Propranolol as advised and I note from Samantha Steed's record a conversation with AR's father on 3/7/21 that AR took one dose of the medication and reported to his father that it is the wrong medication and after extensive research, he told his father that he won't take the medication and asked for a different medication. AR also said to his father that "*he won't take this medication until the doctor speak to him again*". Samantha Steed emailed me on 7/7/21 asking to speak to me about AR's request for medication.

17. I met with Samantha Steed on 9/7/21 to discuss the above. We agreed that there were no acute risks to self or to others from AR stopping Propranolol against medical advice as it was deemed a small dose. We agreed that Samantha Steed would contact AR and reiterate the need for him to follow medical advice.

18. On 9/7/21, I was informed that AR agreed to try the medication Propranolol again. As AR did not present with any risk such as risk to self, or to others and as he needed to give Propranolol full therapeutic opportunity to work, I agreed with Samantha Steed that I would proceed with my original appointment as planned for 11.08.21 and that there was no clinical indication to bring it forward. Samantha offered advice to AR and his parents about the need to follow medical advice, to safely store medication and for parents to supervise AR's medication given his age. The importance of AR and his parents engaging in behavioural activation work and graded exposure for anxiety to complement treatment with medication was also reiterated.

19. I offered the follow up telephone appointment on 11/8/21 as planned and this was with AR

and his father. AR shared that he needed help to manage his fear of going out and fear of meeting people and not with the physical symptoms of anxiety and asked me to prescribe an antidepressant - an SSRI medication. I agreed to discuss this with him at a face-to-face appointment and this was mutually agreed.

20. A professional discussion with all CAMHS professionals (Samantha Steed, Sam Coppard and Jill Locke) involved with AR and his brother was held on 12/8/21. At this meeting, I shared my concerns regarding the "disrespectful" tone in emails and texts sent by father of AR and I noted a level of respect is still required and this should be monitored in terms of interactions with the family. It was agreed that Samatha Steed will continue to discuss the need for AR and his family to engage in therapeutic interventions such as Behavioral Activation, Cognitive Behaviour Therapy and Systemic Family Practice to enable AR to manage his anxiety.

21. A Face-to-Face appointment to discuss Sertraline was arranged for 15/9/21. I was unable to attend this appointment due to contracting and being incapacitated by COVID-19. I duly requested that a resident doctor be asked to review AR on my behalf as it felt important to not cancel this appointment. Dr Aesha Aseri, Higher Specialist Trainee in Child and Adolescent Psychiatry offered to conduct this appointment on my behalf. This involved a comprehensive Mental State Examination (MSE). The clinical notes are included in the CAMHS record for AR and dated 15/9/21. Dr Aseri noted the diagnosis of ASD with a moderate degree of social anxiety.

22. The outcome of the assessment was that AR presented as a young person with social anxiety, which is best understood within the context of ASD, previous bullying and ongoing relational difficulties at home. I had briefed Dr Aseri by email to consider an antidepressant medication for AR as per email dated 2/9/21. Dr Aseri started AR on Sertraline tablets. The rationale for prescribing Sertraline was to enable AR to be able to attend school, which was the main concern presented to CAMHS. I exhibit a copy of this email exchange as **LPR/01 – AHCH000240**

23. As part of psychiatric training, I undertook as a resident doctor in training and subsequently as a consultant, I regularly carry out Mental State Examination (MSE) which involves observing and evaluating various aspects of a child's mental state to identify potential risks. I look for key areas such as appearance, behaviour, speech, mood, affect, thought process and content, perceptual abnormalities and insight. This MSE and assessment

which is inbuilt in every contact helps determine the nature and severity of any mental health concern presented to me and the risk of harm to the child or to others. Risk assessment in CAMHS is based on the presenting symptoms, mental state examination and exploration of thoughts of self-harm, suicide or harm to others during sessions. As was the case in previous assessments, this assessment also did not indicate any risks to self or to others or any psychotic symptoms such as paranoia in AR.

24. As a child psychiatrist who works in a non-forensic setting and in a general CAMHS setting I assess and treat children and young people referred with emotional, behavioural and mental health difficulties. Case Managers document Clinical Risk tool and Risk Assessment and Management Tool on Meditech based on history and clinical presentation. When there are concerns regarding risk of radicalisation or risk to others, CAMHS will request support from specialist services such as Enhanced Support Team or Forensic CAMHS who may use formal risk assessment tools such as SAVRY.

