

Tuesday, 21 October 2025

(10.00 am)

LYNSEY ANN BOGGAN (sworn)

Questioned by MR MOSS

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

Yes, Mr Moss.

MR MOSS: Thank you, sir.

Just start by giving us your full name, if you would, please?

A. Lynsey Ann Boggan.

Q. Thank you. If we could have on screen, please, your statement. It is AHCH000252, Ms Boggan.

Do we see that this is the statement that you gave to this Inquiry dated this year, 29 July?

A. Yes, it is.

Q. Can you just confirm for us, please, that the contents of that statement are true to the best of your knowledge and belief?

A. Yes, that's correct.

Q. Thank you. Let me just start by going through your background. You tell us in paragraph 1 that you are currently employed as the Clinical Lead of the Neurodevelopmental Services for Alder Hey Children's NHS Foundation Trust; is that right?

1

A. Yes, that's correct.

Q. So that's a different CAMHS team, I think, to the one in which AR had CAMHS involvement?

A. Yes, that's correct.

Q. But as you go on to explain in your statement, you also were asked to provide clinical support, I think two days a week, to the Autism Spectrum Disorder Diagnostic Service -- is that right --

A. Yes, that's correct.

Q. -- because you had the requisite experience in that area from your previous role?

A. Yes, correct.

Q. So you were wearing those two hats, yes? Is that right?

A. Yes, that's correct.

Q. Thank you. Then, as I have understood it, as time went on, you became more involved in the autism diagnostic side in this way: you became the interim head of the service for ASD on 1 November 2020?

A. Yes, that's correct.

Q. Then you became the full-time head of that service on 15 March 2021?

A. Yes, that's correct.

Q. By those stages, were you working full-time in that area, rather than just two days a week or was it still two days a week?

3

A. Yes, that's correct.

Q. You qualified, I think, as a registered nurse for learning disabilities, was that back in April 2004?

A. Yes, that's correct.

Q. You worked then in Child and Adolescent Mental Health Services, I think, for over 15 years, including a stint as clinical lead of the Halton and St Helens Autism Assessment Team?

A. Yes, that's correct.

Q. So during that period, you would have had direct experience yourself, is this right, of autism diagnosis?

A. Yes, that's correct.

Q. Then coming to matters in relation to Alder Hey -- and the dates are perhaps important for us to understand when we map it across with what was happening with AR -- you tell us in paragraph 2 that you started working at Alder Hey on 29 June as a specialist practitioner working with children and young people with the Learning Disabilities and Autism team; is that right?

A. Yes, that's correct, that was in the Liverpool CAMHS team.

Q. As you're going to come on to tell us in a moment, you had two roles. That first one was part of the Liverpool -- not the Sefton but the Liverpool CAMHS team?

2

A. The full-time role started in March '21, 15 March, and then that was made permanent in August 2021.

Q. So from March 2021 you were working purely on that side?

A. Yes, that's correct.

Q. I follow. Then coming right up to date, you tell us that your current post, as the Clinical Lead of Neurodevelopmental Service for Alder Hey was one you were appointed to in May this year; is that right?

A. Yes, that's correct.

Q. How was that different to the previous full-time role?

A. So now I have responsibility for the whole of the Neurodevelopmental Service, so that includes the autism diagnostic side, the ADHD diagnostic side and also the ADHD treatment component. So I have overall responsibility for the service as a whole.

Q. Thank you. So was that effectively on a promotion?

A. Yes, it was.

Q. I follow. So, I think you will come onto the detail of this but I think your own direct involvement with AR was actually fairly limited: 3 February 2021, I think a not-in-person discussion?

A. Yes, that's correct.

Q. But you are able to help us, given your now senior position in something of a corporate capacity, having familiarised yourself with the notes, although your own

4

1 involvement was really quite limited?

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

3 **Q.** The issues, I think, that you can help us with are AR's

4 involvement with autism diagnosis and care and

5 signposting for his autism, yes?

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

7 **Q.** I think you've also reviewed in some detail how concerns

8 about his ADHD were addressed?

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

10 **Q.** But we bear in mind that this is largely through your

11 reviewing the records, rather than any involvement you

12 had at the time?

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

14 **Q.** Thank you. Now, against that background, you explain --

15 just looking at the way that the services were

16 organised, could we have on screen, please, page 3 of

17 your statement, paragraph 11.

18 You make the point there that the autism spectrum

19 disorder and ADHD -- attention deficit hyperactivity

20 disorder -- services at Alder Hey have developed, your

21 words, "significantly over time"; is that right?

22 **A.** Yes. That's correct.

23 **Q.** Now, certainly to the uninitiated, the picture is

24 perhaps a little confusing --

25 **A.** Yes.

5

1 we should understand that this is a completely separate

2 team who, at that time, were dealing with it, yes?

3 **A.** Yes, completely separate from CAMHS, yes.

4 **Q.** You go on to explain that in March 2021 -- it's the same

5 paragraph of your statement as we have on screen --

6 there was a Trust-wide programme to restructure the

7 service and that resulted in the separation of the

8 referral pathways for ADHD and ASD.

9 So looking at those aspects, did they remain within

10 community paediatrics at that time or did they become

11 self-contained, separate teams?

12 **A.** Yes, so the transformation programme did commence in

13 2020 but it was quite a large-scale transformation in

14 terms of digital aspects as well, so what happened was

15 new referral forms were created for both ASD, ADHD and

16 community paediatrics, to split them out into separate

17 services. So, at the time, in March 2021 that was when

18 the process was complete, and they became three very

19 separate services. So community paediatrics no longer

20 had oversight for either ASD or ADHD.

21 **Q.** Thank you. So some initial changes with the forms, so

22 there would have been a period, is this right, when the

23 forms were separated out, so it was no longer

24 a community paediatrics general form but it was still

25 under the umbrella of the community paediatrics team but

7

1 **Q.** -- and I want you to help everybody to understand how it

2 was at the time and how it has changed.

3 **A.** Yes.

4 **Q.** So can we start with how things were in 2019, accepting

5 that that was before you even came to Alder Hey.

6 But should we understand from your statement that at

7 that time in 2019, when AR was first referred, the

8 assessment and diagnosis of both autism and ADHD fell

9 within the Community Paediatric Service?

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

11 **Q.** How would patients be referred into the Community

12 Paediatric Service if their teachers or their parents

13 had concerns about autism or ADHD?

14 **A.** So that would be a referral process. So either the GP

15 or the school or a professional who is involved with the

16 child or young person could make a referral and that was

17 mainly on paper at the time that that would come in to

18 the department and be logged as a referral through the

19 Central Referrals Team at Alder Hey Community Division,

20 and then would be added to a waiting list and then

21 triaged and reviewed in turn by the community

22 paediatrician who lived in that locality area. So for

23 AR it would have been over in Southport.

24 **Q.** Yesterday, and I think you were able to follow some of

25 the evidence yesterday, we were dealing with CAMHS and

6

1 then dealing with things so that the changes weren't

2 happening overnight. By March 2021, they were now

3 separate teams for mainstream, if I can use that phrase,

4 community paediatrics, and then you would have the

5 autism spectrum disorder team and the ADHD team or

6 service?

7 **A.** That's correct.

8 **Q.** Thank you.

9 So that's the structural change. You go on to

10 explain in paragraph 12 that the focus of both services,

11 so autism and ADHD, was diagnostic assessment; is that

12 right?

13 **A.** Yes. At that time, the autism diagnostic service was

14 only commissioned for diagnosis only. ADHD --

15 **Q.** Let's stick for the moment with --

16 **A.** Sorry.

17 **Q.** Not at all, it's very helpful but if we can just take it

18 in stages so we can get it clear. So if we stick with

19 the autism service. As I have understood it from your

20 statement, the referral would come in and there's quite

21 a lot of work, as we will look at, I think, in AR's

22 case, that would need to be done with different types of

23 assessment that led, as we will come onto with AR,

24 eventually to a multidisciplinary panel, I think,

25 considering the referral; is that right in simplistic

8

1 terms?

2 **A.** Yes. So the referral was triaged, reviewed and then

3 a plan would have been put in place to capture the

4 assessment information that was required. In AR's case,

5 that was speech and language therapy, assessment and

6 a neurodevelopmental history assessment.

7 **Q.** We will come back to AR's case but from referral,

8 assessment of the referral, there is some technical

9 assessments, speech and language, and things of that

10 kind that would need to be done, and assuming that at

11 each stage of that pathway it was looking like there may

12 be an issue to be considered, the end result of that

13 would be a multidisciplinary team meeting --

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

15 **Q.** -- at which the diagnosis would be confirmed?

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

17 **Q.** When you say in your statement the primary focus was

18 diagnostic assessment, is it right that for autism,

19 a diagnosis having been made of autism, the team would

20 have retained a responsibility for how the diagnosis was

21 conveyed and explained to the patient?

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

23 **Q.** So, it's not a question of multidisciplinary team meets

24 diagnosis on paper and that's the end of it; there's the

25 important process of explaining the diagnosis. But,

9

1 obviously school services as well, there was a School

2 Inclusion Team and Specialist Teacher Service that would

3 support the education aspects of an autism diagnosis.

4 **Q.** Thank you. I appreciate that this question may sound

5 naive and it's second nature to you, but it's helpful,

6 I think, for you to explain it, why with an autism

7 diagnosis does it not lead to ongoing clinical care by

8 a team of doctors and nurses?

9 **A.** Yes, so autism spectrum disorder is obviously

10 a difference in thinking and is classified in terms of

11 a young person's thinking style, how they interact with

12 others, sensory differences and, you know, rigidities

13 around black and white thinking and every young person

14 or child with autism is quite different from another.

15 Some young people can be quite high functioning and get

16 on well in a mainstream school and not need any support

17 to thrive. Some young children may have significant

18 language difficulties alongside, they may need

19 involvement from speech therapy and things. So because

20 every child is unique, we would look at a needs-led

21 approach, instead of just a blanket "This is what we do

22 for children who are autistic".

23 So if a young person did need additional services,

24 they would have been referred to them at that time, if

25 that makes sense, but that would have been around

11

1 thereafter, was it a question, the diagnosis having been

2 made of then -- a slightly clichéd phrase -- but

3 signposting the patient and their family to where

4 support services for the autism spectrum disorder could

5 be obtained?

6 **A.** Yes, that's correct. So the feedback appointment, we

7 would explain all the different services available in

8 that area, so that would have been Sefton, Southport,

9 and then the parents can then have that opportunity to

10 access those services if they wish to, yes.

11 **Q.** Thank you. Who would the providers of those services

12 have been, just give us a real-world flavour for them?

13 **A.** At the time, it was mainly voluntary sector, voluntary

14 independent sector, so ADDvanced Solutions Community

15 Network was commissioned in Sefton to provide some

16 support. There was also Parenting 2000. You've got the

17 CAMHS service, as well, for sort of any mental health

18 difficulties. There was also some voluntary mental

19 health support in the Venus Centre. There was also

20 Aiming High, which is like a mentorship support scheme,

21 and then also there was a small team called the Sefton

22 ASD/ADHD Nursing Service, where they were able to offer

23 some minimal intervention.

24 So there was quite a lot of support that they could

25 have accessed in terms of understanding. And then

10

1 different areas of health or different areas of need.

2 Generally, we have the Equality Act, we had the SEND

3 Code of Practice, so they are standards and guidelines

4 we would follow and they all really discuss how society

5 as a whole needs to put in adjustments in place for

6 young people with neurodiversity. So school for

7 example, you know, breaks, sensory breaks, being able to

8 leave the class. These are all very small, reasonable

9 adjustments that we would expect to be put in place

10 based on the needs of that young person, rather than

11 just a blanket "We need to do this".

12 Also for autism, there isn't a treatment or -- you

13 know, like a cure for it. There isn't anything we can

14 prescribe to make things better. We just need to have

15 a good understanding of how autism impacts on that

16 specific young person, what their areas of need are and

17 how we can support in terms of intervention, which is

18 mainly in the form of parent training and parent

19 support, which is set out in the NICE guidance as well.

20 So NICE guidance clearly states, you know, that

21 parents need to have an understanding to adapt the

22 environment at home and understand how it can be

23 impacted. So I hope that answers the question. Sorry.

24 **Q.** Not at all, it's very helpful. So that helps from

25 hearing it through you as an expert in this area to

12

1 explain why the whole approach is completely different
 2 for autism as a neurodivergence condition from a mental
 3 health disorder, such as depression or an anxiety
 4 disorder or a psychosis, which you may have a patient
 5 who is under the care of a psychiatrist?

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

7 **Q.** So I rudely interrupted you to get you to stick with
 8 autism being a diagnostic service and you've explained
 9 that that would be not just diagnosis but also the
 10 conveying of the diagnosis and then signposting onto
 11 other services.

12 Can you now go on to ADHD because I think that was
 13 principally, at the time, a diagnostic service but with
 14 one exception. Can you just explain that?

15 **A.** So, at the time, the ADHD assessment service would
 16 conduct an assessment with the young person and feed
 17 back that diagnostic outcome, in the same way that I've
 18 explained that they would with autism. However, there
 19 was a small part of the service which could provide
 20 treatment for children and young people who had
 21 significant symptoms of ADHD. So if there was evidence
 22 of a significant impairment and they met the criteria
 23 for treatment, in terms of, like, physical health checks
 24 and things that needed to be in place, then they could
 25 go on to be prescribed treatment, and the treatment side

13

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

2 **Q.** In paragraph 63, you said that:

3 "During the period of AR's involvement with the
 4 autism diagnostic service, there was no formal Meditech
 5 risk assessment pro forma in use for documentation."

6 Just pausing there. What electronic patient record
 7 system was the autism service using at the time, when it
 8 was under community paediatrics and then when it was
 9 a separate service?

10 **A.** It used the Meditech system.

11 **Q.** How did the interplay work with CAMHS records?

12 **A.** Yes, so we were able to view CAMHS' records because they
 13 were on the same system.

14 **Q.** Did you need a permission for that or could you just go
 15 to a separate part of Meditech and see it, or were they
 16 somehow combined?

17 **A.** They're not combined but you can search for CAMHS
 18 records, you didn't need specific permission. You know,
 19 the information was there to view. So ...

20 **Q.** Thank you. So against that background, though, you tell
 21 us that there was no specific risk assessment form for
 22 the autism team in use at that time for risk, and was
 23 that risk to self and risk to others?

24 **A.** Yes. Yes. There was no specific form at all at that
 25 time.

15

1 of the service would be -- it was a nurse-led service --
 2 with some input from some paediatric time but they would
 3 complete reviews with children and young people to check
 4 sort of compliance with medication, side effects and
 5 whether it was being efficient.

6 **Q.** I think in paragraph 12, you describe that part of the
 7 service as the Medication Initiation Clinic; is that
 8 right?

9 **A.** Yes.

10 **Q.** Thank you. Can I ask, for the purposes of most of your
 11 evidence, to stick with that way in which it was at the
 12 time but we will come onto the changes since towards the
 13 end of your evidence.

14 I want to turn now to questions about the assessment
 15 of risk by the autism service. So, if we could look,
 16 please, at page 16 of your statement. If we could have
 17 on screen paragraphs 62 and 63, expanded. You say
 18 there:

19 "Within the CAMHS team at Alder Hey ... risk
 20 assessment is understood as a dynamic and ongoing
 21 process, which is updated in response to any changes in
 22 the young person's risk presentation."

23 I'm going to come back to that a little later in my
 24 questions but you were referring, initially under "Risk
 25 Assessment" there, to the separate CAMHS service, yes?

14

1 **Q.** Can you help us in general terms, as somebody had been
 2 referred in and was going through these various stages
 3 of testing and analysis and referrals, how would risks
 4 to self and risk to others be addressed and assessed,
 5 were they assessed at all? Was that part of the work of
 6 the team?

7 **A.** So I would say that discussion of risk wouldn't have
 8 been a main characteristic of the assessments that the
 9 team did. However, they are obviously all trained in
 10 safeguarding and how to manage if an incident did occur.
 11 So, what would happen in that circumstance is if
 12 a parent or young person had identified a risk or
 13 something that had happened, then the clinician would
 14 act accordingly and take steps to support that risk in
 15 terms of safeguarding referrals or liaison with Alder
 16 Hey safeguarding team, et cetera. But they wouldn't
 17 actually ask direct questions to explore risk, as part
 18 of the assessment for autism at the time.

19 **Q.** So the Alder Hey safeguarding team, where do they sit?

20 **A.** So they are part of our Community Division and they
 21 offer support and advice in times when clinicians may
 22 not be as experienced in risk because community speech
 23 therapy role, obviously, is quite an important role
 24 within the diagnostic team, so their role in risk
 25 management would be quite small in comparison to

16

1 a CAMHS, so it's quite different. So they would often
2 use the safeguarding team for advice and support of when
3 to act on certain challenges that might be presented.

4 **Q.** Thank you.

5 So that safeguarding team within the Community
6 Division, would this be right, that they then could take
7 action with any concerns about risk, which might then
8 involve getting CAMHS involved?

9 **A.** Yes, yes. They would either you know take on that risk
10 and do that or they would inform the clinician of what
11 to do and the steps to follow.

12 **Q.** All right. So it might be direct advice back to the
13 clinicians within the autism service but it might be
14 getting different parts of Alder Hey services involved,
15 including CAMHS?

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

17 **Q.** Might that also involve liaison with other agencies, so
18 on the social care and child and family wellbeing side
19 with the local authority?

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

21 **Q.** But you wouldn't see the assessment of dealing with risk
22 as part of the every day role of the autism team but
23 they would need to know where to get advice if it arose;
24 is that a fair summary?

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

17

1 **Q.** No, no. That's why we seek to clarify these matters.
2 So should we understand that what you really mean is
3 that, in the sense that any nurse or doctor or
4 specialist therapist, who is dealing with a patient who
5 is being assessed, would keep in the back of their mind,
6 "Is there something I need to be worried about with risk
7 with my patient", in that general sense that the autism
8 service would be mindful of risk issues; is that
9 a fairer way to put it?

10 **A.** Yes, yes.

11 **Q.** We've heard evidence about a specific risk tool, the
12 SAVRY, the Structured Assessment of Violence Risk in
13 Youth tool, which is a more sophisticated form of risk
14 assessment, leading to a gradation of risk.

15 From the answers you've given so far, would I be
16 right to think that the autism service wasn't, generally
17 speaking, trained from that tool and weren't really
18 being expected to do that sort of more sophisticated
19 risk assessment?

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

21 **Q.** Thank you. Can I turn then, please, to AR's history and
22 his involvement with and assessment and diagnosis for
23 autism.

24 Can we pick this up, please, in paragraph 14 of your
25 statement, which is at page 4.

19

1 **Q.** Thank you. You say though that:

2 "However, risk was assessed at every appointment,
3 and appropriate action was taken in advance to any
4 safeguarding concerns ..."

5 When you say "risk was assessed at every
6 appointment", is that literally true?

7 **A.** I would probably amend that to say that risk was
8 observed maybe and -- yeah, so I think what I meant by
9 that is that any risks that have been highlighted by
10 parents or young people was acted upon and I think the
11 example that I give is regarding parents' concern that
12 AR would react, you know, quite -- he would struggle to
13 accept the diagnostic decision and might need support
14 with that. So we put in a safety plan around how we
15 would do that in a sensitive way. So I think what
16 I meant by that is we have looked at, you know, how to
17 mitigate risk, rather than actual completing a literal
18 risk assessment document.

19 **Q.** So you understand that when you say in your statement,
20 "However, risk was assessed at every appointment", that
21 might give some the impression that, somehow, there was
22 a formal process by which at each and every meeting you
23 would go through an assessment of risk. You didn't mean
24 that?

25 **A.** Yeah, I didn't mean that. Apologies.

18

1 I just go to this to remind ourselves that, in fact,
2 at the time of the referral, you weren't yet even
3 working at Alder Hey; is that right?

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

5 **Q.** But in paragraph 15, you explain that AR was first
6 referred to the Community Paediatric Service on
7 14 August 2019. Who was that by?

8 **A.** That was by his GP, Dr Arnold.

9 **MR MOSS:** Sir, for your note, we don't need to turn it up,
10 but MERP000490 is where you'll find the record of this.

11 **SIR ADRIAN FULFORD:** Thank you.

12 **MR MOSS:** Just in broad terms, you've got paragraph 16 on
13 screen, but just help us to understand the nature of the
14 concerns that the GP was raising.

15 **A.** Yes, so the GP was concerned that AR was struggling in
16 terms of social interactions, also poor eye contact and
17 hyperfixation on specific interests. I don't think they
18 went into detail about what the interests were at that
19 time but it was clear that there was evidence that
20 an assessment should take place.

21 **Q.** Thank you. I think there was also a family history?

22 **A.** Yes. That's correct.

23 **Q.** Thank you. So you deal in paragraph 16, just looking at
24 the chronology, that's logged on to the systems on
25 Meditech on 18 August, four days after the referral. If

20

1 we look at paragraph 17:

2 "The referral was accepted by the Community
3 Paediatric Department, and AR was added to the waiting
4 list ..."

5 Who would have reviewed that to check the initial
6 acceptance?

7 **A.** At the time, the triage process was directly with the
8 community paediatrician for that locality area, so it
9 would have been the community paediatrician who reviewed
10 and accepted the referral.

11 **Q.** Thank you. You tell us in paragraph 17, is this right,
12 that, at the time, the average waiting time for the
13 first assessment was 11 weeks?

14 **A.** Yes, that information was provided to me by our
15 Behaviour Intelligence Team and they gave me the
16 information to say that the average waiting time is 11
17 weeks.

18 **Q.** Again, you're right to remind us that you are giving
19 evidence here in part in a corporate capacity?

20 **A.** Yes.

21 **Q.** You will have got this information from others but that
22 is the information that's been provided to you?

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

24 **Q.** It follows, doesn't it, that for that first appointment,
25 we would have been expecting to see AR seen for a first

21

1 time, wouldn't it, if one thinks about the very end of
2 January/beginning of February as being the start of the
3 pandemic, it was already well overdue by the time the
4 pandemic started to influence the nation?

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

6 **Q.** Again, it's not a criticism of you, but you have simply
7 not been able to understand why AR's individual case had
8 fallen so far behind, even before Covid struck?

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

10 **Q.** No doubt for all services, obviously -- everyone has
11 an understanding of the impact of Covid but no doubt
12 it's a sensible inference that Covid then made things
13 worse; would that be fair?

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

15 **Q.** But on the face of it, you say elsewhere that timescales
16 for ADHD and for autism are in a situation of crisis and
17 we'll look at that but, based upon what the services
18 average waiting time was, even making allowance for
19 Covid, it looks like there was a shortcoming, would you
20 agree, in the speed with which AR had his first
21 appointment?

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

23 **Q.** Thank you.

24 In the meantime, as you explain in paragraph 18 of
25 your statement, it's right that the service received

23

1 assessment in around about the middle of November 2019?

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

3 **Q.** We know, because you deal with it in this paragraph and
4 later in your statement, that he didn't in fact receive
5 the first appointment until 2 July 2020, over 45 weeks,
6 yes?

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

8 **Q.** Not least because you weren't in post at the time,
9 you'll understand that I don't raise these matters as
10 a criticism of you at all, but having, no doubt, done
11 your best to gather information about this, in your now
12 role, you candidly say in your statement that you're not
13 able to comment on why that first appointment took so
14 long; is that right?

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

16 **Q.** Other than to make a comment, that you accept is
17 speculation, that the impact of Covid influenced the
18 increase in the waiting time, yes?

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

20 **Q.** I appreciate that I am asking these questions through
21 you with the information that you've obtained, not about
22 your personal involvement, but if you would have
23 expected the first appointment around mid-November, for
24 Covid to have had an impact, it would already have had
25 to have fallen quite far behind the average waiting

22

1 communication from The Acorns School, isn't it?

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

3 **Q.** The essence of that was that the deputy headteacher at
4 the time, Joanne Hodson, I think, raised some concerns
5 about issues that had arisen and wanting, in broad
6 terms, to draw those to the attention of the autism
7 service, no doubt because she thought it would be
8 relevant to the referral, yes?

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

10 **Q.** So could we have on screen, please, LCC001417. If we
11 could go to page 3, please, the very bottom of the page
12 if you would, please. So this is 22 November, from
13 Mrs Hodson, and we can see that the email addresses are
14 communitypaediatrics@alderhey:

15 "I really need some help with a referral for a young
16 man who is presenting to us as [autistic], we need to
17 refer him onto this pathway:

18 "He was involved in an incident at ... school ...
19 disclosed to Childline", and so on.

20 So she is referring there to what we know as the
21 October 2019 incident at the Range High School, and she
22 gives some details in relation to that, but flags, does
23 she not:

24 "... significant risk of emotion and awareness with
25 regards to [AR] carrying a knife, implications in using

24

1 one and the risk posed to himself and the school
 2 community."
 3 She had then asked him about the incident at the
 4 admissions meeting at the school and:
 5 "... monotone, emotionless and very matter of fact
 6 about his intentions."
 7 Yes?
 8 A. Yes.
 9 Q. That is flagging both a safeguarding concern, would you
 10 agree, but also factors that might be relevant to the
 11 autism diagnosis?
 12 A. Yes, that's correct.
 13 Q. If we just go over the page. It then sets out that
 14 there had been a referral then to CAMHS but they were
 15 turned down at that stage, and then more information
 16 about AR not socialising, not going out of the family
 17 home, no friends, not involved in gangs, and that's
 18 a reference to the group that he had been passed onto by
 19 CAMHS on the referral:
 20 "We now have serious safeguarding concerns with
 21 regard to [AR]. He is fixating on another student in
 22 his class and is saying that he is bossing him around
 23 and bullying him. Staff are being vigilant but have
 24 seen no evidence of this. Dad has contacted school to
 25 raise his concerns that [AR] is being targeted 'like the
 26

1 said, would not be good to tell people about setting up
 2 a business "because people would think [he] would kill
 3 them" as they did not know him.
 4 He said people -- if we go back to page 3:
 5 "... don't trust others they don't know in case they
 6 get murdered; regularly out of his seat, walked to the
 7 highest part of the ceiling, jumped up and punched
 8 a laminate that was hanging from it ..."
 9 Then 3 December, the most recent one, within art
 10 lesson, this is the colouring the Call of Duty images
 11 incident, saying:
 12 "Why can have these with guns but can't look at guns
 13 on the internet ... 'Can we have a picture of a severed
 14 head then' ..."
 15 She set out how that was responded to.
 16 In fact, it looks, doesn't it, as though The Acorns
 17 School here was making a referral but, in fact, this was
 18 all good information to be aware of for the referral
 19 that in fact had already been received and was starting
 20 to go through the pipeline?
 21 A. Yes, that's correct.
 22 Q. Thank you. That can come down from the screen. You say
 23 in paragraph 19 of your statement, if we can have that
 24 on screen please, it's page 5, you've looked into this
 25 and, again, seeking to assist the Inquiry from work on
 26

27

1 other boy in the other school'.
 2 Then there is a reference to AR researching school
 3 shootings, his father having been informed of that but
 4 then father claiming it was untrue. She attached
 5 supporting documents and the form that was completed for
 6 Lancashire CAMHS but they had indicated that they were
 7 unable to accept AR because he was with a Sefton GP.
 8 So, that letter, would you agree, on its face good
 9 practice, in the sense of it is exactly information that
 10 you would want the service to be receiving from the
 11 point of view of relevant information to an autism
 12 diagnosis that was in the course of being assessed?
 13 A. Yes, that's correct.
 14 Q. Then there was a followup email, I think, on 3 December.
 15 If we can just go back, please, to page 2, I think.
 16 Bottom of the page, please, thank you very much.
 17 So again to "communitypaediatrics", 3 December:
 18 "Further to my referral ... I need to advise you of
 19 further developments and concerns. Could you add this
 20 to the referral information ..."
 21 Then school shootings in America is referred to
 22 again. Then incident on 29 November, punching his hand;
 23 started to work very reluctantly; and then goes into the
 24 information that we traversed yesterday about
 25 a business, setting up a business and what would be
 26

26

1 the records, are you able to tell us what, if any,
 2 response was given by the autism service to those
 3 letters?
 4 A. Yes, unfortunately, I wasn't able to view a formal
 5 response. The emails went to a community paediatric
 6 inbox, which was governed at the time by the community
 7 paediatric team and I wasn't able to find a response
 8 unfortunately. However, I did review the records and
 9 there did seem to be services that had become involved
 10 at that time, following the concerns that Acorns School
 11 had, for example the CAMHS team and, obviously, Criminal
 12 Justice Liaison but this was me reviewing sort of after,
 13 if that makes sense.
 14 Q. Yes. Can I suggest that -- and again not a criticism of
 15 you, but looking at what the records show -- that is
 16 a concern in two respects. The first respect, in
 17 a sense, you have already touched on, and that's the
 18 safeguarding aspect.
 19 As it happens, as the Inquiry has been looking at,
 20 a number of other agencies were seeking to deal with the
 21 safeguarding and risk issues in relation to this and so
 22 that we know that, over time, Prevent was involved, the
 23 school was involved, the local authority was involved,
 24 CAMHS, FCAMHS.
 25 A. Yes.

