**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?



**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



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.



**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,

if we just have on the screen briefly for the moment AHCH000162, you are our first witness from the CAMHS team and this I think is the electronic patient system, yes?

**A.** Yes.

**Q.** You would have had access to that presumably?

**A.** I mean, in theory access, yes.

**Q.** What do you mean in theory access? Did you have access --

**A.** Yes, I would have had access to it, correct.

**Q.** And as part of getting to know the back story, to use a lay term, of your patients, like AR, would you use the electronic patient system records to look back and understand the history?

**A.** I would always do so to get a decent corroborative background picture of what was going on with any patient I was handing over from another consultant.

**Q.** What was the expectation as to how detailed that review should be?

**A.** So, the handover I had focused on the live primary issues at the time really. So, as I recall, and I think -- well, I am sure it is there in my Rule 9 statement -- the live issues at the time were -- well, the main foreground issue --

**Q.** I'm going to interrupt you Dr Molyneux, because if you



can listen to my question, focus on the question that I'm asking and seek to answer it?

**A.** Of course.

**Q.** My question was what the expectation was in how detailed your review of the records should be?

**A.** Well, I would say that the expectation was that I would conduct a reasonable review of the records.

**Q.** Not the whole of the records?

**A.** Well, it would be impossible to conduct a review of the whole of the records.

**Q.** Can we have on screen please AHCH000309. Do you see that this is the standard operating procedure for the Sefton CAMHS? Do you see that there?

**A.** I do indeed, yes.

**Q.** If we go to page 16. If we see in the middle of the page, the paragraph:

"As part of risk management and case management."

**A.** Yes.

**Q.** Do we see there that it includes this:

"It is important that clinicians review [then these words] the whole EPR record at each appointment to ensure that they are aware of any risk factors or contextual risks that might have arisen since the last appointment."

**A.** I see that, yes.



**Q.** Is that not the standard operating procedure and the expectation?

**A.** That would appear to be the case, yes.

**Q.** And your practice, therefore, in not reviewing it in totality, I think you indicated that it wouldn't be practicable to do so, does that suggest that there is a mismatch between what the expectation was and what the practice was, or certainly your practice was?

**A.** I wouldn't say so. When it says "it is important that clinicians review the whole EPR record", I mean, it is important and it's important that it is reviewed. I would say that I did carry out a reasonable review.

**Q.** Apart from the electronic patient record, did you have and what was said to you verbally in the handover, did you have any other sources of information?

**A.** I can't think of what other sources of information would look like other than verbal handover and written records.

**Q.** So far as other agencies were concerned, again it may seem an obvious question to you, but please just help us --

**A.** No, of course.

**Q.** Would you have access to local authority records, for example, or would you be dependent upon how liaison with the local authority had been written up in the



electronic medical records?

**A.** So it would be a bit of a mixture. So, there's a section on the EPR where scanned documentation from other agencies working with us would go in. That works a lot better now than it has done in the past, I think it is fair to say. Also, it would be those sorts of allusions to and, you know, the kind of core elements of importance, interagency discussions would appear in things like session notes and other good kind of go to sourcing. Obviously I'm aware that you are not familiar with the details of the record yourself, but another good and robust --

**Q.** Taking it shortly, I think from the answer you have given, you would only see matters from a local authority to the extent that they had been scanned into the electronic records or contained within session notes within the electronic record. You didn't have direct access to other agencies' record-keeping?

**A.** No, no, no. Forgive me, I don't know whether that's changed very recently. I know that there are discussions around a kind of a --

**Q.** Just deal with how it was at the time?

**A.** Not to my knowledge, I wouldn't have direct access to local authority information or anything.

**Q.** What about nonmental health medical records? Did you

have access to medical records outside the mental health records? Physical healthcare records, GP records?

**A.** There are a couple of things to say about that. I'm fortunate to work for Alder Hey NHS Foundation Trust which obviously has, you know, a physical health component as well as a mental health component, so to speak. So it is relatively easy because it is the same NHS trust. Well, it is very easy to kind of access secondary care and tertiary care physical health records.

GP information, as I understand it, can be obtained and could at the time by something called the National Spine, but my understanding of the practice was that that, certainly at the time -- again, this is my understanding of the practice -- that would be something that would need to be requested through admin staff.

**Q.** So I am going to go through some aspects of the history of AR from before July 2022 and I want you to just help the Inquiry whether you were aware of it.

**A.** Okay.

**Q.** So were you aware when you took on AR onto your caseload that he had admitted taking knives into school on some ten occasions leading up to an incident where Childline were called in October 2019?

**A.** No, I was aware of -- will you allow me to read out from



the initial psychiatric letter that --

**Q.** No, but if we have on screen AHCH000163.

**A.** I mean, the short answer is I wasn't aware of it.

**Q.** Just pause. Let me bring it up on the screen. At page 95. Do you see at the bottom there an entry in the electronic records for 15 September 21. Do you see that there?

**A.** I do indeed, yes.

**Q.** If we go over the page, do we see that that's by Dr Aseri, about six lines down, clinicians present?

**A.** Yes, I can see.

**Q.** Under "presenting complaints" we see 1 and 2, and then there is a history that is given. Is that what you were seeking to read out?

**A.** Yes, that looks like what's in this letter I have here.

**Q.** That's why I'm taking it so rather than reading it out we can see it on the screen. So we see there:

"AR tells me that he started experiencing worries about leaving his house since September 2019. This was related to AR being bullied at his old school, Range High School, which is a mainstream school. Due to this he was noted to attend school carrying a knife in his bag which led to his permanent exclusion from the school. There was no history of AR being physically aggressive towards anyone at school on this occasion."



Was that the sum total of your knowledge in relation to that?

**A.** Yes.

**Q.** So you didn't know that that had been on ten occasions that he carried a knife into school?

**A.** I certainly did not know that, no.

**Q.** You didn't know that, although his explanations for that perhaps varied, that there were some indications that he was bringing the knife in with a distinct intention of causing at least very serious harm?

**A.** I absolutely did not know that, no.

**Q.** So that was October 2019. Then in a ICT lesson on 15th November, did you know that AR had been engaged in searching for material on a school computer relating to school shootings in America?

**A.** No.

**Q.** Did you know that AR had been involved in searching for a number of graphic images of degloving injuries on the school computer at about the same time?

**A.** Not at the time, no.

**Q.** When did you first learn about that?

**A.** Since the tragic events of 29 July 2024.

**Q.** Were you aware that on 29 November 2019, during a lesson, in relation to talking about setting up a new business, that AR had said that people would think he



would kill them as they did not know him and he went on to say "people don't trust others they don't know in case they get murdered". Were you aware of that statement of concern?

**A.** No idea at the time, no.

**Q.** On 3rd December 2019, during an art lesson, colouring in images from the video game Call of Duty, AR questioned why he was allowed to look at those images from Call of Duty, but couldn't look at guns on the internet, and then asked to look at a picture of a severed head?

**A.** Again, these are things I have only found out since July 2024.

**Q.** And were you aware that AR had attacked a student with a hockey stick in an incident in December 2019?

**A.** No.

**Q.** You weren't aware of that incident at all in addition to the October one?

**A.** No.

**Q.** The statements that he gave in relation to that were perhaps contradictory at times but, again, there was an indication that his intent, at least on some accounts, was that he would have been prepared to use the knife and potentially to kill the person he was targeting?

**A.** I didn't have any knowledge of that at the time.

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



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



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



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

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



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



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



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

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

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

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

**A.** Of course.

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



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

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

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

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

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

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

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



is a reasonable level of triangulation of information.

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

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

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

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

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



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

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

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

**A.** No.

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

from the records?
**A.** Again Mr Moss, I can't inform myself of them if I don't know or have any indication to suspect that they are there.
**Q.** If you had been aware of the full background as I have outlined to you, would that have affected your assessment of AR throughout the time that you were his psychiatrist?
**A.** It would certainly have altered the perspective, yes. I'm not saying necessarily in a fundamental way, but it would have altered the perspective, yes.
**Q.** And would this be right, that most fundamentally the way in which it would have altered the perspective was to put a focus upon AR's risk to others?
**A.** It would have shone more light in that direction, I agree, yes.
**Q.** Because I think you are aware in general terms that by the time that AR was being discharged from CAMHS all together, and that was slightly after he had been discharged from your psychiatric care, the risk to others was said to be "none" on 23rd July 2024?
**A.** I don't think that was an entry by myself.
**Q.** No, I didn't suggest it was. But that would not have been the assessment of his risk to others, given that significant forensic history, would it?



**A.** I can't really make a definite statement on that because again what you have got in the intervening time is the perspective that's emerging from reviews of AR directly, during which time he is saying repeatedly to people, or denying that he has thoughts of harm to others and parents aren't foregrounding any risk in that direction either.
**Q.** Potentially would all of that information about AR also have been relevant when you considered the question of diagnosis and whether he was suffering from a mental disorder and, if so, which?
**A.** Could you repeat the question, sorry?
**Q.** Yes. Potentially would all of that information about AR also have been relevant when you were considering the question of diagnosis and whether AR was suffering from a mental disorder and, if so, which disorder? It would have been relevant information to take into account.
**A.** It would have been relevant information, even if just to provide some context.
**Q.** What was your actual understanding of the risk that AR posed to others when you took over his psychiatric care?
**A.** Minimal.
**Q.** Do you now accept that -- when you say minimal, do you mean your understanding was minimal, or you thought the risk was minimal?



**A.** I thought the risk of harm to others at the time I took over his care was minimal.
**Q.** And would you now accept that that was inadequate?
**A.** Well, early on in my involvement I obviously got a sense from parents and he himself. He denied thoughts of harm to others and parents were, you know, denying that there was any issues or not bringing forward any issues in that area.
**Q.** Again, forgive me for going back to it, but if in March he had carried a knife on a bus, and had told police officers he had thoughts of stabbing people with it, an assessment that his risk to others was minimal, leaving aside who was responsible for that, but objectively speaking, that was not an adequate assessment of his risk to others?
**A.** Objectively speaking, it would appear to be the case that, as you intimate there, in March 2022 his risk of harm to others was not minimal, no.
**Q.** Were you aware that there had been a referral to forensic CAMHS?
**A.** When I took over the case.
**Q.** Yes.
**A.** No.
**Q.** Did you become aware of that while he was on your caseload?



**A.** No.
**Q.** Is that something which you think you should have been aware of if the systems had been working properly?
**A.** The system in the wider sense, yes.
**Q.** Could we have on screen please GMMH000007.
Just so you get your bearings on this, can you see that this is a letter dated 9 March 2020?
**A.** Yes.
**Q.** If we just go over please to page 2, it is from Mr Hicklin, John Hicklin?
**A.** Yes.
**Q.** He says there, if we can just have the text of the -- that's visible -- enlarged please, Sarah. He was saying:
"I made comment that risk assessment will be complicated by his likely diagnosis of ASC. The known evidence in this field concurs with the discussion we had about AR with professionals."
Then he outlines some particular risk factors including: "Specialist interests associated with the condition; hostility to parents; lack of awareness of wrongdoing; deficits in empathy or lack of recognition of fear in others; not seeing consequences."
He goes on to say:
"I am of the opinion that assessment by our service"

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

He is talking about the meeting that he had attended:

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

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

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

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

**A.** No, indeed.

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



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

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

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

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

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



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

**Q.** This is 9 March 2020.

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

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

**A.** Yes, indeed.

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

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

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

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



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

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

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

since.
**Q.** And so if, and again I have to summarise quite a lot of evidence and I will try to do so in a way that's short but I hope fair. If, for example, the first Prevent referral can be summarised in this way, that there was a mixture of really quite concerning information about AR that was put through on that Prevent referral, but the assessment was that he was not somebody who was prone to be radicalised into terrorism itself, but this was more likely to arise because of his autism and that CAMHS, together with other agencies, but particularly CAMHS were giving the requisite help in relation to those risks, that would have been important for you to know, wouldn't it, that that was the overall assessment of where Prevent were coming from?
**A.** It would.
**Q.** Rather than it is a trivial referral, there's nothing to see here?
**A.** I think, again, my sense of the -- it is an important negative aspect -- so my sense of what the one referral was, was the second one, which I think was the Facebook post, which I think was about Gaddafi, wasn't it? But my recollection was at the time it was to do with Hitler. But the first one, yeah, it would have been important for me to know the details of that, yeah.



**Q.** But again, you didn't go back through the notes to look at what was in the CAMHS notes about that, including in relation to the first referral?
**A.** Well, again, my understanding was that there had been one Prevent referral that had been about something that professionals regarded or evidently regarded as, you know, relatively trivial and no further action by the Prevent process and that was the sum total of my knowledge. If the sum total of my knowledge is there was one Prevent referral, I don't have an indication to go and look for others.
**Q.** Thank you. I am going to move to a different topic now which is the ongoing work that you were involved in with AR from when you took him on on your caseload, from July 2022 through to September 2023.
**A.** Yes.
**Q.** I think if we look at paragraph 11, page 4 of your statement.
**A.** Paragraph 11, yes.
**Q.** Page 4. You deal there with the fact you first saw AR in person on 28th July 2022, yes?
**A.** I didn't see him in person on that home visit. He had gone up to his bedroom before my arrival. That was an hour and a half, to two-hour conversation with Alphonse and Laetitia in the downstairs living room.



**Q.** You had your first home visit on 28th July, but he himself was present but not talking to you. He was in his room.
**A.** He had absented himself prior to my arrival, yes.
**Q.** You set out there, is this right, I'm going to try to take it relatively shortly, but the principal concern at this first meeting with his parents with you was his weight loss due to restrictive eating and longstanding his refusal to leave the house. Was that the main concern at that stage?
**A.** Correct.
**Q.** You agreed to prescribe him a one-off dose of diazepam, a mild sedative, to enable him to be able to attend an in-person appointment at the Southport clinic?
**A.** Correct.
**Q.** You explain in paragraph 19, if we can go on to page 7 please that AR and his father then attended that clinic as planned on I think 1st August 2022. Is that right?
**A.** That is right, yes.
**Q.** What was your impression of him on that clinic appointment?
**A.** Well, as I say there, or in subsequent paragraphs, he came across as somebody who wasn't interested himself in being there, didn't particularly want to engage, wasn't depressed, was euthymic in mood, I guess. He came



across -- I regarded him as an average sullen teenage boy really.
**Q.** You say in paragraph 20 that:
"Overall he presented as stable in terms of his mental health."
Yes?
**A.** Yes, correct.
**Q.** You also say right at the bottom of the page that:
"There was no evidence of any thoughts of harm to self or others."
Would you have specifically asked him about -- I'm going to focus on risk to others for reasons you will understand -- would you have specifically asked him about thoughts of harm to others?
**A.** So, my recollection is that I asked him about thoughts of harm to self in the second appointment of 29 December 2022, which I insisted on sort of seeing him alone. I did a comprehensive, you know, tour of all of those risk parameters.
**Q.** Forgive me, but I specifically asked you about the risk of harm to others. So on 1st August, when you say there was no evidence of any thoughts of harm to self or others, would you have asked him about thoughts of harm to others?
**A.** I may have asked him. I can't say definitively that

