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?

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?

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?

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

involvement was really quite limited?
A. Yes, that's correct.
Q. The issues, I think, that you can help us with are AR's involvement with autism diagnosis and care and signposting for his autism, yes?
A. Yes, that's correct.
Q. I think you've also reviewed in some detail how concerns about his ADHD were addressed?
A. Yes, that's correct.
Q. But we bear in mind that this is largely through your reviewing the records, rather than any involvement you had at the time?
A. Yes, that's correct.
Q. Thank you. Now, against that background, you explain -- just looking at the way that the services were organised, could we have on screen, please, page 3 of your statement, paragraph 11.

You make the point there that the autism spectrum disorder and ADHD -- attention deficit hyperactivity disorder -- services at Alder Hey have developed, your words, "significantly over time"; is that right?
A. Yes. That's correct.
Q. Now, certainly to the uninitiated, the picture is perhaps a little confusing --
A. Yes.

Q. -- and I want you to help everybody to understand how it was at the time and how it has changed.
A. Yes.
Q. So can we start with how things were in 2019, accepting that that was before you even came to Alder Hey.

But should we understand from your statement that at that time in 2019, when AR was first referred, the assessment and diagnosis of both autism and ADHD fell within the Community Paediatric Service?
A. Yes, that's correct.
Q. How would patients be referred into the Community Paediatric Service if their teachers or their parents had concerns about autism or ADHD?
A. So that would be a referral process. So either the GP or the school or a professional who is involved with the child or young person could make a referral and that was mainly on paper at the time that that would come in to the department and be logged as a referral through the Central Referrals Team at Alder Hey Community Division, and then would be added to a waiting list and then triaged and reviewed in turn by the community paediatrician who lived in that locality area. So for AR it would have been over in Southport.
Q. Yesterday, and I think you were able to follow some of the evidence yesterday, we were dealing with CAMHS and

we should understand that this is a completely separate team who, at that time, were dealing with it, yes?
A. Yes, completely separate from CAMHS, yes.
Q. You go on to explain that in March 2021 -- it's the same paragraph of your statement as we have on screen -- there was a Trust-wide programme to restructure the service and that resulted in the separation of the referral pathways for ADHD and ASD.

So looking at those aspects, did they remain within community paediatrics at that time or did they become self-contained, separate teams?
A. Yes, so the transformation programme did commence in 2020 but it was quite a large-scale transformation in terms of digital aspects as well, so what happened was new referral forms were created for both ASD, ADHD and community paediatrics, to split them out into separate services. So, at the time, in March 2021 that was when the process was complete, and they became three very separate services. So community paediatrics no longer had oversight for either ASD or ADHD.
Q. Thank you. So some initial changes with the forms, so there would have been a period, is this right, when the forms were separated out, so it was no longer a community paediatrics general form but it was still under the umbrella of the community paediatrics team but

then dealing with things so that the changes weren't happening overnight. By March 2021, they were now separate teams for mainstream, if I can use that phrase, community paediatrics, and then you would have the autism spectrum disorder team and the ADHD team or service?
A. That's correct.
Q. Thank you.

So that's the structural change. You go on to explain in paragraph 12 that the focus of both services, so autism and ADHD, was diagnostic assessment; is that right?
A. Yes. At that time, the autism diagnostic service was only commissioned for diagnosis only. ADHD --
Q. Let's stick for the moment with --
A. Sorry.
Q. Not at all, it's very helpful but if we can just take it in stages so we can get it clear. So if we stick with the autism service. As I have understood it from your statement, the referral would come in and there's quite a lot of work, as we will look at, I think, in AR's case, that would need to be done with different types of assessment that led, as we will come onto with AR, eventually to a multidisciplinary panel, I think, considering the referral; is that right in simplistic