28

1 Q. So other parts of the system were looking at this. But
 2 it's right, isn't it, that given that those emails from
 3 The Acorns School had raised significant issues as to
 4 risk and safeguarding that were of concern, you would
 5 want to have seen the autism service, within community
 6 paediatrics, responding on the record in some way, not
 7 necessarily dealing with those safeguarding risks
 8 themselves, but assuring themselves that they were being
 9 dealt with?
 10 A. Yes, that's correct.
 11 Q. Would you agree that it is concerning that there is no
 12 such record of any such response?
 13 A. Yes, I would.
 14 Q. Secondly, can I suggest that the way in which this may
 15 be concerning is this: given that there was already
 16 a referral from the GP and this is now a school which
 17 was a referral unit, with a deputy head who is showing,
 18 would you agree, a good working knowledge of what may be
 19 relevant to an autism diagnosis, yes?
 20 A. Yes, I'd agree.
 21 Q. Alongside the concerns about behaviour and safeguarding
 22 risks, would you not think that these emails ought to
 23 have triggered a prioritisation of AR's case through the
 24 diagnosis pipeline?
 25 A. Yes, I would expect that. Yes.

29

1 A. Yes.
 2 Q. Does that seem to be, again appreciating that you're
 3 speaking -- you're in the unfortunate position for
 4 having to speak for others in the service at the time,
 5 but does that seem to you, on reflection, to be a marked
 6 shortcoming?
 7 A. Yes. I would agree.
 8 Q. Thank you. We know that CAMHS were involved at this
 9 stage, they're one of the bodies that I have spoken
 10 about in terms of others who were dealing with this and
 11 there was a strategy meeting, and then we know that
 12 Mr Morgan of CAMHS had a meeting with AR on 20 December.
 13 We know that, in relation to that -- I'm not going
 14 to bring up all the records in relation to this -- but
 15 we know Skott Morgan updated social care as to his
 16 discussions with AR and noted that AR was currently on
 17 the ASC pathway. Have you seen any records from the
 18 community paediatrics side of things suggesting that
 19 CAMHS generally, or Mr Morgan in particular, contacted
 20 the autism service to say anything about AR?
 21 A. No, I haven't.
 22 Q. While Acorns School had put the autism service on notice
 23 of their concerns, would you have expected there to have
 24 been some communication between CAMHS and the autism
 25 service, given the extent to which CAMHS were involved,

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1 Q. In particular, if we track back to the timeline that you
 2 were helping with a little bit earlier this morning, one
 3 of the obvious things, certainly by 3 December email,
 4 should have been, "Hang on a minute, we are already past
 5 our 11-week average and this is a young man in relation
 6 to whom there are serious safeguarding concerns,
 7 carrying knives, serious risk issues, he needs to be
 8 seen now very quickly for the assessment"?
 9 A. Yes, unfortunately at the time, I don't think there was
 10 an expedition process, as far as I'm aware but, again,
 11 I'm not really 100 per cent sure on that.
 12 Q. Well, to an extent one understands that but you don't
 13 need a defined process to pick up the phone on receipt
 14 of an email like that, check the position and just to
 15 say to those who are giving the appointments, "We are
 16 already late with this pupil, we have now got two people
 17 referring in and he's been carrying knives to school and
 18 looking at school shootings and talking about severed
 19 heads, this is one to do quickly".
 20 A. Yes, I would agree.
 21 Q. That doesn't need some formal process, it just needs the
 22 application of common sense?
 23 A. Yes.
 24 Q. In fact, the assessment still was not offered until
 25 July?

30

1 going to meetings with Prevent, for example?
 2 A. Yes, I would. Yes.
 3 Q. We are going to be exploring with other witnesses the
 4 fact that, going into 2020, there were two meetings at
 5 which Forensic CAMHS were involved and assessments by
 6 Forensic CAMHS about risk, and comments upon the risk,
 7 but in particular indicating there was a limit to how
 8 much FCAMHS could say until there was a diagnosis.
 9 Dealing with that stage, which is February and March
 10 2020, is there any indication on the autism service
 11 records of a chaser or a request for a prioritisation
 12 coming in from other agencies, saying, effectively, "AR
 13 is on your pathway for diagnosis, but there's a lot
 14 going on, can you give him prioritisation, can you hurry
 15 up, can you tell us what the outcome is?"
 16 A. No, I haven't been able to locate that information in
 17 the record.
 18 Q. So if it is a fair summary of what was going on with
 19 other agencies, that there was discussion of the risk
 20 that AR may pose to others and concern about that, and
 21 that autism and his diagnosis of autism had not yet been
 22 made but was potentially significant to how this was all
 23 going to be handled, is it right that, from the
 24 investigations that you have done, those agencies didn't
 25 communicate that to the autism service at all?

32

1 A. Yes, that's how it seems. Yes, correct.
 2 Q. Thank you. In your statement, you go on helpfully to
 3 track through the chronology, so you tell us in
 4 paragraph 20, lower down on the same page, about the
 5 telephone appointment that did then take place on
 6 2 July. Who was that with, first of all? Who was the
 7 clinician?
 8 A. It was Dr Acharya, who was a locum consultant
 9 paediatrician at the time.
 10 Q. Thank you. I don't think AR was involved in that in
 11 person, was it his father --
 12 A. Yes, it was.
 13 Q. -- who provided the information on that occasion? You
 14 deal with it in paragraph 20. What was the upshot of
 15 that consultation and what was covered by it?
 16 A. It appears that the focus of that appointment was around
 17 social communication differences and how he presented
 18 sort of with rigid thinking, so Dr Acharya decided to
 19 focus on autism diagnostic assessment. There doesn't
 20 seem to be much exploration regarding ADHD assessment at
 21 that time. So she -- her outcome was to place him on
 22 the autism pathway, which then obviously was becoming
 23 independent.
 24 Q. Thank you. So in very simplistic terms, would it be
 25 right that there was enough concerns that, even though

33

1 that right?
 2 A. Yes, that's correct.
 3 Q. There is a report for that issued, I think, on
 4 27 October; is that correct?
 5 A. Yes, that's correct.
 6 Q. Sir, AHCH000096 at pages 4 to 5 but we don't need to
 7 turn it up.
 8 Then, paragraph 25 on page 7, again in the
 9 chronology you explain that on 17 November 2020, there
 10 was then a telephone appointment with AR's father and
 11 this was being conducted by telephone and it was with
 12 Kate Murphy, who was a neurodevelopmental practitioner
 13 and registered nurse, yes?
 14 A. Yes, that's correct.
 15 Q. So what would the purpose of that consultation have
 16 been?
 17 A. So the purpose of the neurodevelopmental history
 18 assessment is it's part of NICE guidance for us to
 19 explore all of the history of a young person. So the
 20 conversation would have been around birth history, sort
 21 of pregnancy, all the way through the developmental
 22 milestones, how they were met, if there were any delays,
 23 then we would talk about school history, nursery history
 24 and then, obviously, focus on the social communication
 25 differences that may have been seen in terms of his play

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1 AR wasn't present personally, from the history and
 2 information provided by Alphonse R, AR's father, to
 3 convince Dr Acharya that AR was suitable for further
 4 assessment along the autism pathway?
 5 A. Yes, that's correct.
 6 Q. You explain in paragraph 21, and you have touched upon
 7 it, that you're unable to understand fully why
 8 Dr Acharya did not discuss ADHD symptoms further on that
 9 occasion; is that right?
 10 A. Yes.
 11 Q. I'm concentrating at the moment on the autism timings
 12 but, given that concerns had been raised about autism
 13 and ADHD, would you agree that that, on the face of it,
 14 appears to be something of an omission: you would have
 15 expected ADHD to have been traversed at that meeting?
 16 A. Yes, because it was the reason for referral, it was
 17 requesting both assessments, so I would expect that to
 18 have been explored in a bit more detail, yes.
 19 Q. Thank you.
 20 Sir, for your note, AHCH000096, I think the clinic
 21 letter arising out of that first assessment.
 22 SIR ADRIAN FULFORD: Thank you very much.
 23 MR MOSS: Then paragraphs 23 to 24, on page 6, you explain
 24 that, in the ongoing process, AR was then assessed by
 25 a speech and language therapist on 28 August 2020; is

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1 skills, interaction with others, sort of making friends.
 2 So it's quite a comprehensive assessment, which focuses
 3 on the DSM criteria for autism spectrum disorder, to get
 4 that information from parents.
 5 Q. AR, I think, by that date, would have been 14?
 6 A. Yes.
 7 Q. Would that be the expectation, that this was parents --
 8 in this case, father -- doing that or would you expect,
 9 if they were willing and consenting, the patient
 10 themselves?
 11 A. Yes, so primarily the history is usually from parents or
 12 main care givers because we're asking about very early
 13 history when the young person maybe couldn't remember
 14 that. But in some circumstances, some young people do
 15 want to be involved and that is optional but it wouldn't
 16 be a requirement for us to be able to get that detailed
 17 history because we always do an appointment with the
 18 young person as well and, obviously, he'd had his
 19 appointment with the speech therapist, so we felt that
 20 we'd got his views in that sense. But it is optional
 21 for young people to attend, especially at the age of 14,
 22 if they wish to.
 23 Q. Thank you. Now, arising out of that, those two core
 24 assessments have been done and you tell us in
 25 paragraph 26 that what happens next is there is the

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1 multidisciplinary panel meeting that we touched on
 2 earlier in your evidence and I think, in AR's case, that
 3 took place on 30 December 2020 -- is that right --
 4 **A.** Yes, that's correct.
 5 **Q.** -- with Dr Sultan, a consultant paediatrician, Ruth
 6 Mitchell, a highly specialist speech and language
 7 therapist, and Dawn Divine a physician associate. They
 8 were the ones making up the panel; is that right?
 9 **A.** That's correct.
 10 **MR MOSS:** Sir, we don't need to turn it up but AHCH000100,
 11 pages 35 to 36, is the record of that meeting.
 12 **SIR ADRIAN FULFORD:** That's very helpful.
 13 **MR MOSS:** Now, in terms of the basic outcome of that, you
 14 explain at the end of paragraph 27 that the panel
 15 concluded that further assessment of potential ADHD
 16 symptoms was warranted but they found that AR met the
 17 diagnostic criteria for autism.
 18 **A.** Yes, that's correct.
 19 **Q.** I want to ask you about the information about risk and
 20 behaviours that was known by that time and whether it
 21 was taken into account. So there'd been a strategy
 22 meeting in December 2019; there'd also been the
 23 involvement of FCAMHS in the first three months of 2020;
 24 there'd been information about AR carrying knives ten
 25 times to school, that's October 2019, telling

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1 review all of that and use the information to help with
 2 the conclusion because it was quite evident that there
 3 was highly expressed interests that were evident within
 4 that report.
 5 **Q.** So just unpicking that a little bit. Should we
 6 understand that, so far as the autism service side of
 7 Meditech is concerned, there wasn't a distillation of
 8 all of that risk information on the autism service
 9 Meditech records?
 10 **A.** Sorry, say that again. Sorry.
 11 **Q.** I'm so sorry. It was a bad question. I'm picturing at
 12 the moment, in terms of the electronic systems, that
 13 both the autism service and CAMHS are using the same
 14 electronic patient records but they are keeping their
 15 own records, yes?
 16 **A.** Yes, that's correct.
 17 **Q.** As we were exploring yesterday, a lot of risk
 18 information was in fact recorded in different places in
 19 different ways in the CAMHS electronic records?
 20 **A.** Yes, that is correct.
 21 **Q.** From your review of the autism service records, had
 22 anybody extracted that information from the CAMHS side
 23 of the records and distilled it into the autism service
 24 records?
 25 **A.** Not in that way, no. No.

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1 a policeman that he was pretty certain he would have
 2 used the knife; there was information that was available
 3 in relation to getting a detention and making a comment
 4 about "That's why teachers are murdered"; there was
 5 a case of a fight with another pupil; there is then the
 6 hockey stick incident on 11 December; and information,
 7 taking it fairly shortly, about inappropriate interests
 8 on the internet, violence, school shootings; and
 9 an interest in graphic imagery.

10 Would all of those things have been relevant, first
 11 of all, to that multidisciplinary panel meeting?

12 **A.** Yes, it would have.

13 **Q.** From the records, do you think that that information
 14 was, in fact, available to the panel?

15 **A.** It was available. It would have been on the record.
 16 However, I think, as discussed yesterday, the records
 17 are quite hard to follow and you would have had to
 18 really, really look to find the actual CAMHS risk
 19 assessment that was completed. However, the school
 20 report that we received from Acorns School -- so as part
 21 of autism diagnostic process we have to request school
 22 information as part of that multi-agency assessment and
 23 they actually provided a very, very comprehensive report
 24 which -- they included a chronology of risk as well.

25 So I assume that the panel would have been able to

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1 **Q.** Can you see from the minutes of the multidisciplinary
 2 panel any evidence that they had, in fact, gone to the
 3 CAMHS record and pulled lots of information about risk
 4 out of the CAMHS records?

5 **A.** I would have to look at it again, I'm sorry -- you know,
 6 the minutes for that meeting. But I can't remember
 7 exactly whether they did mention any risk but I would
 8 hope that they did read some of it, but I don't know
 9 whether they -- how much detail they went into.

10 **Q.** All right. What you do tell us is that Acorns -- not
 11 the original emails we were looking at -- but the
 12 detailed report that they provided did refer in some
 13 detail to a chronology of risks and concerns?

14 **A.** Yes, that would have been available, yes.

15 **Q.** Can we just see AHCH000100. Could we try page 35. Have
 16 I correctly identified the MDP record?

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

18 **Q.** I'm not going to read it all out but perhaps could you
 19 just enlarge from "Assessment" down at the bottom of the
 20 page?

21 **SIR ADRIAN FULFORD:** So this was from Acorns?

22 **A.** Sorry, no, this is minutes of the meeting that was held,
 23 so this is the multidisciplinary meeting with Dr Sultan
 24 and speech therapy and physician associate, where
 25 they've reviewed the records, and it's clear that they

40

1 have looked at the school information because they've
 2 mentioned details there about what school have said, so,
 3 yes.
 4 And I think as well, just above, they do mention
 5 what they've read in this meeting as well and school
 6 information is highlighted there.
 7 **SIR ADRIAN FULFORD:** Thank you.
 8 **MR MOSS:** Just go over the page because I know it continues
 9 on page 36, please.
 10 **A.** Yes.
 11 **Q.** Does that look like to you that they were relying on the
 12 school report --
 13 **A.** Yes.
 14 **Q.** -- rather than any detailed information that they had
 15 distilled out of CAMHS?
 16 **A.** Yes, usually if they have reviewed any CAMHS notes or
 17 reports, they would list that in the section that says
 18 "Reports viewed", which is on the previous page.
 19 **Q.** If we can go to page 35.
 20 **A.** It doesn't appear -- "Assessments comprised of", it
 21 doesn't appear that they've reviewed CAMHS' notes, no.
 22 **Q.** But the educational psychology report, school
 23 information report, yes?
 24 **A.** Yes, yes.
 25 **Q.** So, although, fortunately, the school information helped

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1 information about aspects of AR's behaviour and his
 2 family dynamics. I'm going to take this relatively
 3 shortly but there is information in respect of AR and
 4 how he was dealing with other agencies that suggest that
 5 he was minimising his own actions, so the seriousness of
 6 his assaults; that he was at times evasive, unwilling to
 7 take responsibility; that he'd shown signs of
 8 dishonesty; that he was argumentative; that he was
 9 driven by a perception of grievance; that he lacked
 10 reflection; that he lacked remorse; he lacked empathy in
 11 relation to mental health clinicians; that he, if not
 12 manipulating, was trying to lead the conversations to
 13 get particular medication. Would all of that have been
 14 relevant to the multidisciplinary panel?
 15 **A.** I think it just really explains why he met the criteria
 16 for autism diagnosis really because a lot of what you
 17 are describing, you know, he did have highly fixated
 18 interests, he would often research and research into
 19 things, which at times was obviously medication and
 20 things, so that was part of his condition. I think we
 21 also noticed that, in the education psychology report,
 22 they highlighted that there were concerns around his
 23 emotional understanding and expression of emotion. So
 24 he actually really struggled to understand what empathy
 25 is and how other people feel in different situations,

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1 to provide some details in relation to this, would you
 2 agree that a shortcoming, in relation to the information
 3 that was being provided, was there was a lot of relevant
 4 information on the CAMHS system that doesn't seem to
 5 have been distilled for the multidisciplinary panel?
 6 **A.** Yes, that's correct.
 7 **Q.** Thank you. That can come down from the screen. We will
 8 come on in just a moment to look at what happens
 9 hereafter but in high level it's right, isn't it, that,
 10 having conveyed the diagnosis to AR's family, the
 11 referral was then closed to the autism service, no doubt
 12 because it was diagnostic, as we explored earlier on.
 13 Would that be fair, in high level summary?
 14 **A.** Yes, that's correct.
 15 **Q.** If the service had been aware of all of that information
 16 about risk, would the case have remained open to the
 17 autism service, do you think?
 18 **A.** No, it would not.
 19 **Q.** Why's that?
 20 **A.** Because the service was solely commissioned for
 21 diagnostic support. So our role would have been to
 22 ensure that services were in place to carry on that
 23 support and manage that risk but it wouldn't have been
 24 the responsibility of the actual assessment team.
 25 **Q.** I'm asked to explore with you quite a bit of further

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1 and I think the speech and language therapist as well
 2 noticed that he often misinterpreted facial expressions,
 3 he didn't understand what people meant, he often
 4 perceived tone of voice incorrectly.
 5 So I think everything you describe there is part of
 6 a neurodivergent profile that he obviously had
 7 significant difficulties in relation to his autism
 8 diagnosis.
 9 **Q.** So consistent with that which was already known and
 10 being assessed; would that be fair?
 11 **A.** Yes, that is correct.
 12 **Q.** But presumably, in the ideal world, that information
 13 about how AR was engaging would also have been made
 14 available to the panel. It would have been helpful
 15 additional information?
 16 **A.** Yes, it would.
 17 **Q.** But should we take it from your evidence that the effect
 18 of that, so far as autism is concerned, is that it would
 19 simply have reinforced the picture that the panel
 20 already had?
 21 **A.** Yes, that's correct.
 22 **Q.** We don't see -- again, I'm not going to go to lots of
 23 records to prove a negative, but I think you would agree
 24 that we don't see from the multidisciplinary panel or
 25 the autism service records from around that time, any

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1 readout from the process to say, "In addition to the
2 autism diagnosis, there is a serious concern about risk
3 or risk to others". The risk factors don't seem to be
4 part of what the diagnostic service were looking at;
5 would you agree?
6 **A.** Yes, that's correct.
7 **Q.** Is it too much of a simplification for me to suggest
8 that the reason for that is that the autism service
9 would have been expecting others to deal with that?
10 **A.** Yes, that's correct.
11 **Q.** If the panel had been aware that there was a diagnosis
12 of conduct disorder and there wasn't, so it's
13 a hypothetical, but would that have made any difference?
14 **A.** No. I mean, there may have been some additional
15 recommendations added to the report but very similar
16 recommendations, in terms of, like, parent support,
17 accessing services, et cetera.
18 **Q.** We have seen -- and I'm going to come back to FCAMHS
19 a little later -- from the FCAMHS input in March 2020
20 an indication that a diagnosis of autism could
21 complicate the risk assessment in a number of ways and
22 that, for some with autism, features associated with
23 autism, particularly fixation on certain interests, can
24 lead to an increased risk to others. In general terms,
25 would you agree with that?

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1 **(11.30 am)**
2 **SIR ADRIAN FULFORD:** Yes, Mr Moss.
3 **MR MOSS:** Thank you, sir.
4 Ms Boggan, let's turn then to how the
5 multidisciplinary panel's diagnosis was conveyed. You
6 tell us in paragraphs 28 and 29 of your statement --
7 it's page 7, please. So just refresh your memory of
8 paragraph 28 at the bottom of the page, and then 29.
9 I think, initially, it was by telephone that AR's
10 father was informed. Is the date 20 January 2021?
11 **A.** Yes, that's correct.
12 **Q.** Alphonse R was concerned about how AR would take the
13 diagnosis and was that because AR didn't himself accept
14 that he had autism at that stage?
15 **A.** Yes, that's correct.
16 **Q.** I think it was against that background that there was
17 an agreement to have a feedback meeting on 3 February,
18 top of page 9 of your statement, paragraph 33; is that
19 right?
20 **A.** Yes, that's correct.
21 **Q.** Again, we remind ourselves obviously of the Covid
22 context, and that, I think, was done by video call, with
23 AR and his father present and that was when you did have
24 a direct involvement yourself?
25 **A.** Yes, it was.

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1 **A.** Yes, I would.
2 **Q.** It might be thought that, for AR, the fact that he was
3 now diagnosed with autism, together with all of the risk
4 information, meant that there was now that confirmed
5 increase of risk. Did the autism service have any part
6 to play in noticing that in the first place and then
7 doing anything about it?
8 **A.** I think, obviously, risk management is everyone's
9 responsibility and I do accept that. However, I think
10 the autism team's direct responsibility would be to
11 ensure that the right services were in place and I know
12 we will probably come onto it but I think in the
13 feedback discussion with father and the concerns, we did
14 escalate -- the autism team escalated to CAMHS and
15 ensured that an appointment was booked to carry on that
16 intervention and support. So that would be our
17 responsibility, in terms of making sure that service was
18 involved to manage that risk.
19 **MR MOSS:** Thank you.
20 Sir, I'm coming onto how the diagnosis was conveyed
21 to AR and his family, would that be a convenient moment?
22 **SIR ADRIAN FULFORD:** It would. I will sit again at 11.30
23 am.

24 **(11.16 am)****(A short break)**

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1 **Q.** So how would that meeting have been run? Just give us
2 the feel of it and the headlines from it.
3 **A.** So, within the meetings, we would go through with the
4 young person all of the information that we had gathered
5 and all of the different people that had been involved
6 in the assessment. So we would just revisit that with
7 him, and we would have explained sort of why we were
8 trying to elicit the information and just reminded him
9 of that, and then we would have tried to frame it in
10 a positive way for him, because I think he had quite
11 negative connotations regarding what autism was at that
12 time.
13 So we tried to frame it in a really neuroaffirmative
14 way, that it's just a profile of needs, it means that he
15 thinks differently to everyone else and he may have some
16 differences from his neurotypical peers, and we just
17 tried to explain that, by understanding his differences,
18 it would enable him to get further support and help in
19 school.
20 And so we would have gone through all of the
21 diagnostic criteria and how he met that and the
22 difficulties we had seen, and then we would have spent
23 a lot of time explaining that the diagnosis had been
24 given and that it had been confirmed, and then we would
25 have spent time talking with him, about what support was

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1 available after, if he wished to engage with that, and
 2 his parents as well, you know, what they can access in
 3 terms of signposting.
 4 **Q.** Now, you've explained in the course of that answer, and
 5 set out in your statement, that an intention here would
 6 be to be neuroaffirmative --
 7 **A.** Yes, that's correct.
 8 **Q.** -- and, not least because of a degree of non-acceptance
 9 by AR conveyed by his father, you would have no doubt
 10 aimed for this to be a supportive session -- yes --
 11 **A.** Yes, we would have.
 12 **Q.** -- which would have been seeking to start the process of
 13 AR understanding the diagnosis?
 14 **A.** Yeah, we really would have spent time trying to help him
 15 understand and gain some insight into the difficulties
 16 that he might have been experiencing and not really
 17 understanding what that was. So we were able to give it
 18 a name for him and explain that the challenges were
 19 because of his autism and go through that with him, and
 20 help him to sort of understand a little bit more about
 21 himself.
 22 **Q.** In my layperson's terms, emphasising that the diagnosis
 23 meant simply that he would process and look at some
 24 things differently, compared to his neurotypical
 25 peers --

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1 and in as best way as we could, try to support him to
 2 understand that, without causing a negative reaction.
 3 **Q.** While understanding that this would not have been the
 4 time to do anything that might have been perceived by AR
 5 or indeed his father as confrontational or challenging
 6 his behaviours and that risk information of concern, did
 7 you yourself do anything outside of the meeting, perhaps
 8 with other agencies, to check that that was being taken
 9 forward?
 10 **A.** Yes, so following on from the conversation with father,
 11 he was very keen for CAMHS involvement to remain, to be
 12 able to address some of the difficulties that they were
 13 experiencing, and I think father at the time felt -- he
 14 thought that the case had been closed to CAMHS. So
 15 I agreed that I would look into that for him and I asked
 16 him to email me with some more details about what he was
 17 struggling with at home, I think to give him
 18 an opportunity to be more open and honest about what was
 19 happening, without obviously AR being present.
 20 And he did email me and, following that, I then had
 21 a conversation with the CAMHS manager, as I'd reviewed
 22 the case and could see that on the actual system the
 23 case was still open to CAMHS and it hadn't actually been
 24 discharged. So I asked for a review appointment to be
 25 arranged, so that support could be embedded and in place

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1 **A.** Yes, that's correct.
 2 **Q.** -- but that doesn't equate to less valuable or wrong,
 3 matters of that kind, it just means that there are some
 4 differences which may need to be addressed in various
 5 different ways?
 6 **A.** Yes, that's correct.
 7 **Q.** Now, realistically, against that background, in fairness
 8 to you, this would not have been the time to bring into
 9 play concerns about what he might have been looking at
 10 online, in terms of what you refer to as "spending
 11 considerable time on intense interests", in
 12 paragraph 34, because this was one where, in layperson's
 13 terms, you wanted to get him on board and keep him on
 14 board?
 15 **A.** Yes, that's correct.
 16 **Q.** But were you, at this stage, personally aware of that
 17 risk information that I have summarised?
 18 **A.** Yes, I was aware that there were some incidents where
 19 he'd harmed other people and I think we -- I think that
 20 was why we went around it so sensitively in terms of how
 21 we delivered the news. I think father's concerns were
 22 mainly around, you know, his emotional wellbeing but,
 23 obviously, there was that risk which had been evident in
 24 the school reports that we had received, and so we
 25 needed to be careful and ensure that he was, you know --

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1 and, obviously, at that time, there was some other
 2 services, I think, that were involved as well, in the
 3 background. So, yes, I mean, in my view, I suppose,
 4 I did handover that responsibility to the CAMHS service
 5 to pick that up.
 6 **Q.** That was in terms of Alphonse R, I think, wanting
 7 himself to ensure that there was further CAMHS
 8 involvement, and you have indicated how you passed that
 9 on. But more specifically, did you include within that
 10 a concern about, "Now we have a diagnosis of autism
 11 confirmed for this particular pupil, given the risk
 12 information that we're aware of, this does rather cement
 13 concerns around risk, so we do need to be careful about
 14 internet use and matters of that kind"; were you
 15 emphasising those aspects?
 16 **A.** I can't remember if I did say that specifically.
 17 Unfortunately -- yeah, I'm sorry, I'm not sure about
 18 that.
 19 **Q.** Again, do you think that might have been an appropriate
 20 thing to do?
 21 **A.** Yes, it would have.
 22 **Q.** You've touched on the request from Alphonse R and
 23 I think he requested, in addition, that there be an ADHD
 24 assessment; is that right?
 25 **A.** Yes, that's correct.