I did not.
**Q.** And you will forgive me for going back to it, but if you had known that as recently as March he had been found with a knife, and it is not something that he said, the police have seen the knife, taken it off him and given it back to parents, and said that he had the knife because he wanted to stab somebody and had made reference to poison, those matters that you would have been bound to explore with him, however cautiously?
**A.** Of course.
**Q.** But they weren't explored because you didn't know of them?
**A.** Correct.
**Q.** In part because you hadn't read the records?
**A.** I hadn't had indication to pursue any further in the records from the reasonable assurance of ostensible clinical presentation that I was given from the documentation and the handover and the parental appointment that I had.
**Q.** I mean, does it not concern you now that those matters were available in the records, the most recent incident in particular and that you hadn't picked it up, does that not trouble you?
**A.** It does, yes.
**Q.** You explain in paragraph 21 that you discussed trying



a different SSRI and for sertraline and fluoxetine I think was the medication that you were thinking of. Is that right?
**A.** Fluoxetine, that is correct, yes.
**Q.** And you prescribed a low initial dose on this occasion?
**A.** Very low, yes.
**Q.** I'm asked to explore with you whether you had thought about talking therapies may have been a better approach at this stage. Do you have a view on that?
**A.** I can see why you are asking that question. So, the way the CAMHS -- our CAMHS service and CAMHS services in general work is that people will be assigned typically and it works ... people will be assigned a case manager who has a primary therapist role. So they will meet the young person, provide that sort of basic talking therapy input. Then if there is a further indication identified for a specific talking therapy on top of that, that's a further referral that can be made. I mean, in this case, as with a lot of cases that I come across, it is important to -- well, it's of primary importance really to establish that therapeutic relationship and if you are in a position to be able to prescribe a medication for somebody that will take the edge off their distress, a big part of the therapeutic role of that is that it goes some way towards establishing a therapeutic



relationship.
**Q.** In terms of the recent medication history, take it from me for the moment, but I can bring it up on screen if you want me to, but as recently as 7th April of the same year, 2022, your predecessor, Dr Ram, had indicated that she would increase sertraline up to 100mg for 2 months after which she said without any clear improvement it would be known that medication wasn't right for AR.
So on one view moving to a different medication might be thought to be contrary to what Dr Ram's thinking had been, which was to try and increase dose of sertraline, but with a view that if that didn't bring about a marked improvement, that medication wasn't the way to go.
**A.** I can understand why you are asking that question. I think this is within the remit, if you like, of acceptable variation between psychiatric practice. I tend to go to higher doses probably less than the average of my colleagues, but there is variation amongst my colleagues.
**Q.** You deal in paragraph 28 on page 10 with the fact that there was then a telephone review on 1st September, which I think was positive. Is that right?
**A.** From memory, yes. I probably say it there, do I?
**Q.** In fairness to you, in terms of the new medication,



Alphonse R, AR's father, was reporting an improvement in presentation since starting on the fluoxetine. You had a further review I think on 1 December 2022, paragraph 29, just over the page please. Is that right?
**A.** I'm trying to remember and orientate myself a little bit now.
**Q.** It is on the screen if it helps?
**A.** Yes.
**Q.** So, from father, a positive report in terms of rate, continuing to improve, but on the other hand, as regards the fluoxetine, AR had stopped taking this some weeks previously. Is that right?
**A.** That's what I say there, yes.
**Q.** Again, we are taking it from the statement rather than going through lots of notes, and he said it was because he didn't feel it had any effect, yes?
**A.** Again, that's -- I'm having to go back -- I can't remember, but yes, that's what I have written.
**Q.** You say you wondered he had experienced the fluoxetine as somewhat over-activating. Then you say this:
"Having momentarily overlooked the fact that he had of course been prescribed sertraline previously already, proposed that he might be interested in trying sertraline instead."
Is that right?

**A.** Yes.
**Q.** The reference to momentarily overlooking the previous prescription, I took you to the standard operating procedure in terms of informing yourself of what was in the notes, but of course that was the medication that Dr Ram had been attempting to use and had increased the dose of, which was in the very recent records.
How did it come to be, Dr Molyneux, if you were paying appropriate attention to the notes, that you thought about trying a medication that had already been attempted?
**A.** You say it was in the very recent record. I think it was -- was it -- we are now April to December, aren't we, I think was the gap, is it?
**Q.** Yes. The treating records for that year, you had had a handover from Dr Ram?
**A.** Yes, in the July. But we are now in the December.
**Q.** But had you just forgotten about that, had you?
**A.** I mean, I had -- again, I had momentarily overlooked it.
**Q.** If it were suggested that that is indicative of a pattern, Dr Molyneux, of you not paying sufficient attention to what is in past notes, what would you say?
**A.** Could you say that again, sorry?
**Q.** If it were suggested that that is indicative of a pattern of you not paying sufficient attention to what



is in the past notes, what would you say?
**A.** I would say that's unfair, in my opinion.
**Q.** Thank you. You go on to explain in paragraph 30 that having reviewed Dr Ramasubramanian's record since, you can see that she had previously prescribed sertraline. You go on to say:
"In retrospect, in light of everything we now know but do not have known at the time", and I have challenged you on that about what could have been known at the time, "I wonder if this wasn't an example of an attempt on AR's part to consciously and deliberatively manipulate professionals."
Just explain why you were making that reflection?
**A.** So this is a reflection that I have made in the process of doing the Rule 9 statement. I guess it would fit in with a general pattern, a general contextual pattern that seems to have been established by AR and his behaviour throughout his trajectory of involvement with all of the various services, but that wasn't apparent certainly to me at the time.
**Q.** Just help us with what you are suggesting you think AR was actually doing?
**A.** Well, I'm wondering, I'm wondering if he was trying to manipulate professionals.
**Q.** But if he had sertraline previously and he had reported



that it wasn't effective, hence trialing something else and going to fluoxetine, what would be the benefit for him of getting sertraline again?
**A.** Again, it is a wondering without forming any definitive conclusions about it. The sense in retrospect, through having worked with AR and his approach to medications was that he almost seemed to have a shopping list for what exactly he wanted in terms of medications.
**Q.** Did you get the impression that he looked a lot of stuff up about medications? That he was knowledgeable about them?
**A.** I did get that impression, yes.
**Q.** Was that unusual of someone of his age?
**A.** I don't think it's particularly common. I won't say it was particularly uncommon. I mean, it might even be -- maybe I'm being too unfair even to say that. I mean, you do get a lot of doctor Googling going on now, you know, with children and adult patients really, people looking up medications and coming up with hypotheses about what medication they would like.
In fairness to the point you are making though, Mr Moss, I think it is fair to say that he was more that way than most. Yeah.
**Q.** If I could have paragraph 32, please, page 12. You next see AR on 29 December. You have mentioned that already



doctor, and you say you are conscious that you have not seen AR in clinic alone yet and you ask to do so and they agreed to that. Just looking at the totality of paragraph 32, it appears that on this occasion he seemed physically healthier again and mental state apparently stable. Is that the overall impression?
**A.** Correct.
**Q.** You on go over the page at paragraph 34. On each of the three occasions on which you met AR face to face:
"... he presented, in essence, as an unremarkable, sullen, untalkative, gawky teenage boy."
I have touched on this already, but presumably you would have to agree that if you had known the full forensic history of risk, you would have been more concerned about what might lie behind the seemingly unremarkable, sullen, untalkative, gawky teenage boy?
**A.** I think there's two elements to this which I think we need to be careful to distinguish. With the benefit of hindsight of the events --
**Q.** Forgive me, I am going to interrupt you. Please don't use hindsight, but please think about what was knowable at the time, as I have explained it to you.
Had you known that which was knowable, either because it was known to other agencies and not communicated to CAMHS, or more especially it was known

to CAMHS because it was on the records, I will ask my question again: you would presumably have been keen to look behind what risks may lie behind the seemingly unremarkable, sullen, untalkative, gawky teenage boy?

**A.** The index of suspicion for potential risk of harm to others would have been increased, yes, although not to that level. That is the point I would like to --

**Q.** Not to a level where you may have foreseen the dreadful events of July --

**A.** Of course.

**Q.** But if in that year he had been carrying a knife and said that he had been doing that because he wanted to stab somebody, it wouldn't just be higher, it would have been significantly higher?

**A.** I agree. Yes.

**Q.** But because it wasn't, presumably you didn't press him on issues about risk to others? You say you may have asked him about risk --

**A.** I definitely did ask him about risk of harm to others.

**Q.** But did you then take his answers at face value?

**A.** Yes.

**Q.** If he denied risk to others?

**A.** Yes.

**Q.** Because you didn't know the history?

**A.** I didn't know elements of the history, no.



**Q.** And looking at the system as a whole, rather than for the moment at your individual performance, that was a failure?

**A.** Looking at the system as a whole? The system in the wider sense. Yes, it was a shortcoming, yeah.

**Q.** Because as the treating psychiatrist, if you had known about those matters, it would have been a significant part of your duty to ensure that they were explored with him?

**A.** Certainly beyond taking an answer of "no" to a question of "do you have any thoughts of harm to others" at face value, yes, I agree.

**Q.** And that his risk to others was assessed and recorded rather than just focusing on the risks to AR?

**A.** Could you clarify that point again, sorry.

**Q.** So, not just that you would have explored it, that it would have been your duty to explore it, but beyond that that, his risk to others would need to be assessed and recorded, and I'm going to suggest shared as well, rather than just focusing on the risks to AR?

**A.** Well, it would have been a question of, again, not necessarily taking a negative answer at face value, but remaining -- having a higher index of suspicion that that answer might not be correct.

**Q.** Yes, but going on to that, when risk assessments were



being done, the risk to others would have to be treated very seriously, recorded and shared?

**A.** Well, you can only go on what you have sort of got in front of you. I'm not so sure it would -- well, it wouldn't, would it? It wouldn't change the previous perception of risk of harm to others as nothing, but it wouldn't necessarily increase it. It would just, I guess, it would leave the point pending for clinicians working with him to need to look into further and establish a greater degree of assurance, that there either was or wasn't a significant risk. Because there may not have been at that time.

**Q.** Thank you. You formalised I think at 29 December appointment the cessation of fluoxetine. Is that effectively because he had stopped taking it? Is that right?

**A.** That's what it says. Again, there was lots of chopping and changing with the medications, and so my memory is a little, you know, not perfectly clear about these things, but that's what's written there, yes.

**Q.** I'm asked to explore with you whether the continued attempts to restart SSRI medication was appropriate in a patient whose adherence appeared to be so erratic. Can you help with that?

**A.** I think, from another angle, we were asked several times



in the Rule 9 statements what did you do to engage AR? Why did you not do more to engage AR? This I would see on the flip side of the point that you are conjecturing, I would see it as really our service bending over backwards to try and engage him in any way we could, given that he had a very specific shopping list, so to speak, of "I want some medication that makes me feel better". I think it was incumbent on us to do what we could to try and engage him in that way.

**Q.** That takes us in the chronology to the end of 2022. I think as we had a 10.30 am start, I think it is not fair to go the whole morning without a break. Can we take a short break?

**SIR ADRIAN FULFORD:** We certainly can. I will sit again at 12.00 pm.

**(11.46 am)**

**(A short break)**

**(12.00 pm)**

**SIR ADRIAN FULFORD:** Yes, Mr Moss.

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

Dr Molyneux, we had reached the start of 2023, and as you explain your statement, in 2023 the next appointment was scheduled for 6th February. Could we have on screen page 14 of your statement, paragraph 37.

This is another occasion where AR refused to speak

to you himself but what you say at the end of paragraph 37 is that AR's father communicated that:

"AR was largely being left to his own devices as regards administration of the sertraline medication, evidently on account of AR's father's ostensible fear of riling AR through too close a level of scrutiny."

Is that right?

**A.** Yes, that's correct.

**Q.** And what was your assessment of that position in terms of how that might play out in terms of risks?

**A.** There wasn't a sense of serious violence from AR towards his father from what was being told to me.

**Q.** Was that not part of why AR's father was fearful of riling AR because AR had attacked him on previous occasions?

**A.** The sense was, or as far as I could see the sense was of, yes, aggression, but short of violence, not significant violence.

**Q.** You tell us in paragraph 38 that arising from this you had a sense of being uncomfortable because there was a relative lack of parental scrutiny around the taking of medication. Is that right?

**A.** Correct, yes.

**Q.** And would you agree an inability, it would seem, on Alphonse R's part to get AR to take his medication?



**A.** Yes.

**Q.** There was then a further appointment on 27 February, you tell us about that in paragraph 39 of your statement, and I think that was an occasion where AR did attend in person. Is that right?

**A.** Yes. That was the last occasion on which he attended in person to see me.

**Q.** You describe there that he was looking to be prescribed now with a totally different type of medication. Is that right?

**A.** Yes.

**Q.** And again, what did you make of that?

**A.** It reflected, similar to what I recall having seen in the previous appointment I think, this focus on his part of thinking of himself solely in terms of, you know, as the only possible therapeutic options for him as being neurochemical.

**Q.** And what about his knowledge of the different types of medication that he was actively seeking? Again, was that somewhat unusual?

**A.** Well, he had clearly been Googling. Again, I wouldn't say it was particularly unusual in and of itself.

**Q.** Now after that your next scheduled appointment was 15th May but at the bottom of page 15 of your statement you deal with an exchange you had the day before on



14th May involving Kate Morris, who by then had taken over as AR's case manager, yes?

**A.** Correct, yes.

**Q.** And, sir, for your note it is AHCH000185, the exchange of emails. But let me see if I can summarise it. It is right, isn't it, that effectively AR's father copied you into an email to school indicating that he wanted AR to have a different teacher on the basis that AR found the particular teacher to be boring?

**A.** That was the -- that was what was apparent, yes.

**Q.** And I think Ms Morris passed that onto you with a comment to the effect "seriously", no doubt referring to the seeming understanding that it was appropriate to ask for a change of teacher just because the pupil felt the teacher was boring.

**A.** I don't know if you have redacted one element of it, but I forwarded it to Kate with a kind of -- I think a kind of, you know -- I think it was like three exclamation marks or something, like can you believe this.

**Q.** Rest assured, I haven't redacted anything. I'm just trying to summarise it for speed. Three exclamation marks from you. She comes back with:

"Seriously!!! This is more systemic ... than mental health do you think?"

Then you responded:



"Don't know whether it's ... overaccommodation ... safeguarding ... or gaslighting ... or some combination of the above. But the one thing that's clear is that it's systemic."

Help us with that. When you said "the one thing that's clear it's systemic", what did you actually mean?

**A.** So systemic has a very particular meaning in the context of child and adolescent mental health practice. Systemic refers to, broadly speaking, family approaches. So family therapy would be considered the kind of classic systemic family therapy. So it is looking at the system, something wrong with the system rather than something being a problem, the problem being located in the person in the individual themselves.

**Q.** So the family systems and the family dynamics as opposed to mental disorder. Is that a fair contrast?

**A.** Correct.

**Q.** That was the contrast you were seeking to draw?

**A.** Absolutely that.

**Q.** Again, just focus on the questions, please. "Overaccommodation", by that you meant what exactly?

**A.** So overaccommodation, so the parents basically being unable or unwilling to enforce and implement reasonable boundaries and so just allowing their child to do what they want in broad terms.

