

Monday, 20th October 2025

(10.30 am)

DR ANTHONY JOHN MOLYNEUX (sworn)

SIR ADRIAN FULFORD: Thank you very much, please have a seat.

A. Thank you.

SIR ADRIAN FULFORD: Yes, Mr Moss.

Questioned by MR MOSS

MR MOSS: Thank you, sir.

Dr Molyneux, could you start by giving us your full name if you would, please?

A. Certainly. It is Anthony John Molyneux.

Q. Thank you. If we could have on screen, please, AHCH000253. We see, do we not, a copy of your statement to this Inquiry? It is dated 30th July 2025, so this year. Can you just confirm that the contents of that statement are true to the best of your knowledge and belief?

A. That's correct, yes.

Q. You tell us on that first page of your statement that you were employed as a consultant child and adolescent psychiatrist by Alder Hey Children's NHS Foundation Trust. Is that right?

A. That is correct, yes.

Q. Since 2019?

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my colleagues will have a specific remit for research, one will have a specific remit for the Mental Health Act, pharmacology and so on, and mine is the neurodevelopmental lead role. So really what it entails is being the main link between the neurodevelopmental pathways. It has recently become integrated into one pathway, but the main link between those pathways and the psychiatry group.

Q. We are going to hear evidence, particularly tomorrow, that in the way things were initially organised it was the paediatrics team I think that led on the diagnosis, is that right, for autism?

A. That's my understanding of it. If I can get the timings right, so the new autism pathway, which was centrally coordinated for the first time really, outside of the remit of all the other, you know, the governance of community paediatrics, that new way of doing things began around 2019/2020, as I recall.

Q. Thank you. We will pick that up with others. In broadest overview, is this right, that you took over from your colleague, Dr Ram, from whom we will be hearing next, in July 2022?

A. For the care of AR?

Q. For the care of AR.

A. Psychiatric care. That is correct, yes.

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A. Yes, April 2019.

Q. You qualified as a doctor I think first in 2009?

A. Yes.

Q. Your route to that I think was that you did biological sciences at Cambridge and then came here to Liverpool University to do a medicine degree?

A. That's correct.

Q. You have been a member of the Royal College of Psychiatrists since April 2014 and a consultant since 2017?

A. Correct, yes.

Q. Thank you. In paragraph 2, you explain that you carry the neurodevelopmental lead role for Alder Hey Psychiatry Consultants Group and that you have done that since July 2017. Is that right?

A. That's correct, yes.

Q. At the time of your involvement with AR, did that include any oversight of the autism spectrum disorders and ADHD services?

A. I wouldn't say so much as oversight. The neurodevelopmental lead role is not an executive role as such. Each member of the psychiatry group at Alder Hey, the consultant group has a different nominated lead role. They are nonexecutive roles. They are not paid or they are not separate jobs, so to speak. So one of

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Q. You were the assigned consultant psychiatrist on the team for AR and you remained assigned in that way to AR until you discharged him in I think April of 2024?

A. Correct, yes.

Q. Thank you. I want to turn against that introduction to ask you about the time when you were allocated AR's case and your awareness of the background and risk information in relation to him and I'm actually going to take a little bit of time with this because of its potential importance.

So, when you first were allocated AR onto your case load, did you receive a handover?

A. I did indeed, yes.

Q. Who was it from?

A. It was from my colleague, Dr Ram. Dr Ramasubramanian. Dr Ram we call her.

Q. Keep your voice up a little louder.

A. Dr Ramasubramanian, yes.

Q. And how was that handover over completed? Was it in person? Was it electronic? How was it done?

A. It was an in-person handover.

Q. How long would the handover have taken?

A. Oh, I mean, I don't think any more than half an hour or so.

Q. Thank you. And in terms of your sources of information,

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1 if we just have on the screen briefly for the moment
 2 AHCH000162, you are our first witness from the CAMHS
 3 team and this I think is the electronic patient system,
 4 yes?
 5 A. Yes.
 6 Q. You would have had access to that presumably?
 7 A. I mean, in theory access, yes.
 8 Q. What do you mean in theory access? Did you have
 9 access --
 10 A. Yes, I would have had access to it, correct.
 11 Q. And as part of getting to know the back story, to use
 12 a lay term, of your patients, like AR, would you use the
 13 electronic patient system records to look back and
 14 understand the history?
 15 A. I would always do so to get a decent corroborative
 16 background picture of what was going on with any patient
 17 I was handing over from another consultant.
 18 Q. What was the expectation as to how detailed that review
 19 should be?
 20 A. So, the handover I had focused on the live primary
 21 issues at the time really. So, as I recall, and
 22 I think -- well, I am sure it is there in my Rule 9
 23 statement -- the live issues at the time were -- well,
 24 the main foreground issue --
 25 Q. I'm going to interrupt you Dr Molyneux, because if you

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1 Q. Is that not the standard operating procedure and the
 2 expectation?
 3 A. That would appear to be the case, yes.
 4 Q. And your practice, therefore, in not reviewing it in
 5 totality, I think you indicated that it wouldn't be
 6 practicable to do so, does that suggest that there is
 7 a mismatch between what the expectation was and what the
 8 practice was, or certainly your practice was?
 9 A. I wouldn't say so. When it says "it is important that
 10 clinicians review the whole EPR record", I mean, it is
 11 important and it's important that it is reviewed.
 12 I would say that I did carry out a reasonable review.
 13 Q. Apart from the electronic patient record, did you have
 14 and what was said to you verbally in the handover, did
 15 you have any other sources of information?
 16 A. I can't think of what other sources of information would
 17 look like other than verbal handover and written
 18 records.
 19 Q. So far as other agencies were concerned, again it may
 20 seem an obvious question to you, but please just help
 21 us --
 22 A. No, of course.
 23 Q. Would you have access to local authority records, for
 24 example, or would you be dependent upon how liaison with
 25 the local authority had been written up in the

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1 can listen to my question, focus on the question that
 2 I'm asking and seek to answer it?
 3 A. Of course.
 4 Q. My question was what the expectation was in how detailed
 5 your review of the records should be?
 6 A. Well, I would say that the expectation was that I would
 7 conduct a reasonable review of the records.
 8 Q. Not the whole of the records?
 9 A. Well, it would be impossible to conduct a review of the
 10 whole of the records.
 11 Q. Can we have on screen please AHCH000309. Do you see
 12 that this is the standard operating procedure for the
 13 Sefton CAMHS? Do you see that there?
 14 A. I do indeed, yes.
 15 Q. If we go to page 16. If we see in the middle of the
 16 page, the paragraph:
 17 "As part of risk management and case management."
 18 A. Yes.
 19 Q. Do we see there that it includes this:
 20 "It is important that clinicians review [then these
 21 words] the whole EPR record at each appointment to
 22 ensure that they are aware of any risk factors or
 23 contextual risks that might have arisen since the last
 24 appointment."
 25 A. I see that, yes.

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1 electronic medical records?
 2 A. So it would be a bit of a mixture. So, there's
 3 a section on the EPR where scanned documentation from
 4 other agencies working with us would go in. That works
 5 a lot better now than it has done in the past, I think
 6 it is fair to say. Also, it would be those sorts of
 7 allusions to and, you know, the kind of core elements of
 8 importance, interagency discussions would appear in
 9 things like session notes and other good kind of go to
 10 sourcing. Obviously I'm aware that you are not familiar
 11 with the details of the record yourself, but another
 12 good and robust --
 13 Q. Taking it shortly, I think from the answer you have
 14 given, you would only see matters from a local authority
 15 to the extent that they had been scanned into the
 16 electronic records or contained within session notes
 17 within the electronic record. You didn't have direct
 18 access to other agencies' record-keeping?
 19 A. No, no, no. Forgive me, I don't know whether that's
 20 changed very recently. I know that there are
 21 discussions around a kind of a --
 22 Q. Just deal with how it was at the time?
 23 A. Not to my knowledge, I wouldn't have direct access to
 24 local authority information or anything.
 25 Q. What about nonmental health medical records? Did you

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1 have access to medical records outside the mental health
 2 records? Physical healthcare records, GP records?
 3 **A.** There are a couple of things to say about that. I'm
 4 fortunate to work for Alder Hey NHS Foundation Trust
 5 which obviously has, you know, a physical health
 6 component as well as a mental health component, so to
 7 speak. So it is relatively easy because it is the same
 8 NHS trust. Well, it is very easy to kind of access
 9 secondary care and tertiary care physical health
 10 records.
 11 GP information, as I understand it, can be obtained
 12 and could at the time by something called the National
 13 Spine, but my understanding of the practice was that
 14 that, certainly at the time -- again, this is my
 15 understanding of the practice -- that would be something
 16 that would need to be requested through admin staff.
 17 **Q.** So I am going to go through some aspects of the history
 18 of AR from before July 2022 and I want you to just help
 19 the Inquiry whether you were aware of it.
 20 **A.** Okay.
 21 **Q.** So were you aware when you took on AR onto your caseload
 22 that he had admitted taking knives into school on some
 23 ten occasions leading up to an incident where Childline
 24 were called in October 2019?
 25 **A.** No, I was aware of -- will you allow me to read out from

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1 Was that the sum total of your knowledge in relation
 2 to that?
 3 **A.** Yes.
 4 **Q.** So you didn't know that that had been on ten occasions
 5 that he carried a knife into school?
 6 **A.** I certainly did not know that, no.
 7 **Q.** You didn't know that, although his explanations for that
 8 perhaps varied, that there were some indications that he
 9 was bringing the knife in with a distinct intention of
 10 causing at least very serious harm?
 11 **A.** I absolutely did not know that, no.
 12 **Q.** So that was October 2019. Then in a ICT lesson on
 13 15th November, did you know that AR had been engaged in
 14 searching for material on a school computer relating to
 15 school shootings in America?
 16 **A.** No.
 17 **Q.** Did you know that AR had been involved in searching for
 18 a number of graphic images of degloving injuries on the
 19 school computer at about the same time?
 20 **A.** Not at the time, no.
 21 **Q.** When did you first learn about that?
 22 **A.** Since the tragic events of 29 July 2024.
 23 **Q.** Were you aware that on 29 November 2019, during
 24 a lesson, in relation to talking about setting up a new
 25 business, that AR had said that people would think he

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1 the initial psychiatric letter that --
 2 **Q.** No, but if we have on screen AHCH000163.
 3 **A.** I mean, the short answer is I wasn't aware of it.
 4 **Q.** Just pause. Let me bring it up on the screen. At
 5 page 95. Do you see at the bottom there an entry in the
 6 electronic records for 15 September 21. Do you see that
 7 there?
 8 **A.** I do indeed, yes.
 9 **Q.** If we go over the page, do we see that that's by
 10 Dr Aseri, about six lines down, clinicians present?
 11 **A.** Yes, I can see.
 12 **Q.** Under "presenting complaints" we see 1 and 2, and then
 13 there is a history that is given. Is that what you were
 14 seeking to read out?
 15 **A.** Yes, that looks like what's in this letter I have here.
 16 **Q.** That's why I'm taking it so rather than reading it out
 17 we can see it on the screen. So we see there:
 18 "AR tells me that he started experiencing worries
 19 about leaving his house since September 2019. This was
 20 related to AR being bullied at his old school, Range
 21 High School, which is a mainstream school. Due to this
 22 he was noted to attend school carrying a knife in his
 23 bag which led to his permanent exclusion from the
 24 school. There was no history of AR being physically
 25 aggressive towards anyone at school on this occasion."

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1 would kill them as they did not know him and he went on
 2 to say "people don't trust others they don't know in
 3 case they get murdered". Were you aware of that
 4 statement of concern?
 5 **A.** No idea at the time, no.
 6 **Q.** On 3rd December 2019, during an art lesson, colouring in
 7 images from the video game Call of Duty, AR questioned
 8 why he was allowed to look at those images from Call of
 9 Duty, but couldn't look at guns on the internet, and
 10 then asked to look at a picture of a severed head?
 11 **A.** Again, these are things I have only found out since
 12 July 2024.
 13 **Q.** And were you aware that AR had attacked a student with
 14 a hockey stick in an incident in December 2019?
 15 **A.** No.
 16 **Q.** You weren't aware of that incident at all in addition to
 17 the October one?
 18 **A.** No.
 19 **Q.** The statements that he gave in relation to that were
 20 perhaps contradictory at times but, again, there was
 21 an indication that his intent, at least on some
 22 accounts, was that he would have been prepared to use
 23 the knife and potentially to kill the person he was
 24 targeting?
 25 **A.** I didn't have any knowledge of that at the time.

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1 Q. And were you aware that what he ended up doing on that
 2 occasion, when he couldn't get hold of the person that
 3 he perceived to be the bully, was he just attacked
 4 another boy seemingly at random who happened to be in
 5 the corridor?
 6 A. Again, these are only elements that I have discovered
 7 since July 2024.
 8 Q. Were you aware that on 29th February 2020, that in
 9 relation to that incident, he was convicted and received
 10 a ten-month referral order?
 11 A. No.
 12 Q. Were you aware that in the strategy meeting in
 13 December 2019, it also emerged from the school that he
 14 had been looking up matters or discussing matters in
 15 relation to the Manchester Arena attack and had said
 16 that it had been a "good battle"?
 17 A. I had no idea of that at all at the time and when I --
 18 if I might add -- when I found out that since
 19 29 July 2024, I found that particularly chilling
 20 actually.
 21 Q. And then 20th April 2021, school computer, still before
 22 your time, as his consultant, but school computer,
 23 viewing web pages relating to the London Bridge terror
 24 attack, and then speaking in some detail about the IRA,
 25 MI5, MI5 wanting to kill people in the IRA and showing

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1 made to the police after AR had thrown food and
 2 overfilled the bath so to flood it. Were you aware of
 3 that?
 4 A. No.
 5 Q. Would you not have expected in light of the candid
 6 answers that you have given that you weren't aware of
 7 those, save for some knowledge round the October
 8 incident, would you have expected to have known about
 9 those matters? Were they not important?
 10 A. Of course, yes. I think it is crucial that somebody in
 11 my position ought to know those things.
 12 Q. Keep your voice up please.
 13 A. I think it is crucial that somebody in my position ought
 14 to know those things at that time.
 15 Q. Thank you. We will come back to this, but any
 16 assessment of the risk that AR posed to others while you
 17 were the treating psychiatrist, would be deeply flawed
 18 without knowledge of those matters?
 19 A. It would -- let's just say it would have a significant
 20 blind spot.
 21 Q. Would you not agree that it would be likely to be deeply
 22 flawed?
 23 A. I think that's arguable, yes.
 24 Q. Dr Molyneux, not all of that history and the detail that
 25 I have explained it was available in the medical

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1 a distinct interest in those sort of topics?
 2 A. No idea at all.
 3 Q. 5th November 2021, AR trashing the house leading to his
 4 mother calling the police?
 5 A. No.
 6 Q. 30 November, AR kicking his father and throwing a plate
 7 at a rental car causing damage to the car windscreen?
 8 A. No.
 9 Q. Then 21 January 2022, where AR had made comments in
 10 school about the Holocaust, talked about the death of
 11 Diana, water poisonings and saying that sometimes
 12 violence was necessary?
 13 A. No.
 14 Q. 17 March 2022, moving closer in time to when you took
 15 over as the consultant psychiatrist, he went missing
 16 from his home address. He was found on a bus later the
 17 same day in possession of a knife. Were you aware of
 18 that?
 19 A. No.
 20 Q. Were you aware that when the police asked him about it
 21 he made remarks about wanting to stab people and either
 22 saying that he had had thoughts about making poison or
 23 that he had tried to make poison?
 24 A. No idea.
 25 Q. Then a further incident on 14th May, when calls were

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1 records?
 2 A. No.
 3 Q. But aspects of it were. Were you aware that the hockey
 4 stick incident was in the electronic records, that there
 5 was a reference to it?
 6 A. No.
 7 Q. Have you looked at the records in preparation for your
 8 evidence and seen that?
 9 A. I have seen it referenced in the bundle of documents
 10 that we have. I'm not so sure whether it is part of the
 11 overall chronology or part of our EPR that I have seen.
 12 Q. And the fact that AR had been subject to a ten-month
 13 referral order, again I give the paragraph references to
 14 the internal review, 168 in the internal review by Alder
 15 Hey for the hockey stick incident, 177 in the ten-month
 16 referral order where it sets out that that was
 17 information that was available from the records.
 18 A. I didn't know that.
 19 Q. And the fact that he had taken a knife into school with
 20 the intention of using it, again, was recorded in the
 21 records.
 22 Sir, for your note, AHCH000162 page 3.
 23 SIR ADRIAN FULFORD: Thank you.
 24 MR MOSS: So we don't necessarily need to have it up on
 25 screen, but it is there in the electronic records.

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1 A. Again, that seems to be at variance from what's in the
 2 clinical letter that I saw.
 3 Q. But that's the importance of reading through the notes
 4 and being fully informed of them?
 5 A. It is although, you know, in my defence if I see a good
 6 psychiatric letter that tells me something, that's --
 7 I think it is reasonable to conclude that that's
 8 accurate. And of course if I might say a little more on
 9 that; when any doctor or clinician meets a patient
 10 family for the first time, it is always not just
 11 an opportunity, but an obligation to get a complete
 12 history, an up-to-date history from the new patient, the
 13 new family, and that was an opportunity that I had on
 14 the first home visit of 28th July 2022 and I would say
 15 that crucially, and what strikes me as different from
 16 pretty much every other case I have ever come across
 17 within my professional career, whereas I would have
 18 expected that information to be foregrounded in what the
 19 family told me when I spent an hour and a half to two
 20 hours with them on that date on July 2022, I didn't hear
 21 any of that.
 22 Q. No, and in due course we will ask questions of course of
 23 AR's family, but in a sense is what you are telling us
 24 that you relied on the last clinic letter and didn't
 25 yourself go back through the records and see all these

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1 it was in the electronic CAMHS note?
 2 A. Correct. I wasn't aware of it at the time, no.
 3 Q. The London bombings reference as well, 163, page 19.
 4 The incident of throwing juice over his father and
 5 assaulting him. Same document, page 29. Trashing the
 6 home, same document, page 119. And the going missing
 7 from home AHCH000164, page 37. Doctor, all of those
 8 were within the records.
 9 A. Indeed.
 10 Q. So, you have referred back -- can we go back on screen
 11 to AHCH000163 at page 95, please -- I think these are
 12 the internal notes. I think you were referring to
 13 a clinic letter that may have gone out with the same
 14 contents presumably.
 15 If we just go on to 96 so we can see the substance
 16 of it again. What grade was Dr Aseri?
 17 A. She was a registrar.
 18 Q. So more junior to you?
 19 A. Correct.
 20 Q. Did you not think it was incumbent on you to do a proper
 21 check through the records rather than just relying on
 22 this one clinic letter to see what the detailed
 23 information was since AR had come to CAMHS?
 24 A. I mean, I know Dr Aseri, I worked with her at the time,
 25 I regarded her and continue to regard her as a good

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1 references that were there to be seen?
 2 A. I guess it is a question -- it seems to me it is
 3 a question of unknown unknowns, isn't it? If you get
 4 good assurance from a good assessment letter that the
 5 state of affairs is a certain state of affairs, and you
 6 get a good handover and you look at a selection of
 7 recent letters and recent notes and so on, one would
 8 expect that that gives reasonable assurance. It would
 9 be impossible to spend the requisite amount of time
 10 going through every aspect of every patient's clinical
 11 record.
 12 Q. That's what the standard operating procedure appears to
 13 envisage, but let me just continue because the fact that
 14 AR had been viewing inappropriate content online in
 15 relation to terrorism was also in the notes. Are you
 16 aware of that now?
 17 A. I'm aware of that now. Yes.
 18 Q. The fact that he had researched -- that's
 19 AHCH000162 page 9 for your note, sir -- the fact that he
 20 had researched the Manchester bombing there is
 21 a reference to that in the CAMHS notes, 162 page 10.
 22 Are you now aware of that?
 23 A. Say again?
 24 Q. You said the Manchester bombing reference was
 25 particularly chilling and you weren't aware of it, but

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1 competent doctor. A registrar is not by any means
 2 a junior grade. Somebody at a registrar level has been
 3 working as a qualified doctor for a number of years.
 4 I've never had any issue with her assessment
 5 capabilities at all and neither did anyone else. She
 6 was a very popular and very valued member of the team.
 7 My sense of what this likely speaks of, and this is
 8 something that I think -- this is my impression now --
 9 that I think has become more visible in retrospect, in
 10 hindsight, is there would appear to be repeated
 11 instances throughout AR's trajectory through our service
 12 and evidently other public sector agencies too, there
 13 would appear to be repeated occurrences of the family
 14 appearing to, shall we say, stage-manage the
 15 presentation of information provided to professionals.
 16 Q. Dr Molyneux, you spoke earlier about unknown unknowns?
 17 A. Yes.
 18 Q. The fact that parents of a youth might downplay and not
 19 volunteer information about their involvement in
 20 violence is a known known. That's a risk that you as
 21 a psychiatrist should have been taking into account.
 22 Would you not agree?
 23 A. How can I answer that? I guess it is a possibility.
 24 Q. Is it a possibility, or is it a simple fact of competent
 25 psychiatric practice? If you are dealing with offenders

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1 who are youths, it is something that you should be
 2 prepared for all the time, that the parents may downplay
 3 that, or may not wish to volunteer information about it?
 4 That's just something of risk that you should us always
 5 have in mind, is it not?

6 **A.** It is something that you should always have in mind, but
 7 again, I think you can only take reasonable steps to try
 8 and mitigate that. Again, it falls back on unknown
 9 unknowns, I think. And my sense of working with this
 10 family, and again this is something that's only possible
 11 to see with the benefit of hindsight and other of my
 12 colleagues have had the same on reflection and with the
 13 benefit of hindsight, others of my colleagues have had
 14 the same and reported the same experience. The level of
 15 studied manipulation of presentation is something -- at
 16 a level -- and again, it is only possible to see this
 17 I think with the benefit of hindsight, but it is
 18 something that's there at a level that I have never
 19 experienced before.

20 **Q.** Dr Molyneux, I'm going to come back to that.

21 **A.** Of course.

22 **Q.** But can I please, without discourtesy, ask you please to
 23 focus on your standards of practice and the standards of
 24 CAMHS, rather than going to the sidelines and looking at
 25 the family and what they may and may not have

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1 is a reasonable level of triangulation of information.

2 **Q.** But I have been through, without going to the issues
 3 about the family, I have been through what was visible
 4 from the notes which is many, although not at all, of
 5 the longer list that I went through with you at the
 6 start.

7 How can it be, if you met your professional duties
 8 in that regard, that that information was visible on the
 9 records, but you were ignorant of it?

10 **A.** Because it is not easily visible on the records,
 11 I guess, so it remains in the territory of unknown
 12 unknowns. If you don't know something's there, you
 13 can't go looking for it. If you don't have a suspicion
 14 that that is there, you won't have an indication to go
 15 looking for it.

16 **Q.** That brings into play a third issue then, doesn't it,
 17 that the handover from Dr Ram can't have been all that
 18 effective because this whole aspect of these histories
 19 of his earlier offending and risk information -- you say
 20 unknown unknowns -- but if there had been a good
 21 handover to you, you would have been put on notice there
 22 was quite a lot of concerning risk information in 2019
 23 and 2020 in particular, and then a worrying incident in
 24 March 2022 where he has been found with a knife?

25 **A.** I guess I can't speak for Dr Ram. However, knowing now

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1 volunteered. Because what I'm asking you about here is
 2 matters that were available and were on the records and
 3 what I'm going to suggest to you that the picture that
 4 emerges is twofold:

5 Firstly, the system within CAMHS for keeping track
 6 of the risk information was very poor because, as the
 7 consultant taking over, there should have been a system
 8 whereby this important historical information was
 9 visible to you. Do you agree with that?

10 **A.** I agree that -- yes, public sector systems in general --

11 **Q.** Not public sector systems. The CAMHS system at Alder
 12 Hey. Please focus on the questions that I'm asking you.

13 **A.** I would say it should have been better and steps have
 14 since been taken to improve it.

15 **Q.** And the second aspect, Dr Molyneux, is that you failed
 16 in your duty adequately to check the notes yourself to
 17 inform yourself of this important risk information that
 18 was visible on the notes had you checked them more
 19 thoroughly?

20 **A.** I don't accept that submission that I failed in my duty.
 21 I believe that I took reasonable steps to glean
 22 a reasonable level of assurance from the notes, from the
 23 verbal handover that I had and then my initial meeting
 24 with the family on the first home visit of
 25 28th July 2022. I feel that that, all else being equal,

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1 some of the -- well, all of the more granular detail of
 2 those earlier aspects of AR's journey through our
 3 service, I think we need to be careful about judging
 4 what may or may not have been known by clinicians who
 5 were involved at the time.

6 I think we need to be careful about judging that and
 7 viewing that with the benefit of hindsight. For
 8 example, without the benefit of hindsight, without the
 9 benefit of -- without the experience of, the
 10 unprecedented experience of the tragic events of
 11 29 July 2024, without that knowledge, for example, three
 12 Prevent referrals that each say nothing to see here,
 13 nothing to see here, nothing to see here, I would say
 14 gives a good level of assurance that there is nothing to
 15 see here.

16 **Q.** But the repeated incidents of carrying knives into
 17 school and then being found with a knife in March 2022,
 18 just months before you took over, that's just central
 19 information that you had to know, leaving aside the
 20 conclusions from the Prevent referral. That's not
 21 hindsight and it is not unknowns unknowns. They are
 22 matters on the record that you as the treating
 23 psychiatrist were not aware of?

24 **A.** No.

25 **Q.** And I'm going to suggest you did not inform yourself of

24

1 from the records?

2 **A.** Again Mr Moss, I can't inform myself of them if I don't

3 know or have any indication to suspect that they are

4 there.

5 **Q.** If you had been aware of the full background as I have

6 outlined to you, would that have affected your

7 assessment of AR throughout the time that you were his

8 psychiatrist?

9 **A.** It would certainly have altered the perspective, yes.

10 I'm not saying necessarily in a fundamental way, but it

11 would have altered the perspective, yes.

12 **Q.** And would this be right, that most fundamentally the way

13 in which it would have altered the perspective was to

14 put a focus upon AR's risk to others?

15 **A.** It would have shone more light in that direction,

16 I agree, yes.

17 **Q.** Because I think you are aware in general terms that by

18 the time that AR was being discharged from CAMHS all

19 together, and that was slightly after he had been

20 discharged from your psychiatric care, the risk to

21 others was said to be "none" on 23rd July 2024?

22 **A.** I don't think that was an entry by myself.

23 **Q.** No, I didn't suggest it was. But that would not have

24 been the assessment of his risk to others, given that

25 significant forensic history, would it?

25

1 **A.** I thought the risk of harm to others at the time I took

2 over his care was minimal.

3 **Q.** And would you now accept that that was inadequate?

4 **A.** Well, early on in my involvement I obviously got a sense

5 from parents and he himself. He denied thoughts of harm

6 to others and parents were, you know, denying that there

7 was any issues or not bringing forward any issues in

8 that area.

9 **Q.** Again, forgive me for going back to it, but if in March

10 he had carried a knife on a bus, and had told police

11 officers he had thoughts of stabbing people with it,

12 an assessment that his risk to others was minimal,

13 leaving aside who was responsible for that, but

14 objectively speaking, that was not an adequate

15 assessment of his risk to others?

16 **A.** Objectively speaking, it would appear to be the case

17 that, as you intimate there, in March 2022 his risk of

18 harm to others was not minimal, no.

19 **Q.** Were you aware that there had been a referral to

20 forensic CAMHS?

21 **A.** When I took over the case.

22 **Q.** Yes.

23 **A.** No.

24 **Q.** Did you become aware of that while he was on your

25 caseload?

27

1 **A.** I can't really make a definite statement on that because

2 again what you have got in the intervening time is the

3 perspective that's emerging from reviews of AR directly,

4 during which time he is saying repeatedly to people, or

5 denying that he has thoughts of harm to others and

6 parents aren't foregrounding any risk in that direction

7 either.

8 **Q.** Potentially would all of that information about AR also

9 have been relevant when you considered the question of

10 diagnosis and whether he was suffering from a mental

11 disorder and, if so, which?