terms?
A. Yes. So the referral was triaged, reviewed and then a plan would have been put in place to capture the assessment information that was required. In AR's case, that was speech and language therapy, assessment and a neurodevelopmental history assessment.
Q. We will come back to AR's case but from referral, assessment of the referral, there is some technical assessments, speech and language, and things of that kind that would need to be done, and assuming that at each stage of that pathway it was looking like there may be an issue to be considered, the end result of that would be a multidisciplinary team meeting --
A. Yes, that's correct.
Q. -- at which the diagnosis would be confirmed?
A. Yes, that's correct.
Q. When you say in your statement the primary focus was diagnostic assessment, is it right that for autism, a diagnosis having been made of autism, the team would have retained a responsibility for how the diagnosis was conveyed and explained to the patient?
A. Yes, that's correct.
Q. So, it's not a question of multidisciplinary team meets diagnosis on paper and that's the end of it; there's the important process of explaining the diagnosis. But,

thereafter, was it a question, the diagnosis having been made of then -- a slightly clichéd phrase -- but signposting the patient and their family to where support services for the autism spectrum disorder could be obtained?
A. Yes, that's correct. So the feedback appointment, we would explain all the different services available in that area, so that would have been Sefton, Southport, and then the parents can then have that opportunity to access those services if they wish to, yes.
Q. Thank you. Who would the providers of those services have been, just give us a real-world flavour for them?
A. At the time, it was mainly voluntary sector, voluntary independent sector, so ADDvanced Solutions Community Network was commissioned in Sefton to provide some support. There was also Parenting 2000. You've got the CAMHS service, as well, for sort of any mental health difficulties. There was also some voluntary mental health support in the Venus Centre. There was also Aiming High, which is like a mentorship support scheme, and then also there was a small team called the Sefton ASD/ADHD Nursing Service, where they were able to offer some minimal intervention.

So there was quite a lot of support that they could have accessed in terms of understanding. And then

obviously school services as well, there was a School Inclusion Team and Specialist Teacher Service that would support the education aspects of an autism diagnosis.
Q. Thank you. I appreciate that this question may sound naive and it's second nature to you, but it's helpful, I think, for you to explain it, why with an autism diagnosis does it not lead to ongoing clinical care by a team of doctors and nurses?
A. Yes, so autism spectrum disorder is obviously a difference in thinking and is classified in terms of a young person's thinking style, how they interact with others, sensory differences and, you know, rigidities around black and white thinking and every young person or child with autism is quite different from another. Some young people can be quite high functioning and get on well in a mainstream school and not need any support to thrive. Some young children may have significant language difficulties alongside, they may need involvement from speech therapy and things. So because every child is unique, we would look at a needs-led approach, instead of just a blanket "This is what we do for children who are autistic".

So if a young person did need additional services, they would have been referred to them at that time, if that makes sense, but that would have been around

different areas of health or different areas of need.

Generally, we have the Equality Act, we had the SEND Code of Practice, so they are standards and guidelines we would follow and they all really discuss how society as a whole needs to put in adjustments in place for young people with neurodiversity. So school for example, you know, breaks, sensory breaks, being able to leave the class. These are all very small, reasonable adjustments that we would expect to be put in place based on the needs of that young person, rather than just a blanket "We need to do this".

Also for autism, there isn't a treatment or -- you know, like a cure for it. There isn't anything we can prescribe to make things better. We just need to have a good understanding of how autism impacts on that specific young person, what their areas of need are and how we can support in terms of intervention, which is mainly in the form of parent training and parent support, which is set out in the NICE guidance as well.

So NICE guidance clearly states, you know, that parents need to have an understanding to adapt the environment at home and understand how it can be impacted. So I hope that answers the question. Sorry.
Q. Not at all, it's very helpful. So that helps from hearing it through you as an expert in this area to

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

A. Yes, that's correct.

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

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

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

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

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

A. Yes.

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

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

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

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

A. Yes, that's correct.

Q. In paragraph 63, you said that:

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

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

A. It used the Meditech system.

Q. How did the interplay work with CAMHS records?

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

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

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

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

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

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

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

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

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

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

Q. Thank you.

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

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

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

A. Yes, that's correct.

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

A. Yes, that's correct.

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

A. Yes, that's correct.

Q. Thank you. You say though that:

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

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

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

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

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

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

A. Yes, yes.

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

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

A. Yes, that's correct.

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

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

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

A. Yes, that's correct.

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

A. That was by his GP, Dr Arnold.

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

SIR ADRIAN FULFORD: Thank you.