**Q.** Safeguarding was the second option. We all understand what safeguarding means in the general sense. But when you said you don't know whether it is overaccommodation, safeguarding or gaslighting, what were you using "safeguarding" in that context to mean?
**A.** So my sense of safeguarding at that point, and indeed later, was solely in the sense of these, you know, the systemic problems that are there, either the parental inability or unwillingness to implement boundaries are not placing due life expectations on this lad such that he will -- you know, he's going to have reduced opportunities in the world of education, training and work.
**Q.** Reducing it to my layperson's terms, is it this sort of a concept, in a way it is connected to the overaccommodation, if you don't set boundaries and insist for example that he tries to attend education regularly, he will end up having suffering and there will be a safeguarding concern because it will have a very detrimental impact on his life opportunities in the future?
**A.** Yes, exactly. He will have greatly diminished life opportunities.
**Q.** And the gaslighting in this context? Again, it is a common term, but what did you mean using it as



a psychiatrist here?
**A.** So, I might need to refer to what I have actually written because I use quite a subtle sort of explanation of what's going on. Really what this spoke of -- what this spoke of to me, what it alluded to was the interaction I had observed between AR and Alphonse at the 27 February appointment this kind of -- this quite passive aggressive bickering and I had actually written in the notes after that session that some of Alphonse's -- I wrote a couple of things -- AR's responses to Alphonse seemed to be sort of oppositional for oppositional's sake, just like if dad said black, AR would say white. But from Alphonse himself, it seemed like there were one or two things he said that seemed quite -- like they were in quite a subtle way trying to get under his skin a bit and that's what I meant by the gaslighting.
**Q.** Beyond the email and what -- the exchange that you had with Ms Morris and what you recorded in the notes, you are clearly coming to this view of what you later describe as the overarching problem of this sense of not setting boundaries. What did you actually do about that in terms of taking things forward?
**A.** So, I communicated that to Kate Morris as case manager, you know, so that she was aware. And so that remained



our understanding -- well, I was kind of checking out what her opinions were as well and I think she gives her agreement. But, yeah, so that in turn it could be shared with any sort of multidisciplinary professionals that are also involved.
**Q.** Did you ever ask any questions about whether there was any boundary setting on AR's internet use?
**A.** I can't recall -- I can't say that I definitively did not. I may have done.
**Q.** I will be corrected if I'm wrong, but I don't think there's any record of a specific time when you raised that within your notes of your discussions, either with father or with AR.
**A.** No. Again, I can't recall it being specifically discussed, although, on the 25th September home visit, which we will come to in due course no doubt, I had a good comprehensive conversation with Alphonse in which I got a sense of the overall difficulties as they were being presented to us anyway.
**Q.** And again, isn't that indicative -- I'm going to deal with it at a systems level for now -- of again the system not working properly, because if you had been sighted on concerns about school, internet use, looking up London Bridge bomb, interest in Manchester Arena and use of the internet to look up school shootings, what



for you was a lack of boundaries being set in not insisting on AR attending school, not insisting on him taking his education, parents perhaps giving into AR's wishes the whole time, the potential for AR to be doing what on earth he liked online in the family home would be an important other aspect that you would have wanted to explore, wouldn't it?
**A.** It would have been an important other aspect to be aware of but, again, I get and submit what you are alluding to, that if I would have known about the previous aspects of internet use and things like that, that would have put a different complexion on the level of concern, yes.
**Q.** Because you didn't know about that, and again I'm going to suggest in part because you hadn't informed yourself about that from the notes, that was never done?
**A.** Again, I would come back to that by saying it was an unknown unknown. If I didn't know that there were concerns, I didn't know that there were concerns to be further explored.
**Q.** Thank you. Be that as it may, the next appointment with AR was due the next day, 15th May, the day after that exchange, and I think you can confirm that that was another occasion when he didn't attend, but AR's father emailed you to alert you to the fact that he wasn't

going to be attending?
**A.** From memory -- I don't have it in front of me now -- from memory I think so.
**Q.** Paragraph 49, page 18. It is the minute to go before the scheduled face to face.
**A.** Yes, I recall that. Correct.
**Q.** I think arising out of that, in fairness to you, you followed that up. So you requested an update by email given the nonattendance and you received an assurance from AR's father -- I'm looking at paragraph 50 now at the bottom of the page -- that AR was consistently taking his sertraline at that time and the only problematic aspect was with sleep. Yes?
**A.** That's what it says, yes.
**Q.** And going over the page to 51, I think it was arising out of this, I think for the first time that melatonin medication to help ease AR's sleep was first discussed and something that you recommended.
**A.** Something I suggested, yes.
**Q.** I'm asked to explore whether there is any contraindication to melatonin and sertraline being taken together in the case of a child. Are you aware of that?
**A.** None whatsoever.
**Q.** There was then a multi-agency meeting on 25th May. You deal with that in your paragraph 53 at the bottom of



that page, please. You say the overall feeling expressed by school was positive in relation to AR's mental health but it was apparent that he was only attending school very sporadically, yes?
**A.** Is that what it says? Yes. It looks that way.
**Q.** Yes. At the bottom of the page.
**A.** Yes.
**Q.** You go on to say that this was I think:
"... a further indication that the overarching problem was essentially systemic and related to parental overaccommodation."
Just over the page, I think.
**A.** Yes, that was my memory at the time, correct.
**Q.** This was also, paragraph 55 -- you have dealt with it but just so we place it in time -- was one of the two occasions -- paragraph 55 -- when the Prevent programme was mentioned?
**A.** According to my recollection, yes.
**Q.** Thank you. I think thereafter it is fair to say, isn't it, that there were attempts made to try to get AR to reengage with direct contact?
**A.** Absolutely.
**Q.** But by this stage you hadn't seen him face to face since late February?
**A.** Correct.



**Q.** Given what you in fact knew about the risk to others, which you described as understanding to be minimal, did you in fact think at this time that AR's lack of engagement may have given rise to an increased risk in relation to the risk to harm of others, the very fact that he was withdrawing?
**A.** Of others? Risk of harm to others?
**Q.** Yes.
**A.** Again, if my sense of things at the time was that he did not and had not posed a material risk of harm to others, it was not foregrounded in my sense of things at that time. I should add as well, you know, and this is a theme that runs through the whole story of AR's connection with services and with our service, our sole conduit for information was Alphonse and Alphonse was telling us Alphonse's concerns.
**Q.** Dr Molyneux, that's not actually accurate, is it? What you have just said is that your sole conduit for information was Alphonse. Another conduit for information was the engagement between agencies and the information that's on the medical notes. That's another important conduit.
If you will forgive me, you appear consistently to go back to saying we could only take things from the family, but in 2019 and 2020 in particular there had



been a series of multi-agency meetings involving CAMHS, sometimes involving FCAMHS, and an exchange of information and that exchange of information may itself have been imperfect, but in all the ways that I have put to you, information in relation to that was on his mental health records that were available for you.
So it is just not accurate, Dr Molyneux, for you to assert that the only conduit for information was Alphonse.
**A.** A couple of points in response to that. I take your point about that there were multi-agency meetings going on live in the present. I agree you are correct to say that Alphonse wasn't the only other conduit for information. The other conduit for information in terms of a present sense of what was going on was the multi-agency meetings and that one on 25th May was giving a sense of reassurance. Given that, why would I or anybody, if the sense is that there's an ongoing message of reassurance, why would it occur to me to go back and look through the notes just in case there's something that I'm not aware of that's different in the past?
**Q.** But the overall pattern, if he is not attending school and he is not engaging with CAMHS, at least in meetings with you, that might suggest that he is to some extent

withdrawing from sources of support and it circles back to the fact that had you known more about the risk information, the risk of others to information, that would have been something I suggest of a red flag?

**A.** I agree if I would have known more about the historic information regarding risk -- assessed risk of harm to others -- that would have changed the complexion of my sense of him in the present time at that time.

**Q.** And I think you were due to see AR again on 3rd July 2023, and then on 18th September 2023, and he refused to attend both of those appointments?

**A.** Correct.

**Q.** As you describe, can we just have it on screen so we have it in front of you, it is paragraph 62 page 23, is this right, that you became concerned about continuing to prescribe sertraline to a 16-year-old who was not providing good evidence of his own consent to that medication?

**A.** Correct.

**Q.** Thank you. Is that all the context, you have touched upon it, that led to the home visit that you carried out on 25th September?

**A.** Yes.

**Q.** Let's turn to that then. So, home visit 25th September. Can we have paragraph 63 at the bottom of that page.



But on that occasion I think, although you did a home visit, the family welcomed you into the living room but it was apparent that AR, having been out previously, had gone into his bedroom, refusing to meet with you and on this occasion it is clear that he had been in the living room just before. So he was definitely, my words, avoiding you?

**A.** Oh yes.

**Q.** And if we jump forward in your statement please, but it is talking about this occasion, it is page 31, paragraph 82 at the top of the page. You refer there to Alphonse being, and then your words are these:

"cheerfully unable or unwilling even to attempt to place upon AR the reasonable expectation that he at least speak to me."

**A.** Yes.

**Q.** And he, that is Alphonse, spoke of AR being "seemingly happy just doing what he wants to do".

That cross-references back to the paragraph dealing with this meeting.

Can you just expand on that and the reference there to "seemingly happy just doing what he wants to do", that's AR, and to Alphonse being "cheerfully unable or unwilling to attempt to place upon AR the reasonable expectation" of speaking to you. What did you mean by



those things?

**A.** Well, I mean, I guess I mean what I have said. I think I used the word -- I think it is just a little bit above this -- I used the word "exasperation".

The picture, as it was presented to me, was one of that, you know, this lad chopping and changing his engagement, messing about with medication, doing what he wanted with it and dad, you know, not seemingly concerned about the lack of boundaries he was able to enforce really.

This was a lad who, moreover, was not confined to his room, but had been just merrily in the living room doing what he wanted, having his snacks and things, and then doing what he wanted and scarpering to his room. So my sense was why are we as a service continuing to bang our head against the wall with this lad who has been deemed time and time again not to have a mental disorder and for whom this is primarily a social care issue of parents not being able to implement boundaries or willing to implement boundaries?

**Q.** Is there a risk that you, in forming that view, were underestimating the level of difficulty for AR's parents and quite how difficult AR's behaviour had made things for them?

**A.** I recall, Mr Moss, that this was a specific question



that came from the parents, wasn't it, from Alphonse and Laetitia, I think. And, honestly when, you know, when you look back with the benefit of hindsight and the chronology from what we now know of what was going on from the purchases that were being made and the Royal Mail deliveries to the house and things like that, I find it a little bit, you know -- I don't know what the word is -- I wonder how the parents can say that there was -- what was the word you used, sorry?

**Q.** I asked if there was a risk that you were underestimating the level of difficulties for AR's parents and how difficult his behaviour had made things for them?

**A.** I wonder how the parents can say that when we now know that what they were doing at the time was taking orders for machetes and whatnot being delivered to the house, but not telling anyone about that.

**Q.** And is there any truth in their perception that your input was very high level and superficial and that you showed no inclination, pleasant though you were, to get to the bottom of the problem?

**A.** Again, I dispute that in its entirety. I am, you know -- is the very fact that you have got a consultant psychiatrist doing a home visit here not demonstrative in itself of really trying to do what I can to get to

the bottom of the problem? But of course, like any other clinician in this situation, you can only go on the evidence that's presented to you and if, as it later seems to have turned out with the benefit again of hindsight, if it was the case that the most salient evidence indicative of AR's presentation was being evidently deliberately withheld from us, can that be a criticism that's levelled at clinicians?

**Q.** You will understand that I'm giving you an opportunity to comment on that, which is part of the process of achieving fairness for you so you can comment upon it.

**A.** Thank you.

**Q.** So as you know, but others may not, but it has just been indicated by the doctor that it was possible for us over the weekend to put extracts from AR's parents' statements, but only extracts, to this witness, so that he is able to have that opportunity to comment. It has not been possible yet to disclose the statements but that is imminent so that all the other core participants will get them very soon. Thank you.

On the same occasion, I think AR's father informed you that AR had stopped taking the sertraline about two months ago. Is that right?

**A.** I recall that was the case, yes.

**Q.** And as a result, I think you decided to formalise the



cessation of sertraline, again on the same basis, that if he stopped taking it anyway, it is not appropriate that it continues to be prescribed?

**A.** Correct.

**Q.** Thank you.

You say in paragraph 78, still in relation to this home visit, that it might conceivably -- I'm so sorry, it is paragraph 78, page 29 -- so in relation to this visit:

"It might ... be wondered as to whether indeed I was satisfied that the information provided to me by AR's father was reliable, particularly given that I had been unable in the course of the visit to examine AR in person. The answer to such a question would of course be yes. At the time, I had no reason to doubt AR's father's reliability or honesty (subsequent to the horrific events ... is quite a different matter); ... I doubted his effectiveness as a parent, but that's quite a different matter to doubting someone's reliability or honesty."

Were you there reverting to the same aspects, that perhaps through this Inquiry or through the criminal process you have subsequently been aware of the delivery of weapons?

**A.** Yes.



**Q.** Which you would understand one or both of the parents were aware of but never mentioned to you?

**A.** Never mentioned to anyone, I gather. Yes.

**Q.** Thank you. Following that appointment, I think you emailed Ms Morris.

Sir, for your note AHCH000145.

But I think the essence of it was you hadn't been able to see AR for over six months. He hadn't been taking his medication. He was remaining in his bedroom. He hadn't attended college. He had only attended a couple of times in the term. Hadn't left the house for the last few months. Spends all his time watching videos online, including late into the night. Hadn't had a bath or shower in the last month. Early Help were apparently closing the case. It seemed as though a social worker was involved and you concluded with the phrase that you use repeatedly in your statement, that you were struggling to see if there's any further role for psychiatry or CAMHS as a whole. Is that right?

**A.** Correct.

**Q.** Is that because in the circumstances where he is not complying with medication and wasn't seeing you, and parents for reasons that we will explore obviously with them, were not being successful in encouraging AR to see you, that you couldn't see what it was that the CAMHS



service, and you specifically as a psychiatrist were really, my phrase, bringing to the table?

**A.** Essentially, yes. So you have got a young person who has been in the service for a good while, has never presented with a diagnoseable mental disorder, we are very clear by now on our formulation as being a systemic one of parental overaccommodation. This is the issue and so -- and he is indicating by his repeated actions that he does not want to engage with CAMHS. So how is it productive or helpful for CAMHS to remain involved when the lead agency at this time ought to be social care?

**Q.** Thank you. Again, although it is a theme that I have put to you a number of times, I do need to come back to it here again. If you had known what was capable of being known at the time about previous risk history, risk to others, wouldn't all of these features -- so increasingly isolating himself away, he's disengaged, he is not engaging with mental health professionals, he is spending increasing amount of time on computers -- wouldn't they all have flagged up actually an increased risk of concern about the risk to others?

**A.** I think that's a fair comment. It would have put a different complexion on things, and even if not by themselves necessarily hugely significantly so. It

could only have increased the sense of a risk of harm to others that would warrant further exploration.

**Q.** And just think about that, and again I seek your candid assistance. Where would that have gone? Would one possibility have been that you would have kept him open to CAMHS because of the risk to others? Is that one possibility?

**A.** I guess what it would have done is increased our index of suspicion and -- yeah, it is difficult, isn't it, to separate out what was known at the time with what's known in hindsight. But again we are thrown back on the fact that he is not engaging with CAMHS. I guess social care would still have been the lead agency, but it would have warranted more flagging of the past risk of harm to others.

**Q.** But forgive me, the answer to my question, that one possibility would have been, would it not, keeping him open to CAMHS for longer, principally because of the risk to others?

**A.** That would have been one possibility.

**Q.** And I think -- I will come back to the fact that you describe social care as should have been the lead agency -- but would this be right, that even if he was going to be discharged from CAMHS, in terms of the risk of harm to others, you would have wanted before his case



was closed to CAMHS to make sure that other agencies were aware of that?

**A.** Absolutely.

**Q.** So a multi-agency meeting?

**A.** Absolutely.

**Q.** Where CAMHS explained why they were closing the case to him but flagging up he is disengaging, we can't do anything physically more?

**A.** Absolutely.

**Q.** But we do have these concerns about risk and actually the fact that he is spending more time on his computer, the fact he is not engaging with us, the fact we can't even see him is all quite concerning?

**A.** So past concern around risk of harm to others, period of ostensible lower risk of -- an apparent lower risk of harm to others, and now a further lack of engagement. Yes.

**Q.** If we can look please together, Doctor, at paragraph 77 of your statement, it is page 29. I want to explore another possibility of a course of action with you. You say in your paragraph 77:

"If the adjudged risk had been high, based on the information available to us at the time, in the context of a suspected mental health disorder, we could and of course would have considered arranging an assessment



under the Mental Health Act 1983 (as amended) ..."

Is that right?