12 **A.** Could you repeat the question, sorry?

13 **Q.** Yes. Potentially would all of that information about AR

14 also have been relevant when you were considering the

15 question of diagnosis and whether AR was suffering from

16 a mental disorder and, if so, which disorder? It would

17 have been relevant information to take into account.

18 **A.** It would have been relevant information, even if just to

19 provide some context.

20 **Q.** What was your actual understanding of the risk that AR

21 posed to others when you took over his psychiatric care?

22 **A.** Minimal.

23 **Q.** Do you now accept that -- when you say minimal, do you

24 mean your understanding was minimal, or you thought the

25 risk was minimal?

26

1 **A.** No.

2 **Q.** Is that something which you think you should have been

3 aware of if the systems had been working properly?

4 **A.** The system in the wider sense, yes.

5 **Q.** Could we have on screen please GMMH000007.

6 Just so you get your bearings on this, can you see

7 that this is a letter dated 9 March 2020?

8 **A.** Yes.

9 **Q.** If we just go over please to page 2, it is from

10 Mr Hicklin, John Hicklin?

11 **A.** Yes.

12 **Q.** He says there, if we can just have the text of the --

13 that's visible -- enlarged please, Sarah. He was

14 saying:

15 "I made comment that risk assessment will be

16 complicated by his likely diagnosis of ASC. The known

17 evidence in this field concurs with the discussion we

18 had about AR with professionals."

19 Then he outlines some particular risk factors

20 including: "Specialist interests associated with the

21 condition; hostility to parents; lack of awareness of

22 wrongdoing; deficits in empathy or lack of recognition

23 of fear in others; not seeing consequences."

24 He goes on to say:

25 "I am of the opinion that assessment by our service"

28

1 that is to say FCAMHS "is not indicated as until his
2 diagnosis is complete we would not be able to contribute
3 further to the understanding of risk."

4 He is talking about the meeting that he had
5 attended:

6 "I made comment that though AR being outside of
7 access to full time education increases the risk, we
8 would therefore support access to appropriate provision
9 being expedited. He would also likely benefit from
10 access to social support outside of the family. It was
11 reported that the case will step down to early help and
12 as suggested this letter can be shared with relevant
13 professionals. The case will now be closed to FCAMHS
14 but any professional can contact the service for
15 clarification of this letter or if review is indicated
16 because of a significant change in circumstances or risk
17 behaviour."

18 I do not think you would have been aware of that
19 advice from FCAMHS at any stage when you were treating
20 AR?

21 A. Say the last bit again there, sorry?

22 Q. I do not think you would have been aware of that advice
23 from FCAMHS at any stages when you were treating AR?

24 A. No, indeed.

25 Q. It follows that to the extent that this was saying we

29

1 A. I'm aware now that it is now know that there were
2 scanning problems. I think it is worth saying and worth
3 flagging that this was -- I think this was around about
4 February 2020 sort of time? March 2020?

5 Q. This is 9 March 2020.

6 A. And I don't think, not just for our organisation but
7 throughout the public sector, I do not think the huge
8 impact of the Covid-19 pandemic and all of the tumult
9 that that brought in right across the sector, I do not
10 think that can be overstated.

11 Q. We will pick that up with Dr Killen in terms of how this
12 came about. You didn't know about FCAMHS. You did have
13 some information about Prevent. I think you say in your
14 statement that there were two occasions when that was
15 mentioned?

16 A. Yes, indeed.

17 Q. You mentioned earlier in your evidence this morning of
18 what you took from that, I think you used the phrase
19 "nothing to see here". Is that right?

20 A. Is that the phrase I've used in my statement?

21 Q. I'm paraphrasing, but I think that is the phrase you
22 used earlier this morning?

23 A. I beg your pardon, but you are correct in substance. My
24 recollection is that there were only -- I only
25 encountered two references to Prevent throughout my

31

1 can't help more on the complex question of risk until
2 the autism diagnosis is made, but you can come back to
3 us if there is a relevant change, if that's what this
4 letter means, were you aware that, in February 21, AR
5 had received his autism diagnosis?

6 A. I was aware that -- so when I took over his case I was
7 aware that he had an autism diagnosis. I couldn't --
8 looking back, I do not think I could have pinpointed to
9 when he got it, but I was aware he had an autism
10 diagnosis.

11 Q. But it follows that you wouldn't have been aware that
12 there was potentially an invitation for FCAMHS to refer
13 him back to FCAMHS for further assessment of risk once
14 the diagnosis was known?

15 A. I wouldn't have been aware of that. By the way, I'm not
16 entirely in agreement with the conjecture that an autism
17 diagnosis needs to be made before risk can be taken into
18 account necessarily. I don't necessarily agree with
19 that opinion. But that's their opinion at the time.

20 Q. We are going to hear evidence that these letters were
21 not in fact scanned onto the system, so in fairness to
22 you it looks as though these letters wouldn't have been
23 available if you did go back through the notes. Were
24 you aware of that, that it is now known that there were
25 scanning problems?

30

1 entire period as AR's consultant psychiatrist. One was
2 a reference -- and a passing "nothing to see here"
3 reference or equivalent really in the multi-professional
4 meeting of I think 25th May 2023. Another reference was
5 in a file, informal kind of review of the case as we
6 approached discharge, as I had an informal conversation
7 with the case manager at the time, Kathryn Morris.

8 Q. Even if they appeared to be reassuring references, did
9 that not stimulate some sort of professional curiosity
10 on your part to go back through the notes and see why
11 there had been a Prevent referral and to understand how
12 that reflected on the earlier notes before you became
13 involved?

14 A. Well, the first thing to say about that is that only one
15 was mentioned and I did recall in that final
16 conversation with Kate Morris, I did recall my
17 recollection of what the substance of the Prevent
18 discussion was about at the 25th May 2023
19 multi-professional meeting, and it was -- my
20 recollection was that there were some relatively
21 trivial -- my recollection -- relatively trivial
22 reference to Hitler, or something like that. I think it
23 is a misremembering of the Gaddafi Prevent referral,
24 which I think was the second referral, but that's
25 something I have only been able to kind of clarify

32

1 since.

2 **Q.** And so if, and again I have to summarise quite a lot of
3 evidence and I will try to do so in a way that's short
4 but I hope fair. If, for example, the first Prevent
5 referral can be summarised in this way, that there was
6 a mixture of really quite concerning information about
7 AR that was put through on that Prevent referral, but
8 the assessment was that he was not somebody who was
9 prone to be radicalised into terrorism itself, but this
10 was more likely to arise because of his autism and that
11 CAMHS, together with other agencies, but particularly
12 CAMHS were giving the requisite help in relation to
13 those risks, that would have been important for you to
14 know, wouldn't it, that that was the overall assessment
15 of where Prevent were coming from?

16 **A.** It would.

17 **Q.** Rather than it is a trivial referral, there's nothing to
18 see here?

19 **A.** I think, again, my sense of the -- it is an important
20 negative aspect -- so my sense of what the one referral
21 was, was the second one, which I think was the Facebook
22 post, which I think was about Gaddafi, wasn't it? But
23 my recollection was at the time it was to do with
24 Hitler. But the first one, yeah, it would have been
25 important for me to know the details of that, yeah.

33

1 **Q.** You had your first home visit on 28th July, but he
2 himself was present but not talking to you. He was in
3 his room.

4 **A.** He had absented himself prior to my arrival, yes.

5 **Q.** You set out there, is this right, I'm going to try to
6 take it relatively shortly, but the principal concern at
7 this first meeting with his parents with you was his
8 weight loss due to restrictive eating and longstanding
9 his refusal to leave the house. Was that the main
10 concern at that stage?

11 **A.** Correct.

12 **Q.** You agreed to prescribe him a one-off dose of diazepam,
13 a mild sedative, to enable him to be able to attend an
14 in-person appointment at the Southport clinic?

15 **A.** Correct.

16 **Q.** You explain in paragraph 19, if we can go on to page 7
17 please that AR and his father then attended that clinic
18 as planned on I think 1st August 2022. Is that right?

19 **A.** That is right, yes.

20 **Q.** What was your impression of him on that clinic
21 appointment?

22 **A.** Well, as I say there, or in subsequent paragraphs, he
23 came across as somebody who wasn't interested himself in
24 being there, didn't particularly want to engage, wasn't
25 depressed, was euthymic in mood, I guess. He came

35

1 **Q.** But again, you didn't go back through the notes to look
2 at what was in the CAMHS notes about that, including in
3 relation to the first referral?

4 **A.** Well, again, my understanding was that there had been
5 one Prevent referral that had been about something that
6 professionals regarded or evidently regarded as, you
7 know, relatively trivial and no further action by the
8 Prevent process and that was the sum total of my
9 knowledge. If the sum total of my knowledge is there
10 was one Prevent referral, I don't have an indication to
11 go and look for others.

12 **Q.** Thank you. I am going to move to a different topic now
13 which is the ongoing work that you were involved in with
14 AR from when you took him on on your caseload, from
15 July 2022 through to September 2023.

16 **A.** Yes.

17 **Q.** I think if we look at paragraph 11, page 4 of your
18 statement.

19 **A.** Paragraph 11, yes.

20 **Q.** Page 4. You deal there with the fact you first saw AR
21 in person on 28th July 2022, yes?

22 **A.** I didn't see him in person on that home visit. He had
23 gone up to his bedroom before my arrival. That was
24 an hour and a half, to two-hour conversation with
25 Alphonse and Laetitia in the downstairs living room.

34

1 across -- I regarded him as an average sullen teenage
2 boy really.

3 **Q.** You say in paragraph 20 that:

4 "Overall he presented as stable in terms of his
5 mental health."
6 Yes?

7 **A.** Yes, correct.

8 **Q.** You also say right at the bottom of the page that:

9 "There was no evidence of any thoughts of harm to
10 self or others."
11 Would you have specifically asked him about -- I'm
12 going to focus on risk to others for reasons you will
13 understand -- would you have specifically asked him
14 about thoughts of harm to others?

15 **A.** So, my recollection is that I asked him about thoughts
16 of harm to self in the second appointment of
17 29 December 2022, which I insisted on sort of seeing him
18 alone. I did a comprehensive, you know, tour of all of
19 those risk parameters.

20 **Q.** Forgive me, but I specifically asked you about the risk
21 of harm to others. So on 1st August, when you say there
22 was no evidence of any thoughts of harm to self or
23 others, would you have asked him about thoughts of harm
24 to others?

25 **A.** I may have asked him. I can't say definitively that

36

1 I did not.

2 Q. And you will forgive me for going back to it, but if you

3 had known that as recently as March he had been found

4 with a knife, and it is not something that he said, the

5 police have seen the knife, taken it off him and given

6 it back to parents, and said that he had the knife

7 because he wanted to stab somebody and had made

8 reference to poison, those matters that you would have

9 been bound to explore with him, however cautiously?

10 A. Of course.

11 Q. But they weren't explored because you didn't know of

12 them?

13 A. Correct.

14 Q. In part because you hadn't read the records?

15 A. I hadn't had indication to pursue any further in the

16 records from the reasonable assurance of ostensible

17 clinical presentation that I was given from the

18 documentation and the handover and the parental

19 appointment that I had.

20 Q. I mean, does it not concern you now that those matters

21 were available in the records, the most recent incident

22 in particular and that you hadn't picked it up, does

23 that not trouble you?

24 A. It does, yes.

25 Q. You explain in paragraph 21 that you discussed trying

37

1 relationship.

2 Q. In terms of the recent medication history, take it from

3 me for the moment, but I can bring it up on screen if

4 you want me to, but as recently as 7th April of the same

5 year, 2022, your predecessor, Dr Ram, had indicated that

6 she would increase sertraline up to 100mg for 2 months

7 after which she said without any clear improvement it

8 would be known that medication wasn't right for AR.

9 So on one view moving to a different medication

10 might be thought to be contrary to what Dr Ram's

11 thinking had been, which was to try and increase dose of

12 sertraline, but with a view that if that didn't bring

13 about a marked improvement, that medication wasn't the

14 way to go.

15 A. I can understand why you are asking that question.

16 I think this is within the remit, if you like, of

17 acceptable variation between psychiatric practice.

18 I tend to go to higher doses probably less than the

19 average of my colleagues, but there is variation amongst

20 my colleagues.

21 Q. You deal in paragraph 28 on page 10 with the fact that

22 there was then a telephone review on 1st September,

23 which I think was positive. Is that right?

24 A. From memory, yes. I probably say it there, do I?

25 Q. In fairness to you, in terms of the new medication,

39

1 a different SSRI and for sertraline and fluoxetine I

2 think was the medication that you were thinking of. Is

3 that right?

4 A. Fluoxetine, that is correct, yes.

5 Q. And you prescribed a low initial dose on this occasion?

6 A. Very low, yes.

7 Q. I'm asked to explore with you whether you had thought

8 about talking therapies may have been a better approach

9 at this stage. Do you have a view on that?

10 A. I can see why you are asking that question. So, the way

11 the CAMHS -- our CAMHS service and CAMHS services in

12 general work is that people will be assigned typically

13 and it works ... people will be assigned a case manager

14 who has a primary therapist role. So they will meet the

15 young person, provide that sort of basic talking therapy

16 input. Then if there is a further indication identified

17 for a specific talking therapy on top of that, that's

18 a further referral that can be made. I mean, in this

19 case, as with a lot of cases that I come across, it is

20 important to -- well, it's of primary importance really

21 to establish that therapeutic relationship and if you

22 are in a position to be able to prescribe a medication

23 for somebody that will take the edge off their distress,

24 a big part of the therapeutic role of that is that it

25 goes some way towards establishing a therapeutic

38

1 Alphonse R, AR's father, was reporting an improvement in

2 presentation since starting on the fluoxetine. You had

3 a further review I think on 1 December 2022,

4 paragraph 29, just over the page please. Is that right?

5 A. I'm trying to remember and orientate myself a little bit

6 now.

7 Q. It is on the screen if it helps?

8 A. Yes.

9 Q. So, from father, a positive report in terms of rate,

10 continuing to improve, but on the other hand, as regards

11 the fluoxetine, AR had stopped taking this some weeks

12 previously. Is that right?

13 A. That's what I say there, yes.

14 Q. Again, we are taking it from the statement rather than

15 going through lots of notes, and he said it was because

16 he didn't feel it had any effect, yes?

17 A. Again, that's -- I'm having to go back -- I can't

18 remember, but yes, that's what I have written.

19 Q. You say you wondered he had experienced the fluoxetine

20 as somewhat over-activating. Then you say this:

21 "Having momentarily overlooked the fact that he had

22 of course been prescribed sertraline previously already,

23 proposed that he might be interested in trying

24 sertraline instead."

25 Is that right?

40

1 A. Yes.

2 Q. The reference to momentarily overlooking the previous
3 prescription, I took you to the standard operating
4 procedure in terms of informing yourself of what was in
5 the notes, but of course that was the medication that
6 Dr Ram had been attempting to use and had increased the
7 dose of, which was in the very recent records.

8 How did it come to be, Dr Molyneux, if you were
9 paying appropriate attention to the notes, that you
10 thought about trying a medication that had already been
11 attempted?

12 A. You say it was in the very recent record. I think it
13 was -- was it -- we are now April to December, aren't
14 we, I think was the gap, is it?

15 Q. Yes. The treating records for that year, you had had
16 a handover from Dr Ram?

17 A. Yes, in the July. But we are now in the December.

18 Q. But had you just forgotten about that, had you?

19 A. I mean, I had -- again, I had momentarily overlooked it.

20 Q. If it were suggested that that is indicative of
21 a pattern, Dr Molyneux, of you not paying sufficient
22 attention to what is in past notes, what would you say?

23 A. Could you say that again, sorry?

24 Q. If it were suggested that that is indicative of
25 a pattern of you not paying sufficient attention to what

41

1 that it wasn't effective, hence trialing something else
2 and going to fluoxetine, what would be the benefit for
3 him of getting sertraline again?

4 A. Again, it is a wondering without forming any definitive
5 conclusions about it. The sense in retrospect, through
6 having worked with AR and his approach to medications
7 was that he almost seemed to have a shopping list for
8 what exactly he wanted in terms of medications.

9 Q. Did you get the impression that he looked a lot of stuff
10 up about medications? That he was knowledgeable about
11 them?

12 A. I did get that impression, yes.

13 Q. Was that unusual of someone of his age?

14 A. I don't think it's particularly common. I won't say it
15 was particularly uncommon. I mean, it might even be --
16 maybe I'm being too unfair even to say that. I mean,
17 you do get a lot of doctor Googling going on now, you
18 know, with children and adult patients really, people
19 looking up medications and coming up with hypotheses
20 about what medication they would like.

21 In fairness to the point you are making though,
22 Mr Moss, I think it is fair to say that he was more that
23 way than most. Yeah.

24 Q. If I could have paragraph 32, please, page 12. You next
25 see AR on 29 December. You have mentioned that already

43

1 is in the past notes, what would you say?

2 A. I would say that's unfair, in my opinion.

3 Q. Thank you. You go on to explain in paragraph 30 that
4 having reviewed Dr Ramasubramanian's record since, you
5 can see that she had previously prescribed sertraline.
6 You go on to say:

7 "In retrospect, in light of everything we now know
8 but do not have known at the time", and I have
9 challenged you on that about what could have been known
10 at the time, "I wonder if this wasn't an example of
11 an attempt on AR's part to consciously and
12 deliberately manipulate professionals."

13 Just explain why you were making that reflection?

14 A. So this is a reflection that I have made in the process
15 of doing the Rule 9 statement. I guess it would fit in
16 with a general pattern, a general contextual pattern
17 that seems to have been established by AR and his
18 behaviour throughout his trajectory of involvement with
19 all of the various services, but that wasn't apparent
20 certainly to me at the time.

21 Q. Just help us with what you are suggesting you think AR
22 was actually doing?

23 A. Well, I'm wondering, I'm wondering if he was trying to
24 manipulate professionals.

25 Q. But if he had sertraline previously and he had reported

42

1 doctor, and you say you are conscious that you have not
2 seen AR in clinic alone yet and you ask to do so and
3 they agreed to that. Just looking at the totality of
4 paragraph 32, it appears that on this occasion he seemed
5 physically healthier again and mental state apparently
6 stable. Is that the overall impression?

7 A. Correct.

8 Q. You on go over the page at paragraph 34. On each of the
9 three occasions on which you met AR face to face:

10 "... he presented, in essence, as an unremarkable,
11 sullen, untalkative, gawky teenage boy."

12 I have touched on this already, but presumably you
13 would have to agree that if you had known the full
14 forensic history of risk, you would have been more
15 concerned about what might lie behind the seemingly
16 unremarkable, sullen, untalkative, gawky teenage boy?

17 A. I think there's two elements to this which I think we
18 need to be careful to distinguish. With the benefit of
19 hindsight of the events --

20 Q. Forgive me, I am going to interrupt you. Please don't
21 use hindsight, but please think about what was knowable
22 at the time, as I have explained it to you.

23 Had you known that which was knowable, either
24 because it was known to other agencies and not
25 communicated to CAMHS, or more especially it was known

44

1 to CAMHS because it was on the records, I will ask my
 2 question again: you would presumably have been keen to
 3 look behind what risks may lie behind the seemingly
 4 unremarkable, sullen, untalkative, gawky teenage boy?
 5 **A.** The index of suspicion for potential risk of harm to
 6 others would have been increased, yes, although not to
 7 that level. That is the point I would like to --
 8 **Q.** Not to a level where you may have foreseen the dreadful
 9 events of July --
 10 **A.** Of course.
 11 **Q.** But if in that year he had been carrying a knife and
 12 said that he had been doing that because he wanted to
 13 stab somebody, it wouldn't just be higher, it would have
 14 been significantly higher?
 15 **A.** I agree. Yes.
 16 **Q.** But because it wasn't, presumably you didn't press him
 17 on issues about risk to others? You say you may have
 18 asked him about risk --
 19 **A.** I definitely did ask him about risk of harm to others.
 20 **Q.** But did you then take his answers at face value?
 21 **A.** Yes.
 22 **Q.** If he denied risk to others?
 23 **A.** Yes.
 24 **Q.** Because you didn't know the history?
 25 **A.** I didn't know elements of the history, no.

45

1 being done, the risk to others would have to be treated
 2 very seriously, recorded and shared?
 3 **A.** Well, you can only go on what you have sort of got in
 4 front of you. I'm not so sure it would -- well, it
 5 wouldn't, would it? It wouldn't change the previous
 6 perception of risk of harm to others as nothing, but it
 7 wouldn't necessarily increase it. It would just,
 8 I guess, it would leave the point pending for clinicians
 9 working with him to need to look into further and
 10 establish a greater degree of assurance, that there
 11 either was or wasn't a significant risk. Because there
 12 may not have been at that time.
 13 **Q.** Thank you. You formalised I think at
 14 29 December appointment the cessation of fluoxetine. Is
 15 that effectively because he had stopped taking it? Is
 16 that right?
 17 **A.** That's what it says. Again, there was lots of chopping
 18 and changing with the medications, and so my memory is
 19 a little, you know, not perfectly clear about these
 20 things, but that's what's written there, yes.
 21 **Q.** I'm asked to explore with you whether the continued
 22 attempts to restart SSRI medication was appropriate in
 23 a patient whose adherence appeared to be so erratic.
 24 Can you help with that?
 25 **A.** I think, from another angle, we were asked several times

47

1 **Q.** And looking at the system as a whole, rather than for
 2 the moment at your individual performance, that was
 3 a failure?
 4 **A.** Looking at the system as a whole? The system in the
 5 wider sense. Yes, it was a shortcoming, yeah.
 6 **Q.** Because as the treating psychiatrist, if you had known
 7 about those matters, it would have been a significant
 8 part of your duty to ensure that they were explored with
 9 him?
 10 **A.** Certainly beyond taking an answer of "no" to a question
 11 of "do you have any thoughts of harm to others" at face
 12 value, yes, I agree.
 13 **Q.** And that his risk to others was assessed and recorded
 14 rather than just focusing on the risks to AR?
 15 **A.** Could you clarify that point again, sorry.
 16 **Q.** So, not just that you would have explored it, that it
 17 would have been your duty to explore it, but beyond that
 18 that, his risk to others would need to be assessed and
 19 recorded, and I'm going to suggest shared as well,
 20 rather than just focusing on the risks to AR?
 21 **A.** Well, it would have been a question of, again, not
 22 necessarily taking a negative answer at face value, but
 23 remaining -- having a higher index of suspicion that
 24 that answer might not be correct.
 25 **Q.** Yes, but going on to that, when risk assessments were

46

1 in the Rule 9 statements what did you do to engage AR?
 2 Why did you not do more to engage AR? This I would see
 3 on the flip side of the point that you are conjecturing,
 4 I would see it as really our service bending over
 5 backwards to try and engage him in any way we could,
 6 given that he had a very specific shopping list, so to
 7 speak, of "I want some medication that makes me feel
 8 better". I think it was incumbent on us to do what we
 9 could to try and engage him in that way.
 10 **Q.** That takes us in the chronology to the end of 2022.
 11 I think as we had a 10.30 am start, I think it is not
 12 fair to go the whole morning without a break. Can we
 13 take a short break?
 14 **SIR ADRIAN FULFORD:** We certainly can. I will sit again at
 15 12.00 pm.
 16 **(11.46 am)**
 17 **(A short break)**
 18 **(12.00 pm)**
 19 **SIR ADRIAN FULFORD:** Yes, Mr Moss.
 20 **MR MOSS:** Thank you, sir.
 21 Dr Molyneux, we had reached the start of 2023, and
 22 as you explain your statement, in 2023 the next
 23 appointment was scheduled for 6th February. Could we
 24 have on screen page 14 of your statement, paragraph 37.
 25 This is another occasion where AR refused to speak

48

1 to you himself but what you say at the end of
 2 paragraph 37 is that AR's father communicated that:
 3 "AR was largely being left to his own devices as
 4 regards administration of the sertraline medication,
 5 evidently on account of AR's father's ostensible fear of
 6 riling AR through too close a level of scrutiny."
 7 Is that right?
 8 A. Yes, that's correct.
 9 Q. And what was your assessment of that position in terms
 10 of how that might play out in terms of risks?
 11 A. There wasn't a sense of serious violence from AR towards
 12 his father from what was being told to me.
 13 Q. Was that not part of why AR's father was fearful of
 14 riling AR because AR had attacked him on previous
 15 occasions?
 16 A. The sense was, or as far as I could see the sense was
 17 of, yes, aggression, but short of violence, not
 18 significant violence.
 19 Q. You tell us in paragraph 38 that arising from this you
 20 had a sense of being uncomfortable because there was
 21 a relative lack of parental scrutiny around the taking
 22 of medication. Is that right?
 23 A. Correct, yes.
 24 Q. And would you agree an inability, it would seem, on
 25 Alphonse R's part to get AR to take his medication?

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1 14th May involving Kate Morris, who by then had taken
 2 over as AR's case manager, yes?
 3 A. Correct, yes.
 4 Q. And, sir, for your note it is AHCH000185, the exchange
 5 of emails. But let me see if I can summarise it. It is
 6 right, isn't it, that effectively AR's father copied you
 7 into an email to school indicating that he wanted AR to
 8 have a different teacher on the basis that AR found the
 9 particular teacher to be boring?
 10 A. That was the -- that was what was apparent, yes.
 11 Q. And I think Ms Morris passed that onto you with
 12 a comment to the effect "seriously", no doubt referring
 13 to the seeming understanding that it was appropriate to
 14 ask for a change of teacher just because the pupil felt
 15 the teacher was boring.
 16 A. I don't know if you have redacted one element of it, but
 17 I forwarded it to Kate with a kind of -- I think a kind
 18 of, you know -- I think it was like three exclamation
 19 marks or something, like can you believe this.
 20 Q. Rest assured, I haven't redacted anything. I'm just
 21 trying to summarise it for speed. Three exclamation
 22 marks from you. She comes back with:
 23 "Seriously!!! This is more systemic ... than mental
 24 health do you think?"
 25 Then you responded:

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1 A. Yes.
 2 Q. There was then a further appointment on 27 February, you
 3 tell us about that in paragraph 39 of your statement,
 4 and I think that was an occasion where AR did attend in
 5 person. Is that right?
 6 A. Yes. That was the last occasion on which he attended in
 7 person to see me.
 8 Q. You describe there that he was looking to be prescribed
 9 now with a totally different type of medication. Is
 10 that right?
 11 A. Yes.
 12 Q. And again, what did you make of that?
 13 A. It reflected, similar to what I recall having seen in
 14 the previous appointment I think, this focus on his part
 15 of thinking of himself solely in terms of, you know, as
 16 the only possible therapeutic options for him as being
 17 neurochemical.
 18 Q. And what about his knowledge of the different types of
 19 medication that he was actively seeking? Again, was
 20 that somewhat unusual?
 21 A. Well, he had clearly been Googling. Again, I wouldn't
 22 say it was particularly unusual in and of itself.
 23 Q. Now after that your next scheduled appointment was
 24 15th May but at the bottom of page 15 of your statement
 25 you deal with an exchange you had the day before on

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1 "Don't know whether it's ... overaccommodation ...
 2 safeguarding ... or gaslighting ... or some combination
 3 of the above. But the one thing that's clear is that
 4 it's systemic."
 5 Help us with that. When you said "the one thing
 6 that's clear it's systemic", what did you actually mean?
 7 A. So systemic has a very particular meaning in the context
 8 of child and adolescent mental health practice.
 9 Systemic refers to, broadly speaking, family approaches.
 10 So family therapy would be considered the kind of
 11 classic systemic family therapy. So it is looking at
 12 the system, something wrong with the system rather than
 13 something being a problem, the problem being located in
 14 the person in the individual themselves.
 15 Q. So the family systems and the family dynamics as opposed
 16 to mental disorder. Is that a fair contrast?
 17 A. Correct.
 18 Q. That was the contrast you were seeking to draw?
 19 A. Absolutely that.
 20 Q. Again, just focus on the questions, please.
 21 "Overaccommodation", by that you meant what exactly?
 22 A. So overaccommodation, so the parents basically being
 23 unable or unwilling to enforce and implement reasonable
 24 boundaries and so just allowing their child to do what
 25 they want in broad terms.