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1 Q. In terms of the way in which this was now being taken
2 forward by the autism service, I think there would have
3 been a final report that you touch on in your statement;
4 is that right?

5 A. Yes, that's correct.

6 Q. You agreed, I think, that the final report should be
7 amended to reflect the request for an ADHD assessment --

8 A. Yes, that's correct.

9 Q. -- and a recommendation within that that AR's school
10 should refer AR to the ADHD team for assessment?

11 A. Yes, that's correct.

12 Q. The matter that you touched on a moment ago, you deal
13 with in paragraph 41 of your statement, that's the
14 request by him for CAMHS' involvement, further CAMHS
15 involvement, including ADHD, being necessary. It's
16 paragraph 41 on page 10.

17 You also go on to explain in paragraph 41 that you
18 explained the referral process for ADHD. Now, I think
19 by this stage the requirements had slightly changed.
20 Can you just explain to us what the change was?

21 A. Yes, so ADHD service, at the time they expected the
22 school to complete the referral, in partnership with
23 parents. The reason for that is that NICE guidance, in
24 terms of assessment for ADHD, means that there needs to
25 be clear evidence of difficulties in two domains, so

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1 The final report, including that recommendation that
2 the school be invited to consider a referral; is that
3 right?

4 A. Yes, that's correct.

5 Q. You explain that, upon reviewing the records -- and
6 I think, in context, that's you reviewing the records --
7 sorry.

8 I think we just moved away from the relevant
9 paragraph we were on previously.

10 Paragraph 43, "Upon reviewing the records", and
11 I think, in context, that's you reviewing the records
12 for the purposes of this Inquiry, not at the time?

13 A. Yes.

14 Q. "... I note that this report does not appear to have
15 been copied to the school as I requested. As a result,
16 I am unable to comment on whether the school received
17 the request to initiate the ADHD referral ..."

18 A. Yes, that's correct.

19 Q. Does that appear to be an error at the autism service
20 end, that that wasn't done, as you'd intended?

21 A. Yes, unfortunately at the time, our letter system was
22 quite different. So the clinicians would email letters
23 to administrators to then upload onto the system. So,
24 obviously, you are relying on information to be passed
25 over, et cetera, whereas that's now been corrected and

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1 what that means is two settings, usually school and
2 home, for young people. So when a referral is completed
3 in partnership with school and parents, then the
4 assessment can go forward, you know, quite quickly
5 because that information is available, and I explained
6 that to Alphonse.

7 Q. So, putting it bluntly, it wasn't going to be enough for
8 Alphonse, as AR's father, just to say, "I have concerns
9 about ADHD", and raise it with CAMHS and ask for
10 a referral: there was going to have to be a referral
11 coming in for two sources to get through the gateway?

12 A. Yes, that's correct.

13 Q. You think you explained that?

14 A. Yes.

15 Q. Paragraph 43, over the page, please. The final outcome
16 report, initially, I think, was dated 12 February.

17 Sir, AHCH000096 at page 10 but you don't need to
18 turn it up.

19 But I think you reviewed it and you spotted it, that
20 that aspect, in relation to the school being asked to
21 complete ADHD, hadn't in fact been added; is that right?

22 A. Yes, that's correct.

23 Q. So it was amended, as you've explained. The final one,
24 we will see, was dated 16 February 2021.

25 Sir, for your note LCC000097.

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1 that, obviously, is not how we work now but, at the
2 time, that was the method that was used to send the
3 report to an administrator to then upload and do the
4 copies.

5 Q. Although one understands why you give us the detail
6 about the systems then and the systems now, it's not
7 unimportant because the system had changed, requiring
8 two points of referral. You, as the clinician, were
9 supportive of this and the letter was intended to be the
10 request or the nudge to the school to make their side of
11 the referral. So it's not an insignificant failure, is
12 it, if the letter didn't ever go to the school, would
13 you agree?

14 A. Yes, that's correct.

15 Q. Thank you. In terms of the overall time taken to
16 diagnose AR with autism, we have looked at the early
17 period and you have accepted that there seems to be
18 a shortcoming there. The total period we calculate to
19 be 77 weeks, I think --

20 A. Yes.

21 Q. -- from referral to diagnosis. How does that compare to
22 national averages or national standards for the time?

23 A. I think at the time it was in comparison, there are
24 significant challenges in terms of diagnostic services
25 across the whole of the nation and waiting times are

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1 unfortunately significantly longer than what we would
2 like. So, at the time, it was -- we know that waiting
3 times are over 12 months in a lot of areas,
4 unfortunately. This is obviously not what we want but
5 that was sort of a national picture and still is,
6 unfortunately.

7 **Q.** But within that, that initial period of some eight
8 months or so, from November, which would have been the
9 11-week average, to July, that was a period of delay by
10 Alder Hey's own standards; would you agree?

11 **A.** Yes. I think the KPI targets for community paediatrics
12 at the moment is 18 weeks. So, obviously, it did go
13 over that time, the first appointment.

14 **Q.** I appreciate that it is difficult but are you able to
15 assist the Inquiry as to the impact that that period of
16 time, the 77 weeks, of which eight months was in excess
17 of the 11 weeks for the first appointment, are you able
18 to assist us with whether that period of time or delay
19 would have had an impact on AR?

20 **A.** I would say yes. I mean, I'll be honest and say that
21 I feel autism diagnosis is important in terms of
22 formulation and care planning and how treatment can be
23 implemented, if that makes sense. So, obviously, AR was
24 involved with CAMHS but he had significant difficulties
25 engaging with that process. So, a diagnosis of autism

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1 **Q.** But would it be fair to say that a delay can have
2 an effect on the young person concerned because there's
3 a risk of entrenchment of the difficulties. So in areas
4 like social communication, emotional regulation,
5 behavioural flexibility, sensory processing, there is
6 delay in addressing those issues, so although the autism
7 doesn't get worse, it can have a detrimental effect,
8 a delayed diagnosis, on the individual?

9 **A.** Yes, that's correct. Research will support that delayed
10 diagnosis can have an impact. I think, especially AR's
11 schooling situation, unfortunately, you know, he was
12 struggling to access school. So an autism diagnosis may
13 have informed the planning around his education
14 provision a little bit earlier.

15 **Q.** For ADHD, a delay in diagnosis there, would you agree,
16 could reinforce maladaptive neural pathways? So
17 slightly different with ADHD, that the actual condition
18 could worsen because maladaptive pathways can become
19 stronger?

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

21 **Q.** Thank you. In terms of the support that was then
22 offered, you indicate in your statement that there would
23 have been the provision of signposting to the community
24 sector organisations that would be able to provide
25 support. You have touched in general terms upon those.

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1 would have maybe informed practitioners to use
2 approaches that were more suitable for an autistic young
3 person, sort of adapted approaches, they may have been
4 able to engage him in a different way, maybe using
5 electronic means or text messaging or things like that.

6 So, yes, I would say that the delay was significant,
7 especially in terms of the Forensic CAMHS report, which
8 I obviously wasn't aware of, as it wasn't on the record,
9 but that obviously seems to be heavily weighted towards
10 having a diagnosis of autism and that being completed
11 quickly, which impacted on the risk assessment, I think,
12 that they recommended not being completed. So, yeah,
13 I think, in summary, I would say yes, it is important,
14 the wait was too long, unfortunately.

15 **Q.** So one aspect of that, that you've been candidly
16 accepting there, is the impact on those who were trying
17 to help AR, to some extent, because they may have known
18 that autism that might have been in play, they may have
19 been able to use some of those strategies anyway. But
20 you're accepting that there's that impact.

21 In terms of AR himself, would this be right, with
22 a neurodivergent condition, his autism wouldn't, in any
23 sense, have been made worse by the delay because it is
24 not "treatable"?

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

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1 In relation to the monitoring of whether they were
2 taken up, is any monitoring done or is it effectively
3 left to the parents to ensure that they take up
4 appropriate support?

5 **A.** Yes, so there wouldn't be any monitoring from the
6 diagnostic service, so we wouldn't have oversight on
7 whether services were taken up. As I said earlier on,
8 autism spectrum disorder is quite a unique profile of
9 difficulties and everyone is different. Therefore, some
10 young people may have difficulties in, maybe,
11 inattention or sensory differences, where others may
12 have difficulties in other areas.

13 So the services are available as sort of like a menu
14 of support, really, which parents can then access to
15 look at specific concerns that they may have with the
16 young person or child. So we very much hope and we
17 support parents to be their own advocates in that way
18 and explain that they need to, you know, research and
19 find out about autism and we always say for them to
20 attend as many courses as possible, just to get that
21 awareness and that insight into the autism spectrum and
22 what that means. So, yes, we would very much expect
23 parents and the young person themselves to try and
24 access all that support.

25 **Q.** Support parents to be their own advocates --

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1 A. Yes.

2 Q. -- you will forgive me -- I'm sure it's right that it is

3 done in a supportive way and an informative way to tell

4 parents of the sources of support -- but is the blunt

5 reality of support parents to be their own advocates,

6 that you give them the information in a supportive way

7 and say, "Here's the menu", but the autism service at

8 the time stepped away, having done that?

9 A. Yes, yes, because we are only part of the diagnostic

10 process. We wouldn't have capacity, unfortunately, to

11 follow up in that way.

12 Q. So if parents were thereafter struggling to get that

13 support or -- and I'm not here referring to anything

14 specific in relation to AR's parents -- but were

15 ineffective in as parents in getting the support, is

16 there any autism service in the local healthcare area

17 who are there to help them, post-diagnosis at the time?

18 A. There is. But, again, it's not statutory. So it would

19 be parents seeking that out.

20 Q. From whom? Who would they turn to?

21 A. So there was the small service that I mentioned earlier,

22 the Sefton Nursing ASD and ADHD team. There is a small

23 service that can offer some treatment -- not treatment,

24 some intervention. So that would be some parent

25 training and some individual work with the young person,

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1 against the background of the autism diagnosis are

2 sufficient to deal with the risk to others?

3 A. I think that would depend on a lot of factors. So,

4 obviously, with AR's case, there was concerns around

5 anxiety, isolation, socialisation. So mental health was

6 considered, you know, as a possibility that he was

7 struggling with mental health as a comorbid factor. So

8 CAMHS, obviously, is important in that sense but, if it

9 was another scenario, for example, where there might be

10 domestic violence or something, or another -- or maybe

11 mental health wasn't a factor, then we would refer onto

12 social care or Early Help, for example.

13 Q. I understand but I'm focusing on the cases, including

14 AR's, where the concern is not that the child may come

15 to harm and is not, as such, that the child may have

16 a mental health condition, such as an anxiety disorder,

17 but that the behaviour of the child, now worsened

18 because of a confirmed autism diagnosis, is a risk to

19 the lives of other people.

20 You will understand it's not a criticism of you

21 individually but I come back to the fact that the autism

22 service wasn't resourced or expected to give ongoing

23 support in that case. Notwithstanding the concerns

24 about risk to others, the baton was passed back to

25 another agency --

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1 if that was required, but that would again still need to

2 be sought out by parents.

3 Q. In a case such as AR's, where there was all this risk

4 information of concern, is that process sufficient?

5 A. Sorry, can you clarify?

6 Q. Is signposting parents on to support for autism and then

7 letting the parents advocate for themselves about that,

8 is that sufficient, do you think, in a case in which

9 there's lots of information of concern about risk to

10 others?

11 A. I think in his case, though, he was open to the CAMHS

12 services. So, from our perspective, as an autism

13 diagnostic service, he was already open to a service

14 that has a responsibility for managing risk. So, you

15 know, the information was on the system and had been

16 shared with parents, CAMHS were able to access the

17 information and I think it is quite clear, you know,

18 when I reviewed the records, that CAMHS did talk about

19 the same signposting that we'd given, you know,

20 throughout that journey. So they did have another

21 agency involved at that time.

22 Q. All right. So, because of the resource, what the autism

23 service was resourced and not resourced to do at the

24 time, the baton then gets handed back to CAMHS, does it,

25 to ensure that interventions that are now taking place

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1 A. Yes.

2 Q. -- here, so far as you were concerned, CAMHS?

3 A. Yes, that's correct.

4 Q. Thank you.

5 You deal in your statement with the subsequent

6 decision to discharge AR, presumably, for the reasons we

7 have just been covering, from the autism service?

8 A. Yes.

9 Q. There is a particular point that I want to pick up with

10 you about discharge because you have explained the

11 reasoning and the resourcing of the autism service and

12 what it was expected to do, but we do have on the

13 records that indication from Forensic CAMHS, from back

14 in March 2020, of an offer for them to become further

15 involved if there was a significant change, and

16 an indication that their ability input into the risk was

17 limited by the fact that there'd not yet been

18 a diagnosis.

19 So, against that background, prior to AR being

20 discharged from the autism service, wouldn't it have

21 been appropriate for the autism service to refer AR back

22 to FCAMHS?

23 A. Yes, so unfortunately, as far as I can see, we didn't

24 receive any communication with FCAMHS prior, so as

25 discussed earlier, they didn't ask us to expedite or

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1 contact in any way, giving us that information and, as
 2 discussed yesterday, unfortunately, the FCAMHS reports
 3 that had been submitted -- so two letters -- were
 4 actually never on the record. So I and the rest of my
 5 team wouldn't have known that that recommendation was
 6 even made, unfortunately.

7 **Q.** Had you known that that was made, would you have
 8 referred AR back to FCAMHS?

9 **A.** Yes.

10 **Q.** Being, it seems, for reasons beyond the autism services'
 11 control, ignorant of that at the time, would you have
 12 expected CAMHS, who were aware of the diagnosis, to
 13 re-refer to FCAMHS?

14 **A.** Yes. Yes.

15 **Q.** Do you know why that wasn't done?

16 **A.** I would assume for the same reasons, really, that the
 17 report was not clear on the record, so there was a note
 18 which was very brief saying that FCAMHS had had previous
 19 involvement but closed the case. Obviously, this was
 20 from my review following my involvement. But that
 21 report wasn't really even available when I was doing my
 22 full review of the case. So I would imagine that the
 23 CAMHS practitioner who came in to support after the
 24 autism diagnosis, when she had her appointment, she
 25 probably would have been in the same scenario as we

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1 Is that quite accurate?

2 **A.** No, it isn't. So I think, at the time of my review,
 3 I was looking obviously from the autism diagnostic
 4 team's perspective. So, for us, as a diagnostic team
 5 the risk assessment did have details in that we could
 6 use to support the assessment to go ahead. I think
 7 that's probably what I meant but, following, obviously,
 8 the evidence and the Alder Hey internal review that has
 9 been conducted, it's clear, with further scrutiny, that
 10 the standard operating procedure was not followed and
 11 the risk assessment was not reviewed at the intervals
 12 that it should have been and details were missing.

13 So now, obviously, that I understand that further
 14 information, I would say that that is not true and
 15 I would want to amend that to say that, unfortunately,
 16 it wasn't comprehensive and should have been more
 17 detailed.

18 **Q.** Please don't go into any question of any legal advice
 19 that you had in the course of preparing your statement,
 20 all right, because I don't wish to ask about that and
 21 I have no right to ask about it, but was that expression
 22 that you volunteered, that the risk assessments within
 23 the CAMHS service were comprehensive, was that your own
 24 personal reflection having looked at the notes or was
 25 that an indication from Alder Hey as a trust of how they

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1 were, that it wasn't clear that that recommendation had
 2 ever been made, unfortunately. And -- but that would be
 3 obviously just me thinking what may have happened.

4 **Q.** So from your understanding of the records, Sam Steed,
 5 who I think it would have been on that side, was
 6 blindsided like you?

7 **A.** Yes, I'm guessing so, unfortunately. Yes.

8 **Q.** Thank you.

9 Before we come onto the ADHD side, if we just come
 10 back to the question of risk assessment. I said that
 11 I would come back to page 16, paragraph 62 of your
 12 statement -- if that could just come up on screen,
 13 please, paragraph 62.

14 I have explored with you the autism service
 15 involvement in risk assessment but, having been asked
 16 about the autism service's role in the assessment of
 17 risk, you volunteered some comments about the CAMHS
 18 assessment of risk. I read the first two lines earlier
 19 on but you went on to say that:

20 "Review of the records confirms that risk
 21 assessments completed by clinicians within the CAMHS
 22 service were [your words] comprehensive and included
 23 AR's history of incidents involving violence and
 24 threats, as well as reference to his autism diagnosis as
 25 a factor in his emotional dysregulation."

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1 wanted to present matters?

2 **A.** I think, honestly, I answered the questions that were
 3 given to me in the Rule 9. The Rule 9 question was
 4 something like what was my view of the CAMHS risk
 5 assessment, so I think I've just answered that as
 6 honestly as I did at the time. So that is my own view,
 7 based on, I think, my experience in the diagnostic
 8 service, looking at it from that maybe narrow
 9 perspective. But, no, no one has told me to write
 10 anything at all. That was my own view at the time but,
 11 obviously, now I feel differently about that view.

12 **Q.** So that was a personal reflection by you?

13 **A.** Yes.

14 **Q.** One that you now -- my words -- accept was perhaps
 15 a little rose tinted?

16 **A.** Yes.

17 **Q.** I follow, thank you. Can we turn then to deal with the
 18 ADHD assessment process.

19 We have touched on aspects of this while looking at
 20 autism, so I'll try to deal with it relatively more
 21 briefly. We've seen, haven't we, that the initial
 22 referral in was in relation to both autism and ADHD?

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

24 **Q.** We've traversed how you wanted the final report to cover
 25 the need for a referral from the school for ADHD, on the

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1 background of the fact that the multidisciplinary panel
 2 had indicated that further assessment for ADHD would be
 3 warranted?
 4 **A.** Yes.
 5 **Q.** Is that a fair summary?
 6 **A.** Yes.
 7 **Q.** Could we look at paragraph 44 of your statement, please.
 8 It's on page 11. You deal, coming back then to matters
 9 after February, as to how things went forward, so we
 10 have looked at the autism diagnosis. A couple of months
 11 after that, you say that, upon reviewing the clinical
 12 records you can confirm that Sam Steed met with AR and
 13 his father during the CAMHS appointment, 9 April 2021,
 14 and that AR's father explained that he had requested
 15 a referral to the ADHD service for assessment and that
 16 AR was currently on the waiting list. You say:
 17 "I am unable to comment on whether Ms Steed checked
 18 the records at that time to confirm if an ADHD referral
 19 was active on the system."
 20 But you say it's possible that, given the referral
 21 process has changed, that "Ms Steed noted the active
 22 community paediatrics referral", and concluded that the
 23 community paediatricians were in the process of
 24 considering an ADHD diagnostic assessment.
 25 You make clear helpfully that that's a supposition

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1 stage, would have just thought that AR was on the
 2 waiting list?
 3 **A.** Yes, that's correct.
 4 **Q.** Would it be fair that you can't read too much into it
 5 not being specifically raised on that occasion, in
 6 particular given the April conversation with Ms Steed,
 7 where he may have got the impression that he was on the
 8 waiting list?
 9 **A.** Yes, that's correct.
 10 **Q.** Could we look, please, at the bottom half of
 11 paragraph 49. You say that the ASD and the ADHD
 12 diagnostic services have been restructured to operate
 13 independently from the community paediatrics service at
 14 this time. You've helped us with that but you then say:
 15 "... in my opinion, further justifying the case
 16 closure to the community paediatrics department at that
 17 time."
 18 I'm not quite sure that I followed the logic of
 19 that. Given that the ADHD assessment was outstanding.
 20 **A.** So, I think what I meant by that is the community
 21 paediatrics department then had a very clear remit
 22 around what they would deliver, which was regarding
 23 neurodisability, so physical health issues, medical
 24 issues, children with complex health needs, for example
 25 down syndrome, neurofibromatosis, so their criteria in

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1 on your part?
 2 **A.** Yes.
 3 **Q.** Can we just make sure that I've understood that
 4 correctly: are you saying that there is a risk there
 5 that Ms Steed may have been able to see that the
 6 community paediatrics part of the referral was there and
 7 may not have been aware that now it would need the
 8 school ones too. So, in simplistic terms, she may have
 9 been lulled into thinking this was all was on train?
 10 **A.** Yes, that was my recollection when I read it. It was
 11 a little bit confusing at that time, during that
 12 transition period. So she may have seen that referral
 13 open on the system and thought that it was in hand and
 14 that she didn't need to take any further action.
 15 **Q.** You go on in paragraph 49 of your statement to deal with
 16 the fact that, in the context of a meeting with
 17 Dr Sultan in July 2021, there is no indication that the
 18 family raised ADHD at that stage; is that right?
 19 **A.** Yes, within the records and the notes for that
 20 appointment, I didn't see any discussion around ADHD
 21 from AR or his father. It wasn't documented.
 22 **Q.** Understanding that that's the case and we think that
 23 you're right that it's not documented that that was
 24 specifically raised, but it is entirely possible, indeed
 25 perhaps likely, isn't it, that Alphonse R, at that

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1 July 2021 was specific around health.
 2 So AR, if it had been now -- and, obviously, I know
 3 it isn't -- but he probably wouldn't meet criteria for
 4 that service at all. So I think -- I mean, this again
 5 is just supposition, that maybe the paediatrician had
 6 looked and realised that there were no health issues, so
 7 they closed the case. But, unfortunately, obviously,
 8 the missing piece was the ADHD assessment because that
 9 referral was obviously not open to ADHD at that time.
 10 **Q.** You go on to deal in paragraph 50, that it is not the
 11 case that Alphonse R had somehow accepted that ADHD was
 12 no longer relevant because, as you correctly and fairly
 13 point out in paragraph 50, he raised the ADHD issue
 14 again with Dr Elaine Weir, who was involved, on the
 15 dietician side, at this stage, as a general
 16 paediatrician?
 17 **A.** Yes, that's correct.
 18 **Q.** As a result of that, Dr Weir requested that either the
 19 GP or CAMHS investigate the concerns over ADHD and
 20 initiate an ADHD assessment, yes?
 21 **A.** Yes, that is correct.
 22 **Q.** So that letter is AHCH000096 at pages 27 to 28 and that
 23 was copied to the GP and Dr Molyneux as the psychiatrist
 24 at that time; what happened to that?
 25 **A.** I think, as I have added really, I wasn't able to

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1 identify whether any action was taken, following that
2 letter being sent, because, as I have added later on,
3 the referral that was eventually -- you know, that did
4 come in for ADHD was from school. So, I'm not sure if
5 there was any liaison. There may have been but it just
6 wasn't in the notes. But that eventually did come in,
7 in June '23.

8 **Q.** So that's paragraph 51, and that's Presfield School
9 making the referral, yes?

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

11 **Q.** In general terms, I think you explain in your statement
12 that there were parts of that referral where there
13 wasn't the level of information that would be expected?

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

15 **Q.** You explain that the assessment of that, paragraph 52,
16 was done by Donna Hampson: who was she?

17 **A.** She is an ADHD nurse specialist within the ADHD team.

18 **Q.** We see from your paragraph 52 that she rejected it in
19 February 2024; what were the reasons for the rejection?

20 **A.** In her letter back she just explained that there wasn't
21 sufficient evidence from both home and school to show
22 significant differences in attention, hyperactivity or
23 impulse control. So I think she'd seen that there were
24 gaps in the information and felt that it wasn't -- it
25 didn't -- you know, it couldn't be accepted.

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1 adding additional information that may have been
2 helpful, so she may just not have seen that there was
3 any risk presented but again that is a supposition.
4 **Q.** I understand the degree of reluctance to criticise and
5 perhaps unfairly criticise Ms Hampson but does it really
6 come to this, that you, with all of your expertise,
7 looking at this and knowing what's in the notes, can now
8 see that there was earlier information that would go to
9 ADHD and a suspicion of ADHD, that doesn't seem to have
10 been averted to in the rejection?

11 **A.** Yes. That's correct. Yes.

12 **Q.** Do you think, looking at it appropriately critically, in
13 terms of identifying lessons learned, do you think that
14 sufficient consideration was given by the ADHD service
15 at this stage to the fact that AR was barely attending
16 Presfield School, so that the school referral was
17 inevitably going to struggle with providing detailed
18 information?

19 **A.** Yes, I think I did review the standard operating
20 procedure for the ADHD service at the time, which now
21 has been archived, but that actually did not have any
22 risk consideration within it, unfortunately. So she's
23 obviously followed the standard operational process, as
24 it was, without that consideration of risk which, in my
25 view, is an oversight and that is something we worked

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1 **Q.** But you go on to say that you are unable to comment on
2 whether she reviewed the full medical record as part of
3 the decision-making process but you say it's evident
4 from the referral form that Ms Dawson did not include
5 any examples of evidence of previous risk-related
6 incidents involving AR?

7 **A.** Yes.

8 **Q.** Did you mean by that there was relevant information
9 available on the records, to which Ms Dawson did not
10 refer in her rejection?

11 **A.** I think, as I've explained -- so our record is,
12 obviously, a whole holistic record. So ADHD service
13 would have been able to see CAMHS' notes, they would
14 have been able to see that. Unfortunately, the triage
15 allocated time, the resources that we have, whether she
16 would have been able to review everything in that
17 session, obviously, I'm not sure, but I don't think, you
18 know -- it's -- it wouldn't be standard practice. And
19 also the referral form itself, I think what I mean is
20 the actual ADHD referral form, which was different than
21 the paediatric one, which I explained earlier, had
22 questions specifically around ADHD signs and symptoms
23 but, within that referral form, there wasn't actually
24 a section to add any risk information. So the teacher
25 would have just filled that in and sent it without

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1 really worked hard to correct, since this happened, so.

2 **Q.** With your knowledge of the case papers and it is unfair
3 perhaps to make that as a direct comparison with
4 Ms Hampson -- and I'm not raising this as a criticism of
5 Ms Hampson, I want to be clear about that -- but with
6 your wider knowledge of what's in the case papers do you
7 think that a referral on in the ADHD system would have
8 been appropriate at that time, if the information had
9 been brought properly together?

10 **A.** I do think it was appropriate to assess for ADHD, yes.

11 **Q.** I think you say in your statement you can't say what
12 would have come out of that?

13 **A.** Yes.

14 **Q.** But you think that putting the information together that
15 was available, in fact, AR should have been gone through
16 to a full assessment for ADHD?

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

18 **Q.** You deal with in your statement with the fact that --
19 perhaps we should look at it, paragraph 79, page 21
20 please. You say, as you are not currently a practising
21 nurse prescriber, you don't feel it would be appropriate
22 for you to comment on whether AR would have been
23 prescribed ADHD treatment, if he had received
24 a confirmed diagnosis.

25 I think what you're pointing out there is that AR

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1 had risks relating to dietary restrictions and periods
2 of notable weight loss and that stimulant medications,
3 the first line treatment for ADHD, are known to have
4 side effects, such as suppressing appetite, which can
5 lead to further weight loss.