**A.** Yes.

**Q.** I think you go on to say that that might have been an avenue that might have been explored at the earliest stage if AR's lack of eating and malnourishment and being underweight had come to the stage where there was a significant risk to his own safety?

**A.** It might have reached that point, yes.

**Q.** Now that didn't transpire in terms of the risk to himself from undereating. But I want to ask you about the risk to others and the Mental Health Act possibilities there. Would that, in fact, if you had known all of this about AR's history and he is now disengaging, refusing to see you, refusing to see others, would an assessment under the Mental Health Act have been something that could have been considered?

**A.** Could you just ask that question again, sorry?

**Q.** Yes. If you had known about the indications of risk, and then on top AR is refusing to see you, he is refusing to see others, he is not really attending school, would an assessment under the Mental Health Act have been something that could have been considered?

**A.** I mean, so you would request a Mental Health Act assessment if you are concerned that there's significant



risk of harm to self or others in the context of a mental disorder.

It is difficult to say, isn't it, if I would have been cognisant of earlier ostensible risks of harm to others. I think we have to be careful that we don't let hindsight kind of cloud this.

What we are left with is a situation where, as things stand and as things are apparent to us there, that threshold for considering a Mental Health Act assessment -- I mean it just -- a Mental Health Act assessment just wouldn't be considered in those circumstances. If young people presented in that way were an indication for a Mental Health Act assessment, given what we knew at the time, Mental Health Act assessments would just be happening all over the place and everywhere.

**Q.** Well, you say that, but could we have a look at the views of the Inquiry's independent expert, Dr Irani. This is DIR00001 please. You will be familiar I am sure with this report. If we could go to page 21.

If we could pick up at the top of the page please paragraph 3.2.2.1. It is the top paragraph:

"AR was out with parental control, he had been presenting a risk in the family home, he was withdrawn and spending considerable periods of time on his

computer, he was not looking after himself (he hadn't showered for more than a month)."

Would you agree with all of that?

**A.** Again, I wouldn't have regarded his -- what's reported there as being a risk presentation to others in the family home as significant from what was being presented to us --

**Q.** No, but from what was knowable from the records. So you have those two incidents in November, remember, of violence in the home and two further incidents of violence --

**A.** November when, sorry?

**Q.** November 21. Two incidents in November 21. There is the earlier occasion of an assault on the father in the course of throwing juice and then May 22, there is a further incident in the home.

So I think Dr Irani was here looking at what was on the records and what was capable of being known of presenting a risk in the family home seems a perfectly reasonable conclusion, doesn't it?

**A.** But, again, so you have to go on what's the current risk is as it is being presented to you, and the current risk as it was being presented to us by parents wouldn't have been sufficient to trigger a Mental Health Act assessment.



**Q.** Dr Molyneux, this was a father who was afraid to insist to his son on taking medication for fear of how he might react against a background of reported previous assaults by son on father.

**A.** It was never put across that there was a fear of serious violence. It was described just as aggression.

**Q.** But again that reflects in part material that was knowable on the records that you weren't aware of, the previous occasions where it seems that AR had assaulted his father and other occasions when he had violently thrown things around the family home?

**A.** Again, though we had never characterised him as meeting criteria for a mental disorder, so I wouldn't say that going to the Mental Health Act -- proceeding to the Mental Health Act --

**Q.** Leave that to one side for a moment. The plain words from Dr Irani "he had presented a risk in the family home", that's just accurate, isn't it?

**A.** The risk as it was presented to us at the time did not appear to be, you know, in terms of aggression towards parents, did not appear to be one of significant violence.

**Q.** You don't fully agree with that. Do you agree with the rest of it:

"Out with parental control, withdrawn and spending



considerable periods of time on his computer and not looking after himself?"

**A.** I do, although I think it is a salient point that certainly warrants mention that -- I mean, the way I would look at it in terms of findings of that assessment from that home visit of 25th September 2023, the one element that was a lingering cause of concern did appear to be the not having bathed or showered for a month. I was then within 48 hours given implicit reassurance by Alphonse in an email that said:

"Hi Dr Molyneux, it is good news here, AR has had a shower."

So an explicit communication of good news, an explicit communication of reassurance.

**Q.** Again, we must move on for the sake of time. An email which it is right that you were alert to, indicating that he had had a shower on a single occasion, doesn't mean that he had started looking after himself properly?

**A.** Well, with respect, when a parent who you have no reason at this point not to basically trust, as I have said earlier on, I doubted his effectiveness as a parent, but I didn't doubt his reliability or honesty. When a parent has put into you by email an explicit communication of reassurance "it is good news here", I think a clinician is warranted in accepting that in



the absence of any indication not to.

**Q.** Had you made any queries as to how frequently he was actually showering, given the report that he hadn't done so for a month or so?

**A.** Again, if a parent is saying it is good news here, good news sounds like good news.

**Q.** I'm going to move on.

"Right back in September 2023, when reviewing his attendance and parent's inability to make him engage, these should have been escalated through safeguarding."

Do you agree with that?

**A.** No, as I have said I don't. On the basis of the knowledge that was in front of me at the time, I absolutely do not believe that a Mental Health Act assessment was indicated.

**Q.** Please forgive me, Dr Molyneux, but you must listen to the question, and what you are being directed to. I will come to the Mental Health Act assessment, but what Dr Irani is saying here is right back in September 2023, when reviewing his attendance and parents' inability to make him engage, these should have been escalated through safeguarding. So raising a further safeguarding concern to the local authority.

**A.** So the email that I communicated to Kate Morris, the case manager and by extension to Sam Coppard explicitly

said that I did regard this situation as problematic, I did regard the situation to present with risk, the greatest seeming risk being risk of -- due to the parental overaccommodation -- risk of non-engagement with life opportunities, work, training and vocational aspects.

I asked Kate Morris, and by extension Sam Coppard for their opinions, and they completely agreed with the conclusion that this is not for CAMHS, this is for social care. I don't see what a safeguarding discussion would have achieved, given that we are all in agreement, three experienced clinicians are all in agreement that this is primarily for social care. A safeguarding discussion would, at that time, knowing what we knew, just have agreed with that conclusion.

**Q.** So if it was to be matters that social care would take on rather than CAMHS, does that not reinforce the need for safeguarding concerns to be raised to say: we are not in the best position to deal with this, but you, social care, should, so we want to raise this as a safeguarding concern, but we are going to move to close him to us?

**A.** So, yeah, a discussion with social care would have, you know, obviously by nature of the situation that's being discussed with them, would have flagged safeguarding



concerns, yes.

**Q.** And around the same time, when CAMHS were unable to meet directly with him, and then please note the words, what she is saying is:

"Consideration should have been given to carrying out a Mental Health Act assessment."

All right? That's not saying the Mental Health Act assessment at this stage should have been done, but it is at least indicating consideration should have been given to that. Do you agree with Dr Irani on that or not?

**A.** I agree in a probably quite literal technical sense in that I did give the matter of the Mental Health Act assessment due consideration in the sense of not considering it because it wasn't indicated. I gave the matter its due consideration.

**Q.** And do you think that -- well you say you gave it due consideration, but by definition your consideration that you gave it at the time could not have included all of that information about risk to others?

**A.** Well, no, but historic risk to others, or historic adjudged risk to others. But I do think it is really difficult to separate out the benefit of hindsight of what happened on 29 July 2024. You know, we mustn't lose sight of the fact that early on, and I think this



is a really important point, the clinicians who were involved early on, if they are getting three feedback reports from Prevent saying this doesn't need further escalation, that's three items of reassurance.

**Q.** Again, we come back full circle but the extent to which Prevent not taking him on for that particular programme is reassurance of a lack of intention to cause violence to others would require scrutiny of at least what your own records showed about the Prevent referrals.

**A.** As I said there, I was putting myself in the position of the clinicians who were involved at the time. My -- as I have said already -- knowledge of the involvement of Prevent was that there had been one and it was to do with the --

**Q.** Dr Molyneux, I understand that --

**A.** -- and no further action required and all the rest of it.

**Q.** For the purposes of all these questions, would you assume that you had a full picture of the risk information, so at least everything that was on the CAMHS records from 2019 onwards about previous risk information was known to you and answer the questions on that basis.

So, I think what you are saying is consideration was given to a Mental Health Act assessment on the



information you had, but you didn't think that it was appropriate. Would you accept that that should have been looked at much more closely if you had that additional risk information?

**A.** I think Dr Irani says in her report, doesn't she, that she concedes the point that a Mental Health Act assessment wouldn't have identified a mental health problem, but I think she says it would have provided an opportunity to --

**Q.** Dr Molyneux, just remember my question was would you accept that that should have been looked at much more closely if you had had that additional risk information? Do you accept that?

**A.** I accept that the index of consideration could only have been higher.

**Q.** Thank you. And then turning on to Dr Irani's view, if we go to page 25 please, and look at paragraph 3.4.4.1. It may be that this is what you are alluding to:

"Whilst it is not common practice to consider a Mental Health Act assessment every time a young person disengages from services, given AR's historic risks and his presentation, or the lack of physical evidence of his presentation in the early half of 2024, should have prompted a Mental Health Act assessment."

Do you agree with that?

**A.** I mean, he never presented with suggestion of a mental disorder. I'm not so sure I do agree with it.
**Q.** Can I ask you two aspects of the mental disorder. You make clear in your statement that the symptoms of anxiety that AR had you don't think amounted to a mental disorder. They weren't so severe as to amount to a recognised mental health disorder classified under ICD or DSN, yes?
**A.** Correct.
**Q.** What about conduct disorder?
**A.** So conduct disorder is a kind of diagnosis of exclusion really. It is not a mental disorder. It is really just a cluster of features of anti-social behaviour. It is not considered a mental illness. It is not considered a mental disorder.
**Q.** So you don't think that would have qualified as a mental disorder under the Mental Health Act?
**A.** My understanding is that it might be technically possible to detain someone, but that would be done in a forensic setting, not by a community CAMHS service and you would need to know that somebody ticked the boxes for that diagnosis.
**Q.** And at the very least, with all of the information about risk from his previous behaviour, that's a diagnosis that would have warranted consideration, yes?



**A.** Consideration possibly.
**Q.** And I should ask these questions carefully knowing that there are post event changes to the law in the way that autism is dealt with so far as the Mental Health Act is concerned. But AR's autism itself, could that not at the time potentially have qualified as a mental disorder for Mental Health Act purposes?
**A.** So, autism is considered -- I mean, it is convention really, it is just how things are kind of construed. Autism is considered as a neurodevelopmental disorder. Autism really just refers to the fact that somebody is presenting with -- if you look at the diagnostic criteria -- it refers to the fact that someone is presenting with significant and pervasive social and communication difficulties, in other words significant and pervasive hypersensitivity and significant and pervasive rigidities of thinking, behaviours and interests. Significant and pervasive meaning by definition these items are longstanding, these features are longstanding. The move over recent years, and I think rightly so, has been to discourage detention and indeed voluntary admission of young people to inpatient units. You have an autism diagnosis because such people tend not to do well in patient units.
**Q.** I understand that. And again there are changes to the



law subsequent, or proposed changes to the law, to remove autism, as I understand it, from the Mental Health Act. But, at the time, were you not aware that autism could qualify as a mental disorder for the purposes of the Mental Health Act?
**A.** Again, it is a technical point. It is not done in practice. You don't see people detained under the Mental Health Act for autism in practice, or you haven't.
**Q.** So, if that is right, and we will obviously explore with Dr Irani that a Mental Health Act assessment should have been done, but if you are right that there wasn't a power, does that show in fact that there is a gap in the legislation because there is nothing that can be done in this situation in terms of detention to carry out an assessment, even for a short period of time, even though this young person is locking himself away and refusing to be seen by professionals against a risk of harm to others? Is that a gap in the legislation?
**A.** I don't know. I guess it could be argued as such. I would be very careful -- I mean -- I would be very careful about demanding the need for more laws really. I can see there might be an argument for it. I mean, again, from my point of view, looking at this whole case in retrospect, what strikes me more than anything else



is the unusualness of the parental presentation really. Again by its very nature this is something that's only possible to see with the benefit of hindsight, the extent to which parents were evidently --
**SIR ADRIAN FULFORD:** Dr Molyneux, I am going to ask you to focus on Mr Moss' questions rather than engaging in ruminations --
**THE WITNESS:** I understand --
**SIR ADRIAN FULFORD:** -- about your overall thoughts. So can you --
**THE WITNESS:** I understand sir --
**SIR ADRIAN FULFORD:** -- focus on the issue at hand, please.
**THE WITNESS:** Of course, sir. I --
**SIR ADRIAN FULFORD:** Can you wait for the next question.
**THE WITNESS:** Apologies.
**MR MOSS:** We then move to the stage where the decision to discharge AR from psychiatry altogether. I think that was at 16th April, and at that stage would you agree that rather than having reduced in a sense AR's needs and the concerns about him had escalated by then because of that sense in which he had withdrawn?
**A.** By 16th April 2024?
**Q.** Yes?
**A.** No, I disagree with that. I had been given numerous, as is set out in my Rule 9 report, reassurances by email by

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

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

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

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

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

"[AR] had a history of repetitive and persistent



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

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

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

**Q.** Assume that they were?

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

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

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

**Q.** Thank you. Page 33, please. Same report. Paragraph 4.4.7 in AR's specific case, it is Dr Irani's view that:

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



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

Do you agree with her on that?

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

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

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

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

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

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

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

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



I leave time for any questions for others.

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

**A.** No problem.

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

**A.** Yes.

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

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

Do you want to amend that assertion in any way?

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

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

**Q.** Briefly, what do you mean by a unified system?

**A.** I would like to see public sector agencies be able to access information from each other.

**Q.** So going right back to the question I asked you at the outset about do you have access to other agencies information on some sort of shared platform?

**A.** Not easily, no.

**Q.** You don't have that?

**A.** Not easily or quickly, no.

**Q.** Dr Molyneux, no one would doubt the difficulty of the



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

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

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

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



of July of this year, you knew by then about a lot of the risk information that I had taken you through?

You said "I was aware of that later", yes?

**A.** Some of it. I have become cognisant of more of that information as time has gone on.

**Q.** Presumably you had read through AR's notes for example --

**A.** I had -- I mean, it was a very quick turnaround time for producing the reports, wasn't it?

**Q.** Presumably you read the notes before you drafted this statement, pretty basic?

**A.** Yes.

**Q.** Yes. And having read the notes, and seen the risk information that was available in the notes, you still said "I am 100 per cent confident that not only did I and my organisation do everything we possibly could", if it would be suggested to you that it is concerning in itself that you did not recognise that shortcoming in producing your statement, what would you say?

**A.** I guess that statement there is a reflection of my honest view that I see my colleagues work so hard and if you could see, you know, email timestamps flying around between staff where people are up until all hours of the morning and really, really exhausting themselves doing everything we can for our young people, then the level



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

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

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

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

**Questioned by MR WEATHERBY**

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

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

**A.** Yes.

**Q.** Mr Moss took you to the standard operating procedures about what was required?

**A.** Yes.

**Q.** Given what you have just said a few moments ago, is the mismatch between those two points, is it resources? Is

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



problem that you have highlighted?
**A.** Those steps have already been taken by Alder Hey. So salient information is now, due to amendments and modifications and developments of the ERP -- EPR I should say -- that salient information is now much more visible and all in one place.
**Q.** In a similar situation, on the EPR you would look at it and you would see a box or field which showed the matters that Mr Moss has gone through?
**A.** Yes.
**Q.** Thank you very much.
**SIR ADRIAN FULFORD:** Yes, Mr Bowen.