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

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

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

A. Yes. That's correct.

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

we look at paragraph 17:

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

Who would have reviewed that to check the initial acceptance?

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

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

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

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

A. Yes.

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

A. Yes, that's correct.

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

assessment in around about the middle of November 2019?

A. Yes, that's correct.

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

A. Yes, that is correct.

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

A. Yes, that's correct.

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

A. Yes, that's correct.

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

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

A. Yes, that's correct.

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

A. Yes, that's correct.

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

A. Yes, that is correct.

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

A. Yes, that's correct.

Q. Thank you.

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

communication from The Acorns School, isn't it?

A. Yes, that's correct.

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

A. Yes, that's correct.

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

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

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

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

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

one and the risk posed to himself and the school community."

She had then asked him about the incident at the admissions meeting at the school and:

"... monotone, emotionless and very matter of fact about his intentions."

Yes?

A. Yes.

Q. That is flagging both a safeguarding concern, would you agree, but also factors that might be relevant to the autism diagnosis?

A. Yes, that's correct.

Q. If we just go over the page. It then sets out that there had been a referral then to CAMHS but they were turned down at that stage, and then more information about AR not socialising, not going out of the family home, no friends, not involved in gangs, and that's a reference to the group that he had been passed onto by CAMHS on the referral:

"We now have serious safeguarding concerns with regard to [AR]. He is fixating on another student in his class and is saying that he is bossing him around and bullying him. Staff are being vigilant but have seen no evidence of this. Dad has contacted school to raise his concerns that [AR] is being targeted 'like the

other boy in the other school'."

Then there is a reference to AR researching school shootings, his father having been informed of that but then father claiming it was untrue. She attached supporting documents and the form that was completed for Lancashire CAMHS but they had indicated that they were unable to accept AR because he was with a Sefton GP.

So, that letter, would you agree, on its face good practice, in the sense of it is exactly information that you would want the service to be receiving from the point of view of relevant information to an autism diagnosis that was in the course of being assessed?

A. Yes, that's correct.

Q. Then there was a followup email, I think, on 3 December. If we can just go back, please, to page 2, I think. Bottom of the page, please, thank you very much.

So again to "communitypaediatrics", 3 December:

"Further to my referral ... I need to advise you of further developments and concerns. Could you add this to the referral information ..."

Then school shootings in America is referred to again. Then incident on 29 November, punching his hand; started to work very reluctantly; and then goes into the information that we traversed yesterday about a business, setting up a business and what would be

said, would not be good to tell people about setting up a business "because people would think [he] would kill them" as they did not know him.

He said people -- if we go back to page 3:

"... don't trust others they don't know in case they get murdered; regularly out of his seat, walked to the highest part of the ceiling, jumped up and punched a laminate that was hanging from it ..."

Then 3 December, the most recent one, within art lesson, this is the colouring the Call of Duty images incident, saying:

"Why can have these with guns but can't look at guns on the internet ... 'Can we have a picture of a severed head then' ..."

She set out how that was responded to.

In fact, it looks, doesn't it, as though The Acorns School here was making a referral but, in fact, this was all good information to be aware of for the referral that in fact had already been received and was starting to go through the pipeline?

A. Yes, that's correct.

Q. Thank you. That can come down from the screen. You say in paragraph 19 of your statement, if we can have that on screen please, it's page 5, you've looked into this and, again, seeking to assist the Inquiry from work on

the records, are you able to tell us what, if any, response was given by the autism service to those letters?

A. Yes, unfortunately, I wasn't able to view a formal response. The emails went to a community paediatric inbox, which was governed at the time by the community paediatric team and I wasn't able to find a response unfortunately. However, I did review the records and there did seem to be services that had become involved at that time, following the concerns that Acorns School had, for example the CAMHS team and, obviously, Criminal Justice Liaison but this was me reviewing sort of after, if that makes sense.