6 I think you were there saying that, although you
7 can't say definitively, you are flagging up to the
8 Inquiry, are you not, that there may have been some
9 contraindications to medication in AR's individual case?
10 **A.** Yes, I think I was asked to describe what would happen
11 if he had have received an ADHD diagnosis. So I just
12 wanted to make the Inquiry aware that it would have been
13 quite complex to be able to prescribe for AR, due to
14 physical health limitations, involvement with dietetic
15 services, et cetera. There would have had to have been
16 comprehensive reviews to look at it, really, and
17 obviously unsure whether he would have met criteria or
18 not but I just wanted to give some information in regard
19 to that.

20 **Q.** Thank you.

21 Just bringing this topic of my questioning to
22 a close, I think five opportunities can be identified
23 where the ADHD process was at least suboptimal. First,
24 on 2 July 2020, that's Dr Acharya, who took forward
25 autism but not, it seems, questioning about ADHD?

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1 professionals in AR's care to know about a diagnosis of
2 ADHD if, in fact, the progression of the referral had
3 led to that diagnosis; is that fair?

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

5 **Q.** Thank you.

6 Turning to my final topics then, please: changes and
7 improvements at Alder Hey. I will just deal with some
8 matters in relation to this.

9 So, in paragraph 60 -- could we just have that on
10 screen, please, it's page 15, I think -- there is now
11 a process in which, on the autism side, the service has
12 developed so that there is a greater involvement
13 post-diagnosis and services that can be offered. Could
14 you give a high-level summary of what those are?

15 **A.** Yes. So Alder Hey diagnostic team, we are responsible
16 for delivering a workshop which is to the young people
17 themselves and this explains what autism is in a really
18 neuroaffirmative strength-based way and often can be
19 really helpful for young people if they are struggling
20 to accept or understand maybe why they have received
21 that diagnosis. So that workshop is available for ages
22 11 up to 19 and we deliver that with our specialist
23 clinicians.

24 We also deliver a parent training programme, which
25 is called Riding the Rapids and this is based around the

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

2 **Q.** Secondly, when the final outcome letter was not copied
3 to the school, inviting them to do a referral?

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

5 **Q.** Thirdly, on 9 April, when Alphonse R raised the ADHD
6 position and nothing seems to have happened from that,
7 which may have arisen out of a degree of confusion about
8 the new referral process?

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

10 **Q.** Fourthly, Dr Weir's referral, with the caveat that it is
11 possible that that may have trickled into what then
12 happened with Presfield but you can't see any records
13 that Dr Weir's request was actually directly actioned?

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

15 **Q.** Fifthly, the Presfield referral that was made, you
16 accept that if the information had all been pulled
17 together that would have and should have been
18 progressed?

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

20 **Q.** So it comes to this, doesn't it, there were multiple
21 failures to press the ADHD assessment for AR forwards?

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

23 **Q.** In paragraph 80, in a similar way to the issues about
24 delay with the autism diagnosis, I think, in relation to
25 ADHD, you accept that it would have been helpful for

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1 principles of giving parents the information to be able
2 to identify triggers that may be causing different
3 behaviours at home or things that might be challenging,
4 so it's a very empowering sort of ten-week intervention
5 where we go through working with the family about
6 a goal-based outcome, so they may want to reduce
7 aggression at home, for example, then we would work with
8 them step by step to develop an intervention plan, and
9 that was developed in the University of Manchester and
10 we've had that in place since, but again that is for
11 parents to opt into for that support.

12 Then we also have a commissioned partnership with
13 ADDvanced Solutions Community Network, who I have
14 mentioned, and they deliver a workshop for parents and
15 carers to actually understand what autism is and what
16 strategies we can use to put in those reasonable
17 adjustments, as I mentioned earlier, at home and also
18 change their communication style, things like that. So
19 it's quite comprehensive and goes through all the areas
20 of what autism is.

21 And then also ADDvanced Solutions offer a coaching
22 model of support, so, again, this is very, very helpful
23 for young people when they are struggling to understand
24 diagnosis or how that impacts for them. So it's a very
25 individualised goal-based approach, where the clinician

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1 will support the young person one to one in an area that
2 they need support with.

3 **Q.** Can I ask you about that fourth one. You have indicated
4 it's something that can be used where young people are
5 struggling to understand their diagnosis. Would that
6 individualised coaching have a role for a case like
7 AR's, where the difficulty may be not so much in coming
8 to terms with the diagnosis or understanding the
9 diagnosis but where there are additional factors of risk
10 to others?

11 **A.** Yes, it would. Yes.

12 **Q.** Have there been cases -- obviously, please don't name
13 names, I know that you won't -- where the individualised
14 coaching, as part of the autism service post-diagnostic
15 offer has given support to individuals within that
16 cohort?

17 **A.** Yes. So I'm not sure if the Inquiry is aware of the
18 Vanguard project in relation to young people who are
19 vulnerable to exploitation and criminality.

20 So we've been involved with that in Liverpool in
21 Sefton since, I think, 2022 and part of that, there was
22 a neurodevelopmental offer developed to support young
23 people with that exact need that you've just described
24 and the coaching offer was embedded as part of that. So
25 there was a cohort of young people who were deemed very

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1 been an urgent case, which would have meant that we
2 would have added him to a fast-track list.

3 As he was open to CAMHS at the time, we would have
4 initiated what we call our enhanced CAMHS pathway,
5 whereby we would have worked in partnership with the
6 case manager to ensure that that developmental history
7 and information was gathered straightaway urgently and
8 then we would have booked them into an appointment with
9 a consultant psychiatrist and speech therapist, where
10 they would have done a joint assessment, looking at risk
11 specifically as well, but also looking at
12 neurodevelopmental conditions and they would have
13 provided that diagnostic outcome then and there.

14 So it would have been extremely quick, and obviously
15 I mention we also have the Vanguard project, which is
16 another arm to it, where we have a close relationship
17 with the YOS service and we have all children who are
18 open to criminal justice or in any way can also access
19 the fast-track as well. So there's a lot of safeguards,
20 I feel, that we would be aware of young people -- but
21 not at the time, unfortunately.

22 **Q.** That's a factor presumably, some detail there backing up
23 the comment you made earlier in your statement, about
24 how far the service has moved on since --

25 **A.** Yes, I feel, yes.

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1 vulnerable to criminality and exploitation and they
2 received that support and also family-based coaching as
3 well.

4 **Q.** Thank you. I might ask if you can provide us with
5 a written note with some more details in relation to
6 that --

7 **A.** Yes, of course.

8 **Q.** -- if you would. Thank you.

9 Then also at paragraph 91 of your statement, you set
10 out some details, which just for the moment I'm going to
11 put on screen, just in part for the learned Chair's
12 note, without going through them all.

13 Do the improvements mean that in a case like AR's,
14 in the circumstances where there's concern about
15 criminal behaviour, risk to others, would there now be
16 a process for prioritising the assessment in that sort
17 of case?

18 **A.** Yes. Completely. It's completely been revised. So now
19 we have a very comprehensive triage process, so you
20 triage with two clinicians and any cases where there's
21 any risk presented would be escalated up to the lead
22 professional on duty and then what we would do is review
23 the case and we use a risk stratification tool, which
24 has been embedded across Cheshire and Mersey to identify
25 urgent enhanced and routine cases, and AR would have

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1 **Q.** Finally, just in terms of reflection on events,
2 paragraph 85 of your statement, page 22. You said that
3 the only gap that you had identified at the time of your
4 statement was in relation to clinicians not having
5 checked whether the ADHD assessment had been started; is
6 that right?

7 **A.** Yes, I think -- I suppose to expand on that really, the
8 gap of the ADHD assessment as a whole, you know, in all
9 those other circumstances as well.

10 **Q.** We have been through that but in that area.

11 **A.** Yes.

12 **Q.** Paragraph 86, over the page, you say that the Meditech
13 Expanse system may have contributed to the gap and you
14 note difficulty over the paper letter not being
15 autogenerated in a way that did not mean it was copied.

16 Then in paragraph 88, you say in the middle of the
17 paragraph:

18 "In my opinion, AR received a supportive service
19 during his time with Sefton CAMHS. However, I believe
20 that embedding more dedicated training and specific
21 interventions -- such as adapted [CBT], and acceptance
22 and commitment therapy (ACT) tailored for children with
23 autism -- within all CAMHS services will be essential
24 for creating positive change."

25 Does that reflect that that's a change that still

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1 needs to come: more of the adaptive form of CBT and ACT?

2 **A.** Yes, I mean, I'm just -- just talking, I suppose, as

3 a general term, you know, CAMHS services are not

4 universally designed for neurodiversity and, although

5 there are very skilled clinicians in Sefton CAMHS

6 service and Liverpool CAMHS service, not all clinicians

7 would have had a very, very high level of training in

8 neurodiversity, which I feel is important.

9 So there is work going on in our Cheshire and Mersey

10 partnership to develop a neurodiversity CAMHS pathway so

11 we can make recommendations around what therapies, what

12 support, what training needs to be embedded across all

13 of CAMHS, so that any young person who accesses a CAMHS

14 service is going to get the same level of support, and

15 that work is currently ongoing as part of the Cheshire

16 and Mersey neurodiversity recovery programme.

17 **Q.** Arising out of the issues that we have explored with

18 previous witnesses, three further reflections should be

19 added, yes? There was a delay in the first assessment

20 for AR for autism?

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

22 **Q.** There was a failure to fast-track his autism

23 assessment --

24 **A.** Yes.

25 **Q.** -- against the background of risk to others?

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1 been earlier -- but would it also have altered the

2 appreciation of his risk to others, and that's what

3 I think I want to just question you about a little bit.

4 You gave evidence -- for your note, sir, it was

5 about 10.26 on the realtime transcript -- that, in

6 a normal assessment, you wouldn't expect specific

7 questions on risk to be asked, correct?

8 **A.** In a routine assessment, yes.

9 **Q.** But given -- and again, just assuming for the purpose of

10 my question that there was enough information available

11 following the various meetings, the strategy meeting on

12 17 December, where I don't think there was a member of

13 the ASD team available, but there were enough

14 inter-agency people there for the messages to get

15 through, but at that meeting and then the meetings with

16 FCAMHS later on in January, that had there been a true

17 appreciation that on 7 October, the Childline incident,

18 where we say was the active homicidal -- the murderous

19 intent was clear, that that rather got lost in the wash;

20 were you aware of that?

21 If that hadn't got lost in the wash and the hockey

22 stick was looked on as the second major incident -- so

23 you've got intent to kill followed by going equipped to

24 kill -- so, when the professionals were thinking about

25 a proper forensic examination at that stage in January

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

2 **Q.** And there was a failure arising from poor record keeping

3 to refer his case back into FCAMHS, which the autism

4 service would have done, if it had known of FCAMHS'

5 original recommendation?

6 **A.** Yes, it would have done.

7 **MR MOSS:** Just looking to my left.

8 Mr Bowen.

9 **SIR ADRIAN FULFORD:** Yes, Mr Bowen.

10 **Questioned by MR BOWEN**

11 **MR BOWEN:** Thank you, sir.

12 I ask questions on behalf of the bereaved families.

13 Just before I start, sir, could I just say that I have

14 had specific permission in relation to question 14 of

15 the Rule 10. I'm aware that quite a lot of it has been

16 covered, so if I'm in danger of duplication, please --

17 I know you won't -- do not hesitate to stop me and I've

18 set my timer.

19 **SIR ADRIAN FULFORD:** I won't hesitate, Mr Bowen.

20 **MR BOWEN:** I gather that.

21 The point that I'm looking at specifically is that,

22 had the assessment taken place closer to what I call the

23 hockey stick incident that you are aware of, aren't you,

24 on 11 December, would that have altered both the timing,

25 which I think we've covered -- it would and should have

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1 and not delay, can you conceive of any decision other

2 than to expedite and fast-track, even given there was no

3 fast-track official system in place?

4 **A.** Yes, I mean, I do agree that there shouldn't have been

5 a delay. The risk was obviously very present at that

6 time and the assessment should have been done then and

7 there and I think maybe, if it had have happened, the

8 practitioners involved talk openly about how they felt

9 he was autistic and that is in the records, and so

10 I think there were a lot of practitioners around that

11 time that must have been very aware of the symptoms

12 being quite significant. So if a diagnosis had been

13 made then, at the time, then I assume that FCAMHS would

14 have done the assessment that they refer to, if that

15 makes sense, in the letters. They may have carried on

16 and done that as part of that robust support package.

17 **Q.** Yes, so the assessment that they were prepared then to

18 wait for, knowing that it could take up to a year, was

19 really, in truth, given what they all suspected, more of

20 a confirmation of what they thought was his

21 presentation, rather than a genuine question of did he

22 have it; is that fair?

23 **A.** I mean, that's how it seems from the records, is that

24 people in their meetings very openly was talking about

25 him as if he may already have been diagnosed because his

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1 symptoms were so significant. So, yeah, I think the
 2 confirmation of diagnosis was just that: a confirmation
 3 of what people already thought at the time.
 4 **Q.** Right. So, had it happened then much more quickly and
 5 had there been a true appreciation of risk, is it fair
 6 that the assessment itself would have maybe taken
 7 a month?
 8 **A.** Yes.
 9 **Q.** Probably no more than that?
 10 **A.** Yes, that's correct.
 11 **Q.** So by possibly the end of January, certainly into
 12 February, we would have had confirmation that he had
 13 ASD?
 14 **A.** Yes.
 15 **Q.** He is then in the system, they are talking to each
 16 other, there is a proper understanding of the risk.
 17 Would it then have followed that they probably would
 18 have got hold of the ADHD aspect as well, at that time?
 19 **A.** I mean, it's hard to say but I would assume, I would
 20 assume -- yeah, I would assume so.
 21 **Q.** Okay. Towards the end of Mr Moss' questions, he covered
 22 the possible use of lisdexamfetamine, Elvanse or
 23 something like that, assuming there wasn't a problem
 24 with diet and weight, can you just confirm that's a sort
 25 of -- I think it's called a dopamine-releasing agent --
 89

1 I think there is some consideration of medication when
 2 it's quite severe, but it's not my area of expertise so
 3 that's just sort of -- yeah.
 4 **Q.** But would you agree that early intervention into that
 5 particular problem is essential?
 6 **A.** Yes, I would. Yes.
 7 **MR BOWEN:** Thank you.
 8 **SIR ADRIAN FULFORD:** Thank you very much, Mr Bowen.
 9 **Questioned by THE CHAIR**
 10 **SIR ADRIAN FULFORD:** Just one area from me and then you are
 11 finished.
 12 **A.** Thank you.
 13 **SIR ADRIAN FULFORD:** You have given evidence, to an extent,
 14 about records and how things weren't always in the right
 15 place or weren't easily to be found, so the great
 16 example, in one sense, has been the FCAMHS letter, which
 17 was not on the autism service record. So on that, just
 18 focusing on that, what has happened since that has
 19 ensured that that won't happen again?
 20 **A.** Okay. So following, obviously, the incident and the CQC
 21 inspection when they visited us, we have made
 22 significant improvements regarding the record keeping.
 23 So scanning, as it was, has completely gone. What would
 24 happen is that the information would be uploaded
 25 directly. So it is sort of hard to explain without you
 91

1 **A.** Yes.
 2 **Q.** -- and the four main things it does is reduces
 3 impulsivity, improves emotional regulation, less mental
 4 noise and distraction and better concentration and
 5 follow through?
 6 **A.** Yes.
 7 **Q.** So all the things that could have really impacted upon
 8 his behaviour and the way that he lived his life?
 9 **A.** Yes, potentially, if he'd have met diagnostic criteria
 10 for ADHD, but we still don't know if he would have, but,
 11 yes, that is what the medication is designed for in
 12 young people who do have a diagnosis of ADHD.
 13 **Q.** All right. The combination of high intelligence, lack
 14 of empathy, fascination with violence, a potential
 15 conduct disorder and ADHD all add up to a really toxic
 16 mix?
 17 **A.** Yes, it is concerning, yes.
 18 **Q.** It may be that you can't help with this last question:
 19 you were asked about the effect of delay on autism, do
 20 you know much about the effect of delay on any potential
 21 conduct disorder that he may or may not have had?
 22 **A.** What I do know about conduct disorder is the
 23 recommendations for intervention are quite similar to,
 24 I think, what was offered anyway. So it relates to
 25 parent interventions, systemic family therapy support.
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1 seeing it but the session notes that we would go into
 2 one by one with the date, any external report that is
 3 received would now be there listed. So, for example, it
 4 would say "FCAMHS report" quite clearly and it would say
 5 "School information, ASD" quite clearly. So any
 6 external reports that are received are now directly
 7 visible on the record, you don't have to go through any
 8 additional apps and things like that.
 9 The risk assessment information, as it was at the
 10 time, you had to go through one by one and find the risk
 11 document. Now, that has all been collated into one
 12 document on the very front screen. So we have a risk
 13 assessment for CAMHS, which, when that is updated, the
 14 historic info is kept on there, which I think is really
 15 good, but then you are able to update it with your new
 16 information, so you can clearly see this happened then,
 17 this happened then, this happened then, and it's all in
 18 one document.
 19 We also have a neurodevelopmental risk assessment
 20 because I think obviously what was mentioned there, you
 21 know, we should be assessing risk in the ASD service.
 22 There are some cases where we are made aware of
 23 significant risks and we haven't really had anywhere to
 24 put that information or to make sure that that is shared
 25 appropriately. So now we have another document which
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1 sits alongside the CAMHS one, which is clearly visible
2 for anyone who goes on Alder Hey record. So they are
3 the two main areas, and I think I mentioned earlier the
4 referral form as well is a lot more comprehensive. So
5 if another agency wanted to flag an urgent case for
6 autism or ADHD assessment, they can, and they've got
7 that place to write and that information so that can be
8 shared.

9 **SIR ADRIAN FULFORD:** Are these systems user friendly?

10 **A.** I would say so. Yeah, I would say so.

11 **SIR ADRIAN FULFORD:** So it's easy to operate, as well as
12 being easy to view, if, for instance, you are looking
13 for risk?

14 **A.** Yes.

15 **SIR ADRIAN FULFORD:** Now, does that then mean that, when
16 Mr Moss set out the long list of worrying features of
17 AR's past and you observed that they would have been on
18 the records but they were very difficult to find, that
19 problem has been solved by the description you have just
20 given of the changes that have been made; is that right?

21 **A.** Yes.

22 **SIR ADRIAN FULFORD:** So are you confident now that the
23 problems that arose in AR's case, if the systems are
24 applied properly, at least to that extent, would not be
25 repeated in the future?

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1 themselves carry an element of risk, if you are putting
2 new systems in place, new ways in which people are
3 expected to work, hopefully they will succeed but they
4 aren't necessarily going to succeed. To what extent is
5 the implementation being monitored.

6 **A.** In what way do you mean, audit or ...

7 **SIR ADRIAN FULFORD:** To see whether it's working? To see
8 whether material that should, for instance, be available
9 is available in the right form, in the right place, in
10 a comprehensible fashion?

11 **A.** So we do have an audit policy around record keeping,
12 which -- since I have been in post, we have done
13 a monthly audit around record keeping to ensure that
14 everything is on the place. I think we would probably
15 have to look at a wider audit and we have done this for,
16 for example, the outcome reports. As you've noticed the
17 outcome report for this case was not shared with who we
18 had asked it to be shared with. So now we do
19 an external audit, for example, checking with school
20 nursing service, GP practice, so we have done that to
21 check that the reports are getting to the right place.

22 **SIR ADRIAN FULFORD:** What I really have in mind is I have
23 heard the expression used quite a lot over the last few
24 days of people in AR's position being on "journeys", or
25 the parents but whether there is a -- obviously you

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1 **A.** Yes. I just -- I suppose I want to add as well, I mean
2 regarding the letters, at the time, obviously, it was
3 a lot of responsibility on administrators to do clinical
4 letters. So we have reviewed that again as a service
5 and as a Trust, and the clinicians themselves are
6 responsible to upload letters, so we now have our own
7 access. So if that was now, it would be me, myself,
8 uploading that report, checking the copies, checking it
9 was all accurate.

10 So that's obviously been put in place and I think,
11 obviously, there was some concerns about the ADHD
12 assessment not being taken forward and that has been
13 a very -- that has been a concern for me. So since
14 I started, really, so in September 2025, we merged
15 together as a full neurodevelopmental team. So as
16 I mentioned when I first -- it was introduced, I'm now
17 responsible over both. So if AR or a similar child was
18 referred to me tomorrow, we would assess simultaneously.
19 So we would do everything together in a holistic way
20 because it is very overlapping, as you've probably, you
21 know, learned from what you have heard and we would have
22 looked at AR for ASD/ADHD at the same time and it would
23 have been very much more of a collaborative supportive
24 assessment.

25 **SIR ADRIAN FULFORD:** So very considerable changes, which in
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1 can't do it with every person who has passed through the
2 system -- but whether there's a sufficient investigation
3 taking, as it were, some past examples to make sure that
4 this is working as an end-to-end process.

5 **A.** Yes, 100 per cent and, you know, we are going to -- we
6 are very -- I mean, it's only October, so the transition
7 only started in September, so we are still very much in
8 that transformation. We have a transformation board, we
9 have regular meetings, we have involvement from our
10 parent care forums for that feedback as well and we will
11 try to continually check and double check to try and
12 avoid any failings.

13 **SIR ADRIAN FULFORD:** I may be asking for some updates as to
14 the results of those checks Ms Boggan.

15 **A.** Of course, yes.

16 **SIR ADRIAN FULFORD:** Thank you very much indeed.
17 So, 1.50 pm?

18 **MR MOSS:** Sir, could I perhaps ask for 1.40 pm?

19 **SIR ADRIAN FULFORD:** Yes, of course. Thank you for your
20 evidence.

21 1.40 pm.

22 (12.49 pm)

23 (The short adjournment)

24 (1.40 pm)

25 **JOHN HICKLIN (sworn)**

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Questioned by MS WAKEMAN

1
2 **SIR ADRIAN FULFORD:** Thank you very much. Please have
3 a seat.
4 Yes, Ms Wakeman.
5 **MS WAKEMAN:** Would you start by stating your full name
6 please.
7 **A.** My name's John Keith Andrew Hicklin.
8 **Q.** If we could have your witness statement on screen, it is
9 GMMH000014. Is this your witness statement?
10 **A.** It is.
11 **Q.** Are the contents of that statement true to the best of
12 your knowledge and belief?
13 **A.** They are.
14 **Q.** Just start with some questions about your background and
15 experience, we can take the statement down thank you.
16 So as I understand it, you qualified as a mental
17 health nurse in 1988?
18 **A.** That's correct.
19 **Q.** You have been working in adolescent forensic community
20 service from 2000 --
21 **A.** Yes.
22 **Q.** -- and FCAMHS, Forensic Children and Adolescent Mental
23 Health Service, that we have been referring to, started
24 operating in 2017; is that correct?
25 **A.** I believe that to be correct, yes.

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1 intervention, as I understand it?
2 **A.** That's correct, yes.
3 **Q.** If we could bring on screen GMMH000015. This should be
4 the corporate statement from FCAMHS provided by Dr Imran
5 and Ms Brown. If we could have a look at page 3,
6 please, and paragraph 2 there in the middle. So we said
7 the first role was advice and they have explained here
8 that the FCAMHS practitioner will:
9 "... engage with professionals closely involved with
10 the young person to gather pertinent information."
11 It's utilised to form a structured narrative of the
12 young person's difficulties, integrating information
13 from various sources to elucidate the reasons for
14 presentation development and maintenance and
15 subsequently provide guidance and recommendations to
16 professionals working with the young person to address
17 areas of unmet need and mitigate high-risk behaviours.
18 Is that a summary of the advisory and consultation
19 role?
20 **A.** Yes, definitely.
21 **Q.** If we could zoom out again and look at the next
22 paragraph down which is "Assessment". Here they explain
23 that:
24 "In complex high-risk cases, where it has not been
25 possible to develop a formulation from consultation and

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1 **Q.** At the time of your contact in relation to AR's case, in
2 2019 and 2020, you were working as a clinical nurse
3 specialist within FCAMHS --
4 **A.** That's correct, yes.
5 **Q.** As I understand it, you have retired in May 2022.
6 I think you returned to work for a few days a week for
7 a short period but pretty much then you've been
8 retired --
9 **A.** That's right.
10 **Q.** -- and you're retired now?
11 **A.** I am, yes.
12 **Q.** Thank you. So just to start by understanding the role
13 of FCAMHS. Is it right that FCAMHS is commissioned by
14 the Greater Manchester Mental Health Trust to operate
15 its services in the North West?
16 **A.** Yes, I believe that to be correct. Yes.
17 **Q.** Putting it very simply, does FCAMHS have three key
18 roles: firstly, consultation and advice?
19 **A.** Yes, that would be one role, yes.
20 **Q.** If you just keep your voice up, so it is picked up by
21 the microphone.
22 Secondly, assessment?
23 **A.** Yes, I would think that's --
24 **Q.** We will come onto the detail of what it means later.
25 Thirdly, in some limited cases, it's some

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1 a specialist opinion is required, an FCAMHS practitioner
2 will undertake a direct assessment. This involves
3 interviewing the young person, their parents or carer
4 and, if necessary ... specialist assessment tools."
5 Then an assessment report is developed which
6 "provides recommendations to the professional network".
7 Does that paragraph fairly summarise the assessment
8 role?
9 **A.** Yes, it does. Yes.
10 **Q.** So you'd only be carrying out this assessment in
11 high-risk cases where there is a need for a specialist
12 opinion; is that fair?
13 **A.** Sorry, can you just say that again?
14 **Q.** So the assessment would only typically be done in
15 complex, high-risk cases, where you need a specialist
16 opinion; is that right?
17 **A.** I think where it hasn't been possible to gain a full
18 understanding of risk and risk management strategies at
19 a consultative level, then consideration of assessment
20 then would take place.
21 **Q.** Within the FCAMHS statements, there is some reference to
22 a forensic assessment; is that referring to this type of
23 assessment?
24 **A.** I would say that arguably all -- both the consultation
25 and this kind of assessment could be classed as -- well,

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1 I guess the consultation would be classed as a forensic
2 understanding and this assessment, I think, yes, I think
3 that's the same thing. I don't know what specific bit
4 of information you're referring to but I would imagine
5 it is the same thing as this, yes.

6 Q. Thank you.

7 Is this assessment that we're talking about here, is
8 this different to a risk assessment and, if so, how?

9 A. I would say it was different. I would say this
10 assessment that we are talking about, in this section 3,
11 "Assessment", as suggested, it's where we would go
12 out -- probably actually with two clinicians, I would
13 imagine -- and interview family and the young person.
14 We would still have a consultation meeting, if that
15 hadn't taken place already, with professionals as part
16 of that process, consider any other information that's
17 pertinent, and then produce, probably, what would be
18 perhaps a longer report, a bit more in depth report than
19 you will see from my letters that were around
20 a professional consultation.

21 Does that answer your question? Is that --

22 Q. Yes. So is it right that this assessment and the report
23 that would follow, that wouldn't be a substitute for
24 a risk assessment?

25 A. I think that our services, I think, as has been stated,

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1 I was part of the service. I think that's reflective of
2 some changes in the service that have taken place
3 subsequent to my retirement. I would have seen, if you
4 would have given me that title to talk to, without the
5 bit underneath, I would have talked about kind of
6 potential involvement post-assessment, directly with the
7 young person, if it was appropriate for our service to
8 do interventions at that point with a young person.
9 I think that first whole sentence/paragraph there is
10 reflective of how the service currently works, rather
11 than how it did work when I was a member of the team.