25. It was noted in the MDT meeting on 23/9/21 that the family had agreed to engage in Family Therapy and the Riding the Rapids course.

26. I offered a planned follow up appointment for AR on 13/10/21 during which no improvement regarding AR's functioning or school attendance was reported by his father. I was able to speak to both AR and his father. I suggested an increase in the dosage to 75 mg from 50 mg of Sertraline to give AR full therapeutic benefit from Sertraline. I also noted that AR was no longer on Propranolol tablets.

27. I arranged a follow up appointment for AR on 15/11/21. His father informed me that there have been positive changes in AR since he has been taking 75 mg of Sertraline. AR's father informed me that he has noticed that AR is not as snappy or irritable and his responses towards him had been generally calmer than what it used to be. Father of AR also told me that AR had attended school for 4 days the week before the appointment.

28. AR himself reported an improvement in anxiety levels. He told me that he managed to attend a dental appointment and went to an indoor shopping centre. He said that he did not feel anxious when he was outside.

29. AR said that he felt that he is making improvements. AR said that he felt very tired on 75 mg of Sertraline but requested an increase in the dosage. I advised him that once the

tiredness wears off, I will consider increasing to 100 mg and this was agreed.

30. I was not made aware of the incident that occurred on 5/11/21, during which AR trashed his home and which necessitated his mother to call the police. Neither AR nor his father informed me of this incident during his appointment on 15/11/21. As a psychiatrist, I would expect the young person and his family to be open and honest with me during appointments about any concerning behaviour. If I had been informed about this incident, I would have explored this further with AR and his family and ensured that they are offered the right support.

31. I was pleased to note subsequently from Samantha Steed's session notes that she had offered support and guidance to AR's mother on the day of the incident and that the situation had calmed down following her call to AR's mother.

32. During the appointment on 15/11/21, I was given the impression that AR has been calmer and less irritable since Sertraline was increased to 75 mg and that he has been able to return to school.

33. On 21/11/21, Father of AR contacted Crisis Care Team for support following 2 incidents of intimidating behaviours by AR towards father, including reported verbal threats and pouring milk over father of AR. The note states that parents of AR were able to de-escalate. Crisis Care Team offered advice and support and documented this as primarily a social issue. The Crisis care staff informed case manager Samantha Steed only and I was not made aware of this incident.

34. On 30/12/21 I received a message from our administrative member of staff that the father of AR had requested that the follow-up appointment to review AR's medication due on the 24/1/22 be changed to a Face-to-Face appointment. I responded to this email by saying that it would be entirely appropriate to conduct medication reviews for SSRI medication virtually, especially when the young person is reported to be stable and improving on the medication with no reported side effects from it. This was based on both the introduction of hybrid working following the COVID-19 restrictions together with my clinical impression and judgement that AR did not present with risk to self or to others that warranted a Face-to-Face appointment. During my entire involvement, AR did not present as a risky patient. I duly responded to the request and spoke with the father of AR and with AR to discuss the request. I offered a face-to-face review, but AR requested a video appointment instead.

The appointment was changed to a video appointment as per AR's preference.

35. On 24/1/22, I offered a virtual video appointment for AR via MS Teams but AR unfortunately misunderstood and had logged on to Attend Anywhere instead. Attend Anywhere is a video appointment tool used by the Trust. I sent him a link for MS Teams again, but he preferred to talk to me over the phone. I spoke to his father first and then with AR. AR was very positive over the phone and said that he was making good progress. He said that he experienced anxiety when he went out and that the anxiety symptoms go away after he is outside. I understood this to mean that the symptoms settled once he was out and about. He denied any symptoms of low mood or thoughts of self-harm. He shared that he was working well with Michelle Warner, his CAMHS Key Worker, and went to a nearby co-op with her and he said he enjoyed it. AR was happy to continue Sertraline 75 mg mane and did not report any side effects. No risks were identified to or by me at that time.

36. The quality of AR's treatment and my supervision of AR's mental health was not impacted by the need to conduct video and/or telephone appointments rather than face-to-face appointments. AR had consistently presented with no risk to himself or to others based on several assessments and follow up appointments offered by me during the period of my involvement and based on the face-to-face assessment by Dr Aesha Aseri. I was in regular contact and discussion with the case manager Samatha Steed and the Key worker Michelle Warner about AR's presentation and we all agreed that AR did not present with risks of self-harm, suicidality or harm to others. At no point during my involvement did AR present with any symptoms of a serious mental illness. I was thoughtful and responsive to all calls and requests made by AR and his family and offered virtual appointments at AR's request to continue to engage him and to enable him to attend follow up appointments with me. This would be considered the usual approach to engage a patient with ASD and who reports difficulties leaving the house. If I had not taken this approach, AR would have disengaged, and I would not have been able to review his response to treatment.