**Questioned by MR BOWEN**

**MR BOWEN:** I ask questions on behalf of the bereaved families and I would just like to spend a few moments asking you about conversations that you have had with other staff members over your time in the case.
**A.** Of course.
**Q.** First of all, Samantha Steed?
**A.** Yes.
**Q.** Who I think was the case manager between August 22, I think -- sorry --
**A.** I think she came to it around August 22.
**Q.** Finished on 5th September 22. So she was there at the earlier stage and then we had Kathryn Morris?



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



**A.** Yes.
**Q.** They will know the history?
**A.** Yes. If I could just go back to your last point. Sam Steed's role or time as case manager came to an end just as mine was -- as my role -- as my time as consultant was beginning.
**Q.** Yes, exactly, and there are documents, we don't have time to go through them, where there are emails between you, discussions about safeguarding incidents for instance. Do you remember that?
**A.** There was one email from Sam Steed that was -- it is early on in my Rule 9 statement, isn't it? It is an email that was sent as a reply to an email from one of the secretaries to say that they had cancelled an appointment and Sam Steed did a joint email reply to myself, Vicky Killen our clinical lead.
**Q.** That is right. I think the reference for that, sir, is AHCH000290 and 000164 I think.

We know from Kathryn Morris' witness statement -- sir, again for your note particularly paragraphs 119, 168 and 180, that's 000278 -- that certainly those periods of time, and for those references it is 5th June 23, that's 119, sir. 22nd February I think '24, 168, and 23rd July 24, she gives evidence specifically about the referral to CAMHS being due to

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



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



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



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

had had involvement with Prevent and Forensic CAMHS. I was also aware that he was discussed in multidisciplinary team meetings in MDT 3, previously and placed on the routine psychiatry waiting list.

Following that, in May 2021, he was discussed again and the notes suggest that he was making progress but he was requesting medication and hence he was placed on the psychiatry -- urgent psychiatry waiting list and then allocated to me.

**Q.** So that's how he was first allocated to you and I understand your first appointment with him was on 1 July 2021?

**A.** That's correct.

**Q.** What information did you have access to about AR at the start of your involvement? We saw this morning the electronic patient system. Would that be the main source of information?

**A.** Yes. So as a consultant child psychiatrist, I would heavily rely on information on the electronic patient records and verbal kind of information from the case manager, whom he is open to. I was aware that there had been previous FCAMHS and Prevent involvement, basically from some session notes or some notes on electronic patient records and from the case manager Samantha Steed, but I did not have any access to reports



or letters from either of these services.

**Q.** And is that typical, that you wouldn't have access to other agencies' record systems?

**A.** Not unless they are scanned or -- at the time in 2021, we used to have something called Image Now on electronic patient records. So any information or letters that are scanned from external agencies would be visible through the ImageNow app. Unfortunately there was nothing on ImageNow for AR.

**Q.** Okay. So the system in CAMHS at that time was that you were essentially reliant on other agencies sending you information or records that they may have and somebody at CAMHS uploading that onto the CAMHS system?

**A.** That's correct.

**Q.** You said that you had access to the electronic patient system, the CAMHS records. You explain at paragraph 12 of your statement that you familiarised yourself with AR's background history by reviewing the Alder Hey records. Did you review his records in their entirety?

**A.** I reviewed his records in its entirety from the point he was referred into CAMHS. So I was aware that there had been three CAMHS referrals made. The first one he was signposted to voluntary sector organisation called Parenting 2000 for parenting support. The second referral was also not accepted and following an offence



the third referral, which was made by the Criminal Justice Liaison Service was accepted and he was allocated a case manager. So I had access to information from that point onwards.

**Q.** And you reviewed the records from that point onwards?

**A.** Yes, I did.

**Q.** Is that what was expected of you as a consultant psychiatrist, to you have reviewed the whole records when you take on any patient?

**A.** I would like to say when you say whole records, Alder Hey has so many different departments and electronic patient records may include information from other departments, not just CAMHS. So usually we find that there are relevant information about patients from community paediatrics, for example, which may be relevant to our kind of approach to the patient, especially around the diagnosis of neurodiversity or other kind of information, safeguarding information for example. Sometimes you only have access to view certain records, not all of them, unless they are actually in the form of clinic letters that are uploaded onto a system called Medisec. So if the patient is open say to a paediatric specialty for a physical health problem, I will be able to access their records by reviewing clinic letters if they are uploaded.



**Q.** All right. So when you said you reviewed the whole of the records for AR, just to be clear, which records do you mean? Was it just CAMHS records --

**A.** That's right.

**Q.** And were you provided with an oral or written handover over by the case manager or anyone else when you first became involved?

**A.** So within CAMHS at Alder Hey there is no standardised handover procedure that we follow. A referral to psychiatry would be made via a multi-disciplinary team discussions, an agreement made and a consensus that the patient should be accepted by psychiatry. That information would be then available on electronic patient records in the form of professional discussion often documented by administrative staff. So the administrative staff will capture the discussion and make a brief summary of the discussion and often that is the only information you have with regards to why the patient has been referred to psychiatry.

**Q.** And do you remember in AR's specific case whether you were, like the example you just gave, you were reliant on a written handover, or whether there was a separate oral handover?

**A.** Nothing at all. The only information I had was from the electronic patient records. Sorry, also I had a brief

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



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



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



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

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

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

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

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

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



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

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

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

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

**A.** Absolutely.

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

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



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

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

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

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

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



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

And then Mr Hicklin goes on to conclude:

"I am of the opinion that assessment by our service is not indicated as until his diagnosis is complete we would not be able to contribute further to the understanding of risk."

Then the last sentence:

"The case will now be closed to FCAMHS but any professional can contact the service for clarification of this letter or if review is indicated because of a significant change in circumstances or risk behaviour."

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

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

have made my approach a little bit more holistic to include risk to others as well, because what I had in front of me and what I was aware of did not alert me to consider risk to others as a major factor.

**Q.** Yes. I think now is a good time then to go through some of the specific events that took place involving AR and this is all I'm going to be asking you, if you can confirm in respect to each of these whether you were aware of that when you first started seeing AR in July 2021.

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

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

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

**A.** Yes.

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

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

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



attempting to view graphic images of degloving injuries?

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

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

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

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

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

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

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

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

**A.** Yes.

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

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

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



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

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

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

**A.** No.

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

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

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

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

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

**A.** No.

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



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

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

**A.** Yes, absolutely.

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

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

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

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

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

patient record. Is that right?
**A.** Yes, I think this looks like a referral -- a discussion following referral to the service.
**Q.** Sorry, this is just page 1. If we look at the bottom of page 3, please. If we could zoom in on the bottom paragraph, it says he has been recently excluded after taking a knife into school with the intention of using it if provoked.

If we could also look at page 9, the third paragraph down, which starts "Seized computers", there we can see it says:

"AR spoke to Childline and told them he took a knife into school on 10 separate occasions. Childline spoke to police."

Do you accept that that was on the CAMHS?
**A.** Yes, this looks like a CAMHS record.
**Q.** All right. And the fact that in the hockey stick incident AR had the intention of killing someone, I'm happy to take you to the reference, but perhaps you can take it from me now we have looked at that one, that is also in the CAMHS records and it is the same document at page 4 and 8. The fact that he received a ten-month referral order, you said you were aware that that was on the records?
**A.** Yes.



**Q.** The fact he had been viewing inappropriate content online in relation to terrorism, that was also in the records. That's AHCH000162 page 9, top of the page for the Chair's record. We don't need to bring it up.

There were several other matters also in the records. Firstly, the fact that he had researched the Manchester bombing and considered that it was a good battle from the suicide bomber's perspective. And that he had been researching the London Bridge bombings and making comments about Israel and Palestine at school and had to be referred to Prevent again. And finally the incident where AR threw juice over his father and those references were given, Chair, this morning in the context of Dr Molyneux's evidence?
**SIR ADRIAN FULFORD:** Yes, thank you.
**MS WAKEMAN:** So although you said that you had reviewed the records in full, the only incidents of the ones we have gone through which you were in fact aware of is essentially the hockey stick incident and the referral order that follows. Do you accept that you must have not conducted a very thorough review of the record and you have missed these entries somehow?
**A.** I do accept that, yes. I accept that.
**Q.** How do you think it came to be that crucial background information such as that simply failed to reach you?



**A.** I think when a new patient is referred to you and then you look through records to the best of your ability and feel reassured that two agencies like FCAMHS and Prevent have closed him to their care, and that the current presenting symptom is one of anxiety and avoidant behaviours and school refusal, I guess you know that's one of the reasons why I just moved on to focus on the presenting problems.
**Q.** Is there really two elements of weakness here? Is the first that there was a weakness in the system in the sense that the CAMHS system for keeping track of really important information about risk didn't make it clear to you as an incoming practitioner that that information should have been clearly visible to you on the system, shouldn't it?
**A.** On reflection, certainly I agree with that.
**Q.** But secondly, given that for the entries I have taken you to, that some of that information clearly was on the system, do you accept that you failed to that extent in your duty to adequately check the notes and inform yourself of the background?
**A.** Yes, to an extent. You know, I should have reviewed the record in its entirety. But in many instances you know we get a good picture of the young person referred to you by reviewing records from the time they get referred



to CAMHS and that gives you a clear sense of their journey and their presenting problems. So I guess it was an oversight on my part to have missed some information, but I did know that there was a risk of harming others and that behaviour of him I was aware of at the time of seeing him.
**Q.** Was resourcing an issue which in any way contributed to the failure to do a full review of the records, do you think?
**A.** On reflection, when a patient is referred to psychiatry, it could be -- you know, it could have been really helpful to have a standardised information handover to psychiatry, specifically focusing on the key areas of risk, risk to self, risk to others, risk of self-neglect and risk of vulnerability. That in a one-page format could really, really alert the psychiatrist to key information that you need before you see a patient. So that is definitely a learning that I have taken from this Inquiry.
**Q.** Thank you. Would an awareness of all those incidents that we have gone through, which do demonstrate, I would suggest, a history of violence and an interest in violence, have been important to your assessment of the risk that AR posed to others?
**A.** Certainly, yes.

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



first present during that first appointment?
**A.** During the first appointment AR was insistent that he spoke to me and he did not allow his father to speak to me. So usually during first appointments we would gather information from parents to obtain corroborative history and then talk to the young person or me to the young person to obtain their views and to carry out an assessment. It was very interesting that AR did not want his father to be part of the interview.

He articulated symptoms of anxiety as if he had rehearsed it from a book or from the internet. The way he articulated was quite unusual, and it was very apparent that he was trying to convince me and to persuade me that he needed medication.

On top of that, when we discussed medication and the need for medication, he disagreed with me on multiple occasions and slowly started becoming argumentative. At one point when I finally said that I would give him a trial of a beta-blocker, such as propranolol, to reduce his symptoms of anxiety, which he had articulated very well, the physical symptoms, he disagreed with me yet again and said that he should be on a medication such as an anti-depressant called SSRI medications.

I explained to him that, based on the history that he has given me, I'm not convinced about the indication



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



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

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

**Q.** And from the records?

**A.** And from the records.

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

**A.** That's correct.

**Q.** You have talked a little bit about the prescription drugs that AR was requesting. Before prescribing drugs, did you consider whether talking therapy might have been appropriate?

**A.** I was already made aware by -- in the referral information and the discussions in the MDT that AR had



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

**Q.** We know from your statement that you went on to prescribe AR with propranolol?

**A.** Yes.

**Q.** Because you say that SSRI medication wasn't clinically indicated at that time?

**A.** No.

**Q.** And did he take that propranolol as advised following the appointment?

**A.** No. So, a few days after the first appointment I had a message from the case manager, Sam Steed, that AR had taken propranolol for just one day, so just one dose of medication and then reported to his father -- so this was the reported information from AR's father to Samantha -- that AR had reported that this medication is not right for him and that he will not take it anymore and also shared that he will only take medication if I spoke to him about it. So he was quite demanding that he needed a conversation with me about medication.

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



It is right, isn't it, that following that initial appointment, AR later did agree to try propranolol again?

**A.** That's right. So, for the following conversation with Sam Steed, Sam contacted the family and shared my view that AR should give propranolol a fair trial and that I would be willing to review it at the next appointment.

**Q.** All right. And then you had a further telephone appointment the next month where AR was again asking for SSRI medication?

**A.** That's right.

**Q.** There was then an appointment which I think you weren't able to attend but Dr Aesha Aseri attended?

**A.** That's right.

**Q.** They noted that AR presented with a diagnosis of autism spectrum disorder and a moderate degree of social anxiety and that doctor started AR on sertraline tablets which is a type of SSRI?

**A.** That is correct.

**Q.** In terms of the diagnosis of autism with a moderate degree of social anxiety, was that also your diagnosis as well?

**A.** I think Dr Aseri actually means that AR's presentation at the time was in keeping with anxiety in the context a young person with neurodiversity such as ASD.



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

**Q.** So symptoms of anxiety arising from the ASD?

**A.** Yes, correct.

**Q.** And did you agree with that diagnosis?

**A.** Yes.

**Q.** Did you at any stage give thought to any other diagnoses, for example, conduct disorder?

**A.** Although AR's behaviour and the demanding nature was quite unusual, I did not think about a conduct disorder at that point in time because I did not have evidence for persistent repetitive anti-social tendencies because that is the first feature that would alert a psychiatrist to consider a diagnosis of conduct disorder. Especially in the context of a child with autism spectrum disorder, disruptive behaviours, behaviours of concern, challenging behaviours such as trashing the house or hurting family members, is not unusual. So, within CAMHS we understand this in a kind of a holistic way and we often try and understand this whether this is in the context of ASD first. So considering conduct disorder at that stage was not appropriate.

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

--
**A.** Yes.
**Q.** -- of persistent repetitive, anti-social tendencies?
**A.** Yes.
**Q.** But bearing in mind all of the incidents that we went through earlier, had you known all of that information, would that not have given rise to --
**A.** Absolutely, absolutely. I would have considered that and not just that, I would have contacted forensic CAMHS for a consultation as well.
**Q.** Even though you weren't aware of the invitation to refer back to FCAMHS, just of your own volition --
**A.** Yes.
**Q.** -- you think might have alerted you?
**A.** Yes.
**Q.** So is it right that you wouldn't disagree with Dr Irani when she says that, in her view, AR would meet the diagnosis for conduct disorder?
**A.** I don't disagree with her, but her opinion is based on the fact that she was aware of the entire history and the incidents, so, if you ask me now, I would say yes, but not at the time when I was involved.
**Q.** And just to run through a few more of the appointments. So you had a further appointment on 13th October 2021. At that stage there was no improvement in terms of



functioning and so you increased --
**A.** That's correct.
**Q.** -- the sertraline dosage?
**A.** Yes.
**Q.** A follow-up appointment on 15 November 2021 where there were some positive changes reported?
**A.** That's correct.
**Q.** And it was reported that AR had attended school for four days a week before the appointment. He did also report though -- he reported improvements in his anxiety, but you did also agree to increase his dosage of sertraline?
**A.** Yes. Wasn't that the appointment where he also complained of feeling tired from the medication? And I had said I would review it. So he was also reporting side effects from sertraline, yet asking me to increase the dose, which was quite conflicting. So, I told him that I would consider an increase in medication and to wait until the tiredness wears off.
**Q.** Right. So that appointment was on 15th November 2021 and the Inquiry has heard some evidence about an incident that occurred on 5th November 2021?
**A.** That is correct.
**Q.** During which AR trashed his house and his mother called the police.
**A.** That is right.



**Q.** You note in your statement that at your appointment on 15th November, so ten days after that incident, neither AR nor his father informed you of the incident?
**A.** No.
**Q.** You say at paragraph 30 of your statement that you would have expected the young person and family to be open and honest with you and if you had been informed you would have explored this further to ensure the right support?
**A.** That's correct.
**Q.** Would you have expected Ms Steed, the case manager, to have informed you of that incident if she was aware of it?
**A.** Absolutely. We rely as psychiatrists heavily on information being shared by case managers and with the multi-agency system around the child to inform our treatment and to enable good outcomes.