Q. Yes. Can I suggest that -- and again not a criticism of you, but looking at what the records show -- that is a concern in two respects. The first respect, in a sense, you have already touched on, and that's the safeguarding aspect.

As it happens, as the Inquiry has been looking at, a number of other agencies were seeking to deal with the safeguarding and risk issues in relation to this and so that we know that, over time, Prevent was involved, the school was involved, the local authority was involved, CAMHS, FCAMHS.

A. Yes.

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

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

A. Yes.
Q. Does that seem to be, again appreciating that you're speaking -- you're in the unfortunate position for having to speak for others in the service at the time, but does that seem to you, on reflection, to be a marked shortcoming?
A. Yes. I would agree.
Q. Thank you. We know that CAMHS were involved at this stage, they're one of the bodies that I have spoken about in terms of others who were dealing with this and there was a strategy meeting, and then we know that Mr Morgan of CAMHS had a meeting with AR on 20 December.

We know that, in relation to that -- I'm not going to bring up all the records in relation to this -- but we know Skott Morgan updated social care as to his discussions with AR and noted that AR was currently on the ASC pathway. Have you seen any records from the community paediatrics side of things suggesting that CAMHS generally, or Mr Morgan in particular, contacted the autism service to say anything about AR?
A. No, I haven't.
Q. While Acorns School had put the autism service on notice of their concerns, would you have expected there to have been some communication between CAMHS and the autism service, given the extent to which CAMHS were involved,

going to meetings with Prevent, for example?
A. Yes, I would. Yes.
Q. We are going to be exploring with other witnesses the fact that, going into 2020, there were two meetings at which Forensic CAMHS were involved and assessments by Forensic CAMHS about risk, and comments upon the risk, but in particular indicating there was a limit to how much FCAMHS could say until there was a diagnosis.

Dealing with that stage, which is February and March 2020, is there any indication on the autism service records of a chaser or a request for a prioritisation coming in from other agencies, saying, effectively, "AR is on your pathway for diagnosis, but there's a lot going on, can you give him prioritisation, can you hurry up, can you tell us what the outcome is?"
A. No, I haven't been able to locate that information in the record.
Q. So if it is a fair summary of what was going on with other agencies, that there was discussion of the risk that AR may pose to others and concern about that, and that autism and his diagnosis of autism had not yet been made but was potentially significant to how this was all going to be handled, is it right that, from the investigations that you have done, those agencies didn't communicate that to the autism service at all?

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

AR wasn't present personally, from the history and information provided by Alphonse R, AR's father, to convince Dr Acharya that AR was suitable for further assessment along the autism pathway?
A. Yes, that's correct.
Q. You explain in paragraph 21, and you have touched upon it, that you're unable to understand fully why Dr Acharya did not discuss ADHD symptoms further on that occasion; is that right?
A. Yes.
Q. I'm concentrating at the moment on the autism timings but, given that concerns had been raised about autism and ADHD, would you agree that that, on the face of it, appears to be something of an omission: you would have expected ADHD to have been traversed at that meeting?
A. Yes, because it was the reason for referral, it was requesting both assessments, so I would expect that to have been explored in a bit more detail, yes.
Q. Thank you.

Sir, for your note, AHCH000096, I think the clinic letter arising out of that first assessment.

SIR ADRIAN FULFORD: Thank you very much.
MR MOSS: Then paragraphs 23 to 24, on page 6, you explain that, in the ongoing process, AR was then assessed by a speech and language therapist on 28 August 2020; is

that right?
A. Yes, that's correct.
Q. There is a report for that issued, I think, on 27 October; is that correct?
A. Yes, that's correct.
Q. Sir, AHCH000096 at pages 4 to 5 but we don't need to turn it up.

