Witness Name: John Keith Andrew Hicklin

Exhibits:

Date: 19 August 2025

THE SOUTHPORT INQUIRY

FIRST WITNESS STATEMENT OF JOHN HICKLIN

I, **John Hicklin**, will say as follows: -

INTRODUCTION

1. At the time of my involvement with AR I was employed by Greater Manchester Mental Health Foundation Trust (GMMH), as a Clinical Nurse Specialist within the Forensic Children and Adolescent Mental Health Service (FCAMHS).

2. My role was to provide specialist advice, consultation and assessment of young people who engaged in high-risk and, potentially, offending behaviour, in the context of low-level mental health and neurodevelopmental concerns.

3. I qualified as a mental health nurse in 1988 and subsequently gained further qualifications that culminated in a BSc with Honors in Child and Adolescent Mental Health. I had worked at the Adolescent Forensic Community Service from 2000 and was still employed in my role as a Clinical Nurse Specialist within the team when FCAMHS began operating in 2017. I officially retired on 22 May 2022 and subsequently returned to work in the FCAMHS for approximately three months on a two day per week basis, before retiring fully.

4. This witness statement is made to assist the Southport Inquiry (the "Inquiry") with the matters set out in the Rule 9 request dated 12 August 2025. For ease of reference and to ensure that all matters are appropriately addressed, the questions asked within the request letter are reflected in the sub-headings below.

BACKGROUND

Factual narrative of my involvement

5. AR was referred to FCAMHS on 13 December 2019 by Stephanie Hallaron, Registered Mental Health Nurse for the Criminal Justice Liaison and Diversion Team (under the umbrella of Mersey Care NHS Foundation Trust), and was accepted and allocated to me. I sent an email to Stephanie the same day, suggesting a date of 22 January 2020, for the first consultation meeting. At this meeting I was hoping to gather information so I could better understand AR's risks and needs.

6. Between 13 December 2019 and approximately 2 January 2020, I exchanged several emails with Stephanie Hallaron to organise the arrangements for the professional meeting. Stephanie asked, on 13 December 2019, if I would be able to attend a professional meeting that had already been arranged for 17 December 2019, and I provided my apologies, as I had an existing engagement.

7. I attended a multi-agency consultation meeting with the local professional network involved with AR on 21 January 2020, a summary of this meeting can be found at exhibit GMMH000006, this summarises the discussion and my recommendations. On 22 January 2020, I emailed Stephanie and thanked her for organising the consultation meeting and advised her that I would summarise the meeting as a letter once I had gathered information from Skott Morgan, Practitioner for Sefton CAMHS, who was not in attendance at the meeting. I proposed the 27 February 2020 for a further consultation meeting.

8. On 28 January 2020, I recorded in AR's clinical record that I had attempted to contact Skott Morgan and left two messages. On 11 February 2020, I recorded in the record that I had emailed Skott and informed him that I had left several messages and asked him to contact me. Subsequently, I was able to have a telephone call with Skott. I reference this conversation in exhibit GMMH000007, a letter which summarises the discussion at the second consultation.

9. On 4 March 2020, I attended a second multi-agency consultation meeting with the local professional network, to review professionals progress since the first consultation. It was at this consultation meeting that the decision to discharge AR from FCAMHS was made, with the caveat that he could be referred to FCAMHS if there was a significant change in his risk. The details from this meeting can be found in exhibit GMMH000007, this is a letter which summarises the discussion at the second consultation.

Particular issues related to my involvement

How risks are assessed at FCAMHS

10. During my employment within FCAMHS, the responsibility for assessing and managing the young person's risk, remained with the referrer or lead professional involved in the case. This was the agreed practice at the time. I would, however, support their risk assessment process, by gathering information about the young person's behaviour and risk during the consultation or through assessment. I would use this information to develop an understanding of this risk in the context of any underlying mental health or neurodevelopmental conditions and then provide advice and recommendations for inclusion in their risk management plan.

How risks were assessed in AR's case (to the extent that you were involved in any risk assessment of AR).

11. As described above, it was not the role of FCAMHS to complete a formal risk assessment, but to contribute to the understanding of risk with the professionals working directly with the young person. In AR's case, we initially received a referral which was triaged to ensure that it met the referral criteria for the service.