37. A keyworker is requested for a young person when they struggle to engage meaningfully in CAMHS interventions offered and this was the case with AR. The involvement of Keyworker Michelle Warner and her engagement of AR in the community was requested and agreed to provide more insight and understanding of AR's presentation and risks. This intervention also did not highlight any risk to self or to others.

38. I was not informed of AR's missing episode on 17/3/22. Based on the Electronic Patient Records, this information was shared with case manager Samantha Steed, but not with me. As a consultant psychiatrist, my role in his care at the time was primarily around the prescription/review of medication and I would expect Case Manager/Key Worker to raise issues with me directly or in MDT if they felt my input was needed.
39. If I had been made aware of this episode, I would have discussed this with case manager Samantha Steed to ensure that appropriate advise and support was offered to parents.

40. I was pleased to note while writing this statement that case manager Samantha Steed sought advice from Alder Hey Safeguarding Nurse Emma Walker-Riley regarding the reported incident on 17/3/22 and discussed in her MDT meeting on 23/3/22 and a decision was made to place AR on the list for Autism Adapted CBT. Unfortunately, at this time AR had stated that he no longer wished to engage in Keywork sessions with Michelle Warner and that he no longer needed it.

41. AR was due to start at Presfield School in April 2022.

42. I offered a video appointment for AR on the 7th of April 2022; AR informed me that he can go out if he chooses to and that he does not experience any anxiety symptoms. During the months leading to this appointment, it had become clearer that AR does not need specific help to go out. CAMHS offered specific work from a Keyworker from Sefton CAMHS with whom AR engaged well initially, but during the weeks prior to this appointment, he had stated that he no longer wishes to work with her as he does not need any help to go out.

43. AR's school attendance, which was the main concern and the main reason for referral to Psychiatry, had also remained poor, this does not appear to be due to anxiety of leaving home. I explored low mood symptoms, and he denied having any. AR has always reported that he does not experience any symptoms of low mood or thoughts of self-harm.

44. So, I wondered about the role of medication- SSRI medications with AR. He agreed that he did not need them, but he had anxiety about talking to people. I informed him that the more he exposed himself to people and situations, the more he would be able to talk to people and that since there was no evidence of social anxiety or Generalised Anxiety Disorder, SSRI medications would not be indicated for him.

45. AR wanted to try a different SSRI medication, and I strictly advised him against it for the above reasons.

46. We agreed that a slightly higher dose of Sertraline 100 mg would be tried for 2 months, and should AR not benefit from it, we will be able to conclude that medication is not the right approach for AR and it will be stopped. The plan was to then discharge AR from my care as AR did not present with any evidence of a mental health disorder.

47. On 20/4/22, I received an email from case manager Samantha Steed that AR had stopped taking Sertraline 100 mg for a week. He had reported experiencing heart burn. It was apparent that he was not eating breakfast before taking the medication, that he had poor eating habits and that his medication was not being supervised by his parents as advised.

48. I responded to this email and shared that "*It looks like AR is creating a case for stopping Sertraline, heart burn is not a common side effect of Sertraline*". I raised my concern that AR will use the reason of not taking medication as his reason to not engage with Presfield. I was also concerned that he would demand a different medication as he had already raised this. I requested a joint review with myself and Samantha Steed be arranged and that we discuss our concerns in our MDT meeting.

49. On 26/4/22, I contacted AR's father by telephone to discuss Sertraline and to understand why AR had stopped taking the medication as advised. I reiterated that I had made him aware that Sertraline should be taken after breakfast. I also discussed why AR had been managing his own medication and had access to all the tablets. I mentioned that I was aware that Sam had advised AR's father to take all medications off AR. I confirmed that AR's father had taken all medications off AR and he confirmed this. I advised that as AR has not taken Sertraline for over a week, that could be stopped. I also clarified as per my last clinic letter that I did not see a clinical indication for an SSRI medication for AR. I agreed to offer a review as planned in June 2022. When a patient stops taking medication as advised, it would be usual practice to understand the reasons behind it and offer psychoeducation and ensure that any unused medication is safely stored away. In AR's case, he had stopped taking Sertraline without seeking advice and, in my opinion, with an intention to get this medication changed to another medication of his choice. As this was not clinically indicated or necessary, I remained firm in my opinion and followed my clinical judgement to not prescribe another medication and agreed to review as planned and to consider discharge from psychiatry.