12 Q. I understand. When looking back to the time when you
13 had contact with AR's case, so end of 2019/start of
14 2020, what would FCAMHS' role in intervention looked
15 like?

16 A. I don't think that -- in AR's case, it did not progress
17 to intervention.

18 Q. I understand that. Just if it had done what would it
19 look like?

20 A. It probably would have progressed first to -- I think we
21 are talking hypothetically here. It could have
22 progressed to an assessment first, and I think that
23 would have taken place first and then, if there were
24 additional, I suppose in the cases of where young people
25 have engaged with that process of assessment with our

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1 would avoid kind of completing "a risk assessment" of
2 a young person. We'd see that as primarily the
3 responsibility of the local agency with care
4 coordinating responsibility to complete a risk
5 assessment. We would contribute by trying to help to
6 understand that risk, rather than *per se* completing
7 a risk assessment.

8 Q. I understand, thank you. We will come onto risk
9 assessments later.

10 If we could then go back to this statement that we
11 have on the screen and look at the next paragraph down,
12 which goes over the page, "Intervention", and this was
13 the third limb of FCAMHS' role that we touched upon.
14 Here it explains that:

15 "An FCAMHS practitioner can provide supervision to
16 community practitioners ... in line with the
17 consultation model; [providing] training, reflection or
18 guidance to address issues identified within the
19 formulation; psychoeducation around diagnoses; and
20 time-limited support to young people to understand their
21 formulation."

22 Is that a fair summary of, if you were going to have
23 some kind of intervention role, that's what you will be
24 doing?

25 A. I don't think that's reflective of the service when

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1 service and where it was felt to be that perhaps our
2 service could offer further appointments to continue to
3 develop a relationship perhaps with that young person,
4 then it may be that we would offer some additional
5 appointments to consider whether it's, in fact, our
6 service that could provide some intervention for a young
7 person. That's where that would have naturally gone
8 when I was a member of the team, not necessarily as
9 indicated in this particular document.

10 Q. I understand. What options for intervention did you
11 have to offer young people if you got to that stage, at
12 that time?

13 A. Well, I guess that would be case-by-case dependent on
14 their particular presentation and clinical need. So,
15 I guess that may be kind of one-to-one kind of --
16 working with a young person. Whilst I was saying this
17 is kind of reflective of what happened since I retired,
18 we could also work alongside -- when I was working, we
19 could also work alongside the referring agency, who may
20 have been working with the young person and offering
21 additional support to the interventions that they were
22 providing and -- or indeed, as suggested and indicated,
23 we could potentially provide intervention around high
24 risk and offending behaviour.

25 Q. Turning then to the role of FCAMHS in risk assessments

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1 generally, this is covered in more detail by the other
 2 witnesses from FCAMHS, one of which we will be hearing
 3 from later but I just want to have your personal
 4 understanding first. You said at paragraph 11 of your
 5 statement -- and I think you alluded to this earlier
 6 today -- that it's not the role of FCAMHS to complete
 7 a formal risk assessment but to contribute to the
 8 understanding of risk with the professionals that are
 9 working directly with the young person; is that fair?

10 A. That's fair, yes.

11 Q. So, FCAMHS as you understood it, you wouldn't be
 12 conducting a formal or a structured risk assessment?

13 A. No. In fact, I think we would have been -- by senior
 14 staff within the team, made very clear that that's
 15 exactly what we weren't doing, if you know what I mean.
 16 That's not a double negative, we wouldn't be doing that.

17 Q. I understand. The Inquiry has heard some evidence about
 18 a type of structured risk assessment, called a SAVRY
 19 assessment. Is that something you're familiar with?

20 A. Yes, very familiar.

21 Q. Does that fall within the categories of risk assessments
 22 that, as you understand it, FCAMHS wouldn't carry out?

23 A. Not quite. I think I suppose people have different
 24 things that come into their mind when somebody says risk
 25 assessment. I think it is a specific assessment of

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1 that what comes out with that would guide interventions
 2 that we wouldn't necessarily be completing, that it
 3 would be the responsibility of local services to
 4 complete -- "complete" is the wrong word but kind of do
 5 those interventions.

6 Q. So, in relation to a SAVRY, would you say that FCAMHS
 7 had a supporting role or a leading role?

8 A. It is a good question. I think probably I would go with
 9 supporting role, as being a better description, given
 10 what I've just said.

11 Q. I understand. If we could bring your statement up on
 12 screen and it is page 3, paragraph 10. So you say here
 13 that, during your employment with FCAMHS:

14 "... the responsibility for assessing and managing
 15 the young person's risk remained with the referrer or
 16 lead professional involved in the case. This was the
 17 agreed practice at the time. I would, however, support
 18 their risk assessment process, by gathering information
 19 about the young person's behaviour and risk during the
 20 consultation or through assessment. I would use this
 21 information to develop an understanding of this risk in
 22 the context of any underlying mental health or
 23 neurodevelopmental conditions and then provide advice
 24 and recommendations for inclusion in their risk
 25 management plan."

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1 violent risk. By its title, that's what it is about.

2 But whether that would be classed as -- you know, if
 3 somebody was thinking about kind of having a holistic
 4 risk assessment of a young person, I think that would
 5 just be addressing one aspect of their high-risk
 6 behaviour, which is to do with violence. Does that make
 7 sense?

8 Q. Yes, it does, so would FCAMHS carry out a SAVRY
 9 assessment?

10 A. Well, I guess that sort of we would do that alongside
 11 local services, who would be responsible for any outcome
 12 of that SAVRY assessment. So, the point of probably any
 13 assessment is what comes out of that for any agency to
 14 take forward, in terms of the recommendations that would
 15 come out of an assessment, and the SAVRY definitely
 16 would highlight areas for intervention and -- so we
 17 would be keen to -- if we were going to think about
 18 doing a SAVRY, to do it alongside local services and
 19 agencies that were able to take forward any outcome from
 20 the SAVRY. So I think we'd have to be clear that
 21 that -- from the beginning that that's what would likely
 22 happen.

23 So I have, for example, worked through the aspects
 24 of the SAVRY with professionals in consultation meetings
 25 and as part of an assessment, but with the intention

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1 Is that right?

2 A. That's correct, yes.

3 Q. So who would typically be the lead professional? How
 4 would that be decided?

5 A. Again, I suppose that's a bit case-by-case basis, if I'm
 6 honest. It would often be the referrer. I think often
 7 kind of local agencies, when deciding to make a referral
 8 and agencies being aware of a referral taking place,
 9 would probably decide who would be the best person to
 10 make that referral and they, in most cases, ending up
 11 being the person I would say that was -- we would see as
 12 a case holder and responsible for that.

13 But that potentially could be from any of the likely
 14 agencies that would refer to our service, and that --
 15 you know, that, I suppose, typically would be Children's
 16 Social Care, the Youth Justice Service, mental health --
 17 Child and Adolescent Mental Health Services. I would
 18 say they were the typical ones that would be seen as
 19 a case holder.

20 Q. I appreciate you say it depends on a case-by-case basis
 21 but, in a particular case, how was it decided? Would
 22 that be discussed at a professionals meeting and agreed?

23 A. Yes. I mean -- I think, once a case is allocated to
 24 a clinician, say for example me, once a case is
 25 allocated to me, like in AR's case, the first thing that

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1 I would do would be to make some contact with the
 2 referrer to set up the professionals' meeting, as I did
 3 in AR's case, and I suppose that process allows some
 4 initial understanding of how the referrer fits into that
 5 system and if it was -- I can't remember it happening
 6 all that often, if at all, but if it was clearly that
 7 they weren't going to be the case holder, I would at
 8 that point likely find out who was going to be the case
 9 holder and, I mean, on occasions would have had to, you
 10 know, kind of be clear that we do need a case holder.
 11 You know, if there was nobody that was going to be
 12 holding that case, then we would need a case holder to
 13 be able to effectively respond.

14 Q. I understand. Sir, I think that's a good time to turn
 15 to look at the referral of AR to FCAMHS. So if we could
 16 have a look at GMMH000002.

17 We see here what's called a FCAMHS telephone advice
 18 form?

19 A. Yes.

20 Q. It is a record of a call from Stephanie Hallaron --

21 A. Yes.

22 Q. -- to the duty clinician at FCAMHS?

23 A. Yes.

24 Q. We've obtained a statement separately from Ms Hallaron
 25 and she, as I understand it, worked for the Criminal

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1 Stephanie Hallaron and that's what I would have had
 2 rather than the handwritten advice form. I'm not saying
 3 that wasn't on the system. That probably was on the
 4 system but I can't remember ever seeing it, whether
 5 I did or not, I don't know, but it's possible.

6 Q. Then we see the advice given is noted as:

7 "Advice to refer to FCAMHS, yes. Advice strategy
 8 meeting. Invite all relevant organisations. FCAMHS
 9 will attend given notice."

10 At the bottom:

11 "Refer to CAMHS for ASD assessment and mental health
 12 screening."

13 If we could then have a look at GMMH000003. This is
 14 the actual FCAMHS referral form, which I think is the
 15 document that you were just referring to?

16 A. Yes.

17 Q. So is this the form that you would have been provided
 18 with and reviewed at the start of your involvement?

19 A. Yes.

20 Q. So that's dated the following day, 13 December 2019.

21 A. Yes.

22 Q. We can see the referrer is the same person, Stephanie
 23 Hallaron?

24 A. Yes.

25 Q. If we could have a look at page 4, please. We can see

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1 Justice Liaison and Diversion Team, which is based out
 2 of Merseyside NHS Trust; is that right?

3 A. Yes.

4 Q. So here we can see it is a call on 12 December 2019.
 5 It's about AR. If we go over the page to page 2. Could
 6 we just zoom in on the box that says "Reasons for
 7 telephone contact". We can see there:

8 "Arrested yesterday -- possession of a bladed
 9 article, offensive weapon Section 47 assault. No
 10 previous contact YJS ..."

11 Which I understand to be Youth Justice Service?

12 A. I would think so, yes.

13 Q. "... known and open to Prevent team. Googled about mass
 14 killings, beheadings, ISIS. Took hockey stick into
 15 school and assaulted boy. Previous exclusion for taking
 16 knife into school. ASD presentation -- no diagnosis, no
 17 remorse, [downward arrow] empathy."

18 Did you get given this advice form at the point when
 19 you later -- I know you weren't assigned at this time --
 20 but did you later come to see this advice form?

21 A. I haven't seen this advice form but that wouldn't
 22 necessarily have been the system, as I remember the
 23 system, from three years ago. I wouldn't necessarily
 24 have seen this. I think, by that time, we would have
 25 had a formal referral from the -- in this case -- from

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1 near the top of the page -- I'm not going to obviously
 2 read all of this out but I will pick out a few key
 3 points -- reference to the hockey stick attack, "use of
 4 hockey stick to hit another student and admitting to
 5 having a knife"; do you see that?

6 A. Yes.

7 Q. If we could look further down into "Presenting
 8 problems", the fifth line down:

9 "[AR] reports that he wouldn't have felt sad if he
 10 hurt him."

11 A. Yes.

12 Q. "He was asked if he is planning on killing the student
 13 and he replied, 'I did want to kill him but I don't
 14 think I would. Ideally I wish I did it. But they were
 15 in assembly so it wouldn't have happened'. He is clear
 16 this was revenge."

17 Were you aware of that?

18 A. Was I aware of that?

19 Q. At the time?

20 A. I would have been, yes, yes.

21 Q. Further down, we see that he says that:

22 "AR reported that he liked the student that he had
 23 hit and never had any problems with the boy."

24 This is five lines up from the bottom of that
 25 paragraph.

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1 A. Yes.

2 Q. "AR reports it doesn't bother him that he assaulted the
3 boy as he didn't get hurt that bad."

4 If we could zoom out again. I'm not going to go
5 through the letter but, if you can take it from me that
6 it also mentions that Prevent were involved; is that
7 right?

8 A. Yes, I think, from memory -- I'd have to look at the
9 letter but I think from memory, I think by the time of
10 the first consultation meeting they were no longer
11 involved.

12 Q. Do you also recall it flagging that there were some
13 serious concerns about his use of the internet and the
14 material that he was accessing?

15 A. Yes.

16 Q. There are more features than that in the letter but
17 those are some key features. Looking at those factors
18 together, do you agree that there is a concoction there
19 of really very concerning factors?

20 A. Absolutely, yes.

21 Q. Could we have a look at page 8, please, and the very
22 bottom line. So there's a list of bullet points which
23 are said to be the further risk management plan. One of
24 the bullet points is:

25 "Discuss with band 7 Annie Kelly if a SAVRY

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1 A. Well, that sounds like those two things are connected in
2 what Stephanie was expecting from our service at that
3 time.

4 Q. I understand. So would you understand that to be
5 an expectation from her that you would be potentially
6 carrying out a forensic assessment and also doing a risk
7 management plan?

8 A. I think that -- I mean, I honestly can't remember what
9 was going on in my head at the time of kind of accepting
10 this referral and you know kind of setting up the
11 meetings but I certainly would have been clear in our
12 professional consultation meeting what the scope of that
13 meeting was. As I think can be seen from the letters
14 that I wrote, that included what I would say would be
15 the elements of a risk management plan, as such, that
16 was agreed with the professionals on that date.

17 In terms of the possible assessment, I didn't --
18 I certainly didn't give -- I mean, I think like we read
19 out initially, you know, there was three elements to our
20 service, professional consultation and then assessment
21 by our service. So, clearly, that would have been out
22 there for Stephanie to think and hope that that was what
23 was going to happen in this case, perhaps. But I'm
24 not -- I certainly don't think I gave her any indication
25 that we would be doing an assessment and I wouldn't do

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1 assessment is appropriate."

2 Are you able to assess us with who that is or what
3 organisation she worked for?

4 A. Forgive me, but we are looking at the referral form from
5 Stephanie Hallaron to our service?

6 Q. Yes.

7 A. I presume that Annie Kelly works for her service or with
8 her service alongside. I don't know who Annie Kelly is.

9 Q. Do you remember what your understanding was when you
10 received the referral as to whether somebody else was
11 going to be carrying out a SAVRY assessment?

12 A. I can't say that I remember that, no. I have some
13 further comments about the SAVRY assessment from my
14 first letter, I think but that was following the
15 professional consultation. So that was a little bit
16 further along than this document that we are currently
17 looking at.

18 Q. If we could just go over the page, please. The
19 anticipated outcome is a possible assessment and
20 risk-management plan. I understand this to be Stephanie
21 Hallaron saying that was what she was anticipating being
22 a potential outcome; is that right?

23 A. Yes, that sounds like what she was asking for, yes.

24 Q. What's your understanding of a risk-management plan?
25 What is that and who would be doing it?

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1 that at this stage before a professional consultation
2 has taken place.

3 Q. I understand. So the risk management plan reference
4 there, you would understand that to be essentially the
5 steps that you did in AR's case and we will come to look
6 at the letters later, but the making of recommendations
7 after the consultation?

8 A. Yes, yes.

9 Q. So we know from your statement, of course, that the
10 referral following this form, which we can take down
11 now, thank you, was accepted and it was allocated to
12 you?

13 A. Yes.

14 Q. As well as that referral form that we've looked at, what
15 other information, if any, would you have from, for
16 example, other agencies about AR?

17 A. Again, a slight difference in case by case. Sometimes
18 the referral itself is accompanied by documentation from
19 other agencies. I think if it was in AR's case to be
20 that, then that would have -- they would be -- I'm sure
21 they would have been known to this Inquiry. So if they
22 are not, then they wouldn't have been attached.

23 Q. So you are not able to assist us with your recollection
24 of any further records you were provided with in
25 relation to AR at the start of your involvement?

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1 A. I'm not, no.

2 Q. The Inquiry has received some evidence which initially

3 appeared to suggest that one of the reasons for the

4 referral to FCAMHS was a suspected conduct disorder.

5 I won't bring the document up but, sir, for your

6 reference it's MERP000178 at page 12?

7 SIR ADRIAN FULFORD: Thank you.

8 MS WAKEMAN: So there was a record that did list the reason

9 for referral as suspected conduct disorder. The Inquiry

10 asked Ms Hallaron about that and she said in her

11 statement, which again we don't need to bring up but the

12 reference is MERP000026, page 19, paragraph 52, she

13 said:

14 "I did not have any specific concerns around AR

15 having a conduct disorder at that time and cannot

16 provide any rationale for why this was listed as

17 a referral reason."

18 I just wanted to check whether you were aware at any

19 stage of the reason for referral being said to be

20 a suspected conduct disorder?

21 A. Having reviewed my own letters and documentation that

22 I've seen, I have not seen reference to conduct

23 disorder. I have heard it, I think, in another

24 statement but I have not -- at the time, I don't

25 remember that being a factor.

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1 a specific question, as to whether or not he had conduct

2 disorder, no.

3 Q. So FCAMHS would be dependent on somebody flagging that

4 as an issue in a referral for you to consider it; you

5 wouldn't consider it of your own volition?

6 A. I think, unless in conversation, you know, that -- you

7 know, kind of -- I suppose that was flagging any alarm

8 bells that that was a specific issue. I think it didn't

9 and, you know, even on reflection of my letters, I don't

10 think that was what came out as a pressing issue, if

11 that answers the question, sorry.

12 Q. All right. So back to the acceptance of the referral.

13 I understand from your statement that you emailed

14 Ms Hallaron the same day you got allocated to suggest

15 a date to try and have a first meeting. We know there

16 was a multi-agency meeting that took place on

17 17 December 2019 but I understand that you weren't able

18 to attend that meeting?

19 A. Yes.

20 Q. Did you consider whether to arrange for somebody else

21 from FCAMHS to attend; is that something you would

22 usually do?

23 A. Not necessarily something we would usually do. I mean

24 I guess that sort of once the case is allocated and

25 other people are busy with their cases, that would be

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1 Q. I understand. Just for our understanding, is a conduct

2 disorder something that FCAMHS would have potentially

3 been able to assess and diagnose for or would that not

4 fall within your remit?

5 A. I think potentially, through the second part of the

6 assessment of a young person and with full

7 understanding, it would be possible for FCAMHS to make

8 some comments around whether or not he would meet the

9 threshold for what really is a formulation approach to

10 looking at severe -- I don't know whether the right word

11 is delinquent behaviour, and I'm sure that FCAMHS could

12 comment.

13 If I'm honest with you, it was kind of like

14 something that we, perhaps in early stages of my

15 involvement of what was previously the FACS team, which

16 became FCAMHS, we probably had more involvement with

17 that kind of consideration of conduct disorder at that

18 stage, I would say. I didn't come across it for a few

19 years where that was an expectation or a question at

20 referral or anything like that anybody was questioning

21 in latter years.

22 Q. So are you able to assist us with whether, in AR's case,

23 you ever gave any thought to whether he may have

24 a conduct disorder or not?

25 A. I wouldn't have been given that as a specific thing,

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1 unlikely that somebody -- somebody would have the

2 ability to be able to sort of, with short notice, go to

3 another -- a meeting about another case.

4 It may have been possible. I don't know whether

5 I considered it at the time. I can't remember.

6 Q. All right. But we do know that the first multi-agency

7 consultation meeting which you could attend was on

8 21 January 2020 and you have explained in your statement

9 that, essentially, the purpose of this meeting was to

10 gather information about AR's background, presentation,

11 behaviour and risk --

12 A. That's correct, yes.

13 Q. -- and to use that information to develop understandings

14 of his risks and needs?

15 A. Yes.

16 Q. Then also to provide recommendations to the local -- the

17 professionals that were involved with AR?

18 A. That's correct, yes.

19 Q. Could we have on screen LCC000020, please. So this is

20 a note of the meeting from that day. We see at the

21 start we've got a list of attendees. AR's CAMHS case

22 manager at that time was Mr Skott Morgan and we can see

23 he's not on the list of attendees; is that right? He

24 didn't attend that meeting?

25 A. That's in my letter as well, yes.

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1 Q. Would you have expected him or someone else from CAMHS
2 to attend a meeting such as this?

3 A. Yes, I guess so. Yes. Yes.

4 Q. If we could then look at the first paragraph. We can
5 see there is some discussion about the hockey stick
6 incident. Ms Hallaron was raising concerns that AR had
7 assaulted a child that he said he liked and that the
8 assault was severe. Two lines from the bottom, we've
9 got:

10 "... the child was very lucky not to have been
11 seriously hurt."

12 If we look at the second paragraph from the bottom
13 of the same page. It is talking about you describing
14 the work that your team does: they consider "higher risk
15 and offending behaviour" and, following this meeting,
16 you decide whether the service was able to offer
17 anything, whether it was necessary to meet AR and his
18 family.

19 At the bottom paragraph, it says, "John H then
20 turned to Jo H", who I understand to be Joanne Hodson,
21 the then Deputy Headteacher of Acorns School?

22 A. That's correct, yes.

23 Q. "John H then turned to Jo H and said, 'I've been
24 thinking about what you said before, I don't have
25 a crystal ball, none of us have. We can't say whether

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1 have taken place and information would have been
2 gathered.

3 I would advocate that, you know, kind of there would
4 have been a shared understanding of risk but I would
5 have been keen to have a conversation primarily about
6 how that risk was going to be managed. You know, kind
7 of and I think these -- this discussion would have taken
8 place in the context of him being outside of education
9 at the time of this first meeting and that, in itself,
10 is a known risk indicator. So I would have been keen
11 for that to have been addressed and I think that's
12 probably more the context of the conversation -- the
13 discussion that was being had at the time.

14 Q. I appreciate, given it's a note of what was said at the
15 meeting, that some of the context may have been lost.
16 But it's quite a specific comment and it's
17 a contemporaneous note of the meeting. Do you accept it
18 is probably a more likely recording of what was said
19 than perhaps how you might remember it down the line?

20 A. I think I understand your question. I would say that --
21 the letter that I wrote after this meeting is a fair and
22 agreed summary of the meeting and, at the bottom of that
23 first letter, I asked anybody who received it, if there
24 was any disagreement with the letter, to come back to
25 me.

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1 he's likely to offend again. There are kids who have
2 carried out serious offences, they still have a right to
3 an education'. Jo H replied, 'That might be so', but
4 she wasn't prepared to explain to a parent why a child
5 at our school has been seriously injured."

6 Do you recall that exchange?

7 A. I certainly don't remember saying the -- saying all of
8 that in the way that it is said. However, I wouldn't
9 see what was said as being inaccurate. I think what is
10 likely -- I can comment what I think I'm likely to have
11 meant by those comments but these are not my notes.

12 Q. I appreciate they're not your notes. It appears to be
13 a set of notes attempting to accurately set out what was
14 said at the meeting though. I appreciate there may be
15 some paraphrasing here and there.

16 A. Yeah, and I would have to comment that I don't think
17 that is an accurate reflection of the context of that
18 discussion at that time; which I felt was -- discussion,
19 obviously -- you may come onto ask me this kind of
20 question but we would start the meeting by asking all
21 professionals to say -- go round the room and say what
22 they felt were the risks and the needs of a young person
23 and then probably go back around the room and ask people
24 to contribute to what would be needed to manage those
25 risk and needs and that's the way the discussion would

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1 This, however, isn't that. This is somebody else's
2 notes that I didn't ask for and there was no opportunity
3 for anybody to question these notes. As I said, at the
4 beginning, I don't remember saying that comment or the
5 other comment that -- where I'm quoted as saying
6 specific things. I'm not saying I didn't say it and
7 I would agree with it, I would still agree that nobody
8 can predict the risk and I would still agree that none
9 of us do have a crystal ball in that particular
10 situation. But I don't remember saying those comments
11 and I find the out of context-ness of them to be
12 difficult to comment on really.

13 Q. All right. Well, the Inquiry has a witness statement
14 from Joanne Hodson and she will be giving evidence so we
15 will be able to pick that up in terms of her
16 recollections of the meeting then.

17 If that is an accurate record of what was said, do
18 you agree that that would be quite a surprising comment
19 to make for FCAMHS, whose role is to gather information
20 about risk and to develop an understanding about risk?

21 A. As I think I have said, no I don't, I think it's -- none
22 of us do have the ability to predict the future and it
23 wasn't the role of FCAMHS to predict the future. It was
24 the role of FCAMHS to consider what risk management
25 strategies need to be in place to manage the identified

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1 risk. That was -- that, as I understand, would be the
 2 role of FCAMHS, about risk management not about
 3 predicting future, if that's what you're getting at. If
 4 I've understood the question correctly.

5 **Q.** I think let's look at the other comment that's made in
 6 the meeting and this is -- if we could zoom out again
 7 and go to the next page, please. If we could have
 8 a look at paragraph 4, please. It says you asked about
 9 an ASD diagnosis and whether there was an EHCP; is that
 10 something you would have asked?

11 **A.** I think it is very likely I would have asked that, yes.

12 **Q.** "The school will provide an update. Joanne Hodson says
 13 that, when asked why he had brought a knife to school on
 14 multiple occasions, [AR] had replied 'To use it', his
 15 thinking was very literal. She described frustration in
 16 trying to engage with other agencies before the incident
 17 in December."

18 Does that ring a bell of the types of concerns
 19 raised by the school?

20 **A.** I think definitely the pre-meditated and calculated and
 21 coldness of AR's behaviour at the time. Violent
 22 behaviour was very clearly stated by probably all
 23 agencies represented at that meeting but, yes,
 24 definitely in that context, I think that would have been
 25 very clearly stated.

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1 that. But, again, I would say that they are clearly in
 2 the context of me advocating that we consider risk
 3 management strategies, as opposed to discussing the risk
 4 at that stage. We were discussing the risk, we were
 5 giving people opportunities to say where the risk was.
 6 This was about, I would say, thinking about the future
 7 and how we move on from an understanding of the risk to
 8 finding a way to kind of manage that in a community
 9 setting.

10 If I can say, if it's possible for me to say, at
 11 this stage, we were clearly thinking about managing AR
 12 in the community. There was no suggestion that AR was
 13 kind of -- for example, going to be subject to the
 14 Mental Health Act or to a social care order or youth
 15 justice order that would mean he wouldn't be in the
 16 community any more at this stage. It was about risk
 17 management strategies in the community. That's where my
 18 thoughts would have been coming from at the time.

19 **Q.** Yes. I mean, I don't want to spend too much time going
 20 over this. You say you don't remember saying it. Is it
 21 also right that you can't say you didn't say it?

22 **A.** I can't say I didn't say it and I can't say that I would
 23 disagree with the essence of the fact that we can't
 24 predict the future.

25 **Q.** I understand. To an outsider, looking at both of those

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1 **Q.** "Again John H repeated that there were no crystal balls
 2 and that he would offer a £5 bet to anyone who could say
 3 what was going to happen next. He said that AR clearly
 4 needed some sort of specialist provision with ongoing
 5 therapy and social stories but unfortunately you've been
 6 left holding the baby."

7 Do you recall saying that?

8 **A.** I think, again, that lacks some context to the situation
 9 to make that a kind of -- to make that make sense
 10 really. The situation was clear from my first letter,
 11 that AR was outside of education and, as I said
 12 previously, that in itself is a risk, a known risk
 13 factor and he was suspended, I believe, from -- at the
 14 time of this first meeting from the Acorns provision and
 15 I was keen to know how we were going to move forward
 16 from that. So how we could identify some risk
 17 management strategies so that he could return to some
 18 kind of formal education.

19 **Q.** I understand that there's context that may have been
 20 somewhat lost in a summary note, such as this, but do
 21 you recall saying that comment we have just --

22 **A.** "But unfortunately you've been left holding the baby".

23 **Q.** Yes, and that there are no crystal balls and that you
 24 would offer a £5 bet?

25 **A.** I don't recall saying that. I can't remember saying

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1 comments, it looks rather like you were suggesting
 2 reactive rather than a proactive approach, essentially
 3 just waiting for the next thing to happen, to see what
 4 was going to happen?