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1 Q. Safeguarding was the second option. We all understand
2 what safeguarding means in the general sense. But when
3 you said you don't know whether it is overaccommodation,
4 safeguarding or gaslighting, what were you using
5 "safeguarding" in that context to mean?

6 A. So my sense of safeguarding at that point, and indeed
7 later, was solely in the sense of these, you know, the
8 systemic problems that are there, either the parental
9 inability or unwillingness to implement boundaries are
10 not placing due life expectations on this lad such that
11 he will -- you know, he's going to have reduced
12 opportunities in the world of education, training and
13 work.

14 Q. Reducing it to my layperson's terms, is it this sort of
15 a concept, in a way it is connected to the
16 overaccommodation, if you don't set boundaries and
17 insist for example that he tries to attend education
18 regularly, he will end up having suffering and there
19 will be a safeguarding concern because it will have
20 a very detrimental impact on his life opportunities in
21 the future?

22 A. Yes, exactly. He will have greatly diminished life
23 opportunities.

24 Q. And the gaslighting in this context? Again, it is
25 a common term, but what did you mean using it as

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1 our understanding -- well, I was kind of checking out
2 what her opinions were as well and I think she gives her
3 agreement. But, yeah, so that in turn it could be
4 shared with any sort of multidisciplinary professionals
5 that are also involved.

6 Q. Did you ever ask any questions about whether there was
7 any boundary setting on AR's internet use?

8 A. I can't recall -- I can't say that I definitively did
9 not. I may have done.

10 Q. I will be corrected if I'm wrong, but I don't think
11 there's any record of a specific time when you raised
12 that within your notes of your discussions, either with
13 father or with AR.

14 A. No. Again, I can't recall it being specifically
15 discussed, although, on the 25th September home visit,
16 which we will come to in due course no doubt, I had
17 a good comprehensive conversation with Alphonse in which
18 I got a sense of the overall difficulties as they were
19 being presented to us anyway.

20 Q. And again, isn't that indicative -- I'm going to deal
21 with it at a systems level for now -- of again the
22 system not working properly, because if you had been
23 sighted on concerns about school, internet use, looking
24 up London Bridge bomb, interest in Manchester Arena and
25 use of the internet to look up school shootings, what

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1 a psychiatrist here?

2 A. So, I might need to refer to what I have actually
3 written because I use quite a subtle sort of explanation
4 of what's going on. Really what this spoke of -- what
5 this spoke of to me, what it alluded to was the
6 interaction I had observed between AR and Alphonse at
7 the 27 February appointment this kind of -- this quite
8 passive aggressive bickering and I had actually written
9 in the notes after that session that some of
10 Alphonse's -- I wrote a couple of things -- AR's
11 responses to Alphonse seemed to be sort of oppositional
12 for oppositional's sake, just like if dad said black, AR
13 would say white. But from Alphonse himself, it seemed
14 like there were one or two things he said that seemed
15 quite -- like they were in quite a subtle way trying to
16 get under his skin a bit and that's what I meant by the
17 gaslighting.

18 Q. Beyond the email and what -- the exchange that you had
19 with Ms Morris and what you recorded in the notes, you
20 are clearly coming to this view of what you later
21 describe as the overarching problem of this sense of not
22 setting boundaries. What did you actually do about that
23 in terms of taking things forward?

24 A. So, I communicated that to Kate Morris as case manager,
25 you know, so that she was aware. And so that remained

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1 for you was a lack of boundaries being set in not
2 insisting on AR attending school, not insisting on him
3 taking his education, parents perhaps giving into AR's
4 wishes the whole time, the potential for AR to be doing
5 what on earth he liked online in the family home would
6 be an important other aspect that you would have wanted
7 to explore, wouldn't it?

8 A. It would have been an important other aspect to be aware
9 of but, again, I get and submit what you are alluding
10 to, that if I would have known about the previous
11 aspects of internet use and things like that, that would
12 have put a different complexion on the level of concern,
13 yes.

14 Q. Because you didn't know about that, and again I'm going
15 to suggest in part because you hadn't informed yourself
16 about that from the notes, that was never done?

17 A. Again, I would come back to that by saying it was
18 an unknown unknown. If I didn't know that there were
19 concerns, I didn't know that there were concerns to be
20 further explored.

21 Q. Thank you. Be that as it may, the next appointment with
22 AR was due the next day, 15th May, the day after that
23 exchange, and I think you can confirm that that was
24 another occasion when he didn't attend, but AR's father
25 emailed you to alert you to the fact that he wasn't

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1 going to be attending?

2 A. From memory -- I don't have it in front of me now --

3 from memory I think so.

4 Q. Paragraph 49, page 18. It is the minute to go before

5 the scheduled face to face.

6 A. Yes, I recall that. Correct.

7 Q. I think arising out of that, in fairness to you, you

8 followed that up. So you requested an update by email

9 given the nonattendance and you received an assurance

10 from AR's father -- I'm looking at paragraph 50 now at

11 the bottom of the page -- that AR was consistently

12 taking his sertraline at that time and the only

13 problematic aspect was with sleep. Yes?

14 A. That's what it says, yes.

15 Q. And going over the page to 51, I think it was arising

16 out of this, I think for the first time that melatonin

17 medication to help ease AR's sleep was first discussed

18 and something that you recommended.

19 A. Something I suggested, yes.

20 Q. I'm asked to explore whether there is any

21 contraindication to melatonin and sertraline being taken

22 together in the case of a child. Are you aware of that?

23 A. None whatsoever.

24 Q. There was then a multi-agency meeting on 25th May. You

25 deal with that in your paragraph 53 at the bottom of

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1 Q. Given what you in fact knew about the risk to others,

2 which you described as understanding to be minimal, did

3 you in fact think at this time that AR's lack of

4 engagement may have given rise to an increased risk in

5 relation to the risk to harm of others, the very fact

6 that he was withdrawing?

7 A. Of others? Risk of harm to others?

8 Q. Yes.

9 A. Again, if my sense of things at the time was that he did

10 not and had not posed a material risk of harm to others,

11 it was not foregrounded in my sense of things at that

12 time. I should add as well, you know, and this is

13 a theme that runs through the whole story of AR's

14 connection with services and with our service, our sole

15 conduit for information was Alphonse and Alphonse was

16 telling us Alphonse's concerns.

17 Q. Dr Molyneux, that's not actually accurate, is it? What

18 you have just said is that your sole conduit for

19 information was Alphonse. Another conduit for

20 information was the engagement between agencies and the

21 information that's on the medical notes. That's another

22 important conduit.

23 If you will forgive me, you appear consistently to

24 go back to saying we could only take things from the

25 family, but in 2019 and 2020 in particular there had

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1 that page, please. You say the overall feeling

2 expressed by school was positive in relation to AR's

3 mental health but it was apparent that he was only

4 attending school very sporadically, yes?

5 A. Is that what it says? Yes. It looks that way.

6 Q. Yes. At the bottom of the page.

7 A. Yes.

8 Q. You go on to say that this was I think:

9 "... a further indication that the overarching

10 problem was essentially systemic and related to parental

11 overaccommodation."

12 Just over the page, I think.

13 A. Yes, that was my memory at the time, correct.

14 Q. This was also, paragraph 55 -- you have dealt with it

15 but just so we place it in time -- was one of the two

16 occasions -- paragraph 55 -- when the Prevent programme

17 was mentioned?

18 A. According to my recollection, yes.

19 Q. Thank you. I think thereafter it is fair to say, isn't

20 it, that there were attempts made to try to get AR to

21 reengage with direct contact?

22 A. Absolutely.

23 Q. But by this stage you hadn't seen him face to face since

24 late February?

25 A. Correct.

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1 been a series of multi-agency meetings involving CAMHS,

2 sometimes involving FCAMHS, and an exchange of

3 information and that exchange of information may itself

4 have been imperfect, but in all the ways that I have put

5 to you, information in relation to that was on his

6 mental health records that were available for you.

7 So it is just not accurate, Dr Molyneux, for you to

8 assert that the only conduit for information was

9 Alphonse.

10 A. A couple of points in response to that. I take your

11 point about that there were multi-agency meetings going

12 on live in the present. I agree you are correct to say

13 that Alphonse wasn't the only other conduit for

14 information. The other conduit for information in terms

15 of a present sense of what was going on was the

16 multi-agency meetings and that one on 25th May was

17 giving a sense of reassurance. Given that, why would

18 I or anybody, if the sense is that there's an ongoing

19 message of reassurance, why would it occur to me to go

20 back and look through the notes just in case there's

21 something that I'm not aware of that's different in the

22 past?

23 Q. But the overall pattern, if he is not attending school

24 and he is not engaging with CAMHS, at least in meetings

25 with you, that might suggest that he is to some extent

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1 withdrawing from sources of support and it circles back
 2 to the fact that had you known more about the risk
 3 information, the risk of others to information, that
 4 would have been something I suggest of a red flag?
 5 **A.** I agree if I would have known more about the historic
 6 information regarding risk -- assessed risk of harm to
 7 others -- that would have changed the complexion of my
 8 sense of him in the present time at that time.
 9 **Q.** And I think you were due to see AR again on
 10 3rd July 2023, and then on 18th September 2023, and he
 11 refused to attend both of those appointments?
 12 **A.** Correct.
 13 **Q.** As you describe, can we just have it on screen so we
 14 have it in front of you, it is paragraph 62 page 23, is
 15 this right, that you became concerned about continuing
 16 to prescribe sertraline to a 16-year-old who was not
 17 providing good evidence of his own consent to that
 18 medication?
 19 **A.** Correct.
 20 **Q.** Thank you. Is that all the context, you have touched
 21 upon it, that led to the home visit that you carried out
 22 on 25th September?
 23 **A.** Yes.
 24 **Q.** Let's turn to that then. So, home visit 25th September.
 25 Can we have paragraph 63 at the bottom of that page.

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1 those things?
 2 **A.** Well, I mean, I guess I mean what I have said. I think
 3 I used the word -- I think it is just a little bit above
 4 this -- I used the word "exasperation".
 5 The picture, as it was presented to me, was one of
 6 that, you know, this lad chopping and changing his
 7 engagement, messing about with medication, doing what he
 8 wanted with it and dad, you know, not seemingly
 9 concerned about the lack of boundaries he was able to
 10 enforce really.
 11 This was a lad who, moreover, was not confined to
 12 his room, but had been just merrily in the living room
 13 doing what he wanted, having his snacks and things, and
 14 then doing what he wanted and scarpering to his room.
 15 So my sense was why are we as a service continuing to
 16 bang our head against the wall with this lad who has
 17 been deemed time and time again not to have a mental
 18 disorder and for whom this is primarily a social care
 19 issue of parents not being able to implement boundaries
 20 or willing to implement boundaries?
 21 **Q.** Is there a risk that you, in forming that view, were
 22 underestimating the level of difficulty for AR's parents
 23 and quite how difficult AR's behaviour had made things
 24 for them?
 25 **A.** I recall, Mr Moss, that this was a specific question

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1 But on that occasion I think, although you did a home
 2 visit, the family welcomed you into the living room but
 3 it was apparent that AR, having been out previously, had
 4 gone into his bedroom, refusing to meet with you and on
 5 this occasion it is clear that he had been in the living
 6 room just before. So he was definitely, my words,
 7 avoiding you?
 8 **A.** Oh yes.
 9 **Q.** And if we jump forward in your statement please, but it
 10 is talking about this occasion, it is page 31,
 11 paragraph 82 at the top of the page. You refer there to
 12 Alphonse being, and then your words are these:
 13 "cheerfully unable or unwilling even to attempt to
 14 place upon AR the reasonable expectation that he at
 15 least speak to me."
 16 **A.** Yes.
 17 **Q.** And he, that is Alphonse, spoke of AR being "seemingly
 18 happy just doing what he wants to do".
 19 That cross-references back to the paragraph dealing
 20 with this meeting.
 21 Can you just expand on that and the reference there
 22 to "seemingly happy just doing what he wants to do",
 23 that's AR, and to Alphonse being "cheerfully unable or
 24 unwilling to attempt to place upon AR the reasonable
 25 expectation" of speaking to you. What did you mean by

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1 that came from the parents, wasn't it, from Alphonse and
 2 Laetitia, I think. And, honestly when, you know, when
 3 you look back with the benefit of hindsight and the
 4 chronology from what we now know of what was going on
 5 from the purchases that were being made and the
 6 Royal Mail deliveries to the house and things like that,
 7 I find it a little bit, you know -- I don't know what
 8 the word is -- I wonder how the parents can say that
 9 there was -- what was the word you used, sorry?
 10 **Q.** I asked if there was a risk that you were
 11 underestimating the level of difficulties for AR's
 12 parents and how difficult his behaviour had made things
 13 for them?
 14 **A.** I wonder how the parents can say that when we now know
 15 that what they were doing at the time was taking orders
 16 for machetes and whatnot being delivered to the house,
 17 but not telling anyone about that.
 18 **Q.** And is there any truth in their perception that your
 19 input was very high level and superficial and that you
 20 showed no inclination, pleasant though you were, to get
 21 to the bottom of the problem?
 22 **A.** Again, I dispute that in its entirety. I am, you
 23 know -- is the very fact that you have got a consultant
 24 psychiatrist doing a home visit here not demonstrative
 25 in itself of really trying to do what I can to get to

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1 the bottom of the problem? But of course, like any
 2 other clinician in this situation, you can only go on
 3 the evidence that's presented to you and if, as it later
 4 seems to have turned out with the benefit again of
 5 hindsight, if it was the case that the most salient
 6 evidence indicative of AR's presentation was being
 7 evidently deliberately withheld from us, can that be
 8 a criticism that's levelled at clinicians?
 9 **Q.** You will understand that I'm giving you an opportunity
 10 to comment on that, which is part of the process of
 11 achieving fairness for you so you can comment upon it.
 12 **A.** Thank you.
 13 **Q.** So as you know, but others may not, but it has just been
 14 indicated by the doctor that it was possible for us over
 15 the weekend to put extracts from AR's parents'
 16 statements, but only extracts, to this witness, so that
 17 he is able to have that opportunity to comment. It has
 18 not been possible yet to disclose the statements but
 19 that is imminent so that all the other core participants
 20 will get them very soon. Thank you.
 21 On the same occasion, I think AR's father informed
 22 you that AR had stopped taking the sertraline about two
 23 months ago. Is that right?
 24 **A.** I recall that was the case, yes.
 25 **Q.** And as a result, I think you decided to formalise the

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1 **Q.** Which you would understand one or both of the parents
 2 were aware of but never mentioned to you?
 3 **A.** Never mentioned to anyone, I gather. Yes.
 4 **Q.** Thank you. Following that appointment, I think you
 5 emailed Ms Morris.
 6 Sir, for your note AHCH000145.
 7 But I think the essence of it was you hadn't been
 8 able to see AR for over six months. He hadn't been
 9 taking his medication. He was remaining in his bedroom.
 10 He hadn't attended college. He had only attended
 11 a couple of times in the term. Hadn't left the house
 12 for the last few months. Spends all his time watching
 13 videos online, including late into the night. Hadn't
 14 had a bath or shower in the last month. Early Help were
 15 apparently closing the case. It seemed as though
 16 a social worker was involved and you concluded with the
 17 phrase that you use repeatedly in your statement, that
 18 you were struggling to see if there's any further role
 19 for psychiatry or CAMHS as a whole. Is that right?
 20 **A.** Correct.
 21 **Q.** Is that because in the circumstances where he is not
 22 complying with medication and wasn't seeing you, and
 23 parents for reasons that we will explore obviously with
 24 them, were not being successful in encouraging AR to see
 25 you, that you couldn't see what it was that the CAMHS

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1 cessation of sertraline, again on the same basis, that
 2 if he stopped taking it anyway, it is not appropriate
 3 that it continues to be prescribed?
 4 **A.** Correct.
 5 **Q.** Thank you.
 6 You say in paragraph 78, still in relation to this
 7 home visit, that it might conceivably -- I'm so sorry,
 8 it is paragraph 78, page 29 -- so in relation to this
 9 visit:
 10 "It might ... be wondered as to whether indeed I was
 11 satisfied that the information provided to me by AR's
 12 father was reliable, particularly given that I had been
 13 unable in the course of the visit to examine AR in
 14 person. The answer to such a question would of course
 15 be yes. At the time, I had no reason to doubt AR's
 16 father's reliability or honesty (subsequent to the
 17 horrific events ... is quite a different matter); ...
 18 I doubted his effectiveness as a parent, but that's
 19 quite a different matter to doubting someone's
 20 reliability or honesty."
 21 Were you there reverting to the same aspects, that
 22 perhaps through this Inquiry or through the criminal
 23 process you have subsequently been aware of the delivery
 24 of weapons?
 25 **A.** Yes.

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1 service, and you specifically as a psychiatrist were
 2 really, my phrase, bringing to the table?
 3 **A.** Essentially, yes. So you have got a young person who
 4 has been in the service for a good while, has never
 5 presented with a diagnoseable mental disorder, we are
 6 very clear by now on our formulation as being a systemic
 7 one of parental overaccommodation. This is the issue
 8 and so -- and he is indicating by his repeated actions
 9 that he does not want to engage with CAMHS. So how is
 10 it productive or helpful for CAMHS to remain involved
 11 when the lead agency at this time ought to be social
 12 care?
 13 **Q.** Thank you. Again, although it is a theme that I have
 14 put to you a number of times, I do need to come back to
 15 it here again. If you had known what was capable of
 16 being known at the time about previous risk history,
 17 risk to others, wouldn't all of these features -- so
 18 increasingly isolating himself away, he's disengaged, he
 19 is not engaging with mental health professionals, he is
 20 spending increasing amount of time on computers --
 21 wouldn't they all have flagged up actually an increased
 22 risk of concern about the risk to others?
 23 **A.** I think that's a fair comment. It would have put
 24 a different complexion on things, and even if not by
 25 themselves necessarily hugely significantly so. It

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1 could only have increased the sense of a risk of harm to
 2 others that would warrant further exploration.
 3 **Q.** And just think about that, and again I seek your candid
 4 assistance. Where would that have gone? Would one
 5 possibility have been that you would have kept him open
 6 to CAMHS because of the risk to others? Is that one
 7 possibility?
 8 **A.** I guess what it would have done is increased our index
 9 of suspicion and -- yeah, it is difficult, isn't it, to
 10 separate out what was known at the time with what's
 11 known in hindsight. But again we are thrown back on the
 12 fact that he is not engaging with CAMHS. I guess social
 13 care would still have been the lead agency, but it would
 14 have warranted more flagging of the past risk of harm to
 15 others.
 16 **Q.** But forgive me, the answer to my question, that one
 17 possibility would have been, would it not, keeping him
 18 open to CAMHS for longer, principally because of the
 19 risk to others?
 20 **A.** That would have been one possibility.
 21 **Q.** And I think -- I will come back to the fact that you
 22 describe social care as should have been the lead
 23 agency -- but would this be right, that even if he was
 24 going to be discharged from CAMHS, in terms of the risk
 25 of harm to others, you would have wanted before his case

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1 under the Mental Health Act 1983 (as amended) ..."
 2 Is that right?
 3 **A.** Yes.
 4 **Q.** I think you go on to say that that might have been
 5 an avenue that might have been explored at the earliest
 6 stage if AR's lack of eating and malnourishment and
 7 being underweight had come to the stage where there was
 8 a significant risk to his own safety?
 9 **A.** It might have reached that point, yes.
 10 **Q.** Now that didn't transpire in terms of the risk to
 11 himself from undereating. But I want to ask you about
 12 the risk to others and the Mental Health Act
 13 possibilities there. Would that, in fact, if you had
 14 known all of this about AR's history and he is now
 15 disengaging, refusing to see you, refusing to see
 16 others, would an assessment under the Mental Health Act
 17 have been something that could have been considered?
 18 **A.** Could you just ask that question again, sorry?
 19 **Q.** Yes. If you had known about the indications of risk,
 20 and then on top AR is refusing to see you, he is
 21 refusing to see others, he is not really attending
 22 school, would an assessment under the Mental Health Act
 23 have been something that could have been considered?
 24 **A.** I mean, so you would request a Mental Health Act
 25 assessment if you are concerned that there's significant

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1 was closed to CAMHS to make sure that other agencies
 2 were aware of that?
 3 **A.** Absolutely.
 4 **Q.** So a multi-agency meeting?
 5 **A.** Absolutely.
 6 **Q.** Where CAMHS explained why they were closing the case to
 7 him but flagging up he is disengaging, we can't do
 8 anything physically more?
 9 **A.** Absolutely.
 10 **Q.** But we do have these concerns about risk and actually
 11 the fact that he is spending more time on his computer,
 12 the fact he is not engaging with us, the fact we can't
 13 even see him is all quite concerning?
 14 **A.** So past concern around risk of harm to others, period of
 15 ostensible lower risk of -- an apparent lower risk of
 16 harm to others, and now a further lack of engagement.
 17 Yes.
 18 **Q.** If we can look please together, Doctor, at paragraph 77
 19 of your statement, it is page 29. I want to explore
 20 another possibility of a course of action with you. You
 21 say in your paragraph 77:
 22 "If the adjudged risk had been high, based on the
 23 information available to us at the time, in the context
 24 of a suspected mental health disorder, we could and of
 25 course would have considered arranging an assessment

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1 risk of harm to self or others in the context of
 2 a mental disorder.
 3 It is difficult to say, isn't it, if I would have
 4 been cognisant of earlier ostensible risks of harm to
 5 others. I think we have to be careful that we don't let
 6 hindsight kind of cloud this.
 7 What we are left with is a situation where, as
 8 things stand and as things are apparent to us there,
 9 that threshold for considering a Mental Health Act
 10 assessment -- I mean it just -- a Mental Health Act
 11 assessment just wouldn't be considered in those
 12 circumstances. If young people presented in that way
 13 were an indication for a Mental Health Act assessment,
 14 given what we knew at the time, Mental Health Act
 15 assessments would just be happening all over the place
 16 and everywhere.
 17 **Q.** Well, you say that, but could we have a look at the
 18 views of the Inquiry's independent expert, Dr Irani.
 19 This is DIR00001 please. You will be familiar I am sure
 20 with this report. If we could go to page 21.
 21 If we could pick up at the top of the page please
 22 paragraph 3.2.2.1. It is the top paragraph:
 23 "AR was out with parental control, he had been
 24 presenting a risk in the family home, he was withdrawn
 25 and spending considerable periods of time on his

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1 computer, he was not looking after himself (he hadn't
2 showered for more than a month)."
3 Would you agree with all of that?
4 **A.** Again, I wouldn't have regarded his -- what's reported
5 there as being a risk presentation to others in the
6 family home as significant from what was being presented
7 to us --
8 **Q.** No, but from what was knowable from the records. So you
9 have those two incidents in November, remember, of
10 violence in the home and two further incidents of
11 violence --
12 **A.** November when, sorry?
13 **Q.** November 21. Two incidents in November 21. There is
14 the earlier occasion of an assault on the father in the
15 course of throwing juice and then May 22, there is
16 a further incident in the home.
17 So I think Dr Irani was here looking at what was on
18 the records and what was capable of being known of
19 presenting a risk in the family home seems a perfectly
20 reasonable conclusion, doesn't it?
21 **A.** But, again, so you have to go on what's the current risk
22 is as it is being presented to you, and the current risk
23 as it was being presented to us by parents wouldn't have
24 been sufficient to trigger a Mental Health Act
25 assessment.

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1 considerable periods of time on his computer and not
2 looking after himself?"
3 **A.** I do, although I think it is a salient point that
4 certainly warrants mention that -- I mean, the way
5 I would look at it in terms of findings of that
6 assessment from that home visit of 25th September 2023,
7 the one element that was a lingering cause of concern
8 did appear to be the not having bathed or showered for
9 a month. I was then within 48 hours given implicit
10 reassurance by Alphonse in an email that said:
11 "Hi Dr Molyneux, it is good news here, AR has had
12 a shower."
13 So an explicit communication of good news,
14 an explicit communication of reassurance.
15 **Q.** Again, we must move on for the sake of time. An email
16 which it is right that you were alert to, indicating
17 that he had had a shower on a single occasion, doesn't
18 mean that he had started looking after himself properly?
19 **A.** Well, with respect, when a parent who you have no reason
20 at this point not to basically trust, as I have said
21 earlier on, I doubted his effectiveness as a parent, but
22 I didn't doubt his reliability or honesty. When
23 a parent has put into you by email an explicit
24 communication of reassurance "it is good news here",
25 I think a clinician is warranted in accepting that in

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1 **Q.** Dr Molyneux, this was a father who was afraid to insist
2 to his son on taking medication for fear of how he might
3 react against a background of reported previous assaults
4 by son on father.
5 **A.** It was never put across that there was a fear of serious
6 violence. It was described just as aggression.
7 **Q.** But again that reflects in part material that was
8 knowable on the records that you weren't aware of, the
9 previous occasions where it seems that AR had assaulted
10 his father and other occasions when he had violently
11 thrown things around the family home?
12 **A.** Again, though we had never characterised him as meeting
13 criteria for a mental disorder, so I wouldn't say that
14 going to the Mental Health Act -- proceeding to the
15 Mental Health Act --
16 **Q.** Leave that to one side for a moment. The plain words
17 from Dr Irani "he had presented a risk in the family
18 home", that's just accurate, isn't it?
19 **A.** The risk as it was presented to us at the time did not
20 appear to be, you know, in terms of aggression towards
21 parents, did not appear to be one of significant
22 violence.
23 **Q.** You don't fully agree with that. Do you agree with the
24 rest of it:
25 "Out with parental control, withdrawn and spending

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1 the absence of any indication not to.
2 **Q.** Had you made any queries as to how frequently he was
3 actually showering, given the report that he hadn't done
4 so for a month or so?
5 **A.** Again, if a parent is saying it is good news here, good
6 news sounds like good news.
7 **Q.** I'm going to move on.
8 "Right back in September 2023, when reviewing his
9 attendance and parent's inability to make him engage,
10 these should have been escalated through safeguarding."
11 Do you agree with that?
12 **A.** No, as I have said I don't. On the basis of the
13 knowledge that was in front of me at the time,
14 I absolutely do not believe that a Mental Health Act
15 assessment was indicated.
16 **Q.** Please forgive me, Dr Molyneux, but you must listen to
17 the question, and what you are being directed to.
18 I will come to the Mental Health Act assessment, but
19 what Dr Irani is saying here is right back in
20 September 2023, when reviewing his attendance and
21 parents' inability to make him engage, these should have
22 been escalated through safeguarding. So raising
23 a further safeguarding concern to the local authority.
24 **A.** So the email that I communicated to Kate Morris, the
25 case manager and by extension to Sam Coppard explicitly

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1 said that I did regard this situation as problematic,
 2 I did regard the situation to present with risk, the
 3 greatest seeming risk being risk of -- due to the
 4 parental overaccommodation -- risk of non-engagement
 5 with life opportunities, work, training and vocational
 6 aspects.
 7 I asked Kate Morris, and by extension Sam Coppard
 8 for their opinions, and they completely agreed with the
 9 conclusion that this is not for CAMHS, this is for
 10 social care. I don't see what a safeguarding discussion
 11 would have achieved, given that we are all in agreement,
 12 three experienced clinicians are all in agreement that
 13 this is primarily for social care. A safeguarding
 14 discussion would, at that time, knowing what we knew,
 15 just have agreed with that conclusion.
 16 **Q.** So if it was to be matters that social care would take
 17 on rather than CAMHS, does that not reinforce the need
 18 for safeguarding concerns to be raised to say: we are
 19 not in the best position to deal with this, but you,
 20 social care, should, so we want to raise this as
 21 a safeguarding concern, but we are going to move to
 22 close him to us?
 23 **A.** So, yeah, a discussion with social care would have, you
 24 know, obviously by nature of the situation that's being
 25 discussed with them, would have flagged safeguarding

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1 is a really important point, the clinicians who were
 2 involved early on, if they are getting three feedback
 3 reports from Prevent saying this doesn't need further
 4 escalation, that's three items of reassurance.
 5 **Q.** Again, we come back full circle but the extent to which
 6 Prevent not taking him on for that particular programme
 7 is reassurance of a lack of intention to cause violence
 8 to others would require scrutiny of at least what your
 9 own records showed about the Prevent referrals.
 10 **A.** As I said there, I was putting myself in the position of
 11 the clinicians who were involved at the time. My -- as
 12 I have said already -- knowledge of the involvement of
 13 Prevent was that there had been one and it was to do
 14 with the --
 15 **Q.** Dr Molyneux, I understand that --
 16 **A.** -- and no further action required and all the rest of
 17 it.
 18 **Q.** For the purposes of all these questions, would you
 19 assume that you had a full picture of the risk
 20 information, so at least everything that was on the
 21 CAMHS records from 2019 onwards about previous risk
 22 information was known to you and answer the questions on
 23 that basis.
 24 So, I think what you are saying is consideration was
 25 given to a Mental Health Act assessment on the

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1 concerns, yes.
 2 **Q.** And around the same time, when CAMHS were unable to meet
 3 directly with him, and then please note the words, what
 4 she is saying is:
 5 "Consideration should have been given to carrying
 6 out a Mental Health Act assessment."
 7 All right? That's not saying the Mental Health Act
 8 assessment at this stage should have been done, but it
 9 is at least indicating consideration should have been
 10 given to that. Do you agree with Dr Irani on that or
 11 not?
 12 **A.** I agree in a probably quite literal technical sense in
 13 that I did give the matter of the Mental Health Act
 14 assessment due consideration in the sense of not
 15 considering it because it wasn't indicated. I gave the
 16 matter its due consideration.
 17 **Q.** And do you think that -- well you say you gave it due
 18 consideration, but by definition your consideration that
 19 you gave it at the time could not have included all of
 20 that information about risk to others?
 21 **A.** Well, no, but historic risk to others, or historic
 22 adjudged risk to others. But I do think it is really
 23 difficult to separate out the benefit of hindsight of
 24 what happened on 29 July 2024. You know, we mustn't
 25 lose sight of the fact that early on, and I think this

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1 information you had, but you didn't think that it was
 2 appropriate. Would you accept that that should have
 3 been looked at much more closely if you had that
 4 additional risk information?
 5 **A.** I think Dr Irani says in her report, doesn't she, that
 6 she concedes the point that a Mental Health Act
 7 assessment wouldn't have identified a mental health
 8 problem, but I think she says it would have provided
 9 an opportunity to --
 10 **Q.** Dr Molyneux, just remember my question was would you
 11 accept that that should have been looked at much more
 12 closely if you had had that additional risk information?
 13 Do you accept that?
 14 **A.** I accept that the index of consideration could only have
 15 been higher.
 16 **Q.** Thank you. And then turning on to Dr Irani's view, if
 17 we go to page 25 please, and look at paragraph 3.4.4.1.
 18 It may be that this is what you are alluding to:
 19 "Whilst it is not common practice to consider
 20 a Mental Health Act assessment every time a young person
 21 disengages from services, given AR's historic risks and
 22 his presentation, or the lack of physical evidence of
 23 his presentation in the early half of 2024, should have
 24 prompted a Mental Health Act assessment."
 25 Do you agree with that?