50. On 4/5/22, I received a message from CAMHS administrative staff member that AR's father had called to share a message that AR had refused to engage with staff from Presfield and that he was displaying anger and temper. He wondered whether restarting Sertraline may help AR to engage with school and requested this. As it was felt that Sertraline may help with AR's anxiety, I suggested that AR be restarted on Sertraline 50 mg to be gradually increased to 75 mg and I noted that AR's next appointment with me was on 9/6/21.

51. I wrote to AR's GP to update him of the plan.

52. On 13/5/22, I received an update from Samantha Steed that AR has refused to engage with Presfield school or with home learning. He had stopped Sertraline again saying that he is not interested in taking medication. As AR had reported an increase in salivation in certain situations. The hypersalivation cannot be explained by anxiety, it is a form of behaviour. Father of AR asked for an urgent psychiatry appointment to be arranged.

53. On 13/5/22, I discussed the need to review CAMHS support for AR with Samantha Steed in light of his disengagement from all forms of interventions offered. This is usual practice in CAMHS to reflect as a care team on whether a young person requires ongoing CAMHS involvement if they do not meaningfully engage in the interventions offered. AR had not presented as a young person with a mental health disorder and had not presented as a risk to himself or to others. It is understood that it often gives the wider system such as Education and Social Services a false impression that a young person is mentally ill when they are left open to CAMHS without an active intervention. This is also known to stop other agencies from actively offering their full support to those young people. CAMHS had by this time exhausted all forms of interventions- individual, therapy, behavioural activation, Keyworker and Family Therapy. AR's compliance with medication was clearly very patchy and he stopped medication prescribed to him on several occasions to, in my view, obtain medication of his choice even if they were not clinically indicated.

54. Any further intervention from CAMHS in such situations would be considered if the patient presented with a mental health disorder and with risks to self or to others. As this was not the case based on the clinical presentation and impression of AR, I wondered with the case manager Samantha Steed if CAMHS should consider discharging him. Any such discharge planning would be done in collaboration with the case manager, patient and

family.

55. Following this email, I offered an urgent review for AR due to my ongoing concerns in relation to AR meddling with medication again without seeking medical advice. CAMHS continued to keep AR open to the service following this email discussion despite our reflections on his poor engagement with interventions and poor compliance with medication.

56. On 13/5/22 I also received a message from administrative team to call father of AR urgently. When I called him on the same day, I was told that the urgent concern he wanted to discuss with me was around increase in salivation in AR. He informed me that AR had an appointment with the GP who suggested a dental check for his excessive salivation. As AR was not registered with an NHS dentist, father of AR called emergency dental services who felt it was not an emergency. AR's father was told by the GP that AR could be anxious as he only salivates in places when he is uncomfortable such as classroom. I shared my clinical opinion with father of AR that this is unlikely to be a symptom of anxiety in the absence of other typical symptoms. Father of AR informed me that AR has refused to take Sertraline and has not been talking to his parents. I reiterated that I am not happy that AR stops medication by himself without discussing with me and the risks associated with it. I agreed to see AR urgently as I was concerned about AR meddling with medication again.

57. Samantha Steed and I offered a joint Face to Face appointment for AR on 23/5/22. During the appointment, I explored AR's reasons for stopping medication and other concerns he wanted to discuss. It was clear on further exploration that AR did not have regular eating habits. Due to his poor sleep pattern and as he did not go out or to school, he often missed breakfast. We were informed that he had cereal or toast made by his mother on some days. We noted that AR did not have a fixed mealtime, ate McDonalds at least 3 days a week and did not eat cooked dinner made by his mother as he said he did not like it.

58. In addition, on the day he experienced heartburn, he took sertraline on an empty stomach and was in a lying posture in bed. We discussed how all these could cause acid reflux and contribute to heartburn. We also discussed AR's main concern- salivating excessively and tummy rumbling. AR and his father told us that AR has never drooled but perceives that he had to swallow saliva in his mouth whenever he felt anxious. This did not happen at home. It only happened in situations when he had to speak to people such as school. AR

said that sometimes he did not have any saliva to swallow, but he did the swallowing movements. Following this, he said that his tummy made rumbling noises. AR reported feeling very conscious of people noticing this. I explained how swallowing can stimulate reflex movements in the tummy and acid production and reassured him that none of us had heard any rumbling noises. AR denied any symptoms of low mood or risks to self or others. AR was also interested in knowing from us as to how alcohol could help - we offered psychoeducation on how self-medicating with alcohol could be dangerous and explained the adverse effects of misuse of alcohol.