In this situation the documentation about the incident by the case manager was made on the day of my appointment later in the evening, so I was unable to review that prior to my appointment, and as the family also did not share those concerns, and in fact gave me a completely opposite view, saying that he had improved massively on medication, it was a challenge for me.
**Q.** You are right to note that that incident was entered into the CAMHS record on 15th November.



**A.** Yes.
**Q.** Did you ever check that record yourself, either later on 15th November or at a later date?
**A.** So normally we would go back to review patient records when we have the next appointment with the young person. Purely because of how busy we are and we don't have time to go into the records between appointments unless there is a reason to do so. So I was aware of the fact that there was an incident on 5th November at the appointment following the appointment on 15th November.
**Q.** So you did review the record?
**A.** Yes. And I had also confirmed that the case manager had taken appropriate steps to manage that situation. She had contacted the targeted youth support and family support worker based in West Lancashire to discuss this incident and the family were offered support by Carl, their targeted youth worker, and the other lady, I think it was Sharon, who was the family support worker from West Lancashire.

May I also just add a point here to share that, in AR's case, there was also challenges in multi-agency working and information-sharing purely because of the fact that there were two localities involved. So within Sefton area, you know, having worked there as a consultant for about 15 years, I do know people,

I know the social workers, I know the family support workers because we work with them quite closely. Unfortunately, because AR's home address was based in Banks, the social care support and family support worker, et cetera, came from a different locality and that also posed challenges in terms of communication.

**Q.** Did you do anything at the time to flag that as an issue --

**A.** Yes --

**Q.** -- or is that something that you reflected upon --

**A.** I did.

**Q.** -- in hindsight?

**A.** No, I did. It is in an email to check with the administrative staff about checking whether he should fall within our locality or be referred to West Lancashire CAMHS, and I received a reply that because his GP was based in Sefton, we accept all patients who are open to a Sefton GP. So there was nothing we could do about it.

**Q.** All right. I want to move on to some further incidents. So you explain at 33 of your statement that on 21 November 2021, AR's father contacted the CAMHS crisis team?

**A.** Yes.

**Q.** To say that there had been two incidents of intimidating



behaviour by AR towards him and that included verbal threats and pouring milk over him. Were you made aware of those incidents at the time?

**A.** I wasn't made aware of the incident at the time, but I was able to review that incident at my next appointment and understood that the collective view of crisis care team, following the discussion with father of AR, was that this is essentially a social issue and that it had been addressed. Sorry, and also to add actions had been taken, so the crisis care team advised that there should be a multi-agency meeting to discuss it because this behaviour was within a context of difficult family dynamics. So an early help meeting was held two weeks later which Samantha Steed attended and she was able to discuss appropriate support for the family. So I was aware it had been dealt with properly.

**Q.** And the Inquiry has also heard about a further incident on 30 November 2021 where AR had kicked his father and thrown a plate at a rental car causing the windscreen to crack?

**A.** I wasn't aware of this incident at all.

**Q.** And on 21 January 2022, he had made comments in the school about the Holocaust. Were you aware of that?

**A.** I wasn't aware of that at all.

**Q.** And on 25th January 2022, he had talked about the death



of Princess Diana, water poisonings and said that he believed that sometimes violence was necessary. Were you aware of that?

**A.** No I was not aware of that.

**Q.** Who, in terms of other agencies potentially would you have expected to make CAMHS aware of those matters, or would you have expected that to have come from the family?

**A.** No. In complex situations and children presenting with complex difficulties such as AR, where multiple agencies are involved, which is actually a positive thing -- school, police, and other agencies in the past -- I would expect the person who dealt with the particular incident at the time to share information with all relevant agencies that need to know about it. And that's what did not happen. And I would include police in this as well.

**Q.** I then want to turn to one final incident which was on 17 March 2022, where AR went missing from his home address and he was later found on a bus in possession of a knife. And when the police dealt with him, he made remarks about wanting to stab people, and about either having thoughts about making poison or having made poison. Were you aware of that incident at the time of treating AR?



**A.** I was aware of this incident at the time of treating AR when he was in my care but not immediately after the incident. I was able to review these notes when I saw him after that incident, a few weeks later, and I had -- so the information that you are sharing here about -- further details about him sharing information that he wanted to stab someone was not shared with us. The only information that was shared and which was in the electronic patient records was that AR had gone missing in the morning, so father of AR contacted us via reception to share that he had left the house at 8 am and returned home at 10 am and between 8 am and 10 am AR had left the house and had gone missing. And this was not relayed to me but only to the case manager. So I was not copied into this communication from the administrative staff. It went to the case manager who duly contacted the family and enquired about the incident, only to be told that he had returned home.

She offered an appointment the day after and assessed the risk and enquired with AR about the incident of him going missing. AR was not too keen to go into the details. However, she documented in the records that risk to others was low. Sorry. Risk -- under the risk category the question, she had said no risk. She had also obtained safeguarding advice from

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

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

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

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

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

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

Then you say:

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

I think was that you were talking about just now?

**A.** Yes.



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

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

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

**A.** Yes.

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

**A.** Yes.

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

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

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



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

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

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

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

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

**A.** That's right.

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

**A.** That's right.

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

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



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

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

**A.** That's right.

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

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

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

on 23rd May 22, had been intimidating and disrespectful?
**A.** Yes. So, I'd like to start by saying that this is the very first time in my entire career as a doctor where I have had to request change of psychiatrist because of how I was made to feel by a parent. It is quite unprecedented, in my opinion, and I vividly remember the level of distress I went through at the end of the appointment. I also put an incident form to share this because I felt that no one else from our department or from our CAMHS service should experience that. So I had to put an incident form both in the interest of my own interest and also in the interest of my staff, and followed the due process of requesting a change of psychiatrist by contacting the clinical lead and copied the email to psychiatry lead in Sefton, joined a meeting with the clinical lead to try and mediate this discussion and then went on to kind of have the outcome that actually happened.
**Q.** Yes. It was agreed following that meeting, wasn't it, that you would be replaced with a male psychiatrist?
**A.** That's right.
**Q.** To be clear, with the intimidating and threatening behaviour, did that ever come from AR himself?
**A.** Never.
**Q.** Or was that just from AR's father?



**A.** Never.
**Q.** Is it right that your involvement with AR ended on 23rd June 22 when you were replaced?
**A.** That's correct.
**Q.** We know of course now that Dr Molyneux was assigned to replace AR. What handover took place between you and Dr Molyneux?
**A.** Okay. So when I approached Dr Molyneux about handover of clinical information about AR, I was told by Dr Molyneux that he had already met with Samantha Steed, who had given him a fair bit of information about the patient.

I then gave him verbal kind of handover of salient information that he needed to know and that information predominantly included clinical information about medication compliance, the difficulties I had faced on 23rd May with his father, and about the past history. I have to say that I did not go into a lot of details about the previous involvement with Prevent or FCAMHS with Dr Molyneux.
**Q.** Yes. I think you were listening into Dr Molyneux's evidence this morning, so you will have heard him say that he was essentially unaware of all of the incidents we have gone through today that pre-dated his involvement, save for AR bringing a knife into school



and that he was aware of one Prevent referral. Is that because you didn't pass on any of that information?
**A.** I didn't go into great details about the incidents or the previous behaviours, but it was touched upon. So he was aware that there was some concerning behaviours that necessitated police, Prevent and FCAMHS to be involved. As I said, the focus of handover over was essentially on the handover of treatment that I was providing for AR and the concerns around his non-compliance.
**Q.** You say you didn't go into great detail about the incidents, but did you actually tell him about the hockey stick incident, for example?
**A.** I think I did. I'm not able to recall the entire discussion, but I am sure I would have mentioned it.
**Q.** What about the incident with the possession of the knife on the bus in March 22?
**A.** Again, you know, I can't remember if I specified specific details about information -- you know incidents. I am sure I handed over in a kind of a holistic way, without going too much into the details about each incident.
**Q.** Given what you said earlier that the focus of the handover was about handover of treatment and concerns about non-compliance, do you think you might be mistaken about whether you informed him about, for example, the



hockey stick incident and the bus incident?
**A.** I honestly can't remember.
**Q.** Did you have an expectation that, notwithstanding what you told him in the handover, he would also be separately reviewing the records himself?
**A.** I would think so.

May I add a point on the point of handover?
**Q.** Yes.
**A.** So, again on reflection, just like the point I made about information that's handed over to a psychiatrist when a new referral is made to them, I wonder if a standardised format of handover of information is developed within CAMHS, especially when you are transferring care to another psychiatrist.
**Q.** Thank you. I now want to -- I said I would come back to risk assessment earlier -- and I just want to come back to it now and about how risk was assessed.

It is right, isn't it, that the risk assessments conducted by case managers or any other clinicians within CAMHS would be recorded on the electronic patient system. Is that right?
**A.** Yes. So there are two ways in which risk is recorded. At every contact with a patient, when they complete our session notes, so basically it is an electronic way of documenting what was discussed in a session. There is

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

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

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

**A.** Anyone. Anyone.

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

**A.** That's right.

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

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

**Q.** The Alder Hey internal learning review found that AR was



risk-assessed on triage on 11th October 2019 and 15 October 2019. Sir, for your note that is AHCH000294 page 90, paragraph 352.

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

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

**A.** That is true.

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

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

**Q.** But would you, as the consultant psychiatrist, not think to say to anyone: look, no one has looked at this



child's risk?

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

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

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

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

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

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

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

**A.** No. For example, these are actuarial risk assessments and these are highly specialist and standardised risk assessments that needs training and regular supervision



in terms of how these assessments are conducted and interpreted. So it is not something that community CAMHS/specialist CAMHS services like Sefton CAMHS is equipped or trained to conduct.

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

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

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

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

**A.** Yes.

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

**A.** This is a very wide question to be honest. So AR presented with so many different types of risk: risk due

to non-school attendance, risk from isolation and risk of challenging behaviours and disruptive behaviours causing harm to others. So there were so many different types of risks.

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

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

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

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

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



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

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

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

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

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

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

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

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



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

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

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



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

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

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

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

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

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

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

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

**Questioned by THE CHAIR**

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

**THE WITNESS:** Sure.

**SIR ADRIAN FULFORD:** The first is you will remember that



Ms Wakeman has set out the full list of things that were known that had happened in the past, ten times with a knife, hockey stick, Manchester and all the rest. So imagine that that was all known by whoever had responsibility for AR at Alder Hey. That's number one.

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

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

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

**THE WITNESS:** So, first of all, I would actually review whether Alder Hey CAMHS is the correct service for AR given this information. Because community CAMHS are not equipped to support children and young people presenting with a conduct disorder. It needs to be led by social care and the threshold for discharging a child with conduct disorder would be very, very low because it is a disorder of social construct, the interventions that



we offer are offered by other agencies and also my threshold to involve FCAMHS and Prevent would have been very, very low.

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

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

**SIR ADRIAN FULFORD:** Nothing else? No one else? So you would have referred this back to AR's -- or you would have foreseen that this would have been referred back to AR's parents and no other steps would have been taken?



**THE WITNESS:** No, I'm not saying that. I would expect them to be honest about their concerns with the psychiatrist so that the psychiatrist can take appropriate action which may include requests for an actuarial risk assessment, which may include requesting records from other agencies, which may include referral to FCAMHS and involving Prevent again. So those would have been the actions that would have been taken.

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

**(3.36 pm)**

**(A short break)**

**(3.46 pm)**

**DR OONAGH VICTORIA KILLEN (sworn)**

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

**Questioned by MR MOSS**

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

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

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

**Q.** If we could have your statement on the screen please, it is AHCH000229. It is a statement you gave helpfully earlier on 25 July 2025 and could you just confirm that the contents of that statement are true to the best of

your knowledge and belief?
**A.** I confirm that they're true.
**Q.** To the extent, Dr Killen, that I don't go through all aspects of your statement, it will be published and it stands as your evidence, I want to ask you about some aspects.
**A.** Thank you.
**Q.** On the first page, just by way of background, you are, I think, a senior and experienced clinical psychologist. Is that right?
**A.** That is correct.
**Q.** You took your doctorate in clinical psychology here in Liverpool in 2002. You have additional postgraduate certification in service leadership in 2017?
**A.** Yes, that is correct.
**Q.** As well as being a treating clinical psychologist, you have been, since 2016, is this right, the clinical lead of the Sefton part of the Child and Adolescent Mental Health Service?
**A.** That's correct.
**Q.** And I think prior to that, you had experience as the deputy lead for the same service?
**A.** That is correct.
**Q.** Thank you. And if my maths is correct, I think you worked at Alder Hey altogether for some 23 or so years?



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



**Q.** Thank you. Your role as clinical lead, you describe it in paragraph 10, is this right, is overseeing the delivery of the service and providing assurance with regards to the safety and performance of it to Sefton CAMHS?
**A.** That is correct.
**Q.** And I think separate to that, you haven't become entirely, my words not yours, part of management because I think you still gave some input at the time as a clinical psychologist to individual patients?
**A.** Yes.
**Q.** Thank you. Both of the consultant psychiatrists from whom we have heard today already have been asked and pressed by us as counsel to the Inquiry about information checking and information sharing when they became involved.

Can I just ask you about that. As the clinical lead, what was your expectation in terms of practitioners who are starting engagement with a patient reading back through the previous notes?
**A.** So there is no formalised handover process, but we would expect that the reason for referral, presenting difficulties, care and risk screens would form part of that review of the record. The SOP does outline reviewing the full record, although we recognise that is



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

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

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

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

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

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

**A.** Yes.

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

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



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

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

**A.** Yes.

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

**A.** Yes.

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

**A.** Yes.

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

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

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

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

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



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

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

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

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

**A.** That is correct.

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

**A.** That is correct.

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



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

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

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

**A.** Yes.

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

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

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

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

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



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



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



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

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

"Please mention if any sibling and persons at risk. Yes, brother Dion but only if he hurts," it says "an animal. The family have no pets. What's the nature and degree of the risk? Who is at risk?"

And so on.

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

"Lack of emotional regulation, has ASC."

If we go over the page:

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

Risk management plan:

"Currently under child in need until police have checked in with his computer, et cetera. One this is received we will be able to establish a better plan going forward. AR is to remain at home, without school.



To see myself for some emotional regulation work."

Is that the standard of risk assessment in terms of the quality and level of detail that you would expect for a case of this seriousness?

**A.** No. I think we recognise that the risk management tool was neither filled out comprehensively enough or regularly enough in the record on review and I would agree that the detail, and especially the updated detail following the consultation from FCAMHS, wasn't included and that would have been beneficial.

**Q.** Why was it poor in that way?

**A.** I think it is the level of detail. The concern on his entry, I do not think is fully reflected in this document.

**Q.** And why weren't staff giving enough detail? Is that a training issue? A resource issue? Poor performance?

**A.** I think there is certainly -- we are doing quite a lot of work around -- and have been for a number of years around documentation and the time it takes for case management forms to be completed. We have reduced the number from four to two and there is a way of monitoring that. So I think it is -- I would say, Mr Morgan was a well qualified social worker. I do not think that was a training issue. I think it was -- the lack of detail is due to time taken to complete the form.



**Q.** Doing it too quickly?

**A.** I think so.

**Q.** Keep your voice up.

**A.** Yes, I think so.

**Q.** The two letters from FCAMHS which you have referred to in your statement, can we just look at them quickly please. AHCH000231. The first one.

Just go on to page 2, please. We can see that this is dated 11th February and it is to Ms Hallaron from Mr John Hicklin of FCAMHS following the referral and following meeting that had taken place on 21 January.