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1 A. I mean, he never presented with suggestion of a mental
2 disorder. I'm not so sure I do agree with it.

3 Q. Can I ask you two aspects of the mental disorder. You
4 make clear in your statement that the symptoms of
5 anxiety that AR had you don't think amounted to a mental
6 disorder. They weren't so severe as to amount to
7 a recognised mental health disorder classified under ICD
8 or DSN, yes?

9 A. Correct.

10 Q. What about conduct disorder?

11 A. So conduct disorder is a kind of diagnosis of exclusion
12 really. It is not a mental disorder. It is really just
13 a cluster of features of anti-social behaviour. It is
14 not considered a mental illness. It is not considered
15 a mental disorder.

16 Q. So you don't think that would have qualified as a mental
17 disorder under the Mental Health Act?

18 A. My understanding is that it might be technically
19 possible to detain someone, but that would be done in
20 a forensic setting, not by a community CAMHS service and
21 you would need to know that somebody ticked the boxes
22 for that diagnosis.

23 Q. And at the very least, with all of the information about
24 risk from his previous behaviour, that's a diagnosis
25 that would have warranted consideration, yes?

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1 law subsequent, or proposed changes to the law, to
2 remove autism, as I understand it, from the Mental
3 Health Act. But, at the time, were you not aware that
4 autism could qualify as a mental disorder for the
5 purposes of the Mental Health Act?

6 A. Again, it is a technical point. It is not done in
7 practice. You don't see people detained under the
8 Mental Health Act for autism in practice, or you
9 haven't.

10 Q. So, if that is right, and we will obviously explore with
11 Dr Irani that a Mental Health Act assessment should have
12 been done, but if you are right that there wasn't
13 a power, does that show in fact that there is a gap in
14 the legislation because there is nothing that can be
15 done in this situation in terms of detention to carry
16 out an assessment, even for a short period of time, even
17 though this young person is locking himself away and
18 refusing to be seen by professionals against a risk of
19 harm to others? Is that a gap in the legislation?

20 A. I don't know. I guess it could be argued as such.
21 I would be very careful -- I mean -- I would be very
22 careful about demanding the need for more laws really.
23 I can see there might be an argument for it. I mean,
24 again, from my point of view, looking at this whole case
25 in retrospect, what strikes me more than anything else

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1 A. Consideration possibly.

2 Q. And I should ask these questions carefully knowing that
3 there are post event changes to the law in the way that
4 autism is dealt with so far as the Mental Health Act is
5 concerned. But AR's autism itself, could that not at
6 the time potentially have qualified as a mental disorder
7 for Mental Health Act purposes?

8 A. So, autism is considered -- I mean, it is convention
9 really, it is just how things are kind of construed.
10 Autism is considered as a neurodevelopmental disorder.
11 Autism really just refers to the fact that somebody is
12 presenting with -- if you look at the diagnostic
13 criteria -- it refers to the fact that someone is
14 presenting with significant and pervasive social and
15 communication difficulties, in other words significant
16 and pervasive hypersensitivity and significant and
17 pervasive rigidities of thinking, behaviours and
18 interests. Significant and pervasive meaning by
19 definition these items are longstanding, these features
20 are longstanding. The move over recent years, and
21 I think rightly so, has been to discourage detention and
22 indeed voluntary admission of young people to inpatient
23 units. You have an autism diagnosis because such people
24 tend not to do well in patient units.

25 Q. I understand that. And again there are changes to the

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1 is the unusualness of the parental presentation really.
2 Again by its very nature this is something that's only
3 possible to see with the benefit of hindsight, the
4 extent to which parents were evidently --

5 SIR ADRIAN FULFORD: Dr Molyneux, I am going to ask you to
6 focus on Mr Moss' questions rather than engaging in
7 ruminations --

8 THE WITNESS: I understand --

9 SIR ADRIAN FULFORD: -- about your overall thoughts. So can
10 you --

11 THE WITNESS: I understand sir --

12 SIR ADRIAN FULFORD: -- focus on the issue at hand, please.

13 THE WITNESS: Of course, sir. I --

14 SIR ADRIAN FULFORD: Can you wait for the next question.

15 THE WITNESS: Apologies.

16 MR MOSS: We then move to the stage where the decision to
17 discharge AR from psychiatry altogether. I think that
18 was at 16th April, and at that stage would you agree
19 that rather than having reduced in a sense AR's needs
20 and the concerns about him had escalated by then because
21 of that sense in which he had withdrawn?

22 A. By 16th April 2024?

23 Q. Yes?

24 A. No, I disagree with that. I had been given numerous, as
25 is set out in my Rule 9 report, reassurances by email by

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1 Alphonse, explicit and implicit reassurances that AR was
2 stable and well, so I wouldn't accept it on the basis of
3 the knowledge that we had in front of us that there was
4 evidence of a deterioration.

5 **Q.** On the community dietetics side, by 20th February it had
6 been reported that he had not left the house for four to
7 five months and had an erratic eating pattern again.

8 **A.** I never received that letter by the way. I know this
9 was something that was addressed in the Rule 9 report.
10 But again, if it was described he had not left the house
11 in February 2024 for four to five months, that would
12 imply, a point that I picked up on in my report, that
13 would imply that he had left the house in
14 September/October time, which was shortly after, you
15 know, my home visit where Alphonse was saying that he
16 hadn't left the house. So, overall there was clearly
17 a period of time where he was leaving the house.

18 **Q.** I'm coming towards the end of my questioning. Just
19 a few further areas, please. I should ask you for your
20 assistance and your comments upon Dr Irani's report in
21 different aspects. So, DIR000001 please. This time at
22 page 21.

23 I will take it fairly brief, 3.3.1.2 please, the
24 penultimate paragraph on this page:

25 "[AR] had a history of repetitive and persistent

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1 associated with their area of special interests and is
2 accompanied with a lack of empathy."

3 Do you agree with her on that?

4 **A.** I guess in parts. I wouldn't necessarily say that a
5 diagnosis of autism and is of normal intellect
6 necessarily increases the risk. I think if somebody who
7 meets the criteria for a diagnosis of autism or doesn't
8 has an actual genuine lack of empathy as opposed to just
9 a [unclear]. In other words, if somebody is autistic or
10 not and has a genuine lack of empathy, that increases
11 the risk of --

12 **Q.** In AR's case it did increase the risk, didn't it,
13 because he did have a lack of empathy?

14 **A.** That would appear to be the case.

15 **Q.** And he did have concerning special interests, see his
16 known concerning internet use and fascination with
17 violence.

18 **A.** That wasn't known to me but --

19 **Q.** No, but it was knowable to you. So whichever way you
20 take it, in AR's case, there was increased risk, both
21 because he had a lack of empathy, and because he had
22 concerning special interests.

23 **A.** I guess concerning special interests, risky special
24 interests by definition increases the risk.

25 **Q.** Thank you. I'm going to draw matters to a close so that

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1 pattern of behaviour in which the basic rights of others
2 or major age-appropriate societal norms, rules, or laws
3 are violated such as aggression towards people;
4 destruction of property; deceitfulness and serious
5 violations of rules which pre-dated his first contact
6 with CAMHS. In line with the WHO ICD 11th Edition, he
7 would meet the criteria for a diagnosis of conduct
8 dissocial disorder."

9 I think you accepted earlier that it would have
10 justified consideration. Do you agree with Dr Irani
11 that he actually met the criteria for that diagnosis?

12 **A.** Again, lots of those elements weren't available to me --

13 **Q.** Assume that they were?

14 **A.** Assuming they were. If he's deemed to meet those
15 criteria, then I suppose by definition he does.

16 **Q.** And knowing what you do now, have you got any reason to
17 doubt that he met those criteria?

18 **A.** Knowing what I know now, I mean he was -- he absolutely
19 would meet criteria for that, yes.

20 **Q.** Thank you. Page 33, please. Same report.

21 Paragraph 4.4.7 in AR's specific case, it is Dr Irani's
22 view that:

23 "a diagnosis of autism in someone who does not have
24 a learning disability and is of normal intellect
25 increases the risks, particularly if the risk is

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1 I leave time for any questions for others.

2 Can I indicate that there are sections, Dr Molyneux,
3 in your report, which are helpfully detailed on
4 improvements -- sir, for your note 122 and following and
5 recommendations 126 -- your statement, Dr Molyneux,
6 stands, so I don't need to go through the detail of
7 those but thank you for the detail of them.

8 **A.** No problem.

9 **Q.** But I just want to look at your reflection on events
10 towards the end of your statement at page 45, please.

11 **A.** Yes.

12 **Q.** So the statement at AHCH000253 page 45. You said this:

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

23 Do you want to amend that assertion in any way?

24 **A.** I still agree with it in parts, but I do take your
25 point. I think the challenges that face our service,

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1 which was fortunate enough to get an outstanding result
 2 at an impromptu CQC inspection in March, I think the
 3 challenges that face our service and every service,
 4 health, social care, police et cetera, the public
 5 sector, public services are busier now than they have
 6 ever been. At the same time as that busyness has
 7 increased, fragmentation of services, due to
 8 privatization and deregulation and all the rest of it,
 9 has militated against joint working. Therefore, in my
 10 opinion, no matter how hard anyone and everyone works
 11 within these services, there are system gaps which can
 12 only be remedied I think by having a unified system and
 13 possibly as well I think it would be a helpful move
 14 forward to make use of AI to mitigate against the easy
 15 propensity for information to be lost in systems.

16 **Q.** Briefly, what do you mean by a unified system?
 17 **A.** I would like to see public sector agencies be able to
 18 access information from each other.
 19 **Q.** So going right back to the question I asked you at the
 20 outset about do you have access to other agencies
 21 information on some sort of shared platform?
 22 **A.** Not easily, no.
 23 **Q.** You don't have that?
 24 **A.** Not easily or quickly, no.
 25 **Q.** Dr Molyneux, no one would doubt the difficulty of the

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1 of July of this year, you knew by then about a lot of
 2 the risk information that I had taken you through?
 3 You said "I was aware of that later", yes?
 4 **A.** Some of it. I have become cognisant of more of that
 5 information as time has gone on.
 6 **Q.** Presumably you had read through AR's notes for
 7 example --
 8 **A.** I had -- I mean, it was a very quick turnaround time for
 9 producing the reports, wasn't it?
 10 **Q.** Presumably you read the notes before you drafted this
 11 statement, pretty basic?
 12 **A.** Yes.
 13 **Q.** Yes. And having read the notes, and seen the risk
 14 information that was available in the notes, you still
 15 said "I am 100 per cent confident that not only did
 16 I and my organisation do everything we possibly could",
 17 if it would be suggested to you that it is concerning in
 18 itself that you did not recognise that shortcoming in
 19 producing your statement, what would you say?
 20 **A.** I guess that statement there is a reflection of my
 21 honest view that I see my colleagues work so hard and if
 22 you could see, you know, email timestamps flying around
 23 between staff where people are up until all hours of the
 24 morning and really, really exhausting themselves doing
 25 everything we can for our young people, then the level

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1 task, even if resources were endless, which they are
 2 not, and I don't want my brief further questions on this
 3 to overlook the perfectly valid point that you have made
 4 in that regard. But is not an important reflection that
 5 was missing from your statement the fact that the risk
 6 that AR posed to others became almost completely lost in
 7 how CAMHS dealt with him?

8 **A.** I think there is an element of truth in that. I think
 9 during the middle part of his presentation there was --
 10 the middle part of his trajectory of care there was
 11 an improvement, and also, you know, whether genuinely or
 12 ostensibly, he was presenting with evidence when asked
 13 et cetera, of low risk of harm to others.

14 I think as I alluded to earlier on, Covid was
 15 an important watershed that muddled the water and made
 16 continuity of care difficult. I think another factor
 17 right across the public sector increasingly these days
 18 is the high turnover of staff and when there is high
 19 turnover of staff, that increases gaps in systems. And
 20 my sense is that those gaps that were unavoidable seem
 21 in retrospect to have provided an opportunity for
 22 parents to manage the flow of information in a way that
 23 presented a different picture of reality to
 24 professionals.

25 **Q.** But when you drafted this statement at the very tail end

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1 of need in our society as things have collapsed over
 2 recent years, the level of need has absolutely
 3 skyrocketed and so my 100 per cent confidence statement,
 4 I would like if possible to convey that as a reflection
 5 of how proud I am and how positive I am in my view of my
 6 colleagues and the job they do.

7 Having said that, I take your point and I concede
 8 the point. There are, or were, gaps in the system and
 9 our organisation have taken steps to amend and improve
 10 those, as we are always looking to do all the time.

11 **Q.** Thank you. I follow. I'm just going to turn to my
 12 left.

13 **SIR ADRIAN FULFORD:** Yes, Mr Weatherby.

14 **Questioned by MR WEATHERBY**

15 **MR WEATHERBY:** Thank you, Dr Molyneux. Two very short
 16 points from me arising from what you have said.

17 At the top of your evidence you referred to the
 18 impossibility of being able to read through all of the
 19 records on handover?

20 **A.** Yes.
 21 **Q.** Mr Moss took you to the standard operating procedures
 22 about what was required?
 23 **A.** Yes.
 24 **Q.** Given what you have just said a few moments ago, is the
 25 mismatch between those two points, is it resources? Is

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1 it caseload? Is it having too many cases?
 2 **A.** Yes. I mean -- and that's not a criticism of our
 3 organisation at all. I think we at Alder Hey do
 4 a fantastic job and do as good a job as could be done --
 5 **Q.** Do the best within the resources you have got but the
 6 resources are not sufficient --
 7 **A.** I think we really do and the CQC --
 8 **Q.** If you were properly resourced you would have expected
 9 yourself to have read through the records that Mr Moss
 10 has taken you through?
 11 **A.** I mean, absolutely, yeah, I mean any clinician can only
 12 make risk judgments on the information that's available
 13 to him or her at the time, and so there is a kind of
 14 internal triage process that goes on.
 15 **Q.** Yes.
 16 **A.** As you are attending to your caseload.
 17 **Q.** I understand that. They can only make risk judgments on
 18 the records that they have read?
 19 **A.** Yes.
 20 **Q.** The second point and quickly. Given what you have said
 21 about the impossibility of going through all the records
 22 on handovers, do you think there should be a field on
 23 the electronic patient record showing or listing key
 24 historical incidents or key historical evidence of risk
 25 to self and others? Is that one mitigation of the

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1 **A.** Yes. Sam Steed was case manager number 3. Kate Morris
 2 is case manager 4.
 3 **Q.** April 21, sorry, is when she started?
 4 **A.** Yes.
 5 **Q.** Then Morris, 5th September to July 24.
 6 **A.** 5th September 22, correct, yes. That's about right.
 7 **Q.** Your broad point, as I understand your evidence, is
 8 that, for all the reasons you have discussed, you are
 9 effectively in the dark about the really crucial red
 10 flags at an early stage?
 11 **A.** In the dark about historic --
 12 **Q.** Yes, the forensic -- I won't go through it now, it has
 13 been gone through.
 14 **A.** Yes.
 15 **Q.** And just assuming for the purposes of my questions that
 16 Steed or Morris knew more than you, I don't have time to
 17 go into what they knew?
 18 **A.** I'm not saying they necessarily did or didn't, but yeah.
 19 **Q.** You must have had detailed conversations with them
 20 through your lengthy period of time on the case with
 21 both of those case managers?
 22 **A.** Yes.
 23 **Q.** The role of the case manager is, one assumes, to be
 24 thoroughly invested insofar as time and resources allow
 25 with the patient?

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1 problem that you have highlighted?
 2 **A.** Those steps have already been taken by Alder Hey. So
 3 salient information is now, due to amendments and
 4 modifications and developments of the ERP -- EPR
 5 I should say -- that salient information is now much
 6 more visible and all in one place.
 7 **Q.** In a similar situation, on the EPR you would look at it
 8 and you would see a box or field which showed the
 9 matters that Mr Moss has gone through?
 10 **A.** Yes.
 11 **Q.** Thank you very much.
 12 **SIR ADRIAN FULFORD:** Yes, Mr Bowen.
 13 **Questioned by MR BOWEN**
 14 **MR BOWEN:** I ask questions on behalf of the bereaved
 15 families and I would just like to spend a few moments
 16 asking you about conversations that you have had with
 17 other staff members over your time in the case.
 18 **A.** Of course.
 19 **Q.** First of all, Samantha Steed?
 20 **A.** Yes.
 21 **Q.** Who I think was the case manager between August 22,
 22 I think -- sorry --
 23 **A.** I think she came to it around August 22.
 24 **Q.** Finished on 5th September 22. So she was there at the
 25 earlier stage and then we had Kathryn Morris?

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1 **A.** Yes.
 2 **Q.** They will know the history?
 3 **A.** Yes. If I could just go back to your last point. Sam
 4 Steed's role or time as case manager came to an end just
 5 as mine was -- as my role -- as my time as consultant
 6 was beginning.
 7 **Q.** Yes, exactly, and there are documents, we don't have
 8 time to go through them, where there are emails between
 9 you, discussions about safeguarding incidents for
 10 instance. Do you remember that?
 11 **A.** There was one email from Sam Steed that was -- it is
 12 early on in my Rule 9 statement, isn't it? It is
 13 an email that was sent as a reply to an email from one
 14 of the secretaries to say that they had cancelled
 15 an appointment and Sam Steed did a joint email reply to
 16 myself, Vicky Killen our clinical lead.
 17 **Q.** That is right. I think the reference for that, sir, is
 18 AHCH000290 and 000164 I think.
 19 We know from Kathryn Morris' witness statement --
 20 sir, again for your note particularly paragraphs 119,
 21 168 and 180, that's 000278 -- that certainly those
 22 periods of time, and for those references it is
 23 5th June 23, that's 119, sir. 22nd February I think
 24 '24, 168, and 23rd July 24, she gives evidence
 25 specifically about the referral to CAMHS being due to

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1 low mood, radicalisation, bringing knives to school,
 2 attacks on peers and police involvement.
 3 **A.** Okay.
 4 **Q.** How many times did you speak to Kathryn Morris over the
 5 period of your involvement?
 6 **A.** Quite a few.
 7 **Q.** A regular thing?
 8 **A.** I wouldn't say regular, but on a number of occasions.
 9 **Q.** And if she had known about the really significant events
 10 in the past that would have flagged up risk to others,
 11 she must surely have mentioned it to you?
 12 **A.** I mean, again, I can't speak for Kate Morris and what
 13 Kate Morris knew or didn't know when, and I know she is
 14 a great case manager. I think, and I have alluded to
 15 this point already a couple of times in my submissions
 16 today, I think we need to be really, really careful that
 17 we don't let hindsight cloud --
 18 **SIR ADRIAN FULFORD:** It is a straightforward question,
 19 Dr Molyneux. It comes down to surely Ms Morris
 20 mentioned those matters to you, so what is your memory
 21 of that? Did Kathryn Morris mention low mood,
 22 radicalisation, bringing knives, attacks on peers and
 23 police involvement?
 24 **A.** I don't have a recollection of Kate Morris mentioning
 25 the radicalisation, knives, et cetera. But I have

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1 **THE WITNESS:** Thank you.
 2 **MR MOSS:** Perhaps 2.05 pm.
 3 **SIR ADRIAN FULFORD:** Certainly. We will sit again at
 4 2.05 pm.
 5 **(1.22 pm)**
 6 **(The short adjournment)**
 7 **(2.05 pm)**
 8 **DR LAKSHMI PRABHA RAMASUBRAMANIAN (sworn)**
 9 **SIR ADRIAN FULFORD:** Thank you very much. Do have a seat.
 10 Questioned by MS WAKEMAN
 11 **MS WAKEMAN:** Could you start by stating your full name,
 12 please.
 13 **A.** Yes, my name is Lakshmi Prabha Ramasubramanian.
 14 **Q.** Please could we have your witness statement on screen
 15 which is AHCH000239. Is that your witness statement?
 16 **A.** Yes, that's correct.
 17 **Q.** And is that statement true to the best of your knowledge
 18 and belief?
 19 **A.** Yes.
 20 **Q.** I want to start with some background. So it is right,
 21 isn't it, that you are a consultant child and adolescent
 22 psychiatrist?
 23 **A.** That's correct.
 24 **Q.** And you have been working in the NHS for the last
 25 14 years?

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1 a recollection of Kate Morris referencing the Prevent
 2 referral that had then been rejected.
 3 **SIR ADRIAN FULFORD:** Thank you.
 4 **THE WITNESS:** That's my recollection.
 5 **MR BOWEN:** I do not think anybody is expecting you to
 6 remember everything that was said.
 7 **A.** No.
 8 **Q.** But would you agree with this then, if Morris knew and
 9 I'm saying "if", okay -- if Morris knew -- I daresay she
 10 did know because she has told us -- but given that
 11 Morris knew --
 12 **A.** Right.
 13 **Q.** -- do you think it is more likely than not that it would
 14 have come up in a conversation?
 15 **A.** I'm not so sure I can answer that question. I feel like
 16 I'm being expected to, or being asked to comment on what
 17 Kate Morris knew or didn't know when and I don't think
 18 it is an easy question to answer, I'm sorry.
 19 **SIR ADRIAN FULFORD:** I think, Mr Bowen, we have exhausted
 20 this. He has said he has no memory --
 21 **MR BOWEN:** I'm grateful, sir. I just have one more point.
 22 Did you know about the bus incident?
 23 **A.** No.
 24 **SIR ADRIAN FULFORD:** Dr Molyneux, thank you for your
 25 evidence. You are now free to go.

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1 **A.** That's correct.
 2 **Q.** But in psychiatry generally for over 20 years?
 3 **A.** That's correct.
 4 **Q.** And you are currently working as a consultant child and
 5 adolescent psychiatrist and paediatric neuropsychiatrist
 6 at Alder Hey Children's NHS Foundation Trust?
 7 **A.** That's correct.
 8 **Q.** And is it right that you have held that role since 2011?
 9 **A.** Absolutely, yes.
 10 **Q.** And you work in the Sefton Child and Adolescent Mental
 11 Health Services which --
 12 **A.** Yes.
 13 **Q.** -- we have been referring to as CAMHS?
 14 **A.** Yes.
 15 **Q.** Just as a very brief overview of your involvement, is it
 16 right that you were assigned to AR as his consultant
 17 psychiatrist from 1 July 2021 until 23rd June 2022?
 18 **A.** Yes.
 19 **Q.** So the first main topic I want to ask you about is about
 20 your allocation to AR's case and your awareness of some
 21 of the background information relating to AR when you
 22 first became involved.
 23 **A.** Yes. So, within Sefton CAMHS psychiatry involvement is
 24 requested by multidisciplinary team meetings. I was
 25 aware that AR was already open door service and that he

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1 had had involvement with Prevent and Forensic CAMHS.
 2 I was also aware that he was discussed in
 3 multidisciplinary team meetings in MDT 3, previously and
 4 placed on the routine psychiatry waiting list.
 5 Following that, in May 2021, he was discussed again
 6 and the notes suggest that he was making progress but he
 7 was requesting medication and hence he was placed on the
 8 psychiatry -- urgent psychiatry waiting list and then
 9 allocated to me.
 10 **Q.** So that's how he was first allocated to you and
 11 I understand your first appointment with him was on
 12 1 July 2021?
 13 **A.** That's correct.
 14 **Q.** What information did you have access to about AR at the
 15 start of your involvement? We saw this morning the
 16 electronic patient system. Would that be the main
 17 source of information?
 18 **A.** Yes. So as a consultant child psychiatrist, I would
 19 heavily rely on information on the electronic patient
 20 records and verbal kind of information from the case
 21 manager, whom he is open to. I was aware that there had
 22 been previous FCAMHS and Prevent involvement, basically
 23 from some session notes or some notes on electronic
 24 patient records and from the case manager
 25 Samantha Steed, but I did not have any access to reports

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1 the third referral, which was made by the Criminal
 2 Justice Liaison Service was accepted and he was
 3 allocated a case manager. So I had access to
 4 information from that point onwards.
 5 **Q.** And you reviewed the records from that point onwards?
 6 **A.** Yes, I did.
 7 **Q.** Is that what was expected of you as a consultant
 8 psychiatrist, to you have reviewed the whole records
 9 when you take on any patient?
 10 **A.** I would like to say when you say whole records, Alder
 11 Hey has so many different departments and electronic
 12 patient records may include information from other
 13 departments, not just CAMHS. So usually we find that
 14 there are relevant information about patients from
 15 community paediatrics, for example, which may be
 16 relevant to our kind of approach to the patient,
 17 especially around the diagnosis of neurodiversity or
 18 other kind of information, safeguarding information for
 19 example. Sometimes you only have access to view certain
 20 records, not all of them, unless they are actually in
 21 the form of clinic letters that are uploaded onto
 22 a system called Medisec. So if the patient is open say
 23 to a paediatric specialty for a physical health problem,
 24 I will be able to access their records by reviewing
 25 clinic letters if they are uploaded.