5 **A.** I would say that that -- I would have to refute that and
 6 I would say -- my evidence for refuting that would be my
 7 own letter of summary of this particular meeting, which
 8 I think clearly highlights the conversation that we were
 9 having, recognises the conversation we were having to
 10 identify the risk and strategies that would mitigate
 11 that risk and at no stage did I -- I don't think that my
 12 letter is reactive at all.

13 **Q.** Right. Could we look -- if we could zoom out again,
 14 please -- at the next page, please. Three paragraphs
 15 from the bottom, "Anna J". I think that is a reference
 16 to Anna Jameson at Children's Social Care from LCC; is
 17 that right?

18 **A.** Possibly, yes.

19 **Q.** She says that:

20 "She had been directed at the strategy meeting to
 21 carry out a risk assessment, but she didn't think she
 22 could do this, it should be education. Jo H had pointed
 23 out that Anna had only essentially be asked to do a risk
 24 assessment about a tutor visiting [AR's] house and she
 25 said that she'd be fine doing that."

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1 But it's right, isn't it, when we look at this note
 2 of the meeting, that it wasn't agreed at this meeting
 3 who, if anyone, was going to be conducting a risk
 4 assessment in AR's case?
 5 **A.** A risk assessment with regard to whether or not he could
 6 have a tutor at home?
 7 **Q.** No, a wider risk assessment, looking at the risks he
 8 posed to others?
 9 **A.** It wouldn't have been entirely clear at that stage, no.
 10 **Q.** Right. Is it right that there was also no discussion
 11 about who was going to be the lead agency in AR's case?
 12 **A.** At the stage of the first meeting, I think, that, as per
 13 the referral form, Stephanie Hallaron recognised herself
 14 to be the lead agency and coordinating person. So
 15 I think that I would have seen her as being the lead
 16 agency at this stage. But that's not necessarily saying
 17 that she had to do the risk assessment as to whether he
 18 could have a tutor at home. I think that may have
 19 fallen to education services to do that.
 20 **Q.** All right. So your understanding was that Ms Hallaron
 21 was going to be the lead professional for AR's case at
 22 the time?
 23 **A.** Yes, until her involvement was likely to come to
 24 a conclusion, yes.
 25 **Q.** All right. Following this meeting, you sent a letter to
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1 other letter were missing and she requested them to be
 2 sent over in May 2020. So it doesn't appear that the
 3 letters did make it to CAMHS but would you say that
 4 would be falling at Ms Hallaron's door?
 5 **A.** I would, yes.
 6 **MS WAKEMAN:** Sir, for your record, the email from Dr Killen
 7 chasing the records is at AHCH000234.
 8 **SIR ADRIAN FULFORD:** Thank you.
 9 **MS WAKEMAN:** So within the letter, you note that you
 10 discussed the case with Mr Morgan, the case manager?
 11 **A.** Yes.
 12 **Q.** You note that AR was open to Prevent at the time of the
 13 referral? That's the second paragraph.
 14 **A.** It was closed by the time of the meeting but yes, yes,
 15 at the time of the referral.
 16 **Q.** You note that AR had returned to his school, assaulted
 17 a boy and had been arrested for possessing a bladed
 18 article?
 19 **A.** Yes.
 20 **Q.** You also record that the assault was premeditated. You
 21 kindly provided the Inquiry with some handwritten notes
 22 from the meeting you took as well?
 23 **A.** Yes.
 24 **Q.** I can bring them up if you need to but the reference is
 25 GMMH000005 and you recorded in those notes that AR
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1 Ms Hallaron, basically summarising the issues that were
 2 discussed --
 3 **A.** Yes.
 4 **Q.** -- and making some initial recommendations?
 5 **A.** Yes.
 6 **Q.** If we could get that up on screen, it's GMMH000006.
 7 This is a letter dated 11 February, and we can see at
 8 the top it is addressed to Ms Hallaron.
 9 I just want to pause there to ask you this: do you
 10 recall whether this letter and the second letter that
 11 you sent about AR was sent to CAMHS as well as
 12 Ms Hallaron?
 13 **A.** Okay, my practice at the time would have been to send it
 14 to the case coordinator to send on to her colleagues.
 15 As she set up the meeting -- as I thanked her for
 16 setting up the meeting, I would have also made it clear
 17 that she would share the letter with professionals as
 18 she sees fit.
 19 **Q.** So your understanding was that Ms Hallaron was going to
 20 distribute this to, for example, the CAMHS case manager?
 21 **A.** Yes.
 22 **Q.** Because the Inquiry has heard evidence from Dr Killen,
 23 the clinical lead at CAMHS, that essentially when she
 24 took over the file after the case manager left, and she
 25 was looking at it, she noticed that this letter and your
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1 wanted to kill the intended victim?
 2 **A.** Right.
 3 **Q.** Do you remember that?
 4 **A.** I'm sure that if it's in there then it happened but if
 5 you want to bring it up, that's fine.
 6 **Q.** You also made a note in those notes -- actually, if we
 7 could bring this up, so it's GMMH000005, page 5. It's
 8 the first bullet point at the top of the page:
 9 "Pressure needs putting on the paed team [I assume
 10 that means paediatric team] due to the level of risk and
 11 need for specialist education provision."
 12 Is that right?
 13 **A.** Yes.
 14 **Q.** So you clearly had a concern following that first
 15 meeting that things needed to move quickly, pressure
 16 needed to be applied; is that right?
 17 **A.** Yes.
 18 **Q.** If we could go back to the letter, which is GMMH000006.
 19 You explain at the bottom of page 1 that, at the time of
 20 the meeting -- could we look at the bottom of page 1,
 21 going to the top of page 2, please:
 22 "The expected time for an ASC diagnosis is
 23 approximately two years."
 24 **A.** That's what I was informed, yes.
 25 **Q.** You then, at the top of page 2, say that liaising with
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1 the paediatric team needs to take place, to ensure they
 2 are aware of the concerns and that they contribute. Is
 3 that because the community paediatric team is the
 4 service that does the ASD diagnosis?
 5 A. I think that's what I would have been informed, yes.
 6 Q. Then page 2, paragraph 5. You highlight that AR would
 7 benefit from psychologically informed interventions to
 8 address his high-risk, behaviour, taking into
 9 consideration his likely diagnosis of ASD; is that
 10 right?
 11 A. Yes, correct.
 12 Q. So your view at that time was that it was likely that he
 13 did have ASD?
 14 A. Well, that's what I was -- that's what I was informed,
 15 yes.
 16 Q. If we could then look at -- we know that a second
 17 multi-agency meeting took place on 4 March 2020?
 18 A. Yes, that's correct.
 19 Q. I understand from your statement that the purpose of
 20 that meeting was to review the progress that had been
 21 made since the first consultation?
 22 A. Yes.
 23 Q. If we could have the letter you sent following the
 24 meeting on screen. It is GMMH000007. It's a letter to
 25 Ms Hallaron, again dated 9 March 2020.

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1 because Mr Morgan had said he was going to attend at the
 2 second meeting. So I was expecting that and I would
 3 have expected somebody to attend if -- even if they
 4 closed the case, yes, and I was informed that they had
 5 closed the case.
 6 Q. I understand. If we could zoom out and look at the next
 7 page of this letter. It says:
 8 "I made a comment that risk assessment will be
 9 complicated by his likely diagnosis of ASC."
 10 Then you go on to list a number of aspects that you
 11 say must be taken into account when assessing the risk
 12 of a young person with ASC; is that right?
 13 A. Yes. That's correct, yeah.
 14 Q. Then you go on to say in the last paragraph:
 15 "I am of the opinion that assessment by our service
 16 is not indicated as until his diagnosis is complete we
 17 would not be able to contribute further to the
 18 understanding of risk."
 19 A. That's correct, yes.
 20 Q. Fourth line from the bottom, you say:
 21 "It was reported the case will step down to Early
 22 Help and as suggested the letter will be shared. The
 23 case will now be closed to FCAMHS but any professional
 24 can contact the service for clarification of this letter
 25 or if review is indicated because of a significant

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1 A. That's correct, yes.
 2 Q. At paragraph 2, it says that:
 3 "[AR] has received a 10-month referral order. Anna
 4 Croll [Youth Offending Team] is completing an AssetPlus
 5 risk assessment and will then be coordinating
 6 interventions to address offending behaviour."
 7 A. Yes.
 8 Q. Could you just assist us with what an AssetPlus risk
 9 assessment is in very brief terms?
 10 A. Well, I think possibly the Youth Offending Team are
 11 better off answering that question. I don't want to
 12 speak for them but it's quite a comprehensive look at
 13 the historical and current risk behaviours and
 14 background information that would be pertinent to
 15 understanding the risk and identification of key areas
 16 for their intervention to reduce offending behaviour.
 17 That would be my summary.
 18 Q. You note at paragraph 3 that CAMHS was not present again
 19 at that meeting. You record that:
 20 "The case has been closed to them."
 21 The Inquiry has heard evidence that, actually, AR's
 22 referral to CAMHS wasn't actually formally closed at
 23 that time. If that was the case, if that was right,
 24 would you have expected someone from CAMHS to attend?
 25 A. Clearly, I would have expected somebody to attend

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1 change in circumstances or risk behaviour."
 2 Is that right?
 3 A. That's correct, yes.
 4 Q. So, essentially, in this letter, you were flagging that:
 5 (1) risk assessment might be more complicated if he did
 6 have a diagnosis of ASD?
 7 A. I'd probably turn that the other way round, almost, that
 8 for risk assessment to be accurate we would need to be
 9 certain that that diagnosis had been confirmed. I think
 10 people suspected that was his presentation but that
 11 would need to be confirmed.
 12 Q. There is no record in this letter of any agreement as
 13 such as to who was going to be the lead professional
 14 taking over AR's case?
 15 A. I think -- is it possible to go to the top of that
 16 letter -- this letter again, is that possible.
 17 Q. Of course, yes, if we go back to the first page.
 18 There's a reference to Anna Croll in paragraph 2?
 19 A. Yes, and that's my understanding, that she was going to
 20 be taking over as the lead professional in this case.
 21 Q. So you understood that the Youth Offending Team were
 22 going to have responsibility for implementing your
 23 recommendations or ensuring that others did?
 24 A. Yes, I would say that's a fair comment. Yes.
 25 Q. Did you also understand them to be the lead agency with

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1 responsibility for conducting a structured risk
 2 assessment of AR?
 3 **A.** No, not necessarily. Are you talking about a structured
 4 risk assessment as in the SAVRY?
 5 **Q.** A structured risk assessment which could be in the form
 6 of a SAVRY?
 7 **A.** The comment I was going to say before, in terms of the
 8 SAVRY, I had lots of training about SAVRY regularly and
 9 about -- in my time -- and certainly some caution needs
 10 to be considered when there is a diagnosis of ASC/ASD
 11 because, for obvious reasons -- well, not obvious
 12 reasons but for reasons such as, for example, you know,
 13 one of the factors might be a kind of empathic response,
 14 which young people with ASD -- some young people with
 15 that diagnosis may find those kind of things more
 16 difficult.
 17 So they are kind of crucial factors in understanding
 18 the risk of violence but what I was going to say was, in
 19 my first letter, at the bottom of the first letter, the
 20 interventions that I highlighted as being
 21 psychologically informed interventions around managing
 22 risk, that will have been directly come from my
 23 understanding of the SAVRY and what the likely outcome
 24 of the SAVRY would have been. They are, in themselves,
 25 kind of informed by knowledge of the SAVRY as specific

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1 priority, as that would further give some clarification
 2 to the risk, help with an educational healthcare plan
 3 and also, therefore, help with accessing specialist
 4 education provision. So I think all of those things
 5 would have been seen as a priority above our service
 6 doing another assessment, which was likely to have the
 7 same outcome as I have said, which would be that a full
 8 understanding of whether he met the diagnosis for ASC
 9 was of primary importance.
 10 **Q.** All right. We know from the letters that your
 11 understanding was that the wait time for an assessment
 12 for ASD was about two years at that time and, in the
 13 meeting records, we see that there are some concerns
 14 raised about how long it was going to take.
 15 Did you consider that by closing AR to FCAMHS at
 16 this time to wait for an assessment to be done, is that
 17 you were essentially leaving him without a proper risk
 18 assessment and exposing a risk to members of the public?
 19 **A.** No, I wouldn't say that. I would say that we had done
 20 what we set out to do, which was to provide
 21 an understanding -- a response -- as in the remit of
 22 FCAMHS, a timely response to people's concerns about
 23 risk and a formulated -- what I hoped would be a helpful
 24 summary of the factors that would contribute to others'
 25 risk assessment.

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1 interventions to help reduce the risk of violence.
 2 **Q.** Okay, so although a SAVRY hadn't been conducted, are you
 3 saying that the recommendations you suggested are what
 4 you think would have likely come out of one or --
 5 **A.** Yes.
 6 **Q.** -- had been at the time --
 7 **A.** Yes, yes.
 8 **Q.** All right. So just to go back to my question, who was
 9 it at that time who you understood would be doing
 10 a structured professional risk assessment going forward?
 11 **A.** Well, I don't know whether -- not including the SAVRY,
 12 I think the risk assessment would have been the
 13 AssetPlus assessment from Anna Croll and that she would
 14 have been responsible for that.
 15 **Q.** All right. So we know from this letter that you closed
 16 AR to FCAMHS at this time; why did you think that
 17 a forensic assessment by FCAMHS wasn't appropriate in
 18 this case?
 19 **A.** Well, I guess I felt that there was a collective
 20 understanding of risk. People attending at the meeting,
 21 as I said, would have been given opportunity to
 22 categorise the risk and comment on risk and I felt that
 23 we were able to kind of make some helpful and sensible
 24 recommendations about what would be necessary to manage
 25 that risk and that an ASC/ASD diagnosis was the main

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1 As I said, we did not complete risk assessments but
 2 the information that would be helpful in those that are
 3 completing risk assessment and some guidance as to what
 4 would be helpful, and evidence based interventions to
 5 reduce the risk, that's how I would categorise it, not
 6 as you categorised it, just --
 7 **Q.** Did you give consideration to whether FCAMHS should have
 8 requested an expedited ASD diagnosis assessment?
 9 **A.** I did and I asked Scott Morgan to do that -- at the end
 10 of the first meeting, I spoke to Skott Morgan and asked
 11 him to expedite the concerns of the professionals to the
 12 ASD service.
 13 **Q.** So your understanding was Mr Morgan was going to take
 14 that forward?
 15 **A.** Absolutely, yes. Not necessarily to do that but he was
 16 going to liaise with his team, I think was how it was
 17 put.
 18 **Q.** If we could just bring up your witness statement at
 19 page 9, paragraph 26. You say:
 20 "... the only additional actions that could have
 21 been taken by me would have been to offer an extended
 22 consultation or undertake a forensic assessment which
 23 was not provided by FCAMHS by that time unless
 24 indicated."
 25 We have already covered the forensic assessment

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1 part, so let's leave that to one side, but, in
 2 hindsight, do you think that a period of extended
 3 consultation might have been helpful in AR's case?
 4 **A.** I think, with hindsight, we clearly said that any agency
 5 could refer back to us and we had -- that was kind of in
 6 line with the practice that we had at the time, when
 7 I was involved in this case, to ask agencies to
 8 re-refer, and it was very easy for them to do that,
 9 possibly arguably easier than the first referral because
 10 a telephone conversation with us and a brief summary of
 11 the risk factors that had changed or the risk concerns
 12 that had changed at the time, you know, since our
 13 involvement, would have been enough to -- for us to
 14 reopen the case. So I think that would have been very
 15 easy for us to do that and I would say that was our way
 16 of operating, that was what people -- that's what I and
 17 others did at the time.

18 We didn't -- it wasn't in the -- it wasn't my
 19 practice or other people's practice at the time to hold
 20 the case open beyond what had already been -- I would
 21 argue -- been achieved in terms of the risk management
 22 strategies and mitigating factors -- strategies that
 23 I had identified in the letters, that it wasn't
 24 appropriate for us to keep the case open longer, after
 25 that second meeting.

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1 would be doing the AssetPlus assessment and the -- any
 2 interventions that would come out of that. So I saw
 3 kind of quite a difference in the risk at the time of
 4 the second meeting, being risk -- not the risk changing
 5 but the risk management strategies being in place.

6 **Q.** All right. Of course, we now know that, despite your
 7 invitation for agencies to re-refer back to FCAMHS, that
 8 never in fact took place, did it?

9 **A.** No.

10 **Q.** I just want to go through quickly a number of events
 11 that took place in AR's case after the -- after he was
 12 discharged from FCAMHS. If you could just confirm
 13 whether you would have expected that to have been
 14 an event that would have prompted a re-referral to
 15 FCAMHS, that would be helpful?

16 **A.** Sure.

17 **Q.** Firstly, AR being diagnosed with ASD in February 2021?

18 **A.** I think we would have to kind of -- that would have to
 19 have been considered with what the main factors of that
 20 diagnosis -- what the nuances of that diagnosis were
 21 highlighting, as to whether or not that had implications
 22 for our understanding of risk. If that was the only
 23 risk factor or the only consideration, I think we would
 24 have to know a bit more than just he's received
 25 a diagnosis. I think we would have to understand what

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1 **Q.** As to the decision to close AR to FCAMHS, did you have
 2 any objections from other agencies about that decision?

3 **A.** From other agencies?

4 **Q.** Yes?

5 **A.** No.

6 **Q.** If I may just take one moment, please.

7 So was your overall impression, having sent out that
 8 second letter, was that, essentially, the Youth
 9 Offending Team were going to do their AssetPlus risk
 10 assessment. Did you understand Ms Hallaron to be the
 11 lead professional?

12 **A.** No, I think by that time it was -- by the second -- do
 13 you mean the first? After the second letter, after the
 14 second meeting, I understood Anna Croll to be the --

15 **Q.** So the Youth Offending Team?

16 **A.** The Youth Offending Team, yes.

17 **Q.** Then you were expecting agencies to re-refer back to
 18 FCAMHS, if needed, for further input?

19 **A.** Yes, I think there was quite a bit of change at the time
 20 of the second meeting, from the first meeting, as far as
 21 I was concerned. I was informed that specialist
 22 education provision could now be expedited. I was
 23 informed that he was on a -- in addition to on the ASC
 24 pathway was also on a pathway towards gaining an EHCP.

25 As I said, Anna Croll was -- indicated that she

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1 the nuances of that diagnosis were.

2 **Q.** All right. Then, for all the events I'm going to list
 3 after, they all came after the diagnosis. So if you
 4 could bear in mind it would be diagnosis plus the
 5 events.

6 So, firstly, two further referrals to Prevent in
 7 February 2021 and April 2021?

8 **A.** I presume that was because of additional concerns that
 9 were appropriate for the referral to Prevent, so
 10 absolutely, yes. I think that would be something that
 11 the team would consider as appropriate for a re-referral
 12 to FCAMHS.

13 **Q.** Incidents in November 2021 of violent and volatile
 14 behaviour and verbal threats at home, including pouring
 15 milk over his father?

16 **A.** Quite possibly. Obviously, I would need to know
 17 a little bit more about that, what those violent
 18 incidents were but, yes, I would think that was again
 19 something we would certainly consider as being
 20 a potential re-referral criteria, yes, as meeting that
 21 criteria.

22 **Q.** An incident in March 2022, where AR was found on a bus,
 23 having gone missing from home in possession of a knife,
 24 and when the police dealt with him he made remarks about
 25 wanting to stab people and either having made poison or

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1 thinking about making poison?
 2 **A.** Yes, absolutely.
 3 **Q.** There were other incidents but I'm not going to go
 4 through all of them but there was also a general trend,
 5 certainly towards later stages, of an ongoing lack of
 6 engagement with CAMHS treatment and concerns about him
 7 taking his medication reliably.
 8 **A.** Yes, absolutely. I would say all of those things,
 9 definitely.
 10 **Q.** What about if there was a period of being isolated in
 11 the house -- so this is September 2023 -- not taking
 12 medication, increasing time on computers, lack of
 13 washing, not attending school?
 14 **A.** Yes, I think -- absolutely, I think if that was said in
 15 the context of he's also received a ASC diagnosis,
 16 absolutely that would --
 17 **Q.** All right. If you would have had that re-referral what
 18 would you have done with it?
 19 **A.** I think, as I said, before it would have been very easy
 20 for somebody to contact us, we would perhaps have asked
 21 them to formalise that by dropping us a letter, just to
 22 identify what had happened in the interim period and
 23 then discussion would take place as to who the case
 24 would be allocated to but, given that it had been -- if
 25 you like, it had been allocated to me previously,

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1 **A.** Yes.
 2 **Q.** Did you sit down and think, "It's been a year, no one
 3 has said anything, I should check in", or was it pretty
 4 much closed?
 5 **A.** No, we wouldn't have done that.
 6 **Q.** All right. You have helpfully provided some reflections
 7 in your statement which are mostly at paragraphs 20, 22
 8 and 26. I won't take you to those now but they will be
 9 forming part of your evidence.
 10 Just finally, I'm asked to ask you whether you felt
 11 that resourcing issues within FCAMHS affected the
 12 service that you were able to deliver?
 13 **A.** I guess it's sort of -- any clinician would say you
 14 could also have additional resources but I don't
 15 remember there being any, for example, noticeable
 16 vacancies or anything of that sort, in staffing, if
 17 that's what you meant by that, if that answers that
 18 question.
 19 **MS WAKEMAN:** Thank you. Just for completeness, the
 20 AssetPlus risk assessment, I will just give you, sir,
 21 Chair, the note for your records it's LCC000447.
 22 **SIR ADRIAN FULFORD:** Thank you.
 23 **MS WAKEMAN:** That was conducted in April 2020 and we will be
 24 hearing evidence about that in due course.
 25 **SIR ADRIAN FULFORD:** Grand.

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1 I think some serious consideration would be given to
 2 whether or not it should be re-allocated to me, as
 3 I would have that continuity within the team and, again,
 4 we would be discussing with whoever made that referral,
 5 you know, the kind of best way forward, it would often
 6 probably be in the context, initially, of another
 7 professionals' meeting and going through the process
 8 again, and then consideration as to whether there now
 9 there was a need for us to -- and for us to move that
 10 forward and go to a formal face-to-face assessment.
 11 **Q.** Just generally, at the time of your involvement with AR,
 12 did FCAMHS routinely monitor its referrals where you've
 13 closed a case and said that they should be re-referred
 14 if X, Y, Z happens or if there are these particular
 15 concerns or did you just wait for someone to re-refer
 16 back?
 17 **A.** I don't think there was -- from memory, it may be better
 18 to ask managers that come after me but I don't think
 19 that was routinely done at the time of my involvement,
 20 there wasn't routine -- I think you're saying did we
 21 check up on the recommendations that we made in each
 22 case; is that what you are asking me?
 23 **Q.** Yes, I'm saying if you said, like here, if there is
 24 an ASD diagnosis or significant changes, you want people
 25 to re-refer back to you?

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1 **MS WAKEMAN:** Thank you. I will just look to my left.
 2 Thank you, Mr Bowen KC.
 3 **Questioned by MR BOWEN**
 4 **MR BOWEN:** Good afternoon.
 5 **THE WITNESS:** Good afternoon.
 6 **MR BOWEN:** I ask questions on behalf of the bereaved
 7 families.
 8 I've got some general questions, sir, and I've also
 9 got specific permission in relation to one of the
 10 conduct disorder points under Rule 10. Do you know who
 11 Alexandra Chisnall is?
 12 **A.** Yes, I do. Yes.
 13 **Q.** Who is he?
 14 **A.** She was an administrator with our service at the time.
 15 **Q.** You worked closely with her?
 16 **A.** Yes.
 17 **Q.** You cc'd her in on documents, on certain letters?
 18 **A.** No, I -- not from a clinical perspective. She would
 19 have perhaps been sending those letters out once they
 20 were -- you know, she was the administrator who would
 21 perhaps have sent the letters out.
 22 **Q.** Could we have MERP000178. If we start at page 11,
 23 please, on the screen. We see there, at the top, there
 24 is a reference to Alexandra Chisnall. I think you've
 25 been taken to some of these documents. Could you just

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1 identify what this document is. When you've had a look
 2 at that just if you go to page 12, please. You see
 3 that:
 4 "Referral reason: conduct disorders."
 5 You can see the referral closed 11 March, at the
 6 top. Again "Who received", reference again to
 7 "Chisnall", we've got the timing. Then page 15 of the
 8 document. Again, AR, FCAMHS referral form pdf; document
 9 type, referral forms; document date, 13th. This is the
 10 date that Hallaron makes the reference to you.
 11 Again, Alexandra Chisnall, again time recorded.
 12 Then could you look at page 24, please. Again, this is
 13 AR's case. From John Hicklin, again it's later in the
 14 day, 3.38. Referral of AR to FCAMHS, cc'd to Alexandra
 15 Chisnall. You are writing to Stephanie Hallaron here:
 16 "Thank you for your recent referral ... the case has
 17 been allocated to me. As you may be aware we ask
 18 referrers to arrange a meeting", et cetera.
 19 We've heard about that when you were asked questions
 20 by CTI:
 21 "Better understanding of the risk", et cetera.
 22 Then you set up the meeting. Okay?
 23 You've been told that Stephanie Hallaron, I think
 24 paragraph 52 of her witness statement said:
 25 "I didn't mention conduct disorder."
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1 A. I just don't know.
 2 Q. I'm just slightly surprised that it calls for the best
 3 explanation that we can get for who brought in
 4 a clinical reference to something that might be
 5 suspected in relation to AR. Now, who are the likely
 6 candidates who could have brought it into your referral
 7 documentation?
 8 A. I've got to be honest, I don't know. I didn't -- the
 9 first document that you asked to be brought up, that's
 10 not a document that I use. I presumed that was an admin
 11 kind of document that was done either at opening of the
 12 case or closing of the case.
 13 If you want me to speculate, I wonder whether there
 14 was some kind of dropdown options of kind of the reason
 15 why somebody would be referred. I don't know what that
 16 was and why conduct disorder was put there but it's
 17 not --
 18 Q. Dropdown menu, which is clicked by accident?
 19 A. Well, I don't know. I don't know the answer to that
 20 question.
 21 Q. All right. Well, I can't take it any further. Okay.
 22 Sorry, could you just bring up page 4, again. There
 23 is a code on there saying OV1 on page 4 of MERP000178.
 24 Do you know what that code is? It looks like "CCG"?
 25 A. I think Clinical Care Group would be CCG, I would guess.
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1 The only person who could have possibly brought that
 2 in, as we see from all of these documents, is you.
 3 A. It certainly isn't me.
 4 Q. It isn't you?
 5 A. No.
 6 Q. Well, how does it get in?
 7 A. I don't know. I have not seen that document that was
 8 there previously.
 9 Q. Your name is all over it.
 10 A. It is here, yes. On the previous document that you --
 11 Q. Chisnall's name is all over it?
 12 A. I guess it is an administrative document that's done --
 13 Q. It's not an error.
 14 A. I didn't say "error", I said administrative document.
 15 **SIR ADRIAN FULFORD:** Let the witness finish his answer,
 16 Mr Bowen.
 17 A. I thought it was an administrative document that looked
 18 like it must be a document that has been completed by
 19 admin staff on completion of the case.
 20 **MR BOWEN:** We have to assume that the reference to conduct
 21 disorder is a contemporaneous entry on 13 December.
 22 A. I can't make a further comment about it. I don't know
 23 where that comment has come from -- where conduct
 24 disorder has come from.
 25 Q. I'm not trying to trap you --
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1 Q. Nothing to do with conduct disorders, a specific code
 2 for a specific problem?
 3 A. Again, I'm really, really sorry but I don't know the
 4 answer to that question. Normally, in my working
 5 experience, CCG stood for Clinical Care Group. That was
 6 a shorthand for that but, in this situation, I don't
 7 know what it stands for.
 8 Q. Moving on. It was suggested that you were reactive in
 9 the way you dealt with the referral. I have to suggest
 10 that, rather than being reactive, you were, I don't mean
 11 this rudely in any way, you were a bit dismissive?
 12 A. Of the referral?
 13 Q. Yes, you were a bit dismissive. I'm afraid I don't have
 14 it in my fingertips. I think it is in the minute, from
 15 memory, of the meeting on either the 20th or the 21st.
 16 You explained to the Deputy Head of Acorns, Joanna
 17 Hodson that she had to appreciate that you dealt with
 18 really heavy cases, and is there a danger that you were
 19 rather underestimating the risk that was inherent in the
 20 background facts to AR's conduct?
 21 A. I think I would repeat the question I gave previously,
 22 that my letters in no way at all underestimate the risk
 23 or don't, in fact, highlight the risk that professionals
 24 highlighted to me at the time of taking into
 25 consideration absolutely everything, and I think the
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1 summary of professional concerns is very clear in that
 2 letter and, no, I wouldn't agree --
 3 **Q.** Sorry, I'm deaf I'm afraid, so I have to fiddle with the
 4 kit.
 5 **A.** Did you hear?
 6 **Q.** I can hear you if I press the headphones.
 7 Sorry, could you say that again?
 8 **A.** I would say that my letters entirely take on board the
 9 risk as highlighted by professionals at that meeting and
 10 risk management strategies, as I've clearly stated, and
 11 in no way at all did I underestimate the risk.
 12 **Q.** But did the meeting get a little heated with Hodson: you
 13 had a bit of a bust up with her?
 14 **A.** I don't recall the meeting. Meetings can get heated.
 15 I don't recall the meeting getting heated. I think some
 16 discussion and heated discussion is sometimes helpful
 17 but I don't recall that being any heated discussion or
 18 any overt falling out, or anything of that sort.
 19 Obviously, people -- I think everybody around the table
 20 agreed about the risk and the need for risk and
 21 mitigating strategies.
 22 **Q.** So there's nothing between us on the seriousness of the
 23 risk because of the homicidal ideation in October, going
 24 equipped to murder on 11 December, you knew all of that?
 25 **A.** Yes.