Then, paragraph 25 on page 7, again in the chronology you explain that on 17 November 2020, there was then a telephone appointment with AR's father and this was being conducted by telephone and it was with Kate Murphy, who was a neurodevelopmental practitioner and registered nurse, yes?
A. Yes, that's correct.
Q. So what would the purpose of that consultation have been?
A. So the purpose of the neurodevelopmental history assessment is it's part of NICE guidance for us to explore all of the history of a young person. So the conversation would have been around birth history, sort of pregnancy, all the way through the developmental milestones, how they were met, if there were any delays, then we would talk about school history, nursery history and then, obviously, focus on the social communication differences that may have been seen in terms of his play

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

multidisciplinary panel meeting that we touched on earlier in your evidence and I think, in AR's case, that took place on 30 December 2020 -- is that right --

A. Yes, that's correct.

Q. -- with Dr Sultan, a consultant paediatrician, Ruth Mitchell, a highly specialist speech and language therapist, and Dawn Divine a physician associate. They were the ones making up the panel; is that right?

A. That's correct.

MR MOSS: Sir, we don't need to turn it up but AHCH000100, pages 35 to 36, is the record of that meeting.

SIR ADRIAN FULFORD: That's very helpful.

MR MOSS: Now, in terms of the basic outcome of that, you explain at the end of paragraph 27 that the panel concluded that further assessment of potential ADHD symptoms was warranted but they found that AR met the diagnostic criteria for autism.

A. Yes, that's correct.

Q. I want to ask you about the information about risk and behaviours that was known by that time and whether it was taken into account. So there'd been a strategy meeting in December 2019; there'd also been the involvement of FCAMHS in the first three months of 2020; there'd been information about AR carrying knives ten times to school, that's October 2019, telling

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

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

A. Yes, it would have.

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

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

So I assume that the panel would have been able to

review all of that and use the information to help with the conclusion because it was quite evident that there was highly expressed interests that were evident within that report.

Q. So just unpicking that a little bit. Should we understand that, so far as the autism service side of Meditech is concerned, there wasn't a distillation of all of that risk information on the autism service Meditech records?

A. Sorry, say that again. Sorry.

Q. I'm so sorry. It was a bad question. I'm picturing at the moment, in terms of the electronic systems, that both the autism service and CAMHS are using the same electronic patient records but they are keeping their own records, yes?

A. Yes, that's correct.

Q. As we were exploring yesterday, a lot of risk information was in fact recorded in different places in different ways in the CAMHS electronic records?

A. Yes, that is correct.

Q. From your review of the autism service records, had anybody extracted that information from the CAMHS side of the records and distilled it into the autism service records?

A. Not in that way, no. No.

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

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

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

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

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

A. Yes, that's correct.

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

SIR ADRIAN FULFORD: So this was from Acorns?

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

have looked at the school information because they've mentioned details there about what school have said, so, yes.

And I think as well, just above, they do mention what they've read in this meeting as well and school information is highlighted there.

SIR ADRIAN FULFORD: Thank you.

MR MOSS: Just go over the page because I know it continues on page 36, please.

A. Yes.

Q. Does that look like to you that they were relying on the school report --

A. Yes.

Q. -- rather than any detailed information that they had distilled out of CAMHS?

A. Yes, usually if they have reviewed any CAMHS notes or reports, they would list that in the section that says "Reports viewed", which is on the previous page.

Q. If we can go to page 35.

A. It doesn't appear -- "Assessments comprised of", it doesn't appear that they've reviewed CAMHS' notes, no.

Q. But the educational psychology report, school information report, yes?

A. Yes, yes.

Q. So, although, fortunately, the school information helped

to provide some details in relation to this, would you agree that a shortcoming, in relation to the information that was being provided, was there was a lot of relevant information on the CAMHS system that doesn't seem to have been distilled for the multidisciplinary panel?

A. Yes, that's correct.

Q. Thank you. That can come down from the screen. We will come on in just a moment to look at what happens hereafter but in high level it's right, isn't it, that, having conveyed the diagnosis to AR's family, the referral was then closed to the autism service, no doubt because it was diagnostic, as we explored earlier on. Would that be fair, in high level summary?

A. Yes, that's correct.

Q. If the service had been aware of all of that information about risk, would the case have remained open to the autism service, do you think?