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1 or letters from either of these services.
 2 **Q.** And is that typical, that you wouldn't have access to
 3 other agencies' record systems?
 4 **A.** Not unless they are scanned or -- at the time in 2021,
 5 we used to have something called Image Now on electronic
 6 patient records. So any information or letters that are
 7 scanned from external agencies would be visible through
 8 the ImageNow app. Unfortunately there was nothing on
 9 ImageNow for AR.
 10 **Q.** Okay. So the system in CAMHS at that time was that you
 11 were essentially reliant on other agencies sending you
 12 information or records that they may have and somebody
 13 at CAMHS uploading that onto the CAMHS system?
 14 **A.** That's correct.
 15 **Q.** You said that you had access to the electronic patient
 16 system, the CAMHS records. You explain at paragraph 12
 17 of your statement that you familiarised yourself with
 18 AR's background history by reviewing the Alder Hey
 19 records. Did you review his records in their entirety?
 20 **A.** I reviewed his records in its entirety from the point he
 21 was referred into CAMHS. So I was aware that there had
 22 been three CAMHS referrals made. The first one he was
 23 signposted to voluntary sector organisation called
 24 Parenting 2000 for parenting support. The second
 25 referral was also not accepted and following an offence

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1 **Q.** All right. So when you said you reviewed the whole of
 2 the records for AR, just to be clear, which records do
 3 you mean? Was it just CAMHS records --
 4 **A.** That's right.
 5 **Q.** And were you provided with an oral or written handover
 6 over by the case manager or anyone else when you first
 7 became involved?
 8 **A.** So within CAMHS at Alder Hey there is no standardised
 9 handover procedure that we follow. A referral to
 10 psychiatry would be made via a multi-disciplinary team
 11 discussions, an agreement made and a consensus that the
 12 patient should be accepted by psychiatry. That
 13 information would be then available on electronic
 14 patient records in the form of professional discussion
 15 often documented by administrative staff. So the
 16 administrative staff will capture the discussion and
 17 make a brief summary of the discussion and often that is
 18 the only information you have with regards to why the
 19 patient has been referred to psychiatry.
 20 **Q.** And do you remember in AR's specific case whether you
 21 were, like the example you just gave, you were reliant
 22 on a written handover, or whether there was a separate
 23 oral handover?
 24 **A.** Nothing at all. The only information I had was from the
 25 electronic patient records. Sorry, also I had a brief

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1 conversation with the case manager about AR's request
 2 for medication.
 3 **Q.** Was that when you first became involved or did that come
 4 later?
 5 **A.** Just prior to when I became involved.
 6 **Q.** I want to ask you about some aspects of AR's history
 7 which pre-dated your involvement. You have already
 8 touched on some of these things. I think you have
 9 already said that you were aware that AR had been
 10 referred to CAMHS on multiple occasions?
 11 **A.** That's right.
 12 **Q.** Were you aware that that came from different sources?
 13 **A.** Yes. I was aware that it came from school and from the
 14 Criminal Justice Liaison Service and from the GP.
 15 **Q.** Did you draw any significance from the fact there had
 16 been multiple referrals, for example, that it indicated
 17 there was concern coming from multiple directions?
 18 **A.** It is not unusual for CAMHS to get referrals from
 19 multiple agencies such as GP, primary care or school
 20 health, because when the first referral is not accepted,
 21 often the second route of referral is followed and it is
 22 again not unusual for children with mild presentations
 23 to not be accepted and signposted to our third sector
 24 organisations.
 25 **Q.** I think you have also touched on the fact that you said

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1 weren't scanned into the CAMHS system?
 2 **A.** No.
 3 **Q.** Were you at the time of your involvement with AR aware
 4 of these letters?
 5 **A.** Not at all.
 6 **Q.** Had you seen them?
 7 **A.** Not at all.
 8 **Q.** So how was it that you were aware essentially of the
 9 evidence you just gave about what FCAMHS had said?
 10 **A.** There were a couple of lines on the electronic patient
 11 records, I think it was in the referral and triage
 12 information that AR had previously had involvement with
 13 FCAMHS and Prevent and that he was deemed not to be at
 14 risk to others.
 15 **Q.** Were you aware that FCAMHS had really had quite
 16 a limited involvement in the sense of attending just two
 17 multi-agency meetings when sending these two letters?
 18 **A.** That is correct.
 19 **Q.** Were you aware from your review of the records that, in
 20 February 2021, AR had in fact received his autism
 21 diagnosis?
 22 **A.** Yes, I was aware of that.
 23 **Q.** So, did you consider that there was a need to re-refer
 24 him to FCAMHS in light of that?
 25 **A.** As I was not aware of the FCAMHS recommendation, that

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1 you were aware that AR had been previously referred to
 2 FCAMHS. Is that right?
 3 **A.** That's correct.
 4 **Q.** Were you aware that they discharged him from their
 5 service --
 6 **A.** That's correct.
 7 **Q.** -- in March 2020?
 8 **A.** That is correct.
 9 **Q.** Did you know that the reason for that was because they
 10 said that in order to feed into a risk assessment,
 11 essentially, they would need an autism diagnosis?
 12 **A.** Yes, I was aware of that. But I don't agree with it.
 13 **Q.** We will come onto that.
 14 Were you aware that they had said that if there was
 15 a significant change in circumstances or risk behaviour
 16 that he should be or he could be re-referred to FCAMHS?
 17 **A.** I was not aware of that during my involvement, but as
 18 part of the Inquiry, I have been shared that information
 19 and I only recently became aware of that.
 20 **Q.** Could we have a look at AHCH0000231, please.
 21 If we go to the next page. The Inquiry has received
 22 evidence that there were two letters sent by FCAMHS: one
 23 on the 11th February 2020 and the second on
 24 9 March 2020.
 25 The Inquiry has heard evidence that those letters

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1 wasn't actioned.
 2 **Q.** You have mentioned Prevent referrals. Were you aware
 3 that AR had been referred to Prevent three times?
 4 **A.** Yes.
 5 **Q.** But by July 2021 he was closed to Prevent?
 6 **A.** That's correct.
 7 **Q.** How did you become aware of those referrals?
 8 **A.** Again, based on the couple of lines in the referral and
 9 triage information and on the electronic patient
 10 records.
 11 **Q.** And did you know the reasons for the Prevent referrals?
 12 **A.** Yes, so I was only aware of the fact that prior to my
 13 involvement, AR had hurt a peer with a hockey stick at
 14 school and that he had taken a knife into school and
 15 those were the only two incidents I was aware of.
 16 **Q.** So you weren't aware of the circumstances that led to
 17 the other Prevent referrals?
 18 **A.** No.
 19 **Q.** You say at paragraph 12 of your statement that AR was
 20 closed to FCAMHS and Prevent, this is by the time you
 21 became involved, and was deemed not to be at risk of
 22 radicalisation, counter terrorism or risk to others.
 23 Did you take reassurance from the fact that AR had
 24 been closed to agencies like Prevent and FCAMHS?
 25 **A.** Absolutely. It is extremely reassuring and allows

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1 community psychiatrists like me to focus on what is
 2 presented to you and to kind of treat here and now the
 3 presenting symptoms and not worry about the risk to
 4 others, no. We see FCAMHS and Prevent as highly
 5 specialist organisations and services and rely on their
 6 evidence and reports.

7 **Q.** Is taking the closure by those agencies as
 8 an indication -- you said to essentially just not worry
 9 about the risk presented --

10 **A.** Not really. We do have children with neurodiversity,
 11 such as autism spectrum disorder or ADHD presenting with
 12 disruptive behaviours, challenging behaviours,
 13 behaviours of concern during involvement with CAMHS. So
 14 we are quite, you know, well versed in understanding and
 15 formulating difficulties like that on the basis of
 16 anxiety or autism spectrum disorder. However, when you
 17 have organisations like FCAMHS or Prevent offering us
 18 reassurance that these are just disruptive behaviours
 19 and there is nothing to worry about in terms of harm to
 20 others, it is rather quite reassuring for me.

21 **Q.** In terms of Prevent, how much reassurance could you
 22 really draw from that when you didn't know the details
 23 of the second two referrals or the reasons why they had
 24 been closed?

25 **A.** Okay, so I have had previous involvement with Prevent

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1 informed by the presenting problems. Say, for example,
 2 if a child presents with self-neglect or with
 3 self-harming behaviour, one would start looking at risk
 4 of self-neglect, depression, poor functioning and that
 5 would be the lines of enquiry for a psychiatrist. For
 6 AR, because the presentation was one of avoidance,
 7 anxiety and isolative behaviours, my risk assessment was
 8 heavily informed by that and my lines of enquiry was
 9 into his functioning, his anxiety levels and the risks
 10 he may face because of the fact that he's not having age
 11 appropriate interactions and age appropriate
 12 opportunities.

13 **Q.** All right. We will come back to some of those points
 14 later.

15 Going back to the reassurance you took from Prevent
 16 and FCAMHS closing their referrals, we have already
 17 talked about Prevent, so I will leave that to one side.
 18 Could we just have the FCAMHS letter back up on screen,
 19 which is AHCH000231. Could we look at the bottom of
 20 page 4 please.

21 "The following aspects of young people with an ASC
 22 diagnosis should be taken into account when considering
 23 the risk."

24 Then there is a list. If we go over the page, the
 25 list continues. A number of things drawn out there but

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1 for other patients of mine and I have a fair idea about
 2 how they work and that includes FCAMHS as well, which is
 3 why you know I was able to be reassured that if Prevent
 4 has closed a young person, that's quite reassuring.

5 **Q.** So in your mind that kind of signalled to you that you
 6 didn't need to look into further detail of risk to
 7 others by AR or risk of radicalisation, interest in
 8 terrorism, for example?

9 **A.** Okay, so the reason why AR was referred to me as
 10 a psychiatrist was for anxiety, avoidance behaviours,
 11 isolated behaviours and school refusal. So, as
 12 a psychiatrist working for a therapeutic service, when
 13 I have a reassurance offered by services like FCAMHS and
 14 Prevent that there is no risk to others, it gives me
 15 permission to focus on the presenting problems and to
 16 enable the child to get better and to enable them to
 17 kind of reintegrate with education and reduce their
 18 anxiety levels and that was my goal of treatment.

19 **Q.** So your focus was very much on treating the symptoms?

20 **A.** Absolutely.

21 **Q.** Not necessarily concerned with assessment of risk based
 22 on previous --

23 **A.** No. Psychiatrists conduct risk assessment at every
 24 contact. So our lines of questioning a patient or our
 25 lines of questioning of a parent always is heavily

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1 we see: hostility to parents; lack of awareness of
 2 wrongdoing; deficits in empathy; not seeing
 3 consequences.

4 And then Mr Hicklin goes on to conclude:
 5 "I am of the opinion that assessment by our service
 6 is not indicated as until his diagnosis is complete we
 7 would not be able to contribute further to the
 8 understanding of risk."

9 Then the last sentence:
 10 "The case will now be closed to FCAMHS but any
 11 professional can contact the service for clarification
 12 of this letter or if review is indicated because of
 13 a significant change in circumstances or risk
 14 behaviour."

15 So, Mr Hicklin wasn't saying there is no risk here.
 16 He was simply saying that at that time, until the
 17 diagnosis was complete, they felt they couldn't
 18 contribute further to understanding of risk. So, had
 19 you had access to that letter and been aware of it at
 20 the relevant time, would that have changed how much
 21 assurance you would have drawn from the closure by
 22 FCAMHS?

23 **A.** Absolutely. Absolutely. I would be more interested in
 24 also knowing about AR's thought processes around harming
 25 other people and use of weapons certainly and that would

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1 have made my approach a little bit more holistic to
 2 include risk to others as well, because what I had in
 3 front of me and what I was aware of did not alert me to
 4 consider risk to others as a major factor.
 5 **Q.** Yes. I think now is a good time then to go through some
 6 of the specific events that took place involving AR and
 7 this is all I'm going to be asking you, if you can
 8 confirm in respect to each of these whether you were
 9 aware of that when you first started seeing AR in
 10 July 2021.

11 So, firstly, I think you have mentioned already that
 12 you were aware of this, that AR had admitted taking
 13 knives into school. Were you aware that that was on ten
 14 occasions?

15 **A.** No. I was only aware that he took a knife to school on
 16 one occasion and that he had hurt a peer with a hockey
 17 stick on one occasion.

18 **Q.** So the knife carrying, that was as part of the hockey
 19 stick incident?

20 **A.** Yes.

21 **Q.** Were you aware that he was seen in an ICT lesson on
 22 15 November 2019 looking at material concerning school
 23 shootings?

24 **A.** No, I was not.

25 **Q.** What about the fact that he appears to have been

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1 the person that he perceived to be bullying him, but in
 2 fact another boy who happened to be passing?

3 **A.** Yes, the case manager did inform me about the detail,
 4 that he had hurt the wrong person. That was what
 5 I heard.

6 **Q.** Were you aware, on 1st February 2021, that AR was
 7 posting material relating to Gaddafi on Instagram?

8 **A.** No.

9 **Q.** And that in February 2020, he was convicted in relation
 10 to the hockey stick attack and received a ten-month
 11 referral order?

12 **A.** Yes, I was aware of the fact that he was -- he had
 13 a referral order, yes. That was in the electronic
 14 patient records along with the information about the two
 15 incidents.

16 **Q.** And in April 2021, he was seen on a school computer to
 17 be looking at pages relating to the London Bridge terror
 18 attack and he spoke in detail about the IRA, thought
 19 that the MI5 were being asked to kill people in the IRA?

20 **A.** No, I wasn't aware of that.

21 **Q.** And about the conflict in Israel and Palestine?

22 **A.** No.

23 **Q.** Finally, were you aware of an incident on 17th May 2021
 24 where AR was reported to have thrown juice over his
 25 father and to have hit him?

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1 attempting to view graphic images of degloving injuries?

2 **A.** I was not aware of that.

3 **Q.** And on 29 November he was attending a lesson where
 4 students were asked to promote a business and he said he
 5 didn't think it would be a good idea if his business was
 6 new to the area because people would think he would kill
 7 them as they didn't know him?

8 **A.** I was not aware of that.

9 **Q.** He went on to say that "people don't trust others they
 10 don't know in case they get murdered"?

11 **A.** I also was not aware of that.

12 **Q.** Were you aware that, on 3rd December 2019, in an art
 13 lesson, AR questioned why he was allowed to look at
 14 images from a video game, but couldn't look at guns on
 15 the internet, and he also asked to look at a picture of
 16 a severed head?

17 **A.** No, I wasn't aware of that.

18 **Q.** You have said you were aware of the hockey incident --

19 **A.** Yes.

20 **Q.** -- in September 2019. Were you aware that -- there is
 21 some contradiction in statements as to his intent -- but
 22 were you aware that some of what is recorded he says
 23 that he would have been prepared to use the knife?

24 **A.** I wasn't aware of that.

25 **Q.** And were you aware that the person he attacked was not

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1 **A.** No, I wasn't aware of that.

2 **Q.** Do you agree that all of those incidents looked at
 3 together and individually would be highly relevant to
 4 your understanding of how he was presenting?

5 **A.** Yes, absolutely.

6 **Q.** And any assessment of risk that you were making would be
 7 flawed if you didn't have knowledge of those incidents?

8 **A.** Yes, so risk assessments that we conducted in CAMHS
 9 based on the presenting problems would be considered
 10 quite appropriate, but with insufficient information we
 11 were not focusing on risk to others and that was only
 12 because of the fact that we were not aware of it.

13 **Q.** Well, let's have a look at what was in the CAMHS
 14 records. Not all of those incidents in fairness were
 15 but some of them were. For example, the fact that he
 16 had taken a knife into school on at least ten occasions
 17 and had the intention of using it. That was in the
 18 CAMHS records?

19 **A.** Okay, I think that was a community paediatric record
 20 that we don't have access to. We checked that that was
 21 not a CAMHS record. It was a record from Acorns School
 22 I think -- it was not sent to CAMHS, but to community
 23 paediatrics, if I recall this correctly.

24 **Q.** Let's just have a quick look at the record. So it is
 25 AHCH000162. This shows I believe the CAMHS electronic

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1 patient record. Is that right?

2 **A.** Yes, I think this looks like a referral -- a discussion

3 following referral to the service.

4 **Q.** Sorry, this is just page 1. If we look at the bottom of

5 page 3, please. If we could zoom in on the bottom

6 paragraph, it says he has been recently excluded after

7 taking a knife into school with the intention of using

8 it if provoked.

9 If we could also look at page 9, the third paragraph

10 down, which starts "Seized computers", there we can see

11 it says:

12 "AR spoke to Childline and told them he took a knife

13 into school on 10 separate occasions. Childline spoke

14 to police."

15 Do you accept that that was on the CAMHS?

16 **A.** Yes, this looks like a CAMHS record.

17 **Q.** All right. And the fact that in the hockey stick

18 incident AR had the intention of killing someone, I'm

19 happy to take you to the reference, but perhaps you can

20 take it from me now we have looked at that one, that is

21 also in the CAMHS records and it is the same document at

22 page 4 and 8. The fact that he received a ten-month

23 referral order, you said you were aware that that was on

24 the records?

25 **A.** Yes.

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1 **A.** I think when a new patient is referred to you and then

2 you look through records to the best of your ability and

3 feel reassured that two agencies like FCAMHS and Prevent

4 have closed him to their care, and that the current

5 presenting symptom is one of anxiety and avoidant

6 behaviours and school refusal, I guess you know that's

7 one of the reasons why I just moved on to focus on the

8 presenting problems.

9 **Q.** Is there really two elements of weakness here? Is the

10 first that there was a weakness in the system in the

11 sense that the CAMHS system for keeping track of really

12 important information about risk didn't make it clear to

13 you as an incoming practitioner that that information

14 should have been clearly visible to you on the system,

15 shouldn't it?

16 **A.** On reflection, certainly I agree with that.

17 **Q.** But secondly, given that for the entries I have taken

18 you to, that some of that information clearly was on the

19 system, do you accept that you failed to that extent in

20 your duty to adequately check the notes and inform

21 yourself of the background?

22 **A.** Yes, to an extent. You know, I should have reviewed the

23 record in its entirety. But in many instances you know

24 we get a good picture of the young person referred to

25 you by reviewing records from the time they get referred

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1 **Q.** The fact he had been viewing inappropriate content

2 online in relation to terrorism, that was also in the

3 records. That's AHCH000162 page 9, top of the page for

4 the Chair's record. We don't need to bring it up.

5 There were several other matters also in the

6 records. Firstly, the fact that he had researched the

7 Manchester bombing and considered that it was a good

8 battle from the suicide bomber's perspective. And that

9 he had been researching the London Bridge bombings and

10 making comments about Israel and Palestine at school and

11 had to be referred to Prevent again. And finally the

12 incident where AR threw juice over his father and those

13 references were given, Chair, this morning in the

14 context of Dr Molyneux's evidence?

15 **SIR ADRIAN FULFORD:** Yes, thank you.

16 **MS WAKEMAN:** So although you said that you had reviewed the

17 records in full, the only incidents of the ones we have

18 gone through which you were in fact aware of is

19 essentially the hockey stick incident and the referral

20 order that follows. Do you accept that you must have

21 not conducted a very thorough review of the record and

22 you have missed these entries somehow?

23 **A.** I do accept that, yes. I accept that.

24 **Q.** How do you think it came to be that crucial background

25 information such as that simply failed to reach you?

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1 to CAMHS and that gives you a clear sense of their

2 journey and their presenting problems. So I guess it

3 was an oversight on my part to have missed some

4 information, but I did know that there was a risk of

5 harming others and that behaviour of him I was aware of

6 at the time of seeing him.

7 **Q.** Was resourcing an issue which in any way contributed to

8 the failure to do a full review of the records, do you

9 think?

10 **A.** On reflection, when a patient is referred to psychiatry,

11 it could be -- you know, it could have been really

12 helpful to have a standardised information handover to

13 psychiatry, specifically focusing on the key areas of

14 risk, risk to self, risk to others, risk of self-neglect

15 and risk of vulnerability. That in a one-page format

16 could really, really alert the psychiatrist to key

17 information that you need before you see a patient. So

18 that is definitely a learning that I have taken from

19 this Inquiry.

20 **Q.** Thank you. Would an awareness of all those incidents

21 that we have gone through, which do demonstrate, I would

22 suggest, a history of violence and an interest in

23 violence, have been important to your assessment of the

24 risk that AR posed to others?

25 **A.** Certainly, yes.

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1 Q. Would it also have been relevant to your consideration
 2 of any mental health conditions he posed or diagnosis?
 3 A. Absolutely. It would have alerted me to think about
 4 preoccupation with violence, you know, to rule out
 5 conditions such as obsessive compulsive disorder and,
 6 you know, other kinds of serious mental illness. But
 7 having said that, my assessment and other external
 8 assessments that happened of AR did not indicate any
 9 serious mental disorder.
 10 Q. A related but slightly different point is about the risk
 11 assessments that CAMHS undertook and I just want to turn
 12 to that briefly. Were you aware that when you first
 13 started seeing AR that his case manager at the time,
 14 Mr Skott Morgan, had done an initial risk assessment on
 15 8th January 2020?
 16 A. Yes, I was.
 17 Q. Did you review that risk assessment?
 18 A. Yes.
 19 Q. We don't need to get it up but, sir, for your note it is
 20 AHCH000162 pages 14-15.
 21 **SIR ADRIAN FULFORD:** Thank you.
 22 **MS WAKEMAN:** We will come on later to risk assessments
 23 thereafter as a separate issue. Let's now focus on the
 24 first appointment that you had with AR. So this was
 25 a telephone appointment on 1 July 2021. How did AR

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1 for a medication like SSRI medication because it is
 2 a psychotropic medication that cannot be stopped and
 3 started as and when you need it, it is a long-term
 4 treatment. So I told him that I would continue to
 5 assess his needs and continue with the plan of starting
 6 with propranolol. He reluctantly agreed with me.
 7 I shared all information about the benefits, the pros
 8 and cons of treatment with propranolol, but he didn't
 9 seem quite interested. It was a very brief appointment
 10 because all he wanted was to share his symptoms and get
 11 medication. So it wasn't like a standard thorough
 12 initial assessment that we would normally offer in
 13 CAMHS.
 14 Q. You say it wasn't a standard initial assessment. Is
 15 that because of the way that AR essentially controlled
 16 the narrative of the appointment in your view?
 17 A. Correct.
 18 Q. You said it was quite unusual in the sense that he
 19 seemed like he had researched symptoms of anxiety before
 20 the appointment. Did it give rise to concern for you
 21 that he seemed to be trying to manipulate the treatment
 22 that he was going to be given?
 23 A. He was certainly demanding, argumentative and tried to
 24 dictate treatment. I wouldn't use the word
 25 "manipulative". It felt like he needed to be in control

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1 first present during that first appointment?
 2 A. During the first appointment AR was insistent that he
 3 spoke to me and he did not allow his father to speak to
 4 me. So usually during first appointments we would
 5 gather information from parents to obtain corroborative
 6 history and then talk to the young person or me to the
 7 young person to obtain their views and to carry out
 8 an assessment. It was very interesting that AR did not
 9 want his father to be part of the interview.
 10 He articulated symptoms of anxiety as if he had
 11 rehearsed it from a book or from the internet. The way
 12 he articulated was quite unusual, and it was very
 13 apparent that he was trying to convince me and to
 14 persuade me that he needed medication.
 15 On top of that, when we discussed medication and the
 16 need for medication, he disagreed with me on multiple
 17 occasions and slowly started becoming argumentative. At
 18 one point when I finally said that I would give him
 19 a trial of a beta-blocker, such as propranolol, to
 20 reduce his symptoms of anxiety, which he had articulated
 21 very well, the physical symptoms, he disagreed with me
 22 yet again and said that he should be on a medication
 23 such as an anti-depressant called SSRI medications.
 24 I explained to him that, based on the history that
 25 he has given me, I'm not convinced about the indication

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1 of the session, which is normally not the case with
 2 children.
 3 Q. You say at paragraph 13 of your statement that you
 4 didn't find anything to suggest at that appointment that
 5 AR was a risk to himself or others?
 6 A. Yes.
 7 Q. But presumably that wouldn't be your view had you known
 8 all of the background information that we now know was
 9 in the CAMHS records?
 10 A. No. At the time of the first initial appointment, I had
 11 known that he had taken a hockey stick to school and
 12 hurt another peer and that also he had taken a knife
 13 into school, but I wasn't aware of, you know, wider
 14 information or further incidents. However, at the time
 15 of the assessment, when the line of inquiry or
 16 questioning was focused on anxiety, risk to self and
 17 others, he denied all of them.
 18 Q. Would that not be just relying on his
 19 self-reporting though rather than --
 20 A. Absolutely, I agree with that.
 21 Q. Is it not the case that young people and young children
 22 potentially with mental health issues, other complex
 23 background things, shouldn't necessarily be relied on to
 24 accurately self-report a risk to others?
 25 A. Not really. We work with children with neurodiversity

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1 within CAMHS. Almost 70% of children we see within
 2 CAMHS have a diagnosis of ASD or they are on the ASD
 3 pathway. They are very hard to engage. They are, you
 4 know, children who find it very difficult to work with
 5 CAMHS. So I gave benefit of the doubt to engage him and
 6 to hear his version of his symptoms and that would be
 7 considered a good practice and with a view to gather
 8 further information from the family and the wider system
 9 subsequently.

10 **Q.** And from the records?
 11 **A.** And from the records.

12 **Q.** I think this is the point you touched on a minute ago,
 13 you say in 12 of your statement that AR's presentation
 14 wasn't to do with risk to others but due to reported
 15 anxiety, school refusal and difficulties leaving the
 16 house. Looking back now, do you think you were in fact
 17 more focused on any risk to himself rather than risk
 18 posed to others?
 19 **A.** That's correct.

20 **Q.** You have talked a little bit about the prescription
 21 drugs that AR was requesting. Before prescribing drugs,
 22 did you consider whether talking therapy might have been
 23 appropriate?
 24 **A.** I was already made aware by -- in the referral
 25 information and the discussions in the MDT that AR had

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1 It is right, isn't it, that following that initial
 2 appointment, AR later did agree to try propranolol
 3 again?
 4 **A.** That's right. So, for the following conversation with
 5 Sam Steed, Sam contacted the family and shared my view
 6 that AR should give propranolol a fair trial and that
 7 I would be willing to review it at the next appointment.

8 **Q.** All right. And then you had a further telephone
 9 appointment the next month where AR was again asking for
 10 SSRI medication?
 11 **A.** That's right.

12 **Q.** There was then an appointment which I think you weren't
 13 able to attend but Dr Aesha Aseri attended?
 14 **A.** That's right.

15 **Q.** They noted that AR presented with a diagnosis of autism
 16 spectrum disorder and a moderate degree of social
 17 anxiety and that doctor started AR on sertraline tablets
 18 which is a type of SSRI?
 19 **A.** That is correct.

20 **Q.** In terms of the diagnosis of autism with a moderate
 21 degree of social anxiety, was that also your diagnosis
 22 as well?
 23 **A.** I think Dr Aseri actually means that AR's presentation
 24 at the time was in keeping with anxiety in the context
 25 a young person with neurodiversity such as ASD.

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1 been offered talking therapy and he had refused to
 2 engage with talking therapies.

3 **Q.** We know from your statement that you went on to
 4 prescribe AR with propranolol?
 5 **A.** Yes.

6 **Q.** Because you say that SSRI medication wasn't clinically
 7 indicated at that time?
 8 **A.** No.

9 **Q.** And did he take that propranolol as advised following
 10 the appointment?
 11 **A.** No. So, a few days after the first appointment I had
 12 a message from the case manager, Sam Steed, that AR had
 13 taken propranolol for just one day, so just one dose of
 14 medication and then reported to his father -- so this
 15 was the reported information from AR's father to
 16 Samantha -- that AR had reported that this medication is
 17 not right for him and that he will not take it anymore
 18 and also shared that he will only take medication if
 19 I spoke to him about it. So he was quite demanding that
 20 he needed a conversation with me about medication.

21 **Q.** Then you go on in your statement to give a very detailed
 22 account of the involvement you had thereafter in terms
 23 of the appointments with AR. I'm not going to go
 24 through every appointment or interaction but I will just
 25 draw out a few key points.

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1 So she did not give him a diagnosis of social
 2 anxiety disorder but social anxiety that is commonly
 3 seen in children with autism spectrum disorder.

4 **Q.** So symptoms of anxiety arising from the ASD?
 5 **A.** Yes, correct.

6 **Q.** And did you agree with that diagnosis?
 7 **A.** Yes.