There is quite a lot of detail in here but you will be familiar, I think, with the fact that Mr Hicklin was saying that he discussed the case with Skott Morgan, made Mr Morgan aware of the concerns of professionals.

We see in the second paragraph that he records that AR had been open to Prevent, had been accessing mass shooting videos, now closed to Prevent. The hockey stick attack is dealt with. AR demonstrating little insight into the consequences.

The third paragraph records that AR's presentation likely met the criteria for autism.

And he recorded that:

"Given the level of concern that was felt by professionals, liaison with the paediatric team needs to



take place to ensure that they are aware of the concerns and that the paediatric team contribute to the risk management plan."

From your knowledge of the record, did Mr Morgan adequately record all of the detail in relation to those matters into the CAMHS records?

**A.** No.

**Q.** Again, was that a question of poor individual performance? Not taking enough care?

**A.** I think Mr Morgan left the service quite quickly and it was only after that he had left that we were made aware of the record-keeping. So I can't provide a lot of detail about the reasons for that. But yeah, I would expect the record-keeping standards at this time were below the standard we would expect from our service.

**Q.** Thank you. If we go to the fourth paragraph at the bottom of the page:

"I highlighted that the most important factor in managing the risk will be identification and integration into an appropriate educational provision."

A comment on the educational service. And then over the page:

"The need to complete their own risk assessment ... this will need to be completed in line with the process of gaining an EHCP."

We will come back to the EHCP perhaps in a little moment.

There is also reference in this letter to the importance of the paediatric team getting the ASD diagnosis. From your understanding, at this stage who was the lead agency that was meant to be taking these things forward? You have got different teams -- FCAMHS, CAMHS, you have got the paediatric department working on the ASD diagnosis -- who was meant to be taking it forward?

**A.** I think in respect to the paediatric pathways, it is documented that Mr Morgan had said that he would progress that, although there's no evidence in the notes that that happened. So I would -- it would be appropriate for us as a CAMHS service to forward the ASD diagnosis. I think the caveat with that is where the assessment of the forensic assessment is kind of paused or not completed due to a lack of an ASD assessment and I think -- so I think in this --

**Q.** We will pick some of that up with FCAMHS, but from the point of view of CAMHS, you would have expected, would you not, to see CAMHS in a documented way, my word, trying to expedite the autism diagnosis because of its importance to assessing the risk and to treating AR?

**A.** Yes, and that happens now. That is an improvement that



has happened already with the service.

**Q.** Again, I have to ask you these matters as the service lead. Are you aware that Mr Morgan's evidence even to this Inquiry is that he only met with AR once?

**A.** Yes.

**Q.** But that it is documented contemporaneously. Sir, for your note he wrote to Ms Jameson on 14 February AHCH000095 saying:

"I have met with AR on several occasions."

Yes?

**A.** Yes.

**Q.** And there was only one documented?

**A.** Yes.

**Q.** Again, that failure to make clinical records of meetings with AR, at this time, fell significantly below the required standard?

**A.** It did fall below the required standard and we have done a lot of work to provide assurance that this would not happen now. The way appointments are booked and the way session notes are recorded, it is impossible to have that disconnect.

**Q.** Thank you.

**A.** Highly unlikely.

**Q.** In the letter that we still have on screen, if we can go to the last paragraph, there is a whole raft of



interventions, mainly last paragraph:

"I also highlighted that AR would likely benefit ..."

There is a raft of things there that are being suggested that should be done. So:

"Benefit from interventions; focusing on an ability to think consequentially; improving his capacity for an empathetic response; developing a range of alternative strategies to anger and developing strategies to manage stressors in his life. These interventions should focus on emotional recognition and regulation."

Then it says:

"Skott Morgan will liaise with colleagues in CAMHS and make comment at the forthcoming meeting as to how this need may be met."

Did that happen so far as you can tell from what was documented?

**A.** No, I can't see that in the record.

**Q.** Those at that stage were interventions that, rightly or wrongly, appear to have been given to CAMHS, would you agree, if not to provide, then at least to organise and take forward?

**A.** I think there is an invitation to multiple systems providing these interventions and I think that the



opportunities for learning around multi-agency conversations about who does what is a learning point.

**Q.** Yes. So it should be clear who is going to do what?

**A.** Yes.

**Q.** Who is going to actually provide the interventions but also clear who is going to organise them and check that they have been done?

**A.** Yes.

**Q.** And it doesn't look from the records as though either of that happened; not clear that the interventions happened and not clear that anybody was keeping an eye on them. Would you agree?

**A.** At this point in the record, I would agree there is no evidence of that. There is a subsequent conversation that I had with the Youth Offending Team.

**Q.** Yes, there is some information which we might touch on with the YOT later into some of the aspects. Thank you.

In your paragraph 35 at page 8 of your statement, you say that:

"Interventions linked to reducing risk of offending would be primarily the role of the YOT, the Youth Offending Team ... however, as a safeguarding partner we would heed advice as to the likely effective interventions that we could offer and we did indeed focus on anxiety and social anxiety and emotional

regulation."
**A.** Yes.
**Q.** That aspect of your statement might be taken to suggest that some of these interventions weren't at least ideally for CAMHS to take forward. Would you agree?
**A.** Yes.
**Q.** Others were better placed?
**A.** Yes.
**Q.** Have you seen anything in the documents that suggest that Mr Morgan or others in this service at this time said: this has been put at our door, but actually we are not best placed to do this, can you take them forward?
**A.** I can't see reference to multi-agency meetings or conversations that provides an adequate multi-agency care plan at this point, no.
**Q.** Thank you. Then the second letter, AHCH000231 please, if we could just go to page 4. 9 March. We have seen this before. I'm not going to read it all out because the learned Chair has seen it and you will have heard it referred to. But you will recognise this as Mr Hicklin giving his input on matters to be taken into account for young people with an autism spectrum condition diagnosis.
Bottom of the page, lists 3. If we just go over the page, just remind yourself. Then the passage at the



bottom, which has been read out I think twice today now so I won't read it out again. But, the aspect of FCAMHS saying that until his diagnosis is complete they wouldn't be able to contribute further on the understanding of risk and an invitation to come back.
At this time, do you know whether this letter actually went to CAMHS at the time? Because it is addressed to Ms Hallaron?
**A.** There is no record that it arrived. There is an email that I sent because I didn't have sight of this letter and understood that it existed.
**Q.** That's why I said at the time I am going to come back, but at the time there is no record of that arriving directly at that time?
**A.** No.
**Q.** Thank you. In paragraph 20 of your statement, at page 4, picking matters up at about this time in March, I think you raise concerns within Sefton CAMHS that a number of staff were off poorly and that it had left some patients without case managers. Is that right?
**A.** That's correct.
**Q.** We remind ourselves of course of the significance of those dates. So the first wave of the pandemic obviously, but also I think Mr Morgan, as you have touched upon, had left abruptly in February. You say



2019, I think you made meant 2020?
**A.** Apologies, that was 2020.
**Q.** We just crossed through and say 20. Noting the mitigation -- Covid and a member of staff leaving abruptly -- that did mean that there was a gap for AR at this time where he was without a case manager for quite a significant period. Would you agree?
**A.** Yes.
**Q.** We also see that in terms of the meetings that FCAMHS attended, so different to the original strategy meetings, the FCAMHS attended meetings on 21 January and 4th March 2020. I think you would agree that there was no CAMHS representative at them?
**A.** No, and that would not be in line with our service expectations. Although we were stretched for staffing, we would expect meetings would be covered.
**Q.** I'm asked to explore with you, and I'm going to do so briefly, is there any indication that CAMHS communicated to Lancashire County Council, so their Children's Social Care or the Child & Family Wellbeing Service, about Mr Morgan's departure?
**A.** I can't -- I think there is a reference to an email that I sent, but I think that was to the Youth Justice Team, Anna Jameson. In my statement I think I reference an email that I sent advising that Skott had left and



there was a new case manager identified, but I can't be sure that that went to Lancashire Children Services.
**Q.** Do you think that enough was done in terms of the local authority and social care and the CFW team to put them in the picture about the difficulties that you had at that time in terms of you couldn't cover it, there wasn't a case manager? Do you think that they should have been put more in the picture in relation to that?
**A.** Yes, it would be helpful I think. Information sharing around the system is something that, the more information that's shared in a more timely way of course would be helpful.
**Q.** Against that background, you tell us in paragraph 20 at the bottom of that page, perhaps 20 to 22, that it was within this context that the CAMHS input into the EHCP came to you as service lead because there wasn't a case manager or anybody else to do it. Would that be right?
**A.** That's correct.
**Q.** Just briefly in relation to the document itself. If we have AHCH000003, if we could go to page 2, please. If we look at the bottom of the page. Again I'm not going to read it all out, but if you just remind yourself of it. Then over to page 3, top of the page, there was there a reference, in fairness to you, to the Youth Offending Team intervention on anger management and

offending behaviours. There didn't seem to be any reference to some of the grave information that was available to CAMHS -- the hockey stick incident, the possession of knives in school, internet browsing -- that didn't appear to form part of the matters that you were alerting to?

**A.** No. My focus on completing this was about identifying the health needs and as I understood from the records, they were focusing on emotional kind of development, emotional language, but no it didn't include those other details.

**Q.** Looking back now at the totality of events that I have gone through with other witnesses, as has Ms Wakeman, do you think those matters should have been flagged up more in the EHCP, because some of them were risks occurring at school and at risk of worsening in the school environment in terms of school internet use?

**A.** I think one of the learnings that has come through personally and as a service is that we perhaps assume other people in the system have information, and I think that due to the information being highlighted from schools, I had an assumption that that was already included in the record. For my part in completing this document, I was focusing on the emotional health and wellbeing aspects.



**Q.** Given the risk of him changing schools, it would be important for all of that to be captured in the plan?

**A.** Yes.

**Q.** You deal in your statement with the fact that after this Mr Sam Coppard was identified as the new case manager. Is that right?

**A.** That is correct.

**Q.** I think you gave a handover to him of the information and what you had been doing on the case?

**A.** That is correct.

**Q.** Thank you. In paragraph 27 of your statement, can we just deal with it.

If we pick it up at the bottom of page 5. AHCH000229 page 5. You deal with 17th April 2020. Getting an email from a colleague in Crisis Care advising that Anne Simpson from the Lancashire YOT had been in contact.

Over the page, you refer to being unsure as to the precise time and date of the call. Sir, for your note at AHCH000162 page 30, there is a record of the call in note form.

But, you noted during the phone call that the risk assessment that is shared by Anne Simpson was re-offending risk medium, significant harm risk medium. Risk to children no. As you say in the paragraph below,



you added the comment that this was "unusual". Is that right?

**A.** Yes.

**Q.** If we go over the page to 31. Taking it as briefly as I may. You say with the benefit of hindsight you "would have recorded the conversation with Anne Simpson in more detail and I would have asked specifically about risk to children and the detail of the risk assessments that have identified a medium risk of 're-offending and 'significant harm'."

You would have enquired about and recorded specific details of any Children's Services involvement and any meetings planned for multi-agency communication. The email doesn't appear in the electronic patient record and that is an omission. That was a problem, wasn't it, emails being sent but not copied across to the notes?

**A.** Yes. Our learning around record-keeping is there were a number of omissions predominantly around email or text or loose paper documentation.

**Q.** Again, taking it briefly for speed, but there was something quite peculiar, given AR's risk information, taking a knife into school on ten occasions in October 2019, a serious assault with a hockey stick while carrying a knife on another pupil in December 2019. There was something very odd on its face about



the risk to children being marked as "no"?

**A.** Yes, and I should have been more curious and it also provides an opportunity to read across to the risk management tool as well.

**Q.** Thank you. Then you deal in paragraph 30 with the fact that, on 1st May, following up on the phone call that you had received, I think you then get in contact, is this right, with FCAMHS, and a number of others and you noticed that you hadn't had the read-out from the FCAMHS involvement?

**A.** Yes.

**Q.** You get the FCAMHS letters?

**A.** Yes.

**Q.** The ones that we have looked at. And taking it again shortly, it is right, isn't it, that at the time you had understood that those letters were scanned into the system and would therefore be available for practitioners going forwards?

**A.** Yes.

**Q.** We don't need to turn it up but that would be particularly important because of the FCAMHS letter, 9 March 2021, which gave what might be thought to be helpful guidance in bullet point form on areas of concern on the risk if there was an autism diagnosis, but also what might be thought to be the invitation to

re-refer to FCAMHS if there was a change in position or a diagnosis was confirmed. That was an important letter, yes?
**A.** Yes, I agree.
**Q.** I'm not suggesting, Dr Killen, that it was your fault, but it has emerged that those were not in fact scanned onto the system. Is that right?
**A.** That's correct.
**Q.** And although you passed that information on to Sam Coppard, because they were not physically on the record, there would be an issue about how visible they would be when Sam Coppard stopped being the case manager or if others were involved?
**A.** Yes, I only identified the missing scanning this year.
**Q.** Thank you.
**A.** But yes, it would have been an omission.
**Q.** After the attack?
**A.** Yeah, this year.
**Q.** I should mention that we had made available to us over the weekend, it is now on the Core Participants' disclosure, at AHCH000234 the internal investigation in relation to this, which, in addition to the two letters that are mentioned, indicates that three documents are now permanently lost and it says:
"Given the time that has elapsed, the searches



undertaken and the inability to locate the records, the trust has concluded that these records are permanently missing/lost without any clear audit trail of where they may be."
That is an unsatisfactory state of affairs, would you agree?
**A.** Yes. I think the FCAMHS letters do form part of those which we now do have because I think the dates are the four pages, but yes, it is unsatisfactory.
**Q.** At this time, when you had had to have an involvement as clinical lead and then were passing things onto Sam Coppard, had you yourself spotted the risk that not all of those interventions that Mr Hicklin had recommended had been taken forward?
**A.** The FCAMHS letters were sent to me after my conversation with the Youth Offending Team. During that conversation, the Youth Offending Team advised that through the referral order they would be targeting the offending behaviour and risk to others and they were clear that they felt that the role for CAMHS was to focus on anxiety and anxiety management.
**Q.** Was that in relation to each and every one of the interventions that had been recognised by Mr Hicklin, or was it a more general we'll deal with the offending behaviour?



**A.** I didn't specifically go through each intervention, but I recorded that the focus of the mental health support would be helpfully focused around anxiety, and I was confident that that was going to form part of the care plan going forward.
**Q.** I understand for the CAMHS role, but wouldn't it have been good practice, given that you were aware of the letter and the specific recommendations to check that those were all being -- my words -- ticked off?
**A.** Yes, that would have been helpful.
**Q.** I want to move to early 2021. Because in paragraph 40 of your statement you say that:
"Following the ASD assessment and diagnosis in early 2021, AR's father requested a re-referral to CAMHS on 3rd February 2021."
Is that right?
**A.** Yes. There had been a conclusion of work with Mr Coppard, although the records weren't closed off, so there wasn't a discharge on the system.
**Q.** So Mr Coppard had finished his work and it may be that in other circumstances he might have been discharged, but in fact he hadn't been. Was that an oversight?
**A.** It was an oversight. Yes, he should have been discharged.
**Q.** Technically he was still open?



**A.** Yes.
**Q.** And as you detail there, it is from then that Sam Steed takes over as case manager. Is that right?
**A.** Yes, that is correct.
**Q.** You also say though that:
"Engagement with Ms Steed focused on anxiety management, graded exposure, problem solving and re-engagement with education. This was all consistent with the outcome of the FCAMHS recommendations."
That may be strictly speaking accurate in the sense that that action and that proactive activity was consistent with what FCAMHS were saying, but dare I suggest that the elephant in the room is that FCAMHS had said effectively that it would be a case of re-referring to FCAMHS once the diagnosis of autism was made because they then might be able to give more help in relation to risk?
**A.** I hadn't read the letters like that, I recognise. I read the letters that there would be a change in circumstance. I hadn't read that it was as clear as that and I think that would be helpful. But yes, having re-read the letters more recently, I can see that that would be a helpful intervention after the ASD referral.
**Q.** I'm going to suggest to put that beyond doubt AR was somebody for whom, looking at him as an individual, not

making a generalisation about autism, his autism might increase the risk because he had already shown traits of a specialised interest, an obsessive interest perhaps, or a fascination with violence and violent material?