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1 something that there was a real doubt about?
 2 **A.** To some extent but I think it was important that
 3 what's -- in particular, aspects of that diagnosis would
 4 have contributed to further understanding of the risk.
 5 So I don't think it is *per se* about a diagnosis, to say
 6 somebody has got something, it is about how that impacts
 7 on their behaviour, their thinking and the whole
 8 presentation, that could be very unique to each
 9 individual case.
 10 **Q.** Just on conduct disorders. Do you have much experience
 11 of children with conduct disorders?
 12 **A.** Well, I suppose arguably a significant proportion of
 13 young people within the Criminal Justice System and with
 14 kind of -- that would be referred to a service like
 15 ours, may well meet some criteria for conduct disorder,
 16 yes.
 17 **Q.** Would you agree that, if it's only a conduct disorder
 18 then the likelihood would have been a discharge from
 19 CAMHS and a concentration on social care and behaviour
 20 management?
 21 **A.** I guess that CAMHS themselves may be better able to
 22 answer that question than me but I think that might well
 23 have met some of my experience in the past, yes.
 24 **Q.** All right, but that wouldn't be the case, would it, if
 25 it was comorbid with something else: here, significant

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1 **Q.** You weren't lighthearted, you weren't dismissive, you
 2 thought it should be dealt with in a different way;
 3 that's your case?
 4 **A.** Yes, I think that would be. I think that's a fair
 5 summary. I think I would just also repeat that there
 6 was no indication that this -- at the time, that AR was
 7 likely to be receiving anything other than
 8 a community -- it was all about risk management in the
 9 community. You know, despite --
 10 **SIR ADRIAN FULFORD:** Sorry, two things, Mr Bowen. First of
 11 all, he doesn't have a case.
 12 **MR BOWEN:** I'll withdraw that --
 13 **SIR ADRIAN FULFORD:** Secondly, this is reasonably repetitive
 14 material we've already been over.
 15 **MR BOWEN:** All right. If it's not helpful, I will -- okay.
 16 Could I just move on then to the specific point and
 17 I will deal with it quickly. It's been accepted,
 18 I think, that you were pretty confident that he had all
 19 of the traits of autism: so no remorse, fixation on
 20 bullying, lack of empathy, as examples.
 21 **A.** I was pretty certain that the professionals in the group
 22 were confident that -- all the professionals that I met
 23 were -- that had met him and met his family, were
 24 confident that he would likely meet a diagnosis, yes.
 25 **Q.** So the assessment of ASD was confirmatory, rather than

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1 autism?
 2 **A.** Yes, absolutely, I agree with what you are saying there,
 3 yes.
 4 **Q.** So if you have -- because this is Dr Irani's view, it's
 5 at 3.3.1.5, sir, of the report -- this is the specific
 6 point that I have been given permission to look at. She
 7 says if it is comorbid then that's pretty significant
 8 with a conduct disorder?
 9 **A.** Yes, I can understand that.
 10 **Q.** So that would then not involve a falling away of support
 11 from CAMHS or FCAMHS, you are then very much in the
 12 driving seat because you need to assess forensically?
 13 **A.** I think that's possibly taking -- that second step is
 14 a bit of a -- when it comes to the involvement of
 15 FCAMHS, I think that's taking it a little bit further
 16 than what I would like to agree with this statement.
 17 I think I agreed with you up until you talked about the
 18 FCAMHS involvement there.
 19 I think it is -- the comorbidity that you're talking
 20 about is a very important factor, I agree with you.
 21 I would comment that the interventions that
 22 I highlighted in terms of the SAVRY, in the first
 23 letter, would also be interventions that would be
 24 probably indicated for somebody who was to receive
 25 a conduct disorder as well. I don't think that they're

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1 inappropriate interventions from a psychological
 2 perspective as well.
 3 **Q.** I'm almost there, sir. So with delay -- because, of
 4 course, we did have delay here, for reasons that have
 5 been touched on already -- toxic behaviour becomes more
 6 entrenched and early intervention is essential?
 7 **A.** I think that's a fair point, yes.
 8 **SIR ADRIAN FULFORD:** I think your time is up, Mr Bowen.
 9 **MR BOWEN:** Yes. I have run out of prompts.
 10 **SIR ADRIAN FULFORD:** Thank you very much.
 11 **MS WAKEMAN:** Sir, just for completeness, Mr Moss has very
 12 helpfully informed me that it appears that the 01V code
 13 that the witness was just asked about is
 14 an organisational code within the NHS for data security
 15 purposes. It doesn't appear to be anything linked to
 16 a referral reason but, of course, Alder Hey will be able
 17 to correct that if we are mistaken.
 18 **SIR ADRIAN FULFORD:** Thank you.
 19 Thank you very much indeed for your assistance, you
 20 are now free to go.
 21 **THE WITNESS:** Thank you, sir.
 22 **MS WAKEMAN:** Thank you, sir. May we have a short break?
 23 **SIR ADRIAN FULFORD:** 10 minutes.
 24 **MS WAKEMAN:** Yes, thank you.
 25 **SIR ADRIAN FULFORD:** I will sit again at 3.30 pm.
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1 **Q.** Thank you. We can see from its face that it is
 2 a corporate statement that's jointly authored with your
 3 colleague, Dr Imran, yes?
 4 **A.** Yes, that's correct.
 5 **Q.** We've made arrangements, should it be required, for
 6 Dr Imran to attend later. She wasn't available today
 7 and we're grateful for you providing evidence. If at
 8 any stage during my questioning, we get into areas that
 9 are overly clinical and you feel uncomfortable
 10 answering, please just say so and we can then pick them
 11 up with your colleague later on.
 12 **A.** Thank you.
 13 **Q.** But please give us the assistance that you can.
 14 So just briefly, by way of biography, you've touched
 15 on it a little bit, but you explain in paragraph 3,
 16 page 2 of your statement, that you are the Head of
 17 Operations for the CAMHS division within the Greater
 18 Manchester Health Foundation Trust; is that correct?
 19 **A.** Yes.
 20 **Q.** In terms of your own background, you qualified as
 21 a specialist child and adolescent social worker in 1995?
 22 **A.** Correct.
 23 **Q.** You have specialised in child and adolescent mental
 24 health from 2004 onwards?
 25 **A.** Correct.
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1 (3.19 pm)
 2 (A short break)
 3 (3.30 pm)
 4 **MS AMANDA-JAYNE BROWN (sworn)**
 5 **Questioned by MR MOSS**
 6 **SIR ADRIAN FULFORD:** Please have a seat.
 7 **A.** Thank you, sir.
 8 **SIR ADRIAN FULFORD:** Yes, Mr Moss.
 9 **MR MOSS:** Thank you, sir.
 10 Just start by giving us your full name, if you
 11 would?
 12 **A.** My name is Amanda-Jayne Brown.
 13 **Q.** Thank you. If we could have on screen, please,
 14 GMMH000015. It is a copy of your statement that you
 15 provided to the Inquiry, dated 27 August 2025. Are the
 16 contents of that statement true to the best of your
 17 knowledge and belief?
 18 **A.** They are true, just to add, the opening statement
 19 suggests that during the whole of the relevant period
 20 that I have contributed and held a senior leadership
 21 role. I have held a senior leadership role during that
 22 period but not necessarily directly for the CAMHS
 23 division, which included FCAMHS. I've been part the
 24 FCAMHS and the CAMHS division of the Greater Manchester
 25 Mental Health Trust since September 2023.
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1 **Q.** The Head of Operations role is something you have
 2 carried for seven years with that caveat about the
 3 responsibility for the FCAMHS that you've indicated?
 4 **A.** And adult services, yes, thank you.
 5 **Q.** Thank you. The Forensic Child and Adolescent Mental
 6 Health Services North West, the FCAMHS that we're
 7 speaking of, I think sit within the CAMHS division for
 8 which you are Head of Operations?
 9 **A.** Correct.
 10 **Q.** Thank you.
 11 Can I turn, against that background, then to the
 12 role and remit of FCAMHS and we've heard something about
 13 this from our previous witness. In terms of the advice
 14 and consultation, the first limb of the services that
 15 are provided, is there anything that you wanted to add
 16 to the working level description that Mr Hicklin gave of
 17 that?
 18 **A.** No. I would say that most recently, and prior to this
 19 incident, the standard operating procedures and the
 20 systems and processes have changed within the FCAMHS
 21 arena. That was undertaken when I came into role, not
 22 just within FCAMHS but for the whole of the CAMHS
 23 division, and every service within there. So there have
 24 been some significant changes.
 25 **Q.** I'm going to ask you to stick with how things were at
 160

1 the time --

2 A. Okay.

3 Q. -- in late 2019 and 2020 but when we come to the end of

4 your evidence, you can add in the significance of any

5 changes.

6 A. Thank you.

7 Q. So in terms of how Mr Hicklin was describing the advice

8 and consultation stages, would you broadly agree that

9 what he said was accurate and it was a good indication?

10 A. Correct.

11 Q. Thank you. The second limb, the ability to give direct

12 assessments, what can you assist us with in the

13 circumstances in which FCAMHS would have thought it

14 appropriate to do a direct assessment, rather than only

15 giving advice and consultation to the professionals who

16 were already involved?

17 A. It's my professional opinion that this would have been

18 a MDT discussion back with the FCAMHS team and

19 a decision would have been made whether it was indicated

20 and appropriate to undertake a forensic assessment,

21 whatever that might be. In this case, the SAVRY has

22 been mentioned throughout.

23 Q. Thank you. But should we understand that that would

24 only arise if, at the first stage, the advice and

25 consultation limb, there was a sense by the FCAMHS nurse

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1 multidisciplinary discussion or would somebody in

2 Mr Hicklin's position have to put it forward for

3 discussion, saying this is potentially contentious or

4 complex?

5 A. I'm unclear. That would have to be picked up with

6 Dr Imran.

7 Q. Thank you. The intervention with the young person's

8 professional network, the third limb, Mr Hicklin

9 indicated, I think, some caution about the way that it

10 had been described in your joint statement. If we could

11 have your statement at page 4, please, that wording at

12 the top of the page. In essence, I think he was saying

13 that reflects the current way that FCAMHS might work to

14 intervene, with an emphasis on supporting the

15 practitioners, the professionals, who were already

16 involved. But I think he was indicating that in his

17 time, it might have been a bit more direct, that FCAMHS

18 might be involved in some direct intervention with the

19 person who had been referred.

20 A. In terms of direct intervention, it wouldn't be

21 treatment as such, it would have been an assessment,

22 a period of an assessment and extended assessment.

23 Q. So a time-limited period of assessment but would some of

24 that be face to face with the patient or would that be

25 assessment of what the other professionals were doing?

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1 or the FCAMHS worker that it wasn't possible to give

2 an appropriate formulation of the mental health issue

3 that was in play, or perhaps alternatively that it was

4 so high on the seriousness scale that an assessment

5 might be needed from FCAMHS?

6 A. Sorry, could you repeat the actual question?

7 Q. Yes. I'm really asking you, you say it would be

8 a multidisciplinary panel, how would it get to the

9 multidisciplinary panel: in what circumstances would the

10 frontline FCAMHS worker say, well, actually, there's

11 a problem here and we might need a direct assessment?

12 A. It's general that there is an MDT discussion with the

13 FCAMHS service on a weekly basis and on an *ad hoc* basis,

14 where there may be some contention within cases or

15 there's complexity within cases that need a wider

16 discussion and leading to a variety of further risk

17 assessments.

18 Q. All right. So, the issues that would give rise to

19 FCAMHS offering a direct assessment to the person

20 referred in would be those sort of complexities or

21 contentiousness identified in an FCAMHS

22 multidisciplinary discussion?

23 A. Built on from the consultation that's been offered to

24 the local system.

25 Q. All right. Would all cases be considered at the weekly

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1 A. Both, potentially.

2 Q. Thank you. I'm going to come on to aspects of risk in

3 a number of places but, if we could just look at

4 paragraphs 22 to 24 of your statement, please, page 9.

5 I will come back to this but you say in paragraph 22:

6 "When FCAMHS accepts a referral for a young person,

7 the responsibility for holding and maintaining the risk

8 assessment remains with the referrer or lead

9 coordinating professional."

10 I'm asked to explore this with you: would you accept

11 that FCAMHS, given its experience, is the primary body

12 with the most relevant expertise when assessing the risk

13 of violence of young adults, where it may arise from

14 a mental health condition?

15 A. It needs to be undertaken in partnership with the

16 system, and the system being health, education, social

17 care. Of course, the FCAMHS team have forensic

18 expertise in undertaking specialist assessments that

19 could also add to risk profiles.

20 Q. That forensic expertise, is that something over and

21 above what "standard" CAMHS staff would have in

22 assessing risk?

23 A. Generally, yes.

24 Q. At this time, 2019/2020, was the FCAMHS service in this

25 region commissioned to provide any direct specialist

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1 services for individuals with AR's sort of risk profile?

2 A. Sorry, could you just repeat the question again?

3 Q. Yes. Was the FCAMHS service in this region commissioned

4 to provide any direct specialist services for

5 individuals with AR's sort of risk profile?

6 A. Direct specialist services to AR or?

7 Q. To AR or somebody with AR's sort of risk profile?

8 A. Yes. Assessment.

9 Q. Okay. So we've got the assessment but, in terms of

10 actual interventions, would there have been any

11 potential for therapeutic services, for even inpatient

12 care, matters of that kind?

13 A. They could make some recommendations but it is very

14 unlikely because of the way that the service has been

15 commissioned and resourced that treatments and therapy

16 would be provided by the team. There would be

17 an expectation that that would generally be undertaken

18 by the wider system and the services in the locality --

19 Q. Yes.

20 A. -- which there are few and far between. There is a gap.

21 Q. So very unlikely that that would be provided by FCAMHS.

22 You'd have to then make recommendations for the services

23 offered by others?

24 A. Yes.

25 Q. Even if AR had been diagnosed with a conduct disorder,

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1 you would need somebody who has got a repertoire of

2 therapeutic skills to be able to deliver the treatment

3 after. Therapy staff who hold those skills are few and

4 far between across the system.

5 Q. Thank you.

6 A change in topic now. Could we just look at the

7 process when somebody has been referred in and is open

8 to FCAMHS. Paragraph 14 of your statement please at

9 page 7:

10 "FCAMHS require the young person to be open to

11 a lead coordinating professional for the duration of the

12 service's involvement."

13 You go on to explain that:

14 "If the coordinating professional discharges the

15 young person and no other service takes over

16 coordinating responsibility ... FCAMHS will escalate

17 concern within the local system at a senior level ..."

18 Should we take it from that that FCAMHS would never

19 itself see itself as the lead coordinating professional?

20 A. Correct.

21 Q. It's always in a supporting role?

22 A. Yes. It's a collaborative.

23 Q. Thank you. Consistent with that, page 4 of your

24 statement, with apologies for jumping around, but a link

25 point, paragraph 5:

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1 would the same apply: that wouldn't make a change to the

2 likelihood that there was any direct treatment that

3 could be provided by FCAMHS?

4 A. During this time period, the FCAMHS service would not

5 have provided ASC diagnosis but they do know. They

6 would not have delivered direct intervention and

7 therapeutic treatments. There would be an expectation,

8 if there was a conduct disorder, that within the local

9 system there would be services to support AR and/or his

10 parents.

11 Q. All right. Can you try to be concrete in relation to

12 this: which services provided by which agencies? Give

13 us some examples.

14 A. So, for example, parenting support generally is provided

15 by Early Help and social care, education, mental health

16 support teams. Direct provision of support to AR could

17 have been provided if there was a need for treatment

18 directly from the YOT service and/or CAMHS service,

19 generally.

20 Q. Thank you. The gap that you mentioned a moment ago in

21 the provision at the time, you think is what? Can you

22 just define it for us?

23 A. So, once somebody undertakes a very specific assessment

24 and treatment, such as the SAVRY -- or AIM assessment,

25 for example, but this is not relevant in this case --

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1 "During FCAMHS involvement with a young person, the

2 referrer or other lead professional remains the

3 responsible case coordinator."

4 Yes?

5 A. Yes.

6 Q. So from FCAMHS' point of view, there would always have

7 to be at least one other professional agency involved;

8 do you agree?

9 A. Correct.

10 Q. FCAMHS would never see itself as the lead agency; the

11 person who would be the lead agency would be the person

12 who referred to FCAMHS or another lead professional,

13 presumably if they are allocated the role of lead

14 professional?

15 A. Correct, and generally borne out of recommendations that

16 have been made through consultation or assessments.

17 Q. At a general level, would you agree that, in AR's case,

18 what one doesn't see on the documents is a clear

19 statement of who the lead agency was at each time?

20 A. During this period of time, I would agree, yes.

21 Q. Do we take it from that that that's changed?

22 A. It has changed.

23 Q. Would you agree, in general terms, that the risks of

24 that are obvious because cases could fall between the

25 cracks?

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1 A. Absolutely.

2 Q. In relation to the important aspects for this Inquiry of

3 a structured risk assessment, would you agree that there

4 is a risk that who is meant to be doing the structured

5 risk assessment might fall between the cracks, if it

6 wasn't clear who the lead agency was?

7 A. A structured risk assessment is a little different than

8 a collective risk assessment. Within FCAMHS and with

9 cases of this nature, I would expect, given the recent

10 research and best practice, that there would absolutely

11 be a risk share amongst the system providers. So that,

12 whilst there will be a lead, the risk is shared amongst

13 the whole of the community system.

14 Q. Yes, but somebody has to do the structured risk

15 assessment?

16 A. The structured risk assessments are generally

17 undertaken -- because the structured risk assessments

18 are specialist forensic assessments. They are

19 undertaken by FCAMHS alongside and in support of the

20 information that's available from the rest of the

21 partners in the system.

22 Q. At a general level, do you think, from the records, that

23 that was done in AR's case?

24 A. No. Not to the standard that we would expect.

25 Q. Thank you. In general terms, the closure of a referral

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1 was no specific evidence of detail when somebody would

2 move from consultation to assessment. There was no

3 standard set at that point.

4 Q. Again, I suppose one can't generalise as to the form

5 that the forensic assessment might take but, if we could

6 look at paragraph 17 of your statement, at page 7,

7 please, you helpfully give us some examples of the

8 skills that could be called upon. So specialist LD and

9 mental health nursing, psychological, psychiatric,

10 speech and language, neurodevelopmental assessments.

11 There's quite a multidisciplinary range. So you could

12 choose, or the MDT could choose, an appropriate

13 clinician or a mixture of appropriate clinicians to do

14 that sort of forensic assessment, with quite a lot of

15 specialities covered?

16 A. Or a couple of professionals, really, to complement the

17 assessments that were being undertaken, if there were

18 gaps already within the system and the knowledge within

19 the system.

20 Q. Thank you.

21 A. I think it is noteworthy to say there's been investment

22 into the service, which has meant that the service now

23 has a speech and language therapist and a specialist LD

24 nurse.

25 Q. At the time, we appreciate from your statement that this

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1 to FCAMHS would be taken in what circumstances?

2 A. When there would be no further action required from

3 an FCAMHS department; that there is assurance that

4 recommendations are being carried out; there is a lead

5 professional actively involved; and that the system are

6 working closely together to make sure that identified

7 needs are met.

8 Q. So, it would be appropriate, depending upon the

9 individual circumstances, for FCAMHS to close the

10 referral to it as an agency not when the person has been

11 discharged from care and services altogether but when

12 the FCAMHS role has been dealt with and other agencies

13 are now satisfactorily taking the case forward?

14 A. Correct.

15 Q. So far as forensic assessments by FCAMHS are concerned,

16 was there, at the time, any internal guidance on when

17 that was appropriate to take place? You have said that

18 it would be considered by the MDT but was there any

19 guidance on that on which cases were appropriate for it?

20 A. The standard operating procedure, when I arrived in

21 2023, was very loose and that was refreshed and reviewed

22 and approved at our SLT governance senior meeting in

23 February 2024. It was felt that the standard operating

24 procedure needed tightening up, this was before this

25 incident occurred. So in answer to your question, there

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1 has changed, whereas Mr Hicklin was indicating -- my

2 paraphrase -- the importance of an autism diagnosis

3 being made, at the time, FCAMHS didn't have the capacity

4 to see to those autism assessments being done

5 themselves?

6 A. Correct.

7 Q. That is one area that has changed?

8 A. It has changed. It changed in March 2024.

9 Q. Thank you. If the now system, the post-March 2024

10 system had been in place at the time, with the sort of

11 set of circumstances that you can see for AR, from your

12 knowledge of the papers in late 2019/early 2020, would

13 the FCAMHS-commissioned autism assessment have been put

14 in place?

15 A. Yes.

16 Q. So I want to go back now to the question we touched upon

17 a little bit of risk assessments. Can we go back to

18 your paragraph 22, please.

19 That's the one starting at page 9. Can you help us

20 just to understand now in a little bit more detail, the

21 point that you raised that the structured risk

22 assessment would involve FCAMHS but that would be done

23 in partnership with others: can you just explain how

24 that actually works on the ground?

25 A. I can summarise that. You may be better asking Dr Imran

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1 for the micro-details surrounding that but, generally,
 2 a SAVRY for example is made up of very different
 3 components looking at history, current risks, background
 4 incidents in detail, and lots of other professionals
 5 obviously provide information to ensure that that's
 6 really comprehensive so that there can be a formulation
 7 and scoring system, which would then give outcomes in
 8 terms of a risk score and also opportunity for
 9 treatment.

10 **Q.** So you are going to have to pull the information in from
 11 different sources to inform the risk scoring?

12 **A.** Yes, including family and AR, if possible.

13 **Q.** Forgive me for descending to this, and if we have to
 14 pick this up with Dr Imran let us know, but at some
 15 stage somebody has to sit down with the scoring
 16 structure and assess that information to come up with
 17 the risk scores. Is that person going to be a nurse
 18 from FCAMHS or another professional from FCAMHS, or is
 19 it going to be somebody from one of the other agencies,
 20 for example, here, the CAMHS practitioners?

21 **A.** It is likely to be the FCAMHS service that does that.

22 **Q.** So when you say, "When FCAMHS accepts a referral for
 23 a young person the responsibility for holding and
 24 maintaining the risk assessment remains with the
 25 referrer or lead coordinating professional", does that

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1 practical terms? Who should have been indicating that
 2 a SAVRY would be an appropriate risk?

3 **A.** The FCAMHS service.

4 **Q.** So the FCAMHS service here, you would think, in your
 5 professional opinion, should have flagged up the
 6 desirability of doing that sort of standardised risk
 7 assessment?

8 **A.** Yes, because of the complexity and the high risk evident
 9 within this case.

10 **Q.** I follow. So that's the "could have been indicated
 11 earlier", and then you said, particularly with the CAMHS
 12 service sometimes not coming to the table during these
 13 very vital and important professional meetings and
 14 consultations: did you mean by that that CAMHS not
 15 having come to the two meetings in 2020, that it would
 16 have been appropriate for FCAMHS to flag to CAMHS the
 17 desirability of doing a SAVRY and really try to bring
 18 them more to the table?

19 **A.** Yes.

20 **Q.** Was there more to it than that or have I satisfactorily
 21 summarised what you think should have happened?

22 **A.** I think you've summarised it pretty well. There needed
 23 to have been an escalation that with CAMHS not coming to
 24 the table at the time, that there was a real push to
 25 ensure that they absolutely joined and contributed.

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1 need to be read with the important caveat that, in
 2 appropriate cases, FCAMHS would go alongside the other
 3 agency and actively help score on a standardised type of
 4 risk assessment, yes?

5 **A.** Yes, and it wouldn't be used in isolation. You just
 6 wouldn't use the SAVRY, you'd use lots of other risk
 7 assessments that are undertaken by the individual
 8 services.

9 **Q.** I follow. You candidly said straightaway, when I asked
 10 you whether that had happened satisfactorily in AR's
 11 case, that you thought that it hadn't. Can you just
 12 expand on that answer and explain what you think should
 13 have been done that wasn't?

14 **A.** It's my professional opinion -- and I think that that
 15 needs to be with a caveat that I've not been in clinical
 16 practice for a period of time, I have limited experience
 17 of Forensic CAMHS, although I was able and trained to do
 18 some forensic risk assessments -- that a SAVRY could
 19 have been indicated earlier in this case and escalation
 20 could have been indicated earlier in the case,
 21 particularly with the CAMHS service sometimes not coming
 22 to the table during these very vital and important
 23 professional meetings and consultations.

24 **Q.** So let's break that down. A SAVRY could have been
 25 indicated earlier in this case. What does that mean in

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1 There may have been vital information that they had
 2 during that period that would have been missing from the
 3 risk assessment and they could have contributed greatly.

4 **Q.** Of course, not a question directed at any personal
 5 responsibility on your part at all, but would you agree
 6 that what seems to have happened instead is that
 7 Mr Hicklin in the March letter has given some
 8 indications of the potential risk complications that
 9 could arise because of autism, so sort of factors that
 10 might be coming out of a SAVRY assessment but in
 11 a letter that was on the face of it first of all only
 12 sent to Ms Hallaron --

13 **A.** Correct.

14 **Q.** -- and that that was also, in some senses, a cautious
 15 document because it wasn't giving a full SAVRY
 16 assessment, it was saying these could be the sort of
 17 issues in play but we can't contribute further without
 18 knowing the diagnosis?

19 **A.** Correct.