8 **Q.** Did you at any stage give thought to any other
 9 diagnoses, for example, conduct disorder?
 10 **A.** Although AR's behaviour and the demanding nature was
 11 quite unusual, I did not think about a conduct disorder
 12 at that point in time because I did not have evidence
 13 for persistent repetitive anti-social tendencies because
 14 that is the first feature that would alert
 15 a psychiatrist to consider a diagnosis of conduct
 16 disorder. Especially in the context of a child with
 17 autism spectrum disorder, disruptive behaviours,
 18 behaviours of concern, challenging behaviours such as
 19 trashing the house or hurting family members, is not
 20 unusual. So, within CAMHS we understand this in a kind
 21 of a holistic way and we often try and understand this
 22 whether this is in the context of ASD first. So
 23 considering conduct disorder at that stage was not
 24 appropriate.

25 **Q.** Yes, so you say you didn't have evidence at that stage

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1 --

2 A. Yes.

3 Q. -- of persistent repetitive, anti-social tendencies?

4 A. Yes.

5 Q. But bearing in mind all of the incidents that we went

6 through earlier, had you known all of that information,

7 would that not have given rise to --

8 A. Absolutely, absolutely. I would have considered that

9 and not just that, I would have contacted forensic CAMHS

10 for a consultation as well.

11 Q. Even though you weren't aware of the invitation to refer

12 back to FCAMHS, just of your own volition --

13 A. Yes.

14 Q. -- you think might have alerted you?

15 A. Yes.

16 Q. So is it right that you wouldn't disagree with Dr Irani

17 when she says that, in her view, AR would meet the

18 diagnosis for conduct disorder?

19 A. I don't disagree with her, but her opinion is based on

20 the fact that she was aware of the entire history and

21 the incidents, so, if you ask me now, I would say yes,

22 but not at the time when I was involved.

23 Q. And just to run through a few more of the appointments.

24 So you had a further appointment on 13th October 2021.

25 At that stage there was no improvement in terms of

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1 Q. You note in your statement that at your appointment on

2 15th November, so ten days after that incident, neither

3 AR nor his father informed you of the incident?

4 A. No.

5 Q. You say at paragraph 30 of your statement that you would

6 have expected the young person and family to be open and

7 honest with you and if you had been informed you would

8 have explored this further to ensure the right support?

9 A. That's correct.

10 Q. Would you have expected Ms Steed, the case manager, to

11 have informed you of that incident if she was aware of

12 it?

13 A. Absolutely. We rely as psychiatrists heavily on

14 information being shared by case managers and with the

15 multi-agency system around the child to inform our

16 treatment and to enable good outcomes.

17 In this situation the documentation about the

18 incident by the case manager was made on the day of my

19 appointment later in the evening, so I was unable to

20 review that prior to my appointment, and as the family

21 also did not share those concerns, and in fact gave me

22 a completely opposite view, saying that he had improved

23 massively on medication, it was a challenge for me.

24 Q. You are right to note that that incident was entered

25 into the CAMHS record on 15th November.

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1 functioning and so you increased --

2 A. That's correct.

3 Q. -- the sertraline dosage?

4 A. Yes.

5 Q. A follow-up appointment on 15 November 2021 where there

6 were some positive changes reported?

7 A. That's correct.

8 Q. And it was reported that AR had attended school for four

9 days a week before the appointment. He did also report

10 though -- he reported improvements in his anxiety, but

11 you did also agree to increase his dosage of sertraline?

12 A. Yes. Wasn't that the appointment where he also

13 complained of feeling tired from the medication? And

14 I had said I would review it. So he was also reporting

15 side effects from sertraline, yet asking me to increase

16 the dose, which was quite conflicting. So, I told him

17 that I would consider an increase in medication and to

18 wait until the tiredness wears off.

19 Q. Right. So that appointment was on 15th November 2021

20 and the Inquiry has heard some evidence about

21 an incident that occurred on 5th November 2021?

22 A. That is correct.

23 Q. During which AR trashed his house and his mother called

24 the police.

25 A. That is right.

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1 A. Yes.

2 Q. Did you ever check that record yourself, either later on

3 15th November or at a later date?

4 A. So normally we would go back to review patient records

5 when we have the next appointment with the young person.

6 Purely because of how busy we are and we don't have time

7 to go into the records between appointments unless there

8 is a reason to do so. So I was aware of the fact that

9 there was an incident on 5th November at the appointment

10 following the appointment on 15th November.

11 Q. So you did review the record?

12 A. Yes. And I had also confirmed that the case manager had

13 taken appropriate steps to manage that situation. She

14 had contacted the targeted youth support and family

15 support worker based in West Lancashire to discuss this

16 incident and the family were offered support by Carl,

17 their targeted youth worker, and the other lady, I think

18 it was Sharon, who was the family support worker from

19 West Lancashire.

20 May I also just add a point here to share that, in

21 AR's case, there was also challenges in multi-agency

22 working and information-sharing purely because of the

23 fact that there were two localities involved. So within

24 Sefton area, you know, having worked there as

25 a consultant for about 15 years, I do know people,

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1 I know the social workers, I know the family support
 2 workers because we work with them quite closely.
 3 Unfortunately, because AR's home address was based in
 4 Banks, the social care support and family support
 5 worker, et cetera, came from a different locality and
 6 that also posed challenges in terms of communication.
 7 **Q.** Did you do anything at the time to flag that as
 8 an issue --
 9 **A.** Yes --
 10 **Q.** -- or is that something that you reflected upon --
 11 **A.** I did.
 12 **Q.** -- in hindsight?
 13 **A.** No, I did. It is in an email to check with the
 14 administrative staff about checking whether he should
 15 fall within our locality or be referred to West
 16 Lancashire CAMHS, and I received a reply that because
 17 his GP was based in Sefton, we accept all patients who
 18 are open to a Sefton GP. So there was nothing we could
 19 do about it.
 20 **Q.** All right. I want to move on to some further incidents.
 21 So you explain at 33 of your statement that on
 22 21 November 2021, AR's father contacted the CAMHS crisis
 23 team?
 24 **A.** Yes.
 25 **Q.** To say that there had been two incidents of intimidating

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1 of Princess Diana, water poisonings and said that he
 2 believed that sometimes violence was necessary. Were
 3 you aware of that?
 4 **A.** No I was not aware of that.
 5 **Q.** Who, in terms of other agencies potentially would you
 6 have expected to make CAMHS aware of those matters, or
 7 would you have expected that to have come from the
 8 family?
 9 **A.** No. In complex situations and children presenting with
 10 complex difficulties such as AR, where multiple agencies
 11 are involved, which is actually a positive thing --
 12 school, police, and other agencies in the past --
 13 I would expect the person who dealt with the particular
 14 incident at the time to share information with all
 15 relevant agencies that need to know about it. And
 16 that's what did not happen. And I would include police
 17 in this as well.
 18 **Q.** I then want to turn to one final incident which was on
 19 17 March 2022, where AR went missing from his home
 20 address and he was later found on a bus in possession of
 21 a knife. And when the police dealt with him, he made
 22 remarks about wanting to stab people, and about either
 23 having thoughts about making poison or having made
 24 poison. Were you aware of that incident at the time of
 25 treating AR?

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1 behaviour by AR towards him and that included verbal
 2 threats and pouring milk over him. Were you made aware
 3 of those incidents at the time?
 4 **A.** I wasn't made aware of the incident at the time, but
 5 I was able to review that incident at my next
 6 appointment and understood that the collective view of
 7 crisis care team, following the discussion with father
 8 of AR, was that this is essentially a social issue and
 9 that it had been addressed. Sorry, and also to add
 10 actions had been taken, so the crisis care team advised
 11 that there should be a multi-agency meeting to discuss
 12 it because this behaviour was within a context of
 13 difficult family dynamics. So an early help meeting was
 14 held two weeks later which Samantha Steed attended and
 15 she was able to discuss appropriate support for the
 16 family. So I was aware it had been dealt with properly.
 17 **Q.** And the Inquiry has also heard about a further incident
 18 on 30 November 2021 where AR had kicked his father and
 19 thrown a plate at a rental car causing the windscreen to
 20 crack?
 21 **A.** I wasn't aware of this incident at all.
 22 **Q.** And on 21 January 2022, he had made comments in the
 23 school about the Holocaust. Were you aware of that?
 24 **A.** I wasn't aware of that at all.
 25 **Q.** And on 25th January 2022, he had talked about the death

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1 **A.** I was aware of this incident at the time of treating AR
 2 when he was in my care but not immediately after the
 3 incident. I was able to review these notes when I saw
 4 him after that incident, a few weeks later, and I had --
 5 so the information that you are sharing here about --
 6 further details about him sharing information that he
 7 wanted to stab someone was not shared with us. The only
 8 information that was shared and which was in the
 9 electronic patient records was that AR had gone missing
 10 in the morning, so father of AR contacted us via
 11 reception to share that he had left the house at 8 am
 12 and returned home at 10 am and between 8 am and 10 am AR
 13 had left the house and had gone missing. And this was
 14 not relayed to me but only to the case manager. So
 15 I was not copied into this communication from the
 16 administrative staff. It went to the case manager who
 17 duly contacted the family and enquired about the
 18 incident, only to be told that he had returned home.
 19 She offered an appointment the day after and
 20 assessed the risk and enquired with AR about the
 21 incident of him going missing. AR was not too keen to
 22 go into the details. However, she documented in the
 23 records that risk to others was low. Sorry. Risk --
 24 under the risk category the question, she had said no
 25 risk. She had also obtained safeguarding advice from

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1 Emma Walker-Riley, our safeguarding nurse, and made sure
2 that the family got the right support in terms of
3 reassurance.

4 **Q.** I will just pause you there because we have a separate
5 statement from Ms Steed. Could we bring up your witness
6 statement and look at page 9 please.

7 If we look at the top half of the page. So this is
8 what you say in your statement:

9 "I was not informed of AR's missing episode on
10 17/3/22. Based on the electronic patient records, this
11 information was shared with case manager Samantha Steed,
12 but not with me."

13 As a consultant psychiatrist, your role is primarily
14 around the prescription/review of medication and you
15 would expect the case manager to raise issues with you
16 directly if they felt your input was needed:

17 "If I had been made aware of this episode, I would
18 have discussed this with case manager Samantha Steed to
19 ensure that appropriate advice and support was offered
20 to parents."

21 Then you say:

22 "I was pleased to note while writing this statement
23 that case manager ... sought advice."

24 I think was that you were talking about just now?

25 **A.** Yes.

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1 bus, he had made remarks about wanting to stab people
2 and about potentially having made poison. Is it
3 a matter of grave concern to you that that information
4 did not get to you --

5 **A.** Absolutely, absolutely, absolutely.

6 **Q.** -- as the treating psychiatrist?

7 **A.** As a psychiatrist, working in a therapeutic service,
8 I could understand this incident in various different
9 ways, so if it was made clear that he was carrying a
10 knife on the bus with an intent to harm someone, that is
11 a red flag.

12 **Q.** Moving away from that incident, there were then some
13 issues -- skipping forward a bit -- March/April 22,
14 issues about AR taking his sertraline consistently?

15 **A.** That's right.

16 **Q.** I believe you advised AR's father on 26th April 22 that
17 he should stop taking it altogether if he had already
18 stopped taking it for a week?

19 **A.** That's right.

20 **Q.** Why is it important for sertraline to be taken as
21 prescribed, very shortly?

22 **A.** Sertraline is a medication which has a long half life.
23 So it just means that it takes a long time for children
24 to experience therapeutic benefit from it. Equally
25 discontinuing medication without medical advice can also

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1 **Q.** It is not clear from your statement that you were aware
2 of the bus incident from a review of the records at the
3 time you were treating AR. Would you agree?

4 **A.** I was aware of it when I reviewed the records for my
5 next appointment in April.

6 **Q.** So by April 22, you were aware of the fact that AR had
7 gone missing and was in possession of a knife?

8 **A.** Yes.

9 **Q.** I think in fairness to you that's the sort of sum of the
10 information about it on the CAMHS record?

11 **A.** Yes.

12 **Q.** Rather than the extra details.

13 **A.** So I only had that information, no more than that. So
14 I didn't know that he had shared to the police constable
15 that he wanted to hurt someone with a knife. So a young
16 person carrying a knife, especially who is on the
17 autistic spectrum and who is highly anxious and socially
18 anxious, can sometimes carry weapons for protection.
19 I'm not saying that is correct or legal. That is not
20 correct. However, if I had been aware of this incident,
21 on reflection I could have triggered a referral to
22 FCAMHS. So I think based on what we have discussed that
23 was a red flag.

24 **Q.** Yes. It wasn't recorded on the CAMHS record but the
25 Inquiry has heard evidence that when AR was found on the

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1 lead to what's called discontinuation symptoms which can
2 be quite dangerous. So, because AR was meddling with
3 medication quite a few times during my involvement,
4 I felt that it was safe to just stop the medication so
5 that he doesn't suddenly stop it again against medical
6 advice.

7 **Q.** I think there was then some ongoing issues about him
8 taking it consistently or not going into May 22?

9 **A.** That's right.

10 **Q.** Did you give any consideration at that stage to the fact
11 that his risk to others might have increased if he
12 wasn't engaging properly with the prescribed treatment?

13 **A.** To be very, very honest, having known him for a few
14 months until that point, there was a demand placed on AR
15 to start school, Presfield School, in April. I could
16 see a pattern of behaviour in AR as to whenever demands
17 were placed on him, he would meddle with medication and
18 then blame his inability to do the activity or go to
19 school, for example, on the medication.

20 **Q.** All right, I understand. I then just want to turn
21 briefly to the events that led you to be replaced as
22 AR's psychiatrist. Again helpfully that's set out in
23 quite a lot of detail in your statement which I won't go
24 through in full now. But, essentially, is it right that
25 you felt that AR's father, during and before a session

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1 on 23rd May 22, had been intimidating and disrespectful?

2 **A.** Yes. So, I'd like to start by saying that this is the

3 very first time in my entire career as a doctor where

4 I have had to request change of psychiatrist because of

5 how I was made to feel by a parent. It is quite

6 unprecedented, in my opinion, and I vividly remember the

7 level of distress I went through at the end of the

8 appointment. I also put an incident form to share this

9 because I felt that no one else from our department or

10 from our CAMHS service should experience that. So I had

11 to put an incident form both in the interest of my own

12 interest and also in the interest of my staff, and

13 followed the due process of requesting a change of

14 psychiatrist by contacting the clinical lead and copied

15 the email to psychiatry lead in Sefton, joined a meeting

16 with the clinical lead to try and mediate this

17 discussion and then went on to kind of have the outcome

18 that actually happened.

19 **Q.** Yes. It was agreed following that meeting, wasn't it,

20 that you would be replaced with a male psychiatrist?

21 **A.** That's right.

22 **Q.** To be clear, with the intimidating and threatening

23 behaviour, did that ever come from AR himself?

24 **A.** Never.

25 **Q.** Or was that just from AR's father?

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1 and that he was aware of one Prevent referral. Is that

2 because you didn't pass on any of that information?

3 **A.** I didn't go into great details about the incidents or

4 the previous behaviours, but it was touched upon. So he

5 was aware that there was some concerning behaviours that

6 necessitated police, Prevent and FCAMHS to be involved.

7 As I said, the focus of handover over was essentially on

8 the handover of treatment that I was providing for AR

9 and the concerns around his non-compliance.

10 **Q.** You say you didn't go into great detail about the

11 incidents, but did you actually tell him about the

12 hockey stick incident, for example?

13 **A.** I think I did. I'm not able to recall the entire

14 discussion, but I am sure I would have mentioned it.

15 **Q.** What about the incident with the possession of the knife

16 on the bus in March 22?

17 **A.** Again, you know, I can't remember if I specified

18 specific details about information -- you know

19 incidents. I am sure I handed over in a kind of

20 a holistic way, without going too much into the details

21 about each incident.

22 **Q.** Given what you said earlier that the focus of the

23 handover was about handover of treatment and concerns

24 about non-compliance, do you think you might be mistaken

25 about whether you informed him about, for example, the

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1 **A.** Never.

2 **Q.** Is it right that your involvement with AR ended on

3 23rd June 22 when you were replaced?

4 **A.** That's correct.

5 **Q.** We know of course now that Dr Molyneux was assigned to

6 replace AR. What handover took place between you and

7 Dr Molyneux?

8 **A.** Okay. So when I approached Dr Molyneux about handover

9 of clinical information about AR, I was told by

10 Dr Molyneux that he had already met with Samantha Steed,

11 who had given him a fair bit of information about the

12 patient.

13 I then gave him verbal kind of handover of salient

14 information that he needed to know and that information

15 predominantly included clinical information about

16 medication compliance, the difficulties I had faced on

17 23rd May with his father, and about the past history.

18 I have to say that I did not go into a lot of details

19 about the previous involvement with Prevent or FCAMHS

20 with Dr Molyneux.

21 **Q.** Yes. I think you were listening into Dr Molyneux's

22 evidence this morning, so you will have heard him say

23 that he was essentially unaware of all of the incidents

24 we have gone through today that pre-dated his

25 involvement, save for AR bringing a knife into school

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1 hockey stick incident and the bus incident?

2 **A.** I honestly can't remember.

3 **Q.** Did you have an expectation that, notwithstanding what

4 you told him in the handover, he would also be

5 separately reviewing the records himself?

6 **A.** I would think so.

7 May I add a point on the point of handover?

8 **Q.** Yes.

9 **A.** So, again on reflection, just like the point I made

10 about information that's handed over to a psychiatrist

11 when a new referral is made to them, I wonder if a

12 standardised format of handover of information is

13 developed within CAMHS, especially when you are

14 transferring care to another psychiatrist.

15 **Q.** Thank you. I now want to -- I said I would come back to

16 risk assessment earlier -- and I just want to come back

17 to it now and about how risk was assessed.

18 It is right, isn't it, that the risk assessments

19 conducted by case managers or any other clinicians

20 within CAMHS would be recorded on the electronic patient

21 system. Is that right?

22 **A.** Yes. So there are two ways in which risk is recorded.

23 At every contact with a patient, when they complete our

24 session notes, so basically it is an electronic way of

25 documenting what was discussed in a session. There is

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1 a question which is a mandatory question about risk. We
 2 have to complete that as to whether it is yes or no.
 3 When we say that there is risk, say for example "yes" is
 4 the answer, there is a box just below that, which is
 5 a box for a qualitative comment on what is the risk that
 6 you are worried about? So it could be risk to self,
 7 risk to others, et cetera, risk of self-neglect, risk of
 8 vulnerability, risk due to substance misuse, et cetera.

9 So, at every contact this is documented and that is
 10 again based on the discussions in the session. Without
 11 that, we are not able to sign a session note and
 12 a session note will not be saved.

13 Q. That's the risk assessment by you as the treating
 14 clinician?

15 A. Anyone. Anyone.

16 Q. But is it also right that risk assessments are done more
 17 formally?

18 A. That's right.

19 Q. And we have seen evidence that that should have been
 20 done every three months by the case manager. Is that
 21 your understanding as well?

22 A. That's correct. So care plan is reviewed every three
 23 months, or when a situation changes. So when there is
 24 a change in situation it is reviewed again.

25 Q. The Alder Hey internal learning review found that AR was
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1 child's risk?

2 A. To be very honest, given how busy we are in CAMHS,
 3 I wouldn't have had the time to review what's been
 4 completed and what's not been completed.

5 Q. Knowing now that there was no risk assessment done in
 6 that entire period, is that a matter of concern for you?

7 A. It is a matter of concern and should be flagged up.

8 Q. Because as an outsider looking in one, might think it is
 9 a sign that assessment of risk or concern about risk
 10 posed by AR to others had essentially just fallen by
 11 the wayside. Is that fair?

12 A. Yes, it is fair to say that.

13 Q. You go on to explain at 24 of your statement that where
 14 there are concerns about radicalisation or risk to
 15 others, CAMHS will request support from specialist
 16 services, such as an enhanced support team or Forensic
 17 CAMHS who may use formal risk assessment tools such as a
 18 SAVRY.

19 We are going to hear evidence separately about a
 20 SAVRY in more detail. But is that something that CAMHS
 21 would carry out or would you expect someone else to do
 22 it?

23 A. No. For example, these are actuarial risk assessments
 24 and these are highly specialist and standardised risk
 25 assessments that needs training and regular supervision
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1 risk-assessed on triage on 11th October 2019 and
 2 15 October 2019. Sir, for your note that is
 3 AHCH000294 page 90, paragraph 352.

4 Then the risk management tool was only completed on
 5 three occasions thereafter. 8th January 2020, that was
 6 the assessment by Mr Morgan that I touched on earlier,
 7 and then it was completed on two further occasions: the
 8 22 February 24 and 23rd July 24. And that's
 9 paragraph 355 on page 90.

10 So, during the entire period of your involvement
 11 with AR, there was no risk assessment conducted by
 12 a case manager, was there?

13 A. That is true.

14 Q. And given you were reviewing the records, you say when
 15 you were seeing him, is that not something that you
 16 think you should have noticed as an omission?

17 A. So, within CAMHS, as a consultant child psychiatrist,
 18 I have supervision responsibilities for resident doctors
 19 whom I supervise and case managers have their own
 20 allocated supervisors who are nonmedical staff. So
 21 I would think that that review of clinical notes and
 22 inadequacy of risk assessment would be flagged by their
 23 supervisor.

24 Q. But would you, as the consultant psychiatrist, not think
 25 to say to anyone: look, no one has looked at this
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1 in terms of how these assessments are conducted and
 2 interpreted. So it is not something that community
 3 CAMHS/specialist CAMHS services like Sefton CAMHS is
 4 equipped or trained to conduct.

5 For example, I have heard about it in my training.
 6 I know that this exists, but I don't know anything about
 7 it. Not much more than that. More recently we have
 8 established what's called enhanced support team to work
 9 with highly vulnerable and risky young people and I'm
 10 now aware that we can ask for their support because
 11 staff who work in our Sefton EST service are trained to
 12 offer SAVRY. So that's certainly something that we now
 13 have.

14 Q. At the relevant time when you were treating AR, who
 15 would you have expected to have had responsibility for
 16 completing a SAVRY?

17 A. I would look up to FCAMHS to support us with that.

18 Q. But only if someone at CAMHS or someone elsewhere had
 19 referred to FCAMHS?

20 A. Yes.

21 Q. Is FCAMHS also who you would expect to be the lead
 22 agency essentially for assessing and managing AR's risk,
 23 or would that be someone else?

24 A. This is a very wide question to be honest. So AR
 25 presented with so many different types of risk: risk due
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1 to non-school attendance, risk from isolation and risk
2 of challenging behaviours and disruptive behaviours
3 causing harm to others. So there were so many different
4 types of risks.

5 There are so many agencies involved in his care,
6 which is positive if you look at it. However, it posed
7 immense challenge in terms of interagency communication
8 and interagency working and there was lack of clarity on
9 who offers leadership for assessment in these cases. So
10 it is a really difficult question for me to answer, but
11 I hope we find some form of clarity at the end of the
12 Inquiry about this.

13 **Q.** Based on that answer, is it fair to say that you did not
14 know who the lead agency was?

15 **A.** No. No. Basically the problem is every agency was
16 working in silos. We were doing what we were meant to
17 do and other agencies did their work. We didn't
18 communicate with each other and that contributed to poor
19 outcome.

20 **Q.** Sir, I'm conscious of time. I have only got about five
21 minutes left. I'm in your hands if we can carry on.

22 Thank you. We have talked about risk assessment and
23 the fact that the risk assessments weren't done during
24 your period of involvement by the case manager. You
25 will have seen Dr Irani's report, and we are going to go

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1 within CAMHS including myself as his consultant
2 psychiatrist ... I believe that I have demonstrated
3 good practice by being responsive to calls and requests
4 made by AR and his family. The care provided by Sefton
5 ... CAMHS and by me could be described as enhanced level
6 of care which took several interventions, resources and
7 time from CAMHS. With the benefit of hindsight and
8 wider understanding of the events, it appears that AR
9 and his father were not open and honest with me during
10 their interactions and appointments. I would also say
11 that AR meddled with prescribed medication on multiple
12 occasions to either obtain medication of his choice or
13 to use stopping medication (against medical advice) as
14 his reason to avoid school."

15 So there you don't set out any reflections on things
16 that you or anyone else at CAMHS could have done better
17 or differently. You have obviously now had the benefit
18 of looking at the Alder Hey internal review and also the
19 report of Dr Irani, which I have not taken you through
20 in detail, but you will be aware of its contents. Has
21 the view that you have set out here at 73 changed at
22 all?

23 **A.** Certainly. 100 per cent. So, now that I have knowledge
24 of all the incidents and multiple agencies' involvement
25 in AR's care, I do think that there was at least one

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1 to it in more detail with the next witness, but her
2 ultimate conclusion was that the risk assessment by
3 CAMHS wasn't adequate and the absence of the risk
4 assessment meant that there was no intervention carried
5 out to review AR's risks to others.

6 Is that a fair assessment of it, looking back with
7 what you know now?

8 **A.** So, I agree with that. If Dr Irani means that adequate
9 interventions were not carried out because of the fact
10 that risk assessments are inadequate, I think she is
11 talking about safeguarding social care involvement and
12 timely involvement of FCAMHS. And I do agree with that,
13 you know, especially after the incident in March 2022.

14 **Q.** You have covered in your statement quite a lot of detail
15 improvements that have been made, which I won't go
16 through now, but your statement is in evidence and, sir,
17 for your note it is paragraph 75-78.

18 **SIR ADRIAN FULFORD:** Thank you very much.

19 **MS WAKEMAN:** I finally then just want to draw the threads
20 together and turn to your reflections on your
21 involvement and any lessons learnt.

22 At paragraph 73 of your statement, this is on the
23 bottom of page 16. Thank you. You say there:

24 "On reflection, AR and his family had
25 an extraordinary amount of access to clinical staff

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1 missed opportunity for us to have considered
2 a re-referral to FCAMHS and that could have changed some
3 of the interventions that may have been considered for
4 him.

5 I also feel that on 23rd May, when I reported
6 intimidating behaviours from AR's father towards me and
7 the case manager, I could have or should have considered
8 obtaining safeguarding advice from Alder Hey
9 safeguarding team. And the reason I say this is because
10 if AR's father could behave in that way towards senior
11 clinical staff, I wonder if there were some concerns for
12 AR, and that should have been flagged up. But I'm
13 confident about this particular thing because I had
14 safely handed over his care to the future team and that
15 AR was not left without any support from CAMHS.

16 **Q.** Your witness statement was produced at the end of July
17 of this year. One might think that it is quite
18 surprising that, as the treating consultant
19 psychiatrist, when you wrote that statement you didn't
20 feel really that there was anything you could have done
21 differently. Do you think that you failed to reflect on
22 what had happened here?

23 **A.** With the available information at this time, this was my
24 opinion, especially given that in the period of
25 11 months when AR was open to me, I had offered him nine

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1 appointments and multiple phone calls, responsive,
2 timely phone calls. So this would be considered as
3 quite unusual for a young person who presents with
4 anxiety and avoidance and school refusal.

5 So on that basis I wrote this because a standard
6 number of appointments that would have been offered for
7 another young person with anxiety and school refusal
8 would be about four. Four appointments or five
9 appointments. So he had multiple interventions and
10 those interventions that were offered, including key
11 worker, consultant psychiatrist, CBT parenting and
12 family therapy, they are the evidence-based treatments
13 that one would offer for conduct disorder.

14 So all this makes me think that that reflection is
15 correct with the knowledge at the time.

16 **MS WAKEMAN:** Sir, I don't have any further questions, I will
17 just turn to see if any Core Participants do. No, thank
18 you. Do you have any questions?

19 **Questioned by THE CHAIR**

20 **SIR ADRIAN FULFORD:** I do. Just one thing, Doctor, and
21 I ask this conscious of the problems that go with gazing
22 into crystal balls, but I want to put a question to you
23 based on three propositions really.

24 **THE WITNESS:** Sure.

25 **SIR ADRIAN FULFORD:** The first is you will remember that
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1 we offer are offered by other agencies and also my
2 threshold to involve FCAMHS and Prevent would have been
3 very, very low.

4 **SIR ADRIAN FULFORD:** I'm going to put it slightly
5 differently. If you are saying that it would have been
6 inappropriate for Alder Hey to have acted on all of that
7 information, would you have expected anyone, given the
8 field in which you operate, to have reacted to that
9 level of knowledge and the danger that he apparently
10 posed?