12. At the consultation meeting on 21 January 2020, professionals shared information about AR's behaviour and risk. This information was considered and, using professional judgement and drawing on relevant literature pertinent to child and adolescent forensic psychiatry, and with an understanding of the risk factors outlined in the Structured Assessment of Violence Risk in Youth (SAVRY) tool, an understanding of the risk was developed. It is not the role of FCAMHS to complete the SAVRY as this would be undertaken by the local services (i.e. those working directly with the individual) if deemed necessary, however as a practitioner, I would routinely utilise my knowledge of this tool to support collaborative risk formulation. The information shared during this professional consultation was used to develop recommendations which were then shared via letters see exhibits GMMH000006 and GMMH000007 that detail summaries of the consultation meetings which took place on 21 January and 4 March 2020.

Multi-disciplinary meetings on 21 January 2020 and 4 March 2020

Please explain the nature and purpose of the multi-disciplinary meetings that took place on 21 January 2020 and 4 March 2020 and the next steps/outcomes which resulted from those meetings.

13. The purpose of the multi-disciplinary meeting on 21 January 2020, was to provide consultation to the professional network working with AR and the second meeting was to offer a follow-up consultative review. The consultation meetings were arranged following a referral to FCAMHS on 13 December 2019. At these meetings I gathered information about AR's background, presentation, behaviour, and risk, and used this information to develop an understanding of

his needs and risks. I provided recommendations to the professional network at these meetings for inclusion in their care and risk management plans.

14. After the meeting on 21 January 2020, there were several outcomes agreed based on discussions in the meeting and from subsequent telephone calls with professionals who could not attend the meeting. These outcomes included; CAMHS to consider the recommendations for AR to be provided with psychologically informed interventions relating to his risk of engaging in interpersonal violence, with a focus on emotional recognition and regulation. An action was agreed for Skott Morgan, practitioner for Sefton Specialist CAMHS, to liaise with his colleagues in CAMHS regarding this recommendation and to provide feedback at the next review meeting, which was scheduled for 4 March 2020. There was also discussion regarding the provision of additional support for AR's parents, in relation to his likely diagnosis of autism.

15. It was clear, on the 21 January 2020, that we were awaiting the outcome of other professional involvement, including the police, the criminal justice process, CAMHS, and the paediatric team. By the time of the meeting on 4 March 2020, there were updates available on the nature of progress made by involved professionals.

16. At the meeting on 4 March 2020, updates were provided by professionals that AR had received a 10-month referral order, and the Youth Offending Team would be co-ordinating interventions to address offending behaviour. Children's Social Care had signposted AR's parents to further support in relation to his suspected diagnosis of autism. CAMHS had closed AR's case with a referral being made to the autism assessment pathway. Education professionals from Social Care indicated that there was scope for AR's pathway to specialist education provision to be expedited. The outcome of the meeting was that assessment by FCMAHS was not indicated at that point, until AR's autism diagnosis had been confirmed. AR's case was closed to FCAMHS with advice that professionals could contact the service if a review was required due to a significant change in circumstances or risk.

Please review your handwritten notes of these meetings (GMMH000005) and summarise the key points recorded therein and in particular any points which may be of potential relevance to the Inquiry's terms of reference.

17. I can confirm that I have reviewed my handwritten notes; I believe all key points that may be of relevance to the Inquiry's terms of reference are included in the corresponding letters, see exhibits GMMH000006 and GMMH000007.

Please set out any specific concerns you had in relation to AR at the time of these meetings.

18. Concerns that I had in relation to AR were recorded in the consultation letters, see exhibits GMMH000006 and GMMH000007. I have no additional concerns that were not mentioned in these correspondences.

Why did you consider that assessment by FCAMHS was "not indicated"?

19. I considered that an assessment by FCAMHS was not indicated at that time as the professional consultations that had taken place had enabled a collective understanding of AR's needs and risks to be developed with agreed recommendations for local services to consider whilst an Autism assessment was progressed. An FCAMHS assessment would only be undertaken if an understanding of need and risk could not be established through the consultation process.

In hindsight, do you consider that a forensic assessment by FCAMHS should have been undertaken in relation to AR? If so, why and when? If not, why not?