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

**Q.** A lack of empathy --

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

**Q.** -- in his criminal assaults. And a lack of understanding of consequences, yes?

**A.** Yes.

**Q.** All matters that in fact were highlighted in Mr Hicklin's letter?

**A.** Yes.

**Q.** So even if there was an ambiguity about exactly what the letter meant, knowing the information about AR's risk would have put him, can I suggest, squarely in the category of someone for whom a re-referral to FCAMHS would have been an appropriate step to take?

**A.** Yes.

**Q.** And that should have happened in February 21?

**A.** Yes.

**Q.** You go on in your statement to deal with the change in psychiatrist and your role in relation to that. I have touched on that already briefly and you have indicated that you think that that was appropriate action.



Looking at a slightly different aspect of that, and you may have heard Dr Ram touch on this, do you think the fact that an experienced psychiatrist such as Dr Ram felt intimidated and even threatened to an extent by AR's father and Ms Steed has also reached a stage where effectively the relationship had broken down, do you think that that itself may have been an indication of increased risk at the time?

**A.** I didn't at the time, but I think in reflection, looking at opportunities for multi-agency and multi-system working, which are imperative when we are looking at risk to others, I think that is a helpful reflection.

**Q.** Thank you.

At paragraphs 47 to 51 of your statement, you will appreciate, Dr Killen, that I'm dealing with a lot of helpful detail in your statement, some of it at speed -- on page 11 of your statement you detail aspects in which when AR had ceased engaging, efforts were still made to engage with him. So very briefly, things like offering him home visits, his preferred venue. Would you agree?

**A.** Yes.

**Q.** Preference for a female case manager, which is something I have touched on with you in the appointment of Kate Morris. That leads you in paragraph 52, at page 12 to say:



"Even with the benefit of hindsight, I cannot see that any more could have been done to re-engage AR in the service."

I'm going to come onto other aspects of reflection, but just looking at that in terms of the efforts made to get AR to re-engage, does that remain your view?

**A.** I think on reflection I looked at the phrase "re-engagement", whereas if we look at that as engagement, we can see that he did have multiple case managers, that people changed without preparing him for that change. So I think there are things that we could do across his whole journey that would have been more helpful in terms of not having those breaks in support.

**Q.** So continuity, both in terms of not having breaks, but also continuity of the same people?

**A.** Yes.

**Q.** It can't always be achieved?

**A.** Yes.

**Q.** But if it can't be achieved, then at least mitigating the change by --

**A.** Sharing information.

**Q.** -- sharing information about why it is necessary?

**A.** Yes.

**Q.** Thank you. I want to turn now in the remaining time we have to deal with the assessment of risk at CAMHS. Can



I go straight to this issue. Where did the responsibility for assessment of risk fall as between CAMHS and FCAMHS in AR's case?

**A.** I think that we defer that responsibility to FCAMHS. I think on reflection, and with the benefit of learning, I think the non-assessment by FCAMHS of AR incorrectly reduced our assessment of risk to others. So I think that we would flag to AR -- and I think we mistook, if that's the right word, for the non-assessment as perhaps not meeting threshold for forensic assessment, which with hindsight is not what's in those letters.

**Q.** We will come to those with witnesses tomorrow. But do you now understand that FCAMHS say corporately, actually it was always CAMHS who maintain the lead in responsibility for doing the risk assessments. We would help them with it, but it was never our responsibility to actually do the risk assessment?

**A.** My understanding of working in community mental health services we would defer to the risk assessment by FCAMHS should they do a full assessment. So I would appreciate more commissioning oversight of that. I think it is one of the areas where the interface is not as clear as perhaps it could be and going forward it has to be.

I think it is very difficult for a mental health service to hold and manage risk that you have not

assessed yourself, so I would think that is quite a difficult position and would need a lot of work and thinking about it. I have worked with other young people where FCAMHS we haven't been involved. There are young people who don't consent to having a mental health service that pose risk to others and FCAMHS can continue to be involved with the support of a lead agency such as social care.

So I think that it would be helpful to review that. For my sense, I would consider FCAMHS as providing an assessment of risk and in that regard taking the responsibility for advising around risk.

**Q.** So even now, and again we will explore it tomorrow, but if I have correctly understood their witness statements, when they are saying: we help CAMHS in this context with their risk assessment, but they own the assessment of risk, you don't even agree with that. You think there needs to be greater clarity in that area?

**A.** I think there needs to be greater clarity, especially when risk to others is outside of a significant mental illness, because I think then there is a number of agencies that are required to support and manage that risk and I think greater clarity about information sharing, clinical responsibility and responsibility of managing the risk would be helpful going forward.



**Q.** You accept in your statement, you have touched on it already in your evidence, and it is also reflected in the Alder Hey internal review, which has shown that those risk assessments were not done first of all with the frequency that they should have been?

**A.** That is correct.

**Q.** They should have been every three months, yes?

**A.** Yes.

**Q.** Whereas in fact they were done on -- following the triage of the original referral on 11th October 2019 and of 15th December 2019, thereafter there were only risk assessments on 8th January 2020, 22 February 2024 and 23rd July 2024, yes?

**A.** Yes, there was an additional risk assessment on 12th August that isn't in -- for some reason hasn't pulled through to that record, so there was another one. But in any event --

**Q.** In which year?

**A.** That was in 2021. I think it is 2021.

**Q.** Even allowing for that one further one not dealt with in the internal report for whatever reason, that's not just missing the risk assessments every three months; that is woefully short of it?

**A.** Yes, and at the time, as I say, we have updated our record-keeping kind of policies and we have, I see



a report, it is a live update around the timeliness of risk assessments that are completed. So it did fall far short from what we would hope to provide and I can only apologise for that in this record and provide assurance that going forward the risk form in itself has been improved and also that the monitoring of the timeliness of completion is accessible to me as a lead and my other leads in the service.

**Q.** I won't go through each and every one of them, but you will have reviewed them I know, Dr Killen, with care. I took you to the one by Mr Morgan. Would you agree that across the board they lack sufficient detail in terms of the risk to others?

**A.** Yes.

**Q.** And they lack a proper understanding of the background history of the series of concerning events that we explored with the psychiatrists earlier today in evidence?

**A.** Yes.

**Q.** Just to pick up that, if we look at AHCH000160 in terms of where it leads, this is Ms Morris' risk assessment for 23rd July. You will see soberingly how close to the attack we now are. If you see at the top of the page:

"No reports of AR being a risk to his sibling during my allocation ... Can be verbally abusive towards his



dad and has become upset/angry throwing a phone when the camera was turned towards him by mum. Note by Sam Steed."

Then intentional risk to self which is dealing with other aspects:

"Unintentional risk to self."

Then if we go down to the second half of the page:

"Intentional risk to others and property ...

"AR previously hurt a peer who he mistakenly thought was the peer who had subjected him to bullying. This occurred on the school site. AR attend the school site with the intention of hurting the peer who was bullying him. His intention was to exact revenge and AR was open about this ... thrown a phone in anger during a CAMHS video call ... subject of Prevent referrals ... the latest in connection with AR speaking with a member of staff about troubles in Palestine and Israel."

Then:

"AR took the latest referral very personally and wanted to know what school staff had recorded about him. AR's father eventually showed him the detail of the referral. AR wanted to discuss this with his teacher support," and so on.

"AR is upset the thoughts that school had about him in relation to thinking he is a terrorist threat due to

his world knowledge re matters such as Israel and Palestine. School are concerned at AR knowing the details of the referral. I felt it could be emotionally harmful for him to see the details. I am not aware of the contents referred to. I am aware that AR was upset by the referral ..."

So some detail given there but there is no real attempt there to grade that risk to others. Would you agree?

**A.** Yes, and that's changed in our risk management tool.

**Q.** Just stick with what was done at the time. There was no attempt to grade that?

**A.** No.

**Q.** And there is quite a lot of taking at face value, would you agree, what AR was saying about the matters rather than trying to look at the objective overall picture?

**A.** Yes, I would agree.

**Q.** There is a CYP, I think child young person current view that is done at the same time, AHCP000159. Can you just explain what this document is?

**A.** So this is a clinician-rated problem scale that we complete as part of our work.

**Q.** Thank you. In that document we can see under risk -- poses risk to others -- that the answer is, just under question 16 to question 20:



"Poses risk to others: none."

How did that come to be?

**A.** I think that my colleagues have shared that over the course of AR's journey with CAMHS, the risk to others that was particularly present at his referral and was present at other points in the record was not held as clearly as it could have been. I think this form is getting completed with that practitioner's knowledge of their time when they were as a case manager and I think that some of the learning we have identified is holding those risks across time, is something that will be important going forward.

**Q.** How far short of acceptable was this assessment of risk to others?

**A.** In my learning I identify that I think an actuarial risk assessment will be extremely helpful. When we are assessing risk, we are looking at static and dynamic factors and I think the static factors are really important, but of course those dynamic factors that we can influence and change are often at the forefront of our clinical practice. I think that an actuarial risk assessment helps us hold both of those, which is of course important going forward.

**SIR ADRIAN FULFORD:** Do you want to try again?

**MR MOSS:** My question was how far short of acceptable was



this assessment of risk six days before the attack?

**A.** Yes, it is unacceptable. There was risk on the record and it should have been recorded in this form.

**Q.** How far short of acceptable? Very far?

**A.** Very far.

**Q.** Does it follow that you would agree with the conclusions of Dr Irani in relation to these aspects? I think you have touched on it and helpfully volunteered really some of the answers, but she was pointing, was she not, in her report to the fact that the tool that was being used by CAMHS was inadequate?

**A.** It is too generic to hold onto the specific risks to others that are presented in this example.

**Q.** Because of that, and because of failures earlier on to assess the risk correctly, taking Dr Irani's report very shortly, by the latter stages the risk to others was really not being addressed adequately at all.

Would you agree?

**A.** Yes, I think in terms of looking forward that is something that we would be learning about.

**Q.** There was the ability to do the actuarial type of risk assessment with SAVRY. Would you agree?

**A.** Yes.

**Q.** Did you have people who were trained in using that?

**A.** That aren't members of our team, but we would usually



refer to FCAMHS for that assessment to be completed.

**Q.** Again, would you accept that that should have happened, not just when AR got his autism diagnosis, but at other key stages, most notably perhaps the bus incident in March 2022?

**A.** Yes, and on initial referral.

**Q.** Thank you just give me a moment if you would.

Could we have on screen please DRI000001 at page 25.

Dr Irani's report, and could we have the bottom three-quarters, from 3.5.1 expanded, please. So:

"The adequacy of the interagency working arrangements that were in place generally..."

Can I just check whether you will accept that the fairness of these observations. So 3.5.1.1:

"There were a number of interagency meetings, not all were attended by all parties involved in AR's care consistently."

**A.** I accept that was in the early part of AR's journey and we recognise that multi-agency working could be improved. However, it is of note we did attend all those meetings we were invited to and we did flag on a number of occasions to our colleagues in other services that we were concerned about the lack of progress of AR.

**Q.** 3.5.1.2:

"When other agencies like Prevent were referred to, it was unclear how they carried out their decision making and how this was communicated to the services directly involved with AR."

Do you agree with that?

**A.** Yes.

**Q.** "From the documents made available to me, his presentation at the time was attributed to his diagnosis of autism and felt not to require threshold to referral to Channel."

Was that your understanding too or --

**A.** That was my understanding.

**Q.** "Minutes of multi-agency meetings were not always clearly documented and shared with all parties concerned."

**A.** That is correct.

**Q.** "Latterly, as he disengaged from education and CAMHS, it was unclear who remained involved and who was in communication with the transitions team that was meant to continue working with him."

Fair?

**A.** That's correct.

**Q.** And it is Dr Irani's opinion:

"Whilst there were a number of meetings, in the absence of a lead agency, a clear handover process and



an appropriate risk assessment, the interagency working arrangements were not adequate."

And that's fair?

**A.** I would agree, yes.

**Q.** Thank you.

You have accepted, and it is in the Alder Hey Internal Review that there were also issues of record keeping more generally and the standard of them?

**A.** Yes.

**Q.** Sir, for your note, Dr Killen has -- starting at page 88 of her statement -- got sections on reflections and detailed sections on improvement as well.

Could we just look at one aspect of that, paragraph 89. The questions that remain are how and by whom should the risk concerns related to the indexed offence been identified and monitored.

In circumstances where neither Prevent nor MAPPA were deemed appropriate frameworks, with future learning and with hindsight, future guidance about this would be invaluable.

Is that really flagging up the gap in the arrangements or at least the lack of clarity about who the lead agency is in a case such as AR's?

**A.** Yes.

**Q.** You flag and acknowledge that FCAMHS provided



consultation but didn't complete a direct assessment.

"Recommend that a re-referral of risk should be made." I've covered aspects of that.

A potential for re-referral would have been recorded aggression and home, however this level of aggression with children with complex needs is not significantly out of the ordinary and his parents reported feeling confident to manage risks.

But carrying a knife on a bus?

**A.** Yes.

**Q.** "In addition, there was an incident reported where AR might have left home with a knife" that's what I just asked you about.

Even that, the reference to "might have left home with a knife", in circumstances where what in fact happened was AR did have a knife, the police took it off him, had it in their possession and gave it back to mother, there was a conversation about AR saying that he wanted to stab someone and it is not disputed that there was a conversation at least between AR and the officers about poison; that was crying out for a serious re-assessment of the risk to others?

**A.** I would agree.

**Q.** "It might be that the actuarial risk assessment should be better embedded in multi-agency systems so when risk



arises the historic risk is also taken into account to recognise if further concerns should be flagged."

But, in addition, you as a service, would you agree, must have a process in place to ensure that knowledge that you do have is readily visible for later clinicians so that risk information is not lost?

**A.** Yes, and that is in place now. So as soon as you open up a young person's record, as a CAMHS practitioner, the document and date of the most recent care and risk plan comes up, as does a systemic risk form and the current view and key CAMHS data.

**Q.** Dr Killen, would you forgive me for asking the question as to why that important additional aspect wasn't in your reflections in your witness statement?

**A.** About the electronic patient record or that the --

**Q.** More about the fact that it might be thought that important risk information was known to CAMHS, was documented in CAMHS, not all of it, but a lot of it, but wasn't taken into account by clinicians going through. That would appear to be, it might be thought, a very significant lesson about your own organisation and I'm asking you why, although there is a helpful reflection in paragraph 89, and important ones on gaps, on interrelations with FCAMHS, to an extent with Prevent, but why the matters in your own organisation weren't

identified in a reflections statement by you as the clinical lead?

**A.** I would agree. I think the risk-taking work that we need to do and to have that clear with detail and updated regularly is part of the independent learning review and we will be absolutely taking it on board and I think it is an omission that it was not in my statement.

**Q.** I'm just looking to my left. I do not think there are any questions. Sir, do you have any questions for this witness?

**SIR ADRIAN FULFORD:** I do not. Dr Killen, thank you very much for your frank evidence this morning.

**THE WITNESS:** Thank you.

**SIR ADRIAN FULFORD:** Does that bring us to a close?

**MR MOSS:** That's the end for today. Thank you for sitting late, sir, and 10.00am, if we may, tomorrow.

**SIR ADRIAN FULFORD:** 10.00 am tomorrow.

**(5.00 pm)**



**I N D E X**