11 **THE WITNESS:** When we have high risk presentations in
12 children and young people, the first person to raise
13 those concerns and push for further interventions for
14 keeping the young person or others safe have always been
15 parents. So, when it comes to admitting young people,
16 or when it comes to difficulties in coping with
17 a certain behaviour of a young person, be it
18 self-harming or be it harm to others, parents are the
19 most important people who raise those concerns with the
20 team and say: look, help, help, you know, I think this
21 is dangerous.

22 **SIR ADRIAN FULFORD:** Nothing else? No one else? So you
23 would have referred this back to AR's -- or you would
24 have foreseen that this would have been referred back to
25 AR's parents and no other steps would have been taken?
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1 Ms Wakeman has set out the full list of things that were
2 known that had happened in the past, ten times with
3 a knife, hockey stick, Manchester and all the rest. So
4 imagine that that was all known by whoever had
5 responsibility for AR at Alder Hey. That's number one.

6 Number two, there had been the diagnosis of conduct
7 disorder. All right? So that's the second thing that
8 I want to put in place.

9 And the third is that around July of 2024, with that
10 history and that diagnosis you had also been told that
11 AR had been buying weapons, lethal weapons, and that his
12 actions, certainly by mid-July, tended to indicate
13 an intention to act out a desire at the very least to
14 seriously harm others.

15 Now, if all of that information had been in the
16 possession of Alder Hey, what, if anything, would have
17 been done about it by the psychiatrists at Alder Hey?

18 **THE WITNESS:** So, first of all, I would actually review
19 whether Alder Hey CAMHS is the correct service for AR
20 given this information. Because community CAMHS are not
21 equipped to support children and young people presenting
22 with a conduct disorder. It needs to be led by social
23 care and the threshold for discharging a child with
24 conduct disorder would be very, very low because it is
25 a disorder of social construct, the interventions that
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1 **THE WITNESS:** No, I'm not saying that. I would expect them
2 to be honest about their concerns with the psychiatrist
3 so that the psychiatrist can take appropriate action
4 which may include requests for an actuarial risk
5 assessment, which may include requesting records from
6 other agencies, which may include referral to FCAMHS and
7 involving Prevent again. So those would have been the
8 actions that would have been taken.

9 **SIR ADRIAN FULFORD:** Thank you very much for your evidence,
10 Doctor. Ten minutes.

11 (3.36 pm)

(A short break)

13 (3.46 pm)

DR OONAGH VICTORIA KILLEN (sworn)

15 **SIR ADRIAN FULFORD:** Thank you very much. Please have
16 a seat. Yes, Mr Moss.

17 **Questioned by MR MOSS**

18 **MR MOSS:** Thank you, sir.

19 Dr Killen, just start by giving us your full name,
20 if you would?

21 **A.** Yes, I'm Dr Oonagh Victoria Killen.

22 **Q.** If we could have your statement on the screen please, it
23 is AHCH000229. It is a statement you gave helpfully
24 earlier on 25 July 2025 and could you just confirm that
25 the contents of that statement are true to the best of
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1 your knowledge and belief?
 2 **A.** I confirm that they're true.
 3 **Q.** To the extent, Dr Killen, that I don't go through all
 4 aspects of your statement, it will be published and it
 5 stands as your evidence, I want to ask you about some
 6 aspects.
 7 **A.** Thank you.
 8 **Q.** On the first page, just by way of background, you are,
 9 I think, a senior and experienced clinical psychologist.
 10 Is that right?
 11 **A.** That is correct.
 12 **Q.** You took your doctorate in clinical psychology here in
 13 Liverpool in 2002. You have additional postgraduate
 14 certification in service leadership in 2017?
 15 **A.** Yes, that is correct.
 16 **Q.** As well as being a treating clinical psychologist, you
 17 have been, since 2016, is this right, the clinical lead
 18 of the Sefton part of the Child and Adolescent Mental
 19 Health Service?
 20 **A.** That's correct.
 21 **Q.** And I think prior to that, you had experience as the
 22 deputy lead for the same service?
 23 **A.** That is correct.
 24 **Q.** Thank you. And if my maths is correct, I think you
 25 worked at Alder Hey altogether for some 23 or so years?

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1 **Q.** Thank you. Your role as clinical lead, you describe it
 2 in paragraph 10, is this right, is overseeing the
 3 delivery of the service and providing assurance with
 4 regards to the safety and performance of it to Sefton
 5 CAMHS?
 6 **A.** That is correct.
 7 **Q.** And I think separate to that, you haven't become
 8 entirely, my words not yours, part of management because
 9 I think you still gave some input at the time as
 10 a clinical psychologist to individual patients?
 11 **A.** Yes.
 12 **Q.** Thank you. Both of the consultant psychiatrists from
 13 whom we have heard today already have been asked and
 14 pressed by us as counsel to the Inquiry about
 15 information checking and information sharing when they
 16 became involved.
 17 Can I just ask you about that. As the clinical
 18 lead, what was your expectation in terms of
 19 practitioners who are starting engagement with a patient
 20 reading back through the previous notes?
 21 **A.** So there is no formalised handover process, but we would
 22 expect that the reason for referral, presenting
 23 difficulties, care and risk screens would form part of
 24 that review of the record. The SOP does outline
 25 reviewing the full record, although we recognise that is

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1 **A.** That is also correct, yes.
 2 **Q.** Thank you. We have heard about CAMHS and its role to
 3 a large extent from previous witnesses. But could we
 4 just touch upon the multidisciplinary team aspect. You
 5 deal in your statement with the fact that each
 6 multidisciplinary team had an assistant clinical lead.
 7 Is that right?
 8 **A.** That's correct, yes.
 9 **Q.** And a consultant psychiatrist?
 10 **A.** That's correct.
 11 **Q.** And we have heard from the two psychiatrists for AR.
 12 There would be meetings, I think weekly, lasting two to
 13 three hours for each MDT?
 14 **A.** That's correct.
 15 **Q.** What would be the trigger for a child who is on the
 16 caseload of that MDT gaining discussion at a particular
 17 meeting?
 18 **A.** So, there is a number of different triggers that would
 19 result in a multidisciplinary team discussion. These
 20 include changes in risk profile. They include a young
 21 person being fairly new to the treating team. They
 22 include concerns around -- can include concerns around
 23 safeguarding and they can also include concerns that
 24 a young person is not making the progress that we want
 25 him to make, sometimes known as a stuck progress.

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1 an onerous task, it would be important to pull out those
 2 key documents and also the letters that have been
 3 written about a young person.
 4 **Q.** As the risk for speed almost appearing facetious, SOP,
 5 standard operating procedure, it is not a standard
 6 operating procedure if nobody follows it.
 7 **A.** So I think there is a lack of standardised handover and
 8 this is something in terms of our review of our care,
 9 the record-keeping and the documentation of risk and
 10 care plans was not at the standard that we would hope
 11 for. So we are recognising already in our learning that
 12 the documents around risk and care plan could be much
 13 more visible than they were at the time of the
 14 intervention.
 15 **Q.** But at the time would you agree that it was a weakness
 16 on the evidence we have heard that whereas the SOP
 17 required the full records to be read, it sounds as
 18 though in practice busy clinical practitioners didn't
 19 have time to do that?
 20 **A.** No, and I think on reflection the word "whole" can be
 21 a little bit confusing in the standard operating
 22 procedure as well. So the electronic patient record can
 23 be read sort of across as well as down in terms of
 24 the review. Given in the SOP, the standard operating
 25 procedure, it advises reading the whole EPR between

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1 appointments. I read that as being across the
 2 electronic patient record, although we would hold as
 3 a standard the reviewing of the patient journey prior to
 4 treatment.

5 **Q.** Whichever of those it is, would you agree that in terms
 6 of the practice that was going on at the time in 2019
 7 through to 2022, so from when Dr Molyneux takes over,
 8 that those important clinicians were not getting
 9 an adequate picture of AR's history?

10 **A.** I agree that the electronic patient record was not
 11 facilitating practitioners picking up pertinent
 12 information. It has been much improved now.

13 **Q.** I want to concentrate for the moment on how it was at
 14 the time. I will ask the question again.

15 Would you agree that those important clinicians were
 16 not getting an adequate picture of AR's history?

17 **A.** Yes.

18 **Q.** Thank you. What would be your expectations in terms of
 19 the case manager discussions with the psychiatrist in
 20 terms of filling in on details and areas of concern?

21 **A.** We would expect that a verbal handover, including again
 22 reason for referral, presenting difficulties and a brief
 23 chronology would be shared. I think it is
 24 an improvement that we have identified that this should
 25 be written down, included in the electronic patient

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1 that interacted with AR? What was your impression of
 2 that from the involvement that you did have?

3 **A.** I can confirm that there were two incident forms put
 4 into the electronic patient record after an appointment
 5 in May. Both practitioners felt that AR's father had
 6 been intimidating, aggressive and both the consultant
 7 and the practitioner felt unable to continue to work
 8 with AR.

9 During the complaint resolution meeting, I listened
 10 to the complaint that had also been raised on behalf of
 11 the family and we were able to get to a point that
 12 a plan for continued care could be followed. I didn't
 13 find the parents unduly aggressive or intimidating
 14 during that complaint meeting, but I have no reason to
 15 doubt the account of my colleagues who both felt
 16 separately that they were concerned about the father's
 17 attitude.

18 **Q.** Thank you. So, as a result of that, as we have heard,
 19 we had the change from Dr Ram to Dr Molyneux?

20 **A.** That is correct.

21 **Q.** Sam Steed I think to Kate Morris?

22 **A.** That is correct.

23 **Q.** And within that, looking at some of the positives, would
 24 it be fair to say that you had been able to retain one
 25 of the things that had been thought to be desirable by

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1 record so it is clear that the hand over, what was
 2 included in the handover.

3 **Q.** Thank you. Turning to your personal involvement with
 4 AR, I think you have explained in your statement
 5 paragraph 12, page 3, it can be brought up, but I think
 6 you will agree that you first became aware of AR, is
 7 this right, on 16th December 2019?

8 **A.** Yes.

9 **Q.** And your last direct contact with his family was on
 10 22 June 2022. Is that right?

11 **A.** Yes.

12 **Q.** That was when you completed a complaint resolution which
 13 we will come onto briefly, yes?

14 **A.** Yes.

15 **Q.** I don't think you had any direct contact with AR
 16 himself. Is that right?

17 **A.** No, that is correct.

18 **Q.** And should we understand, therefore, that all of your
 19 involvement personally in AR's case was with your
 20 clinical lead hat on rather than with your clinical
 21 psychologist hat on?

22 **A.** Yes, that is correct.

23 **Q.** I'm asked to explore with you, could you just give
 24 a brief overview of your understanding of the family
 25 dynamics and perhaps AR's father's behaviour and how

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1 AR and AR's family, which was to have a female case
 2 manager?

3 **A.** Yes, that is correct.

4 **Q.** Looking at that aspect, are you still of the view that
 5 those concerns, those incident reports, and the way that
 6 it was handled, was done reasonably well because there
 7 was continuity of care, at least to the extent there
 8 wasn't a break in care, you got alternatives in place?

9 **A.** Yes.

10 **Q.** Thank you. Looking at the referral into CAMHS, you
 11 explain in paragraph 15 of your statement that the early
 12 referrals, when AR was not taken on by CAMHS, you think
 13 were appropriate. Can you just briefly explain why you
 14 were of that view still?

15 **A.** So the initial referral was around being nervous and
 16 anxious. The description was of mild to moderate levels
 17 of anxiety and it was appropriately signposted to
 18 a partner agency that offers treatment for anxiety.

19 The next referral was triaged by our crisis care
 20 team and the concerns related to behaviours of concern
 21 really and the advice from that referral was that they
 22 would be better met with looking at targeted youth
 23 services, so services focusing on diversion and support,
 24 early intervention around youth justice --

25 **Q.** Thank you. By the time of the third referral though,

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1 which is that made on 13 December by Stephanie Hallaron,
 2 things at that stage were clearly more serious, yes?
 3 **A.** Yes.
 4 **Q.** Sir, for your note, AHCH000121. You will be able to
 5 confirm from the papers without it being brought up,
 6 that Ms Hallaron's referral referred to the knife
 7 possession, the hockey stick incident and concerns about
 8 radicalisation, yes?
 9 **A.** Yes.
 10 **Q.** In fact, in her assessment, the risk to others was
 11 assessed as being greater and of more concern than AR's
 12 risk to himself, at that stage. Would you agree?
 13 **A.** Yes.
 14 **Q.** You detail in paragraph 17 and onwards, we don't perhaps
 15 need the full detail, but how that was played out in
 16 terms of CAMHS, so some follow-up phone calls that were
 17 received. I think the upshot of that was Mr Skott
 18 Morgan attending the meeting on the 19th and indeed
 19 a follow-up meeting on 20th December. Is that correct?
 20 **A.** That is correct.
 21 **Q.** If we look at one aspect arising out of that,
 22 Skott Morgan got AR's mother to fill out a child
 23 behavioural questionnaire. Can we have AHCH000090,
 24 please.
 25 **A.** Sorry to ask, was that requested by Skott Morgan or by

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1 **A.** No, and it wouldn't have come to us, the report. We
 2 would have been able to see it if we go looking for that
 3 but it wouldn't have come to us for review.
 4 **Q.** The reason why I wanted to pick this up was that score
 5 in relation to matters including aggressive behaviour,
 6 seems on the face of it to be very high and within the
 7 clinical range. Was that an early warning about the
 8 extent of aggressive behaviour, do you think?
 9 **A.** I think there was some significant concerns in the
 10 referral about aggressive behaviour. This particular
 11 checklist I think highlights the borderline clinical
 12 range and then recommends reviewing other critical items
 13 to further review conduct disorder or conduct problems.
 14 I think if you review the critical items at that
 15 point only one was marked positively. So there was
 16 mixed messages through this checklist in terms of
 17 behaviour. But I don't doubt that there was concerns
 18 around his behaviour because he had come into referral
 19 with significant concerns.
 20 **Q.** Thank you. And taking it from the early position in
 21 relation to this, you have heard questions that have
 22 been asked of other witnesses today. You have seen
 23 Dr Irani's report concluding that AR in her view met the
 24 diagnostic criteria for conduct disorder. First of all,
 25 are you aware that that's what Dr Irani says?

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1 the community paediatric team?
 2 **Q.** I think it was Mr Morgan who asked AR's mother to fill
 3 out the questionnaire. I will be corrected on that if
 4 my notes on it are wrong.
 5 If we just look at page 3 of this.
 6 **A.** I really think that was the community paediatric team.
 7 **Q.** I'm so sorry. Just bear with me for one moment.
 8 Page 17. If we look in the middle two paragraphs
 9 please, so the ones on the CBCL6-18, in the middle of
 10 the page. Do we see in relation to that, that looking
 11 at the top paragraph as it is now on the screen, and
 12 I appreciate that this is covering quite a wide area,
 13 from one of the scores for anxious/depressed,
 14 withdrawn/depressed, somatic complaints, but also
 15 aggressive behaviour syndromes, those were in the
 16 clinical range above the 97th percentile. Do you see
 17 that there?
 18 **A.** I do. But just to be clear, this report was part of the
 19 diagnostic pathway for community paediatrics and it
 20 wasn't part of the CAMHS pathway.
 21 **Q.** Would this have been seen by CAMHS?
 22 **A.** It is available on the record, but it wouldn't be under
 23 the CAMHS record. So it is available on the record but
 24 it wouldn't be part of our pathway.
 25 **Q.** Not, you think, applied by you?

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1 **A.** Yes.
 2 **Q.** And do you think in your position as clinical lead you
 3 would agree with that?
 4 **A.** I think on reflection, and gathering all the
 5 information, I think I heard my consultant colleagues
 6 confirm that that would be a possible diagnosis.
 7 I think the challenge for a community mental health
 8 service is that we work on a formulation-based approach
 9 and there was an existing kind of understanding that
 10 fitted the facts and it fitted the information that we
 11 had. So AR's predominant difficulties throughout his
 12 journey with CAMHS related to his anxiety, his
 13 difficulties engaging in education, his difficulties
 14 going out and that understanding remains relevant.
 15 **Q.** But some risk that conduct disorder may have been
 16 overlooked in that mix?
 17 **A.** On review of the behavioural pattern over a period of
 18 time, it is a pervasive and persistent pattern of
 19 behaviour. I think there are lots of challenges around
 20 the diagnosis, but yes, I would agree with my consultant
 21 colleagues that the consideration of conduct
 22 difficulties could have been revisited.
 23 **Q.** In fairness, it should be noted that many of the
 24 treatment options perhaps would have been the same?
 25 **A.** Yes, that is correct.

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1 Q. Skott Morgan explains in his statement that he completed
2 a risk assessment management tool. Can we have a look
3 at that please, it is AHCH000162, page 14 please. It is
4 the bottom half of the page:

5 "Please mention if any sibling and persons at risk.

6 Yes, brother Dion but only if he hurts," it says

7 "an animal. The family have no pets. What's the nature
8 and degree of the risk? Who is at risk?"

9 And so on.

10 We see at the bottom of the page that what has been
11 filled out there is:

12 "Lack of emotional regulation, has ASC."

13 If we go over the page:

14 "AR attended school to hurt another pupil but got
15 a different one instead. He states this was a planned
16 revenge attack from being bullied. Reports from school
17 about terrorism. AR denies all of this. Prevent have
18 also stated that they have not found anything
19 malicious/radicalised with AR. Unintentional risk to
20 others ... none.

21 Risk management plan:

22 "Currently under child in need until police have
23 checked in with his computer, et cetera. One this is
24 received we will be able to establish a better plan
25 going forward. AR is to remain at home, without school.

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1 Q. Doing it too quickly?

2 A. I think so.

3 Q. Keep your voice up.

4 A. Yes, I think so.

5 Q. The two letters from FCAMHS which you have referred to
6 in your statement, can we just look at them quickly
7 please. AHCH000231. The first one.

8 Just go on to page 2, please. We can see that this
9 is dated 11th February and it is to Ms Hallaron from
10 Mr John Hicklin of FCAMHS following the referral and
11 following meeting that had taken place on 21 January.

12 There is quite a lot of detail in here but you will
13 be familiar, I think, with the fact that Mr Hicklin was
14 saying that he discussed the case with Skott Morgan,
15 made Mr Morgan aware of the concerns of professionals.

16 We see in the second paragraph that he records that
17 AR had been open to Prevent, had been accessing mass
18 shooting videos, now closed to Prevent. The hockey
19 stick attack is dealt with. AR demonstrating little
20 insight into the consequences.

21 The third paragraph records that AR's presentation
22 likely met the criteria for autism.

23 And he recorded that:

24 "Given the level of concern that was felt by
25 professionals, liaison with the paediatric team needs to

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1 To see myself for some emotional regulation work."

2 Is that the standard of risk assessment in terms of
3 the quality and level of detail that you would expect
4 for a case of this seriousness?

5 A. No. I think we recognise that the risk management tool
6 was neither filled out comprehensively enough or
7 regularly enough in the record on review and I would
8 agree that the detail, and especially the updated detail
9 following the consultation from FCAMHS, wasn't included
10 and that would have been beneficial.

11 Q. Why was it poor in that way?

12 A. I think it is the level of detail. The concern on his
13 entry, I do not think is fully reflected in this
14 document.

15 Q. And why weren't staff giving enough detail? Is that
16 a training issue? A resource issue? Poor performance?

17 A. I think there is certainly -- we are doing quite a lot
18 of work around -- and have been for a number of years
19 around documentation and the time it takes for case
20 management forms to be completed. We have reduced the
21 number from four to two and there is a way of monitoring
22 that. So I think it is -- I would say, Mr Morgan was
23 a well qualified social worker. I do not think that was
24 a training issue. I think it was -- the lack of detail
25 is due to time taken to complete the form.

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1 take place to ensure that they are aware of the concerns
2 and that the paediatric team contribute to the risk
3 management plan."

4 From your knowledge of the record, did Mr Morgan
5 adequately record all of the detail in relation to those
6 matters into the CAMHS records?

7 A. No.

8 Q. Again, was that a question of poor individual
9 performance? Not taking enough care?

10 A. I think Mr Morgan left the service quite quickly and it
11 was only after that he had left that we were made aware
12 of the record-keeping. So I can't provide a lot of
13 detail about the reasons for that. But yeah, I would
14 expect the record-keeping standards at this time were
15 below the standard we would expect from our service.

16 Q. Thank you. If we go to the fourth paragraph at the
17 bottom of the page:

18 "I highlighted that the most important factor in
19 managing the risk will be identification and integration
20 into an appropriate educational provision."

21 A comment on the educational service. And then over
22 the page:

23 "The need to complete their own risk assessment ...
24 this will need to be completed in line with the process
25 of gaining an EHCP."

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1 We will come back to the EHCP perhaps in a little
 2 moment.
 3 There is also reference in this letter to the
 4 importance of the paediatric team getting the ASD
 5 diagnosis. From your understanding, at this stage who
 6 was the lead agency that was meant to be taking these
 7 things forward? You have got different teams -- FCAMHS,
 8 CAMHS, you have got the paediatric department working on
 9 the ASD diagnosis -- who was meant to be taking it
 10 forward?
 11 **A.** I think in respect to the paediatric pathways, it is
 12 documented that Mr Morgan had said that he would
 13 progress that, although there's no evidence in the notes
 14 that that happened. So I would -- it would be
 15 appropriate for us as a CAMHS service to forward the ASD
 16 diagnosis. I think the caveat with that is where the
 17 assessment of the forensic assessment is kind of paused
 18 or not completed due to a lack of an ASD assessment and
 19 I think -- so I think in this --
 20 **Q.** We will pick some of that up with FCAMHS, but from the
 21 point of view of CAMHS, you would have expected, would
 22 you not, to see CAMHS in a documented way, my word,
 23 trying to expedite the autism diagnosis because of its
 24 importance to assessing the risk and to treating AR?
 25 **A.** Yes, and that happens now. That is an improvement that
 173

1 interventions, mainly last paragraph:
 2 "I also highlighted that AR would likely
 3 benefit ..."
 4 There is a raft of things there that are being
 5 suggested that should be done. So:
 6 "Benefit from interventions; focusing on an ability
 7 to think consequentially; improving his capacity for
 8 an empathetic response; developing a range of
 9 alternative strategies to anger and developing
 10 strategies to manage stressors in his life. These
 11 interventions should focus on emotional recognition and
 12 regulation."
 13 Then it says:
 14 "Skott Morgan will liaise with colleagues in CAMHS
 15 and make comment at the forthcoming meeting as to how
 16 this need may be met."
 17 Did that happen so far as you can tell from what was
 18 documented?
 19 **A.** No, I can't see that in the record.
 20 **Q.** Those at that stage were interventions that, rightly or
 21 wrongly, appear to have been given to CAMHS, would you
 22 agree, if not to provide, then at least to organise and
 23 take forward?
 24 **A.** I think there is an invitation to multiple systems
 25 providing these interventions and I think that the
 175

1 has happened already with the service.
 2 **Q.** Again, I have to ask you these matters as the service
 3 lead. Are you aware that Mr Morgan's evidence even to
 4 this Inquiry is that he only met with AR once?
 5 **A.** Yes.
 6 **Q.** But that it is documented contemporaneously. Sir, for
 7 your note he wrote to Ms Jameson on 14 February
 8 AHCH000095 saying:
 9 "I have met with AR on several occasions."
 10 Yes?
 11 **A.** Yes.
 12 **Q.** And there was only one documented?
 13 **A.** Yes.
 14 **Q.** Again, that failure to make clinical records of meetings
 15 with AR, at this time, fell significantly below the
 16 required standard?
 17 **A.** It did fall below the required standard and we have done
 18 a lot of work to provide assurance that this would not
 19 happen now. The way appointments are booked and the way
 20 session notes are recorded, it is impossible to have
 21 that disconnect.
 22 **Q.** Thank you.
 23 **A.** Highly unlikely.
 24 **Q.** In the letter that we still have on screen, if we can go
 25 to the last paragraph, there is a whole raft of
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1 opportunities for learning around multi-agency
 2 conversations about who does what is a learning point.
 3 **Q.** Yes. So it should be clear who is going to do what?
 4 **A.** Yes.
 5 **Q.** Who is going to actually provide the interventions but
 6 also clear who is going to organise them and check that
 7 they have been done?
 8 **A.** Yes.
 9 **Q.** And it doesn't look from the records as though either of
 10 that happened; not clear that the interventions happened
 11 and not clear that anybody was keeping an eye on them.
 12 Would you agree?
 13 **A.** At this point in the record, I would agree there is no
 14 evidence of that. There is a subsequent conversation
 15 that I had with the Youth Offending Team.
 16 **Q.** Yes, there is some information which we might touch on
 17 with the YOT later into some of the aspects. Thank you.
 18 In your paragraph 35 at page 8 of your statement,
 19 you say that:
 20 "Interventions linked to reducing risk of offending
 21 would be primarily the role of the YOT, the Youth
 22 Offending Team ... however, as a safeguarding partner we
 23 would heed advice as to the likely effective
 24 interventions that we could offer and we did indeed
 25 focus on anxiety and social anxiety and emotional
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1 regulation."

2 **A.** Yes.

3 **Q.** That aspect of your statement might be taken to suggest

4 that some of these interventions weren't at least

5 ideally for CAMHS to take forward. Would you agree?

6 **A.** Yes.

7 **Q.** Others were better placed?

8 **A.** Yes.

9 **Q.** Have you seen anything in the documents that suggest

10 that Mr Morgan or others in this service at this time

11 said: this has been put at our door, but actually we are

12 not best placed to do this, can you take them forward?

13 **A.** I can't see reference to multi-agency meetings or

14 conversations that provides an adequate multi-agency

15 care plan at this point, no.

16 **Q.** Thank you. Then the second letter, AHCH000231 please,

17 if we could just go to page 4. 9 March. We have seen

18 this before. I'm not going to read it all out because

19 the learned Chair has seen it and you will have heard it

20 referred to. But you will recognise this as Mr Hicklin

21 giving his input on matters to be taken into account for

22 young people with an autism spectrum condition

23 diagnosis.

24 Bottom of the page, lists 3. If we just go over the

25 page, just remind yourself. Then the passage at the

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1 2019, I think you made meant 2020?

2 **A.** Apologies, that was 2020.

3 **Q.** We just crossed through and say 20. Noting the

4 mitigation -- Covid and a member of staff leaving

5 abruptly -- that did mean that there was a gap for AR at

6 this time where he was without a case manager for quite

7 a significant period. Would you agree?

8 **A.** Yes.

9 **Q.** We also see that in terms of the meetings that FCAMHS

10 attended, so different to the original strategy

11 meetings, the FCAMHS attended meetings on 21 January and

12 4th March 2020. I think you would agree that there was

13 no CAMHS representative at them?

14 **A.** No, and that would not be in line with our service

15 expectations. Although we were stretched for staffing,

16 we would expect meetings would be covered.

17 **Q.** I'm asked to explore with you, and I'm going to do so

18 briefly, is there any indication that CAMHS communicated

19 to Lancashire County Council, so their Children's Social

20 Care or the Child & Family Wellbeing Service, about

21 Mr Morgan's departure?

22 **A.** I can't -- I think there is a reference to an email that

23 I sent, but I think that was to the Youth Justice Team,

24 Anna Jameson. In my statement I think I reference

25 an email that I sent advising that Skott had left and

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1 bottom, which has been read out I think twice today now

2 so I won't read it out again. But, the aspect of FCAMHS

3 saying that until his diagnosis is complete they

4 wouldn't be able to contribute further on the

5 understanding of risk and an invitation to come back.

6 At this time, do you know whether this letter

7 actually went to CAMHS at the time? Because it is

8 addressed to Ms Hallaron?

9 **A.** There is no record that it arrived. There is an email

10 that I sent because I didn't have sight of this letter

11 and understood that it existed.

12 **Q.** That's why I said at the time I am going to come back,

13 but at the time there is no record of that arriving

14 directly at that time?

15 **A.** No.