A. No, it would not.

Q. Why's that?

A. Because the service was solely commissioned for diagnostic support. So our role would have been to ensure that services were in place to carry on that support and manage that risk but it wouldn't have been the responsibility of the actual assessment team.

Q. I'm asked to explore with you quite a bit of further

information about aspects of AR's behaviour and his family dynamics. I'm going to take this relatively shortly but there is information in respect of AR and how he was dealing with other agencies that suggest that he was minimising his own actions, so the seriousness of his assaults; that he was at times evasive, unwilling to take responsibility; that he'd shown signs of dishonesty; that he was argumentative; that he was driven by a perception of grievance; that he lacked reflection; that he lacked remorse; he lacked empathy in relation to mental health clinicians; that he, if not manipulating, was trying to lead the conversations to get particular medication. Would all of that have been relevant to the multidisciplinary panel?

A. I think it just really explains why he met the criteria for autism diagnosis really because a lot of what you are describing, you know, he did have highly fixated interests, he would often research and research into things, which at times was obviously medication and things, so that was part of his condition. I think we also noticed that, in the education psychology report, they highlighted that there were concerns around his emotional understanding and expression of emotion. So he actually really struggled to understand what empathy is and how other people feel in different situations,

and I think the speech and language therapist as well noticed that he often misinterpreted facial expressions, he didn't understand what people meant, he often perceived tone of voice incorrectly.

So I think everything you describe there is part of a neurodivergent profile that he obviously had significant difficulties in relation to his autism diagnosis.

Q. So consistent with that which was already known and being assessed; would that be fair?

A. Yes, that is correct.

Q. But presumably, in the ideal world, that information about how AR was engaging would also have been made available to the panel. It would have been helpful additional information?

A. Yes, it would.

Q. But should we take it from your evidence that the effect of that, so far as autism is concerned, is that it would simply have reinforced the picture that the panel already had?

A. Yes, that's correct.

Q. We don't see -- again, I'm not going to go to lots of records to prove a negative, but I think you would agree that we don't see from the multidisciplinary panel or the autism service records from around that time, any

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

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

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

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

available after, if he wished to engage with that, and his parents as well, you know, what they can access in terms of signposting.

Q. Now, you've explained in the course of that answer, and set out in your statement, that an intention here would be to be neuroaffirmative --

A. Yes, that's correct.

Q. -- and, not least because of a degree of non-acceptance by AR conveyed by his father, you would have no doubt aimed for this to be a supportive session -- yes --

A. Yes, we would have.

Q. -- which would have been seeking to start the process of AR understanding the diagnosis?

A. Yeah, we really would have spent time trying to help him understand and gain some insight into the difficulties that he might have been experiencing and not really understanding what that was. So we were able to give it a name for him and explain that the challenges were because of his autism and go through that with him, and help him to sort of understand a little bit more about himself.

Q. In my layperson's terms, emphasising that the diagnosis meant simply that he would process and look at some things differently, compared to his neurotypical peers --

A. Yes, that's correct.

Q. -- but that doesn't equate to less valuable or wrong, matters of that kind, it just means that there are some differences which may need to be addressed in various different ways?

A. Yes, that's correct.

Q. Now, realistically, against that background, in fairness to you, this would not have been the time to bring into play concerns about what he might have been looking at online, in terms of what you refer to as "spending considerable time on intense interests", in paragraph 34, because this was one where, in layperson's terms, you wanted to get him on board and keep him on board?

A. Yes, that's correct.

Q. But were you, at this stage, personally aware of that risk information that I have summarised?

A. Yes, I was aware that there were some incidents where he'd harmed other people and I think we -- I think that was why we went around it so sensitively in terms of how we delivered the news. I think father's concerns were mainly around, you know, his emotional wellbeing but, obviously, there was that risk which had been evident in the school reports that we had received, and so we needed to be careful and ensure that he was, you know --

and in as best way as we could, try to support him to understand that, without causing a negative reaction.

Q. While understanding that this would not have been the time to do anything that might have been perceived by AR or indeed his father as confrontational or challenging his behaviours and that risk information of concern, did you yourself do anything outside of the meeting, perhaps with other agencies, to check that that was being taken forward?