20 **Q.** Meanwhile, CAMHS, who it seems probably didn't have the
 21 skills to do the SAVRY type of standardised risk
 22 assessment, fell back on their own risk assessment tool,
 23 yes? Have you seen some of the CAMHS risk assessments?

24 **A.** I haven't seen Alder Hey's risk assessment but I would
 25 imagine it's not dissimilar to what is used against

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1 Greater Manchester Mental Health Trust.

2 **Q.** So not really having a standardised method of assessing

3 the risk and CAMHS have accepted they are neither as

4 structured, nor as detailed, nor as frequent as they

5 should have been, so that did here, on the risk

6 assessment, would you agree, lead to again the proper

7 standardised type of risk assessment falling between the

8 cracks, here falling between the cracks of FCAMHS and

9 CAMHS, principally?

10 **A.** Yes, there seems vital information missing.

11 **Q.** In terms of the complexity of different agencies

12 thinking that others were in the lead, we don't perhaps

13 need to have it up on screen, but Stephanie Hallaron --

14 sir, for your reference MERP000026, paragraph 61 -- she

15 indicates that, so far as her organisation, CJYS, are

16 concerned -- sometimes thought of as the YOT -- she

17 says:

18 "I was advised that we were not best placed to

19 complete a SAVRY and this could be considered by CAMHS

20 or FCAMHS."

21 Again, that all points to different agencies

22 thinking that other agencies were in the lead for doing

23 the risk assessment, yes?

24 **A.** Well, that element of a risk assessment, yes.

25 **Q.** Can we pause on how matters were at the time and can

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1 and reviewed since this incident, there is very clear

2 mechanisms to move from consultation to specialist

3 forensic assessment, outlined within that standard

4 operating procedure. There is also, as part of that

5 standard operating procedure, the opportunity for audit

6 to ensure that recommendations, where they have been

7 made to the wider system, are audited across a system on

8 a regular basis, via a random snapshot twice a year.

9 There are also multidisciplinary teams that discuss

10 the potential for discharge and supervision is far more

11 robust than previous.

12 **Q.** Thank you. I think what I'm going to do, Ms Brown, we

13 may have Dr Imran along but I might ask you to take away

14 that question, more specifically focusing down on

15 ensuring that appropriate more advanced types of risk

16 assessments and who is responsible for them are now

17 carried out.

18 Yesterday, when Dr Killen gave evidence on behalf of

19 CAMHS, and I put to her the substance of the corporate

20 statement that you and Dr Imran have provided,

21 paraphrasing paragraph 22, she indicated that they,

22 CAMHS, would defer to the risk assessment by FCAMHS and

23 they should do a full risk assessment.

24 When I put to her the essence of paragraph 22, that

25 the responsibility for holding and maintaining the risk

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1 I invite you just to give a summary for the learned

2 Chair of the ways in which you think that is now

3 different, so that there is less risk of the same thing

4 happening?

5 **A.** Thank you. The recommendations and changes that have

6 been made to Greater Manchester Mental Health Trust

7 FCAMHS service so far have been that there has been a LD

8 specialist nurse, there is an autism pathway and

9 assessment --

10 **Q.** I'm going to stop you, I'm so sorry. I think you're

11 reading from a note. That's absolutely fine but could

12 you, please -- I will come back to wider changes but can

13 you focus on this issue because I'm particularly

14 concerned that you should be able to explain to the

15 Chair, in terms of risk assessments in this type of

16 situation -- so not wider changes -- why would you be

17 confident now that there wouldn't be this failure

18 whereby the SAVRY type of risk assessment isn't done by

19 FCAMHS, CAMHS are left to do their own type of risk

20 assessment, meanwhile the YOT team think that it is

21 either CAMHS or FCAMHS who are doing it but nobody, in

22 fact, actually does it?

23 **A.** Okay. So, there are a variety of things that have

24 changed in relation to the risk assessments. Within the

25 standard operating procedure, which has been approved

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1 assessment remained with the lead agency, she said that

2 that wasn't quite how she understood it and she thought

3 that there was still a lack of clarity around this and

4 that she would like to see greater clarity in

5 commissioning as well.

6 So that evidence tends to suggest, even now from

7 a very experienced clinical lead, a lack of clarity

8 about where the divisions of responsibility lie for this

9 type of risk assessment.

10 Is that something you could take away and provide us

11 with an update note on, the current state of play on

12 understanding who bears what responsibility for risk

13 assessments in this type of situation?

14 **A.** Yes.

15 **Q.** Thank you. Looking then at AR's engagement with the

16 FCAMHS service. Much of this has been addressed by

17 Mr Hicklin. Could I ask this: he wasn't able to attend

18 the strategy meeting on 17 December. What would the

19 expectation be in that case? One appreciates it was at

20 relatively short notice. Is that just an operational

21 risk that sometimes you can't field somebody or would

22 FCAMHS have expected to have sent somebody to attend in

23 Mr Hicklin's place?

24 **A.** There would be an expectation that there would be

25 attendance. I think it needs to be borne in mind that

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1 the FCAMHS services are small services. There are just
 2 12 members of staff within that service. They cover
 3 a very wide area but we do also now have a safeguarding
 4 lead that could have attended a strategy meeting on
 5 behalf of FCAMHS to feedback some of that information.
 6 **Q.** Thank you. In terms of the recommendations that
 7 Mr Hicklin made in his two letters, other than the
 8 aspect of risk assessment, which I have touched upon
 9 already, what is your observation on the type of advice
 10 and recommendations that he was giving in those two
 11 letters?
 12 **A.** We've moved to more of a SMART action recommendation and
 13 being very clear about what needs to happen, why it
 14 needs to happen, who are we keeping safe by undertaking
 15 a piece of work and who is responsible, and potential
 16 timelines for work for completion, who will be the lead
 17 professional to undertake and ensure that this is
 18 monitored. It feels a lot more structured, in terms of
 19 the correspondence that is forwarded out. There's also
 20 a greater emphasis and assurance surrounding who
 21 receives a copy of the recommendations, either from
 22 consultation or assessment.
 23 **Q.** Yes, because, would you agree, that one downside of the
 24 letters is that being addressed only to the person who
 25 had referred into FCAMHS, when there were quite a few
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1 still have a right to an education'. Ms Hodson replied,
 2 'That might be so', but she wasn't prepared to explain
 3 to a parent why a child at our school has been seriously
 4 injured."
 5 In fairness to Mr Hicklin, he was keen to explain
 6 that the context to this was that, at this stage, AR had
 7 been permanently excluded from his old school and was
 8 not yet attending his new school, the referral unit,
 9 while the risk was being looked at. So, at that stage,
 10 he was out of education and it's not his note of this.
 11 But, against that background, do you have any
 12 observation on an indication that he may have said
 13 something to the effect of "I don't have a crystal ball,
 14 none of us have, we can't say whether he is likely to
 15 offend again"?
 16 **A.** I wasn't in the meeting. I understand that this is
 17 a note. This is not how I would expect one of our
 18 professionals within FCAMHS to communicate with the
 19 wider system. It doesn't fit the organisation's values
 20 and standards of expectations.
 21 **Q.** On page 2, in the middle of the page, if we just go
 22 over, it's the very middle paragraph:
 23 "John H repeated that there were no crystal balls
 24 and that he would offer a £5 bet to anyone who could say
 25 what was going to happen next. He said that [AR]
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1 agencies involved, and relying that other agency to copy
 2 it round, was not ideal?
 3 **A.** Not ideal.
 4 **Q.** You have indicated that now there would be an emphasis
 5 on the structure, so that it was SMART compliant, so
 6 measurable, time limited, and so on, one understands
 7 that, but looking at the substance of the
 8 recommendations that Mr Hicklin made, were they
 9 generally within the sort of standard that you would
 10 expect, albeit that they could have been structured and
 11 headed better --
 12 **A.** Yes.
 13 **Q.** -- and appropriate for FCAMHS type of advice?
 14 **A.** Yes.
 15 **Q.** You will have heard my learned friend, Ms Wakeman,
 16 asking Mr Hicklin himself about the 21 January meeting
 17 notes; obviously not his note. Could we just have that
 18 back on screen, it is LCC000020. Could we have enlarged
 19 the very last paragraph on the first page.
 20 So:
 21 "Mr Hicklin then turn to Ms Hodson, the Deputy Head,
 22 and said, 'I've been thinking about what you said
 23 before, I don't have a crystal ball, none of us have.
 24 We can't say whether he's likely to offend again. There
 25 are kids who have carried out serious offences, they
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1 clearly needed some sort of specialist provision with
 2 ongoing therapy and social stories 'but unfortunately,
 3 you've been left holding the baby'.
 4 Even if one makes allowance for this being a note,
 5 not verbatim, and for the context that Mr Hicklin may
 6 have been appropriately seeking a re-entry into
 7 education and pressing the need for specialist
 8 provision, and even in the absence of AR or his parents,
 9 would you expect to see reference to offering a bet of
 10 £5 as to what could happen next?
 11 **A.** No.
 12 **Q.** We know that after the second meeting and the letter
 13 that followed from Mr Hicklin, AR was discharged from
 14 FCAMHS' services or FCAMHS' case load. In relation to
 15 that, can you just give us your assessment of whether
 16 that was appropriate or whether there was a different
 17 course open at that stage?
 18 **A.** My own professional opinion is that a professionals
 19 meeting should have been called to ensure that that was
 20 a safe discharge. There were key players who were
 21 missing from the meeting, including CAMHS, and it wasn't
 22 very clear who was going to take on the roles and
 23 responsibilities outlined within the recommendations.
 24 **Q.** Thank you. If we see your paragraph 21 at page 9,
 25 please. GMMH000015.
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1 That's the essence, isn't it, of what you are
 2 seeking to communicate there, the benefit of delaying
 3 discharge, a further multi-agency professional meeting.
 4 First of all, they could have got CAMHS along to that
 5 and the purpose, on the face of the FCAMHS
 6 understanding, would have been in part to try to
 7 encourage CAMHS to keep the case open, yes --
 8 A. Yes.
 9 Q. -- because it was FCAMHS understanding that it was going
 10 to be closed. But, in any event, I think you indicate
 11 also to give clarity around who was going to take
 12 forward the recommendations, yes?
 13 A. Yes.
 14 Q. Also, a formal designation of which the lead agency was
 15 going to be?
 16 A. Yes.
 17 Q. You are, of course, both more experienced and more
 18 senior, and you are also looking at this now with the
 19 knowledge of current practice that has improved and your
 20 knowledge from reading the papers. Can you assist us to
 21 try to gradate this a little bit: do you think the
 22 closure to FCAMHS was a poor professional decision at
 23 the time, with what was known, or do you think it's more
 24 the case that that was understandable at the time but
 25 now there would be a different approach.

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1 There was attendance by the police at his home for
 2 incidents involving a level of violence, some to
 3 property, some to parents and there was the bus incident
 4 in March 2022. Again, I'm not going to list them all
 5 but, certainly, with those events on top of the autism
 6 diagnosis, it would have been appropriate to refer back
 7 into FCAMHS?
 8 A. Absolutely.
 9 Q. Would you go so far as to say it is not just appropriate
 10 but that he should have been referred back to FCAMHS?
 11 A. Yes, by all system partners because that list involves
 12 lots of agencies from health, social care, the police --
 13 Q. Yes.
 14 A. -- education.
 15 Q. So, that would be, as it were, the push of referrals
 16 coming back to FCAMHS?
 17 A. Yes.
 18 Q. What about any pull from FCAMHS: was there any system at
 19 the time to monitor post closure or to monitor -- there
 20 was a sort of quasi-recommendation from Mr Hicklin, "If
 21 things change or you get the diagnosis, come back to us"
 22 -- was there any post-closure monitoring?
 23 A. No, not at the time. That has subsequently changed.
 24 Q. How does that work now?
 25 A. Through the audit system that is now in place within the

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1 A. The latter.
 2 Q. So you wouldn't be saying that the decision to close it
 3 at the time was outside of reasonable professional
 4 practice for FCAMHS at that time?
 5 A. At that time. However, I do still maintain that a SAVRY
 6 should have been undertaken.
 7 Q. I was going to come onto that, and you correctly
 8 predicted my next question, but what you would say is
 9 that the way in which the SAVRY was dealt with or not
 10 dealt with was poor practice?
 11 A. Yes.
 12 Q. Thank you.
 13 AR, having been discharged from FCAMHS'
 14 involvement -- Mr Hicklin was asked about this but at
 15 the time that the formal diagnosis of autism was made at
 16 a meeting in December 2020 and communicated on across
 17 January and February 2021, would that have been
 18 an appropriate time to re-refer AR to FCAMHS?
 19 A. Yes, I feel it's a missed opportunity, particularly
 20 because assessment for ASC doesn't only give
 21 a diagnosis, it gives lots of information about how
 22 somebody functions.
 23 Q. Thank you. I don't need to go through them all but,
 24 after the diagnosis of autism, there is a series of
 25 further events. So there are more Prevent referrals.

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1 service, and by much more robust discharge from the
 2 service and expectations being spelled out of the system
 3 and the risk share across the system.
 4 Q. It is, of course, extremely difficult for practitioners
 5 and for lawyers alike not to use hindsight with
 6 knowledge of the most awful events of 29 July. I'm
 7 going to ask you to try not to use the knowledge of the
 8 events and how awfully matters turned out.
 9 But just with the information about AR's risk that
 10 was known in 2022 and 2023, against what had already
 11 happened in 2019, 2020 and 2021, how surprised are you
 12 that AR wasn't referred back to FCAMHS?
 13 A. There were many missed opportunities.
 14 Q. I appreciate that it's difficult and you may also say
 15 that Dr Imran may be able to assist on this but let's
 16 take some of the key points: with AR having had
 17 an autism diagnosis, if you took the fact that there had
 18 been some further internet activity of concern which
 19 Prevent had looked at but hadn't taken forward, some
 20 instances of violence in the home and then perhaps, most
 21 particularly, AR found with a knife on a bus saying that
 22 he wanted to stab someone and that he had thought about
 23 poison, if that had come to FCAMHS at that sort of stage
 24 with that profile, are you able to help us with the sort
 25 of process that might then have been followed by FCAMHS?

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1 I appreciate that it is hypothetical and speculative to
 2 some extent but can you help us at all on that?
 3 **A.** There shouldn't have been a regurgitation of information
 4 that was already available and within the system but the
 5 new information should have been shared via consultation
 6 and there would absolutely have been a very specialist
 7 forensics assessment undertaken.
 8 **Q.** So you are confident that that would have got beyond the
 9 advice and consultation phase and would have gone to
 10 assessment?
 11 **A.** Yes, because of the complexities. They are very clear.
 12 The risk is very high.
 13 **Q.** Potentially by what: a forensic psychiatrist?
 14 **A.** By the whole of the MDT, potentially.
 15 **Q.** Thank you.
 16 **SIR ADRIAN FULFORD:** Just before you move on, can we stay
 17 with that just for a minute.
 18 **A.** Yes, sir.
 19 **SIR ADRIAN FULFORD:** So reviewed by the whole of the MDT.
 20 **A.** The right professionals within the MDT.
 21 **SIR ADRIAN FULFORD:** Absolutely. To what potential end? So
 22 with what -- what might have come as a result of that?
 23 So beyond people sitting around a table thinking about
 24 it, what practical results?
 25 **A.** There would have been a greater formulation of what was
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1 that gave rise to, but that Anna Croll of the Sefton YOT
 2 had become involved.
 3 You say this meeting could also have been used to
 4 explore who would be contacting the neurodevelopmental
 5 pathway to request that AR's assessment be expedited and
 6 to consider what service could have taken on the
 7 recommendation of delivering psychological
 8 interventions. So should we understand from that that
 9 you also candidly accept that, although there was the
 10 recommendation for the autism to be expedited, or the
 11 assessment to be expedited, there was a lack of clarity
 12 about exactly who was going to take that on?
 13 **A.** Yes, it wasn't clear within the letter, the actions
 14 weren't SMART.
 15 **Q.** Thank you.
 16 I should give you an opportunity to comment on
 17 Dr Irani's assessment of the risk assessment process but
 18 what it comes to is that, in her opinion, the
 19 assessments undertaken in AR's case by CAMHS, community
 20 FCAMHS or in relation to the risks that he presented, or
 21 any safeguarding concerns, again, were not adequate, and
 22 should we understand from your previous answers that you
 23 would agree with Dr Irani in that respect?
 24 **A.** Yes.
 25 **Q.** Thank you. Paragraph 30 of your statement, please. You
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1 occurring, a bringing together of all the information
 2 that was available in terms of the violence and
 3 aggression and risk and extremism that was at play
 4 within this case. From that formulation, there would
 5 have been plans made in terms of supportive treatment
 6 for the family, for the community, and also for AR.
 7 **SIR ADRIAN FULFORD:** Thank you very much.
 8 Sorry, Mr Moss.
 9 **MR MOSS:** Not at all.
 10 Thank you. Have you had the opportunity to see
 11 Dr Irani's report?
 12 **A.** I have.
 13 **Q.** Thank you. She concludes, in terms of multi-agency
 14 working that, in her opinion, rather a number of
 15 meetings in the absence of a lead agency, a clear
 16 handover process and an appropriate risk assessment, the
 17 inter-agency working arrangements were not adequate; do
 18 you agree?
 19 **A.** Yes.
 20 **Q.** Can I ask you, just in terms of your own reflections on
 21 matters, can we look at page 11 of your statement,
 22 please. You repeat there the point about the benefit of
 23 holding another consultation meeting and the involvement
 24 of the Criminal Justice Liaison and Diversion Team and
 25 Sefton CAMHS having discharged AR, and the risks that
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1 deal there with the rapid review of care that was
 2 conducted by GMMH. Sir, for your note, it's GMMH000008.
 3 **SIR ADRIAN FULFORD:** Thank you.
 4 **MR MOSS:** Just taking those briefly, I think in terms of
 5 timescales this is not perhaps the most significant one
 6 but I think, by the current key performance indicator,
 7 the offer of a first consultation meeting was slightly
 8 outside current expectations on timetables; is that
 9 correct?
 10 **A.** Yes.
 11 **Q.** Thank you.
 12 **A.** I think it's worthy to note that there was a Christmas
 13 period in between but, absolutely, there was that
 14 strategy meeting that occurred a couple of days after
 15 the referral was made too.
 16 **Q.** Thank you. Then second bullet point:
 17 "The clinical record for AR does not reveal whether
 18 letters detailing the consultation were sent to all
 19 professionals ..."
 20 That's a point that we've touched upon, I think
 21 you've said, that has changed since?
 22 **A.** Yes.
 23 **Q.** "The consultation letters are well written [so the third
 24 bullet point]; however the clarity and readability of
 25 the letter could be made clearer ..."
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1 That goes to the point about now being SMART
 2 compliant; would you agree?
 3 **A.** Yes.
 4 **Q.** The fourth bullet point:
 5 "The consultation suggested that AR may be
 6 displaying traits indicative of autism, and it was
 7 recommended to Sefton CAMHS that they refer AR to the
 8 local neurodevelopmental pathway."
 9 Then there is reference to the fact that, subsequent
 10 to that, with NHS England increasing FCAMHS funding,
 11 FCAMHS now has a greater capability in that regard to
 12 take autism assessments itself?
 13 **A.** Yes.
 14 **Q.** Accepting that this was a rapid review, we note within
 15 that that -- and it was a very rapid review -- that it
 16 doesn't seem to have identified the very significant
 17 issue around shortcomings in risk assessment that you've
 18 helped us with today. When did those shortcomings
 19 around the risk assessments first become apparent to
 20 FCAMHS?
 21 **A.** I can't be precise with the actual date. My
 22 understanding was I reviewed all of the systems and
 23 processes from September 2023. I would imagine it was
 24 in the fourth quarter of 2023/24 where the SOP was asked
 25 to be revised and reviewed to be far more specific.

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1 In terms of improvements, we have picked on several
 2 of those. So we have covered the fact that autism
 3 assessments can now be done, and I think you wanted to
 4 give an indication of some earlier on and I said that
 5 I would come back to that at the end, so do you want to
 6 give your high-level summary now. If we could have on
 7 screen paragraph 33, it's at page 14.
 8 I think you prepared some notes possibly on just
 9 highlighting some aspects to the Chair. Please feel
 10 free to do so.
 11 **A.** Okay, so the highlights that were detailed within the
 12 reports are the LD and autism pathway and new workers LD
 13 and speech and language therapists. We are also going
 14 to look for an OT to join the team at some point, which
 15 will help greatly. We have a safeguarding strategic
 16 lead that works across the CAMHS division, that helps to
 17 support safeguarding concerns and escalations across
 18 systems. They would do this with the FCAMHS service.
 19 There has been a requirement for clearer
 20 recommendations in a SMART way, also indicating public
 21 safety issues and personal safety issues and
 22 responsibilities.
 23 An audit has been devised and highlighted within the
 24 revised standard operating procedure. This also covers
 25 distribution of consultations and assessments. The

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1 **Q.** But what about in AR's specific case? I think you're
 2 kindly there indicating about when you noticed a need
 3 for improvements but when in relation, after the events
 4 of July, when there was a rapid review in AR's case, it
 5 hasn't identified the shortcomings over risk assessment.
 6 Do you know when that was first identified?
 7 **A.** After a rapid review has been completed, there is
 8 a patient safety panel within the trust and within the
 9 division, it would have been discussed at that point and
 10 within that forum. Also the LPC, the local provider
 11 collaborative took over and delegated responsibility
 12 from NHS England and they had conducted more regular
 13 contract reviews and quality reviews, in partnership
 14 with Greater Manchester Mental Health Trust. It's
 15 helped greatly.
 16 **Q.** The reason why I'm asking this, Ms Brown, for your
 17 assistance, is that it might be thought that it's up
 18 there as a key identification of a shortcoming in this
 19 case and I'm keen to understand from you how that was
 20 first spotted and what was then done about it
 21 specifically seeing that things had gone wrong in AR's
 22 case on the risk assessment, the lack of SAVRY.
 23 Can you help us with --
 24 **A.** I can't help you, I'm sorry.
 25 **Q.** Thank you. We might pick that up with others.

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1 escalation process requirements, where things are not
 2 being picked up quickly by system partners, also forms
 3 very much part of the SOP and that is now in detail.
 4 Where assessments are indicated, these are
 5 undertaken and there is very clear standards that are
 6 set surrounding when to move to assessment.
 7 Lead professional forms part of that SOP and how
 8 that is identified and what to do if there is an out of
 9 area move and/or a need for a different provider to take
 10 the lead.
 11 The discharge is in a lot more detail, in terms of
 12 requirements of MDT and supervision discussions. There
 13 is a new SLT governance assurance framework within the
 14 CAMHS division and across Greater Manchester Mental
 15 Health Trust. There has been a revision of systems and
 16 processes within the service.
 17 An example of that, Chair, would include the
 18 information that was shared earlier, the CCG was
 19 actually the local care commissioning group. So that
 20 was the responsible commissioning group for AR, at the
 21 time, on the referral form, and also the indication of
 22 a conduct disorder in logging a referral was logged,
 23 basically, because that's how a referral is logged and
 24 the nearest definition of a requirement for a FCAMHS
 25 case, rather than it actually being identified as

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1 anxiety or depression.

2 And all system changes have been made. There are
3 now KPIs, so the service is reviewed against those KPIs,
4 within regular contract meetings with the LPC and also
5 within SLT governance, not just within the CAMHS
6 division but within the care group and wider within the
7 organisation, to ensure that standards are being met
8 that have been set, such as timeframes.

9 **Q.** Thank you. You provided information on that in your
10 statement.

11 **A.** Yes.

12 **Q.** With all of those changes and improvements, which I know
13 you have only summarised, could we look at paragraph 34,
14 page 15, because, even with those improvements, against
15 the invitation from the Inquiry to outline any
16 recommendations, you said this -- it comes back to this
17 issue of the gap:

18 "There appears to be a gap in service offer for
19 children and young people who display high-risk and
20 high-harm behaviours, in the absence of a mental health
21 disorder, who would benefit from a structured
22 psychological intervention. Currently the FCAMHS
23 service model, as described in the NHS England FCAMHS
24 Service Specification, sets out no provision for this,
25 and currently there would be feasibility issues to

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1 **A.** Yes.

2 **Q.** Thank you. Sir, I was going to turn to my left but
3 I have had a question come in by email from Mr Nicholls,
4 who, Ms Brown, is junior counsel representing the
5 injured adult victims, and he goes back to the question
6 that I asked you about Mr Hicklin and the comments about
7 the £5 bet and, when you answered that those sort of
8 comments do not reflect FCAMHS value standards and
9 expectations, Mr Nicholls would like to ask: why those
10 comments do not reflect FCAMHS' values, standards and
11 expectations?

12 **A.** They don't reflect the standards and values because they
13 seem very flippant. They don't seem to acknowledge the
14 gravity of the concerns and risks evident.

15 **MR MOSS:** Thank you. I'm just checking with the other
16 teams.

17 Sir, do you have any questions for this witness?

18 **SIR ADRIAN FULFORD:** No questions, one request: first of all
19 to thank you for some extremely helpful evidence,
20 Ms Brown, I'm very grateful to you.

21 **A.** Thank you.

22 **SIR ADRIAN FULFORD:** In your fairly lengthy list of things
23 that have changed, you dealt, I'm reasonably confident
24 to say, with a number of things which are not within
25 your paragraph 33. You went beyond that. You also

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1 offering this within a regional model, due to
2 insufficient resources, and distances would be
3 prohibitively large for young people to attend a central
4 clinic, or practitioners to regularly travel to a venue
5 local to the young person."

6 Yes?

7 **A.** Yes.

8 **Q.** Should we read into that your assessment that, for AR
9 and for others in his category, where there may not be
10 an apparent treatable mental health disorder but there
11 are still very harm risk behaviours and a risk of
12 violence to others, they would benefit from structured
13 psychological intervention -- yes --

14 **A.** Yes.

15 **Q.** -- which at the moment FCAMHS is not commissioned or
16 resourced to provide?

17 **A.** Yes.

18 **Q.** Should we also understand that, in your experience
19 "standard" CAMHS is also not able to provide?

20 **A.** Not always. There is a provision within the local
21 integrated care boards to approach for specialist care.
22 I don't think that that has been utilised across all of
23 our regional trusts to its full capacity with these
24 cases.

25 **Q.** Is that on a case-by-case approval type of basis?

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1 explained them in a rather high-level way. You've
2 already had to put in a lot of work in relation to this
3 Inquiry but I'm going to ask one last request that you
4 set it out in greater detail and submit that in writing
5 by mid-November.

6 **A.** Okay, thank you.

7 **SIR ADRIAN FULFORD:** Is that all right?

8 **A.** Yes, of course.

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

10 **A.** Thank you, sir.

11 **SIR ADRIAN FULFORD:** You are free to go.

12 **MR MOSS:** Thank you, sir. We resume, with your permission,
13 at 10.00 tomorrow with Dr Irani.

14 Also, sir, with your permission, may I give advance
15 notice that because of the realities of the timetable
16 for Thursday, with your permission we propose to sit
17 with a 9.30 start on Thursday morning.

18 **SIR ADRIAN FULFORD:** Certainly, there was also some reading
19 this afternoon?

20 **MR MOSS:** Sir, because of the timescales that was, in any
21 event, going to be pushed back but it's not forgotten
22 and we will come to a summary of other psychiatric
23 evidence in due course.

24 **SIR ADRIAN FULFORD:** We've got time for that on a future
25 day?

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1 **MR MOSS:** We will make time.
 2 **SIR ADRIAN FULFORD:** Thank you all very much. 10.00
 3 tomorrow.
 4 **(4.42 pm)**
 5 **(The Inquiry adjourned until 10.00 am the following day)**
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