16 **Q.** Thank you. In paragraph 20 of your statement, at

17 page 4, picking matters up at about this time in March,

18 I think you raise concerns within Sefton CAMHS that

19 a number of staff were off poorly and that it had left

20 some patients without case managers. Is that right?

21 **A.** That's correct.

22 **Q.** We remind ourselves of course of the significance of

23 those dates. So the first wave of the pandemic

24 obviously, but also I think Mr Morgan, as you have

25 touched upon, had left abruptly in February. You say

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1 there was a new case manager identified, but I can't be

2 sure that that went to Lancashire Children Services.

3 **Q.** Do you think that enough was done in terms of the local

4 authority and social care and the CFW team to put them

5 in the picture about the difficulties that you had at

6 that time in terms of you couldn't cover it, there

7 wasn't a case manager? Do you think that they should

8 have been put more in the picture in relation to that?

9 **A.** Yes, it would be helpful I think. Information sharing

10 around the system is something that, the more

11 information that's shared in a more timely way of course

12 would be helpful.

13 **Q.** Against that background, you tell us in paragraph 20 at

14 the bottom of that page, perhaps 20 to 22, that it was

15 within this context that the CAMHS input into the EHCP

16 came to you as service lead because there wasn't a case

17 manager or anybody else to do it. Would that be right?

18 **A.** That's correct.

19 **Q.** Just briefly in relation to the document itself. If we

20 have AHCH000003, if we could go to page 2, please. If

21 we look at the bottom of the page. Again I'm not going

22 to read it all out, but if you just remind yourself of

23 it. Then over to page 3, top of the page, there was

24 there a reference, in fairness to you, to the Youth

25 Offending Team intervention on anger management and

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1 offending behaviours. There didn't seem to be any
 2 reference to some of the grave information that was
 3 available to CAMHS -- the hockey stick incident, the
 4 possession of knives in school, internet browsing --
 5 that didn't appear to form part of the matters that you
 6 were alerting to?

7 **A.** No. My focus on completing this was about identifying
 8 the health needs and as I understood from the records,
 9 they were focusing on emotional kind of development,
 10 emotional language, but no it didn't include those
 11 other details.

12 **Q.** Looking back now at the totality of events that I have
 13 gone through with other witnesses, as has Ms Wakeman, do
 14 you think those matters should have been flagged up more
 15 in the EHCP, because some of them were risks occurring
 16 at school and at risk of worsening in the school
 17 environment in terms of school internet use?

18 **A.** I think one of the learnings that has come through
 19 personally and as a service is that we perhaps assume
 20 other people in the system have information, and I think
 21 that due to the information being highlighted from
 22 schools, I had an assumption that that was already
 23 included in the record. For my part in completing this
 24 document, I was focusing on the emotional health and
 25 wellbeing aspects.

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1 you added the comment that this was "unusual". Is that
 2 right?

3 **A.** Yes.

4 **Q.** If we go over the page to 31. Taking it as briefly as
 5 I may. You say with the benefit of hindsight you "would
 6 have recorded the conversation with Anne Simpson in more
 7 detail and I would have asked specifically about risk to
 8 children and the detail of the risk assessments that
 9 have identified a medium risk of 're-offending and
 10 'significant harm'."

11 You would have enquired about and recorded specific
 12 details of any Children's Services involvement and any
 13 meetings planned for multi-agency communication. The
 14 email doesn't appear in the electronic patient record
 15 and that is an omission. That was a problem, wasn't it,
 16 emails being sent but not copied across to the notes?

17 **A.** Yes. Our learning around record-keeping is there were
 18 a number of omissions predominantly around email or text
 19 or loose paper documentation.

20 **Q.** Again, taking it briefly for speed, but there was
 21 something quite peculiar, given AR's risk information,
 22 taking a knife into school on ten occasions in
 23 October 2019, a serious assault with a hockey stick
 24 while carrying a knife on another pupil in December
 25 2019. There was something very odd on its face about

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1 **Q.** Given the risk of him changing schools, it would be
 2 important for all of that to be captured in the plan?

3 **A.** Yes.

4 **Q.** You deal in your statement with the fact that after this
 5 Mr Sam Coppard was identified as the new case manager.
 6 Is that right?

7 **A.** That is correct.

8 **Q.** I think you gave a handover to him of the information
 9 and what you had been doing on the case?

10 **A.** That is correct.

11 **Q.** Thank you. In paragraph 27 of your statement, can we
 12 just deal with it.

13 If we pick it up at the bottom of page 5.
 14 AHCH000229 page 5. You deal with 17th April 2020.
 15 Getting an email from a colleague in Crisis Care
 16 advising that Anne Simpson from the Lancashire YOT had
 17 been in contact.

18 Over the page, you refer to being unsure as to the
 19 precise time and date of the call. Sir, for your note
 20 at AHCH000162 page 30, there is a record of the call in
 21 note form.

22 But, you noted during the phone call that the risk
 23 assessment that is shared by Anne Simpson was
 24 re-offending risk medium, significant harm risk medium.
 25 Risk to children no. As you say in the paragraph below,

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1 the risk to children being marked as "no"?

2 **A.** Yes, and I should have been more curious and it also
 3 provides an opportunity to read across to the risk
 4 management tool as well.

5 **Q.** Thank you. Then you deal in paragraph 30 with the fact
 6 that, on 1st May, following up on the phone call that
 7 you had received, I think you then get in contact, is
 8 this right, with FCAMHS, and a number of others and you
 9 noticed that you hadn't had the read-out from the FCAMHS
 10 involvement?

11 **A.** Yes.

12 **Q.** You get the FCAMHS letters?

13 **A.** Yes.

14 **Q.** The ones that we have looked at. And taking it again
 15 shortly, it is right, isn't it, that at the time you had
 16 understood that those letters were scanned into the
 17 system and would therefore be available for
 18 practitioners going forwards?

19 **A.** Yes.

20 **Q.** We don't need to turn it up but that would be
 21 particularly important because of the FCAMHS letter,
 22 9 March 2021, which gave what might be thought to be
 23 helpful guidance in bullet point form on areas of
 24 concern on the risk if there was an autism diagnosis,
 25 but also what might be thought to be the invitation to

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1 re-refer to FCAMHS if there was a change in position or
 2 a diagnosis was confirmed. That was an important
 3 letter, yes?
 4 A. Yes, I agree.
 5 Q. I'm not suggesting, Dr Killen, that it was your fault,
 6 but it has emerged that those were not in fact scanned
 7 onto the system. Is that right?
 8 A. That's correct.
 9 Q. And although you passed that information on to
 10 Sam Coppard, because they were not physically on the
 11 record, there would be an issue about how visible they
 12 would be when Sam Coppard stopped being the case manager
 13 or if others were involved?
 14 A. Yes, I only identified the missing scanning this year.
 15 Q. Thank you.
 16 A. But yes, it would have been an omission.
 17 Q. After the attack?
 18 A. Yeah, this year.
 19 Q. I should mention that we had made available to us over
 20 the weekend, it is now on the Core Participants'
 21 disclosure, at AHCH000234 the internal investigation in
 22 relation to this, which, in addition to the two letters
 23 that are mentioned, indicates that three documents are
 24 now permanently lost and it says:
 25 "Given the time that has elapsed, the searches

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1 A. I didn't specifically go through each intervention, but
 2 I recorded that the focus of the mental health support
 3 would be helpfully focused around anxiety, and I was
 4 confident that that was going to form part of the care
 5 plan going forward.
 6 Q. I understand for the CAMHS role, but wouldn't it have
 7 been good practice, given that you were aware of the
 8 letter and the specific recommendations to check that
 9 those were all being -- my words -- ticked off?
 10 A. Yes, that would have been helpful.
 11 Q. I want to move to early 2021. Because in paragraph 40
 12 of your statement you say that:
 13 "Following the ASD assessment and diagnosis in early
 14 2021, AR's father requested a re-referral to CAMHS on
 15 3rd February 2021."
 16 Is that right?
 17 A. Yes. There had been a conclusion of work with
 18 Mr Coppard, although the records weren't closed off, so
 19 there wasn't a discharge on the system.
 20 Q. So Mr Coppard had finished his work and it may be that
 21 in other circumstances he might have been discharged,
 22 but in fact he hadn't been. Was that an oversight?
 23 A. It was an oversight. Yes, he should have been
 24 discharged.
 25 Q. Technically he was still open?

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1 undertaken and the inability to locate the records, the
 2 trust has concluded that these records are permanently
 3 missing/lost without any clear audit trail of where they
 4 may be."
 5 That is an unsatisfactory state of affairs, would
 6 you agree?
 7 A. Yes. I think the FCAMHS letters do form part of those
 8 which we now do have because I think the dates are the
 9 four pages, but yes, it is unsatisfactory.
 10 Q. At this time, when you had had to have an involvement as
 11 clinical lead and then were passing things onto
 12 Sam Coppard, had you yourself spotted the risk that not
 13 all of those interventions that Mr Hicklin had
 14 recommended had been taken forward?
 15 A. The FCAMHS letters were sent to me after my conversation
 16 with the Youth Offending Team. During that
 17 conversation, the Youth Offending Team advised that
 18 through the referral order they would be targeting the
 19 offending behaviour and risk to others and they were
 20 clear that they felt that the role for CAMHS was to
 21 focus on anxiety and anxiety management.
 22 Q. Was that in relation to each and every one of the
 23 interventions that had been recognised by Mr Hicklin, or
 24 was it a more general we'll deal with the offending
 25 behaviour?

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1 A. Yes.
 2 Q. And as you detail there, it is from then that Sam Steed
 3 takes over as case manager. Is that right?
 4 A. Yes, that is correct.
 5 Q. You also say though that:
 6 "Engagement with Ms Steed focused on anxiety
 7 management, graded exposure, problem solving and
 8 re-engagement with education. This was all consistent
 9 with the outcome of the FCAMHS recommendations."
 10 That may be strictly speaking accurate in the sense
 11 that that action and that proactive activity was
 12 consistent with what FCAMHS were saying, but dare
 13 I suggest that the elephant in the room is that FCAMHS
 14 had said effectively that it would be a case of
 15 re-referring to FCAMHS once the diagnosis of autism was
 16 made because they then might be able to give more help
 17 in relation to risk?
 18 A. I hadn't read the letters like that, I recognise. I
 19 read the letters that there would be a change in
 20 circumstance. I hadn't read that it was as clear as
 21 that and I think that would be helpful. But yes, having
 22 re-read the letters more recently, I can see that that
 23 would be a helpful intervention after the ASD referral.
 24 Q. I'm going to suggest to put that beyond doubt AR was
 25 somebody for whom, looking at him as an individual, not

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1 making a generalisation about autism, his autism might
2 increase the risk because he had already shown traits of
3 a specialised interest, an obsessive interest perhaps,
4 or a fascination with violence and violent material?

5 A. Yes, that is correct.

6 Q. A lack of empathy --

7 A. Yes, that is correct.

8 Q. -- in his criminal assaults. And a lack of
9 understanding of consequences, yes?

10 A. Yes.

11 Q. All matters that in fact were highlighted in
12 Mr Hicklin's letter?

13 A. Yes.

14 Q. So even if there was an ambiguity about exactly what the
15 letter meant, knowing the information about AR's risk
16 would have put him, can I suggest, squarely in the
17 category of someone for whom a re-referral to FCAMHS
18 would have been an appropriate step to take?

19 A. Yes.

20 Q. And that should have happened in February 21?

21 A. Yes.

22 Q. You go on in your statement to deal with the change in
23 psychiatrist and your role in relation to that. I have
24 touched on that already briefly and you have indicated
25 that you think that that was appropriate action.

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1 "Even with the benefit of hindsight, I cannot see
2 that any more could have been done to re-engage AR in
3 the service."

4 I'm going to come onto other aspects of reflection,
5 but just looking at that in terms of the efforts made to
6 get AR to re-engage, does that remain your view?

7 A. I think on reflection I looked at the phrase
8 "re-engagement", whereas if we look at that as
9 engagement, we can see that he did have multiple case
10 managers, that people changed without preparing him for
11 that change. So I think there are things that we could
12 do across his whole journey that would have been more
13 helpful in terms of not having those breaks in support.

14 Q. So continuity, both in terms of not having breaks, but
15 also continuity of the same people?

16 A. Yes.

17 Q. It can't always be achieved?

18 A. Yes.

19 Q. But if it can't be achieved, then at least mitigating
20 the change by --

21 A. Sharing information.

22 Q. -- sharing information about why it is necessary?

23 A. Yes.

24 Q. Thank you. I want to turn now in the remaining time we
25 have to deal with the assessment of risk at CAMHS. Can

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1 Looking at a slightly different aspect of that, and
2 you may have heard Dr Ram touch on this, do you think
3 the fact that an experienced psychiatrist such as Dr Ram
4 felt intimidated and even threatened to an extent by
5 AR's father and Ms Steed has also reached a stage where
6 effectively the relationship had broken down, do you
7 think that that itself may have been an indication of
8 increased risk at the time?

9 A. I didn't at the time, but I think in reflection, looking
10 at opportunities for multi-agency and multi-system
11 working, which are imperative when we are looking at
12 risk to others, I think that is a helpful reflection.

13 Q. Thank you.

14 At paragraphs 47 to 51 of your statement, you will
15 appreciate, Dr Killen, that I'm dealing with a lot of
16 helpful detail in your statement, some of it at speed --
17 on page 11 of your statement you detail aspects in which
18 when AR had ceased engaging, efforts were still made to
19 engage with him. So very briefly, things like offering
20 him home visits, his preferred venue. Would you agree?

21 A. Yes.

22 Q. Preference for a female case manager, which is something
23 I have touched on with you in the appointment of
24 Kate Morris. That leads you in paragraph 52, at page 12
25 to say:

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1 I go straight to this issue. Where did the
2 responsibility for assessment of risk fall as between
3 CAMHS and FCAMHS in AR's case?

4 A. I think that we defer that responsibility to FCAMHS.
5 I think on reflection, and with the benefit of learning,
6 I think the non-assessment by FCAMHS of AR incorrectly
7 reduced our assessment of risk to others. So I think
8 that we would flag to AR -- and I think we mistook, if
9 that's the right word, for the non-assessment as perhaps
10 not meeting threshold for forensic assessment, which
11 with hindsight is not what's in those letters.

12 Q. We will come to those with witnesses tomorrow. But do
13 you now understand that FCAMHS say corporately, actually
14 it was always CAMHS who maintain the lead in
15 responsibility for doing the risk assessments. We would
16 help them with it, but it was never our responsibility
17 to actually do the risk assessment?

18 A. My understanding of working in community mental health
19 services we would defer to the risk assessment by FCAMHS
20 should they do a full assessment. So I would appreciate
21 more commissioning oversight of that. I think it is one
22 of the areas where the interface is not as clear as
23 perhaps it could be and going forward it has to be.

24 I think it is very difficult for a mental health
25 service to hold and manage risk that you have not

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1 assessed yourself, so I would think that is quite
2 a difficult position and would need a lot of work and
3 thinking about it. I have worked with other young
4 people where FCAMHS we haven't been involved. There are
5 young people who don't consent to having a mental health
6 service that pose risk to others and FCAMHS can continue
7 to be involved with the support of a lead agency such as
8 social care.

9 So I think that it would be helpful to review that.
10 For my sense, I would consider FCAMHS as providing
11 an assessment of risk and in that regard taking the
12 responsibility for advising around risk.

13 **Q.** So even now, and again we will explore it tomorrow, but
14 if I have correctly understood their witness statements,
15 when they are saying: we help CAMHS in this context with
16 their risk assessment, but they own the assessment of
17 risk, you don't even agree with that. You think there
18 needs to be greater clarity in that area?

19 **A.** I think there needs to be greater clarity, especially
20 when risk to others is outside of a significant mental
21 illness, because I think then there is a number of
22 agencies that are required to support and manage that
23 risk and I think greater clarity about information
24 sharing, clinical responsibility and responsibility of
25 managing the risk would be helpful going forward.

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1 a report, it is a live update around the timeliness of
2 risk assessments that are completed. So it did fall far
3 short from what we would hope to provide and I can only
4 apologise for that in this record and provide assurance
5 that going forward the risk form in itself has been
6 improved and also that the monitoring of the timeliness
7 of completion is accessible to me as a lead and my other
8 leads in the service.

9 **Q.** I won't go through each and every one of them, but you
10 will have reviewed them I know, Dr Killen, with care.
11 I took you to the one by Mr Morgan. Would you agree
12 that across the board they lack sufficient detail in
13 terms of the risk to others?

14 **A.** Yes.

15 **Q.** And they lack a proper understanding of the background
16 history of the series of concerning events that we
17 explored with the psychiatrists earlier today in
18 evidence?

19 **A.** Yes.

20 **Q.** Just to pick up that, if we look at AHCH000160 in terms
21 of where it leads, this is Ms Morris' risk assessment
22 for 23rd July. You will see soberingly how close to the
23 attack we now are. If you see at the top of the page:

24 "No reports of AR being a risk to his sibling during
25 my allocation ... Can be verbally abusive towards his

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1 **Q.** You accept in your statement, you have touched on it
2 already in your evidence, and it is also reflected in
3 the Alder Hey internal review, which has shown that
4 those risk assessments were not done first of all with
5 the frequency that they should have been?

6 **A.** That is correct.

7 **Q.** They should have been every three months, yes?

8 **A.** Yes.

9 **Q.** Whereas in fact they were done on -- following the
10 triage of the original referral on 11th October 2019 and
11 of 15th December 2019, thereafter there were only risk
12 assessments on 8th January 2020, 22 February 2024 and
13 23rd July 2024, yes?

14 **A.** Yes, there was an additional risk assessment on
15 12th August that isn't in -- for some reason hasn't
16 pulled through to that record, so there was another one.
17 But in any event --

18 **Q.** In which year?

19 **A.** That was in 2021. I think it is 2021.

20 **Q.** Even allowing for that one further one not dealt with in
21 the internal report for whatever reason, that's not just
22 missing the risk assessments every three months; that is
23 woefully short of it?

24 **A.** Yes, and at the time, as I say, we have updated our
25 record-keeping kind of policies and we have, I see

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1 dad and has become upset/angry throwing a phone when the
2 camera was turned towards him by mum. Note by Sam
3 Steed."

4 Then intentional risk to self which is dealing with
5 other aspects:

6 "Unintentional risk to self."

7 Then if we go down to the second half of the page:

8 "Intentional risk to others and property ...

9 "AR previously hurt a peer who he mistakenly thought
10 was the peer who had subjected him to bullying. This
11 occurred on the school site. AR attend the school site
12 with the intention of hurting the peer who was bullying
13 him. His intention was to exact revenge and AR was open
14 about this ... thrown a phone in anger during a CAMHS
15 video call ... subject of Prevent referrals ... the
16 latest in connection with AR speaking with a member of
17 staff about troubles in Palestine and Israel."

18 Then:

19 "AR took the latest referral very personally and
20 wanted to know what school staff had recorded about him.
21 AR's father eventually showed him the detail of the
22 referral. AR wanted to discuss this with his teacher
23 support," and so on.

24 "AR is upset the thoughts that school had about him
25 in relation to thinking he is a terrorist threat due to

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1 his world knowledge re matters such as Israel and
2 Palestine. School are concerned at AR knowing the
3 details of the referral. I felt it could be emotionally
4 harmful for him to see the details. I am not aware of
5 the contents referred to. I am aware that AR was upset
6 by the referral ..."

7 So some detail given there but there is no real
8 attempt there to grade that risk to others. Would you
9 agree?

10 **A.** Yes, and that's changed in our risk management tool.

11 **Q.** Just stick with what was done at the time. There was no
12 attempt to grade that?

13 **A.** No.

14 **Q.** And there is quite a lot of taking at face value, would
15 you agree, what AR was saying about the matters rather
16 than trying to look at the objective overall picture?

17 **A.** Yes, I would agree.

18 **Q.** There is a CYP, I think child young person current view
19 that is done at the same time, AHCP000159. Can you just
20 explain what this document is?

21 **A.** So this is a clinician-rated problem scale that we
22 complete as part of our work.

23 **Q.** Thank you. In that document we can see under risk --
24 poses risk to others -- that the answer is, just under
25 question 16 to question 20:

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1 this assessment of risk six days before the attack?

2 **A.** Yes, it is unacceptable. There was risk on the record
3 and it should have been recorded in this form.

4 **Q.** How far short of acceptable? Very far?

5 **A.** Very far.

6 **Q.** Does it follow that you would agree with the conclusions
7 of Dr Irani in relation to these aspects? I think you
8 have touched on it and helpfully volunteered really some
9 of the answers, but she was pointing, was she not, in
10 her report to the fact that the tool that was being used
11 by CAMHS was inadequate?

12 **A.** It is too generic to hold onto the specific risks to
13 others that are presented in this example.

14 **Q.** Because of that, and because of failures earlier on to
15 assess the risk correctly, taking Dr Irani's report very
16 shortly, by the latter stages the risk to others was
17 really not being addressed adequately at all.

18 Would you agree?

19 **A.** Yes, I think in terms of looking forward that is
20 something that we would be learning about.

21 **Q.** There was the ability to do the actuarial type of risk
22 assessment with SAVRY. Would you agree?

23 **A.** Yes.

24 **Q.** Did you have people who were trained in using that?

25 **A.** That aren't members of our team, but we would usually

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1 "Poses risk to others: none."

2 How did that come to be?

3 **A.** I think that my colleagues have shared that over the
4 course of AR's journey with CAMHS, the risk to others
5 that was particularly present at his referral and was
6 present at other points in the record was not held as
7 clearly as it could have been. I think this form is
8 getting completed with that practitioner's knowledge of
9 their time when they were as a case manager and I think
10 that some of the learning we have identified is holding
11 those risks across time, is something that will be
12 important going forward.

13 **Q.** How far short of acceptable was this assessment of risk
14 to others?

15 **A.** In my learning I identify that I think an actuarial risk
16 assessment will be extremely helpful. When we are
17 assessing risk, we are looking at static and dynamic
18 factors and I think the static factors are really
19 important, but of course those dynamic factors that we
20 can influence and change are often at the forefront of
21 our clinical practice. I think that an actuarial risk
22 assessment helps us hold both of those, which is of
23 course important going forward.

24 **SIR ADRIAN FULFORD:** Do you want to try again?

25 **MR MOSS:** My question was how far short of acceptable was
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1 refer to FCAMHS for that assessment to be completed.

2 **Q.** Again, would you accept that that should have happened,
3 not just when AR got his autism diagnosis, but at other
4 key stages, most notably perhaps the bus incident in
5 March 2022?

6 **A.** Yes, and on initial referral.

7 **Q.** Thank you just give me a moment if you would.

8 Could we have on screen please DRI000001 at page 25.

9 Dr Irani's report, and could we have the bottom
10 three-quarters, from 3.5.1 expanded, please. So:

11 "The adequacy of the interagency working
12 arrangements that were in place generally..."

13 Can I just check whether you will accept that the
14 fairness of these observations. So 3.5.1.1:

15 "There were a number of interagency meetings, not
16 all were attended by all parties involved in AR's care
17 consistently."

18 **A.** I accept that was in the early part of AR's journey and
19 we recognise that multi-agency working could be
20 improved. However, it is of note we did attend all
21 those meetings we were invited to and we did flag on
22 a number of occasions to our colleagues in other
23 services that we were concerned about the lack of
24 progress of AR.

25 **Q.** 3.5.1.2:

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1 "When other agencies like Prevent were referred to,
2 it was unclear how they carried out their decision
3 making and how this was communicated to the services
4 directly involved with AR."

5 Do you agree with that?

6 A. Yes.

7 Q. "From the documents made available to me, his
8 presentation at the time was attributed to his diagnosis
9 of autism and felt not to require threshold to referral
10 to Channel."

11 Was that your understanding too or --

12 A. That was my understanding.

13 Q. "Minutes of multi-agency meetings were not always
14 clearly documented and shared with all parties
15 concerned."

16 A. That is correct.

17 Q. "Latterly, as he disengaged from education and CAMHS, it
18 was unclear who remained involved and who was in
19 communication with the transitions team that was meant
20 to continue working with him."

21 Fair?

22 A. That's correct.

23 Q. And it is Dr Irani's opinion:

24 "Whilst there were a number of meetings, in the
25 absence of a lead agency, a clear handover process and
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1 consultation but didn't complete a direct assessment.

2 "Recommend that a re-referral of risk should be
3 made." I've covered aspects of that.

4 A potential for re-referral would have been recorded
5 aggression and home, however this level of aggression
6 with children with complex needs is not significantly
7 out of the ordinary and his parents reported feeling
8 confident to manage risks.

9 But carrying a knife on a bus?

10 A. Yes.

11 Q. "In addition, there was an incident reported where AR
12 might have left home with a knife" that's what I just
13 asked you about.

14 Even that, the reference to "might have left home
15 with a knife", in circumstances where what in fact
16 happened was AR did have a knife, the police took it off
17 him, had it in their possession and gave it back to
18 mother, there was a conversation about AR saying that he
19 wanted to stab someone and it is not disputed that there
20 was a conversation at least between AR and the officers
21 about poison; that was crying out for a serious
22 re-assessment of the risk to others?

23 A. I would agree.

24 Q. "It might be that the actuarial risk assessment should
25 be better embedded in multi-agency systems so when risk
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1 an appropriate risk assessment, the interagency working
2 arrangements were not adequate."

3 And that's fair?

4 A. I would agree, yes.

5 Q. Thank you.

6 You have accepted, and it is in the Alder Hey
7 Internal Review that there were also issues of record
8 keeping more generally and the standard of them?

9 A. Yes.

10 Q. Sir, for your note, Dr Killen has -- starting at page 88
11 of her statement -- got sections on reflections and
12 detailed sections on improvement as well.

13 Could we just look at one aspect of that,
14 paragraph 89. The questions that remain are how and by
15 whom should the risk concerns related to the indexed
16 offence been identified and monitored.

17 In circumstances where neither Prevent nor MAPPA
18 were deemed appropriate frameworks, with future learning
19 and with hindsight, future guidance about this would be
20 invaluable.

21 Is that really flagging up the gap in the
22 arrangements or at least the lack of clarity about who
23 the lead agency is in a case such as AR's?

24 A. Yes.

25 Q. You flag and acknowledge that FCAMHS provided
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1 arises the historic risk is also taken into account to
2 recognise if further concerns should be flagged."

3 But, in addition, you as a service, would you agree,
4 must have a process in place to ensure that knowledge
5 that you do have is readily visible for later clinicians
6 so that risk information is not lost?

7 A. Yes, and that is in place now. So as soon as you open
8 up a young person's record, as a CAMHS practitioner, the
9 document and date of the most recent care and risk plan
10 comes up, as does a systemic risk form and the current
11 view and key CAMHS data.

12 Q. Dr Killen, would you forgive me for asking the question
13 as to why that important additional aspect wasn't in
14 your reflections in your witness statement?

15 A. About the electronic patient record or that the --

16 Q. More about the fact that it might be thought that
17 important risk information was known to CAMHS, was
18 documented in CAMHS, not all of it, but a lot of it, but
19 wasn't taken into account by clinicians going through.
20 That would appear to be, it might be thought, a very
21 significant lesson about your own organisation and I'm
22 asking you why, although there is a helpful reflection
23 in paragraph 89, and important ones on gaps, on
24 interrelations with FCAMHS, to an extent with Prevent,
25 but why the matters in your own organisation weren't
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1 identified in a reflections statement by you as the
 2 clinical lead?
 3 **A.** I would agree. I think the risk-taking work that we
 4 need to do and to have that clear with detail and
 5 updated regularly is part of the independent learning
 6 review and we will be absolutely taking it on board and
 7 I think it is an omission that it was not in my
 8 statement.
 9 **Q.** I'm just looking to my left. I do not think there are
 10 any questions. Sir, do you have any questions for this
 11 witness?
 12 **SIR ADRIAN FULFORD:** I do not. Dr Killen, thank you very
 13 much for your frank evidence this morning.
 14 **THE WITNESS:** Thank you.
 15 **SIR ADRIAN FULFORD:** Does that bring us to a close?
 16 **MR MOSS:** That's the end for today. Thank you for sitting
 17 late, sir, and 10.00am, if we may, tomorrow.
 18 **SIR ADRIAN FULFORD:** 10.00 am tomorrow.
 19 **(5.00 pm)**

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