59. AR shared that he had not taken Sertraline for a while. After some discussion on the importance of following medical advice and compliance with treatment AR agreed to restart Sertraline. I suggested that he started 50 mg and after 1 week this could be increased to 75 mg.

60. During the appointment, we identified significant concerns around an adult monitoring his medication. Unfortunately, AR wanted to take it himself and there was no consistent adult monitoring it due to work related commitments. So, for AR's safety, we suggested that his father only gave AR one strip of Sertraline at a time and locked away the rest. This was agreed.

61. Physical Health - This appeared to be an area of significant concern. AR appeared to have lost weight. His weight was 45.4 kgs and his height was 172 cms. AR had nutritional deficiencies and had been referred to the dietician who had prescribed shakes and enriched drinks, but he had not been drinking it. He had Vitamin D deficiency. AR's father was unclear about the follow-up arrangements with the dietician and we urged him to follow this up.

62. The main areas of concern that emerged during this appointment were not to do with AR's mental health or risk to self or to others. But we noted concerns in relation to poor eating habits and thinness. We also noted concerns in relation to poor compliance with medication and lack of monitoring of medication by an adult. There were concerns that he was not eating regularly and that he appeared gaunt and very thin.

63. It was agreed that AR would restart Sertraline at 50 mg dosage for a week and then increase to 75 mg mane. Father of AR and AR consented to a professionals meeting with School to discuss next steps to facilitate school attendance. We agreed a plan for AR to

attend school and he was happy to attend school if he could go allowed to go in at lunch time. We facilitated this for AR by contacting Presfield school.

64. On 31/5/22, I received an email from Samantha Steed in which father of AR had asked for the content of my clinic letter from 23/5/22 to be changed. As the content of the letter was a true reflection of the discussions held during the appointment, I felt that it would not be appropriate to change the details. AR informed us that he was left to take his medication himself and that he had access to all the medication issued. This is considered a significant cause for concern as father of AR has been repeatedly told that AR should not be left to manage his own medication, and that excess medication needed to be stored away safely. This was reiterated at the appointment and a safe plan agreed father of AR. The lack of adult supervision, in my view, contributed to AR's patchy compliance and meddling with his medication. I wrote the letter to AR's GP on 25/5/22 to share my concerns regarding the above and requested father of AR to follow up on Dietetics.

65. The professional discussion dated 1/6/22 was held in Samantha Steed's MDT meeting and I was not present at this meeting. The minutes of this meeting appear to indicate that both Samantha and I felt that AR was hypervigilant during the appointment on 23/5/22. This was not my clinical impression of AR and as such is not reflected in my session notes or clinic letter from 23/5/22.

66. Unusually on 14/6/22, I attended a school meeting with Samantha Steed as agreed on 23/5/22 and shared all relevant information regarding AR's presentation and strategies to facilitate school attendance. This is understood as the role of a CAMHS Case Manager, but due to the nature of the demands placed by the family and AR on CAMHS, I joined this meeting in a supportive role. Presfield school agreed to follow their process and make a referral to social services due to concerns regarding poor engagement with education. As I felt that the behaviour of father of AR prior to the session on 23/5/22, during the session on 23/5/22 and following the session via an email was intimidating and disrespectful towards me and directed at me, I did not feel safe to work with father of AR. Father of AR came across as verbally aggressive and physically intimidating towards me on 23/5/22. I understood from Samantha Steed that she felt the same. We shared our concerns that such intimidating behaviours and verbal aggression appears to be directed at us due to our gender. I put an incident form via Ulysses Incident reporting system on 26/5/22 and received a response on 20/6/22 that father of AR had been spoken to and that he had apologised. I exhibit a copy of the incident form as **LPR/02 – AHCH000237** I

also exhibit a copy of the feedback as **LPR/03 – AHCH000238**.

67. AR had come across as argumentative particularly in relation to his demands regarding medication, but I did not feel threatened or intimidated by AR during my involvement.