20. In hindsight, there is possible value in undertaking a forensic assessment on all young people referred to the service. An assessment may elicit additional information and offer a different informed perspective which is difficult to replicate fully by consultation. However, it was the model of the service at the time, with the aim of responding in a timely manner, to prioritise consultation as the initial response from FCAMHS. As outlined above, a forensic assessment

was not indicated at that time due to a sufficient understanding of AR's needs and risks that had been developed through the consultation process.

Why did you decide to close AR's case to FCAMHS?

21. An understanding of need and risk had been developed through the consultative process, and local services had recommendations, which they could progress to meet these identified needs. At that point, there was no further role for FCAMHS. The letter sent following the review consultation meeting (exhibit GMMH000007) indicates that professionals could refer AR to FCAMHS again if there was a significant change in need or risk presentation.

On reflection, do you consider that it was appropriate to close AR's case to FCAMHS in March 2020? If so, why? If not, why not?

22. On reflection, there may be some value in FCAMHS remaining involved for an extended period in all cases, to support local areas in managing risk. However, again this was not how FCAMHS was commissioned to operate and there would not have been sufficient resources to operate in such a way. At the point of consultation, FCAMHS does not become the local appointed case manager for the young person, but rather a support to that individual and others involved in the risk management plan, as outlined above. At the time AR's case was closed to FCAMHS, there was no identified role for the service as the local services were progressing the recommendations from the consultation.

Involvement with other agencies

Insofar as you were involved with other relevant agencies, what is your reflection on your dealing with them in relation to the events under investigation?

23. From my contacts with the other agencies that were involved with AR and participated in the professionals' meetings my reflections are that all agencies provided relevant information to support the consultation process. There was

one occasion where it took several attempts via phone and sending an email to Skott Morgan, mental health practitioner for Sefton CAMHS, before I was able to make contact with him to gain information regarding the CAMHS involvement with, and future management plans for, AR. Once I had spoken to Skott Morgan I was able to include this information in then summary of the first professionals meeting and reflect the actions agreed with Skott accordingly.

24. There was no representation from Sefton CAMHS at either of the professionals' meetings which, on reflection, I feel would have been helpful to facilitate further discussion with the other professionals present and allow for any queries regarding CAMHS involvement with AR to be answered directly.

Reflection on events

Please review GMMH000008. In hindsight, should an autism assessment have been considered as part of the consultative process? If so, why? If not, why not?

25. At the time of my involvement, FCAMHS did not complete autism assessments as this was not part of the service.

On reflection, do you consider that (a) you and (b) your organisation could have done more or done things differently. Please address this both with the knowledge that you had at the time and, if different, now with the benefit of hindsight and/or wider understanding of the events.

26. As outlined above and having reflected, the only additional actions that could have been taken by me would have been to offer an extended consultation or undertake a forensic assessment which were not provided by FCAMHS at the time unless indicated. In AR's case these actions were not indicated at that time.

Do you consider that the (a) guidance; (b) training; and (c) resources available to you were adequate for the nature of the involvement you had in the events under investigation?

27. Greater resources i.e., additional personnel in FCAMHS, allowing additional face to face assessment for all young people, would potentially be beneficial in clinical cases open to FCAMHS. From a personal perspective, I have no concerns with regards to courses that I attended during my career or the supervision that was available and as a result feel that I was adequately equipped with the skills, knowledge and support to undertake my role in FCAMHS.

Improvements

Are you aware of relevant improvements that have been made by your employer since these events?

28. I am not aware of relevant improvements made by my employer, due to being retired.

The Chair is tasked with making recommendations but ensuring, through engagement with relevant practitioners, the recommendations are practicable. Please set out any improvements that could be made relevant to your own area of involvement that would be practicable and make an effective difference.

29. As previously stated, I am no longer involved with the service and have retired. I am also not able to comment on whether FCAMHS being involved in extended periods of consultation for all cases and conducting assessments of all referrals is a pragmatic or realistic suggestion.

Other matters

Having regard to the Inquiry's Terms of Reference and the expectation on all witnesses to give a candid account, are there any other relevant matters that you wish to draw to the Chairman's attention?

30. There are no other matters I would like to bring to the Inquiry's attention.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings many 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: 21st August 2025