A. Yes, so following on from the conversation with father, he was very keen for CAMHS involvement to remain, to be able to address some of the difficulties that they were experiencing, and I think father at the time felt -- he thought that the case had been closed to CAMHS. So I agreed that I would look into that for him and I asked him to email me with some more details about what he was struggling with at home, I think to give him an opportunity to be more open and honest about what was happening, without obviously AR being present.

And he did email me and, following that, I then had a conversation with the CAMHS manager, as I'd reviewed the case and could see that on the actual system the case was still open to CAMHS and it hadn't actually been discharged. So I asked for a review appointment to be arranged, so that support could be embedded and in place

and, obviously, at that time, there was some other services, I think, that were involved as well, in the background. So, yes, I mean, in my view, I suppose, I did handover that responsibility to the CAMHS service to pick that up.

Q. That was in terms of Alphonse R, I think, wanting himself to ensure that there was further CAMHS involvement, and you have indicated how you passed that on. But more specifically, did you include within that a concern about, "Now we have a diagnosis of autism confirmed for this particular pupil, given the risk information that we're aware of, this does rather cement concerns around risk, so we do need to be careful about internet use and matters of that kind"; were you emphasising those aspects?

A. I can't remember if I did say that specifically. Unfortunately -- yeah, I'm sorry, I'm not sure about that.

Q. Again, do you think that might have been an appropriate thing to do?

A. Yes, it would have.

Q. You've touched on the request from Alphonse R and I think he requested, in addition, that there be an ADHD assessment; is that right?

A. Yes, that's correct.

Q. In terms of the way in which this was now being taken forward by the autism service, I think there would have been a final report that you touch on in your statement; is that right?
A. Yes, that's correct.
Q. You agreed, I think, that the final report should be amended to reflect the request for an ADHD assessment --
A. Yes, that's correct.
Q. -- and a recommendation within that that AR's school should refer AR to the ADHD team for assessment?
A. Yes, that's correct.
Q. The matter that you touched on a moment ago, you deal with in paragraph 41 of your statement, that's the request by him for CAMHS' involvement, further CAMHS involvement, including ADHD, being necessary. It's paragraph 41 on page 10.

You also go on to explain in paragraph 41 that you explained the referral process for ADHD. Now, I think by this stage the requirements had slightly changed. Can you just explain to us what the change was?
A. Yes, so ADHD service, at the time they expected the school to complete the referral, in partnership with parents. The reason for that is that NICE guidance, in terms of assessment for ADHD, means that there needs to be clear evidence of difficulties in two domains, so

what that means is two settings, usually school and home, for young people. So when a referral is completed in partnership with school and parents, then the assessment can go forward, you know, quite quickly because that information is available, and I explained that to Alphonse.
Q. So, putting it bluntly, it wasn't going to be enough for Alphonse, as AR's father, just to say, "I have concerns about ADHD", and raise it with CAMHS and ask for a referral: there was going to have to be a referral coming in for two sources to get through the gateway?
A. Yes, that's correct.
Q. You think you explained that?
A. Yes.
Q. Paragraph 43, over the page, please. The final outcome report, initially, I think, was dated 12 February.

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

But I think you reviewed it and you spotted it, that that aspect, in relation to the school being asked to complete ADHD, hadn't in fact been added; is that right?
A. Yes, that's correct.
Q. So it was amended, as you've explained. The final one, we will see, was dated 16 February 2021.

Sir, for your note LCC000097.

The final report, including that recommendation that the school be invited to consider a referral; is that right?
A. Yes, that's correct.
Q. You explain that, upon reviewing the records -- and I think, in context, that's you reviewing the records -- sorry.

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

Paragraph 43, "Upon reviewing the records", and I think, in context, that's you reviewing the records for the purposes of this Inquiry, not at the time?
A. Yes.
Q. "... I note that this report does not appear to have been copied to the school as I requested. As a result, I am unable to comment on whether the school received the request to initiate the ADHD referral ..."