68. I requested a change of psychiatrist and requested that AR be allocated a male psychiatrist by following the due process ie by contacting the Clinical Lead Vicky Killen and Psychiatry Lead Dr Katrin Russell. In hindsight, I followed all processes correctly to ensure my safety and that of my colleague. I should add that this is the first time in my consultant career when I have needed to request a change of consultant due to concerns of this nature.

69. I attended a virtual meeting with Vicky Killen, Clinical Lead and both parents of AR on 23/6/22 and it was agreed that AR would be allocated a male psychiatrist following this meeting. My involvement with AR's care ended on 23/6/22. I duly made a referral to General Paediatrics as agreed on 23/6/22 (typed on 30/6/22).

70. The request for any Mult-Agency meeting would usually be followed up by the case manager Samantha Steed and not by me as the Consultant Psychiatrist. My role as the Consultant Child psychiatrist for AR had ended on 23/6/22.

71. I handed over AR's care by sharing relevant clinical information to Dr Anthony Molyneux verbally on 30/6/22. I also followed up on my referral to General Paediatrics at Vicky Killen's request and discussed AR's progress with his physical health with Dr Molyneux on 2/8/22. This is evidenced in my email of 2/8/22. I exhibit a copy of the email as **LPR/04 – AHCH000236**

Involvement with other agencies

72. I have not been directly involved in any form of dealings with other relevant agencies in relation to the events under investigation except for what I have stated above regarding meeting with Presfield school on 14/6/22.

Reflection on events

73. On reflection, AR and his family had an extraordinary amount of access to clinical staff

within CAMHS including myself as his consultant psychiatrist from 1/7/21 to 23/6/22. I believe that have I have demonstrated good practice by being responsive to calls and requests made by AR and his family. The care provided by Sefton Specialist CAMHS and by me could be described as enhanced level of care which took several interventions, resources and time from CAMHS. With the benefit of hindsight and wider understanding of the events, it appears that AR and his father were not open and honest with me during their interactions and appointments. I would also say that AR meddled with prescribed medication on multiple occasions to either obtain medication of his choice or to use stopping medication (against medical advice) as his reason to avoid school. It is important to note that CAMHS in a health service which is offered to children and young people and their families. It is accessed on a voluntary basis by them and we cannot force them to engage or follow our advice. In AR's case, as I explained above, there was no evidence that he had a mental health disorder, and continued involvement of CAMHS can be counter-productive. Although many young people under the care of CAMHS do have a diagnosis of ASD alongside other mental health issues, the diagnosis itself is not sufficient to warrant CAMHS involvement.

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74. I feel that the guidance, training and resources available to me were adequate for the nature of involvement I had in the events under investigation.

Improvements

75. Since these events, CAMHS staff have been offered training related to meditech around risk and on the new front screen. A Risk scoping exercise was completed by all staff in Sefton Specialist CAMHS followed by Risk Assessment training provided by one of the Assistant Clinical Leads which provided a good recap of Risk assessment and management within CAMHS.

76. The improvements which have been made to the Meditech front screen now provide information to all staff on Risk and Care Plan, Mental Health Triage Assessment, ASD management, Adverse Childhood Experiences, Systemic Risk Assessment document, Details of staff involved from the Mental Health Care Team, CAMHS Risk and Care plan, any safeguarding alerts, summary of active problems including mental health and physical health problems, Learning Disability Status, ADHD shared care details and current medications.

77. The improvements have been effective as all important information about a patient can now be accessed via the front screen and alerts staff to crucial information that previously could only be accessed by clicking on individual session notes.

78. I have reflected on any areas which I think could make a difference to our practice over and above those already implemented. It would be helpful for any calls or messages received by CAMHS administrative staff regarding patients to be shared with all the patient's care team, including the Consultant Child Psychiatrist. This will ensure information regarding patients is shared effectively with everyone involved and improve patient care.

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

Statement of Truth

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

Signed: SIGNATURE

Dated: 24/07/2025

ANNEX 1

Index to the Witness Statement of Lakshmi Prabha Ramasubramanian

Exhibit No.	Inquiry reference No.	Document description
1	LPR/01 – AHCH000240	Email to Dr Aseri on 2 September 2021
2	LPR/02 – AHCH000237	Incident form 26 May 2022
3	LPR/03 – AHCH000238	Incident feedback 20 June 2022
4	LPR/04 – AHCH000236	Email to Dr Anthony Molyneux and Vicky Killen on 2 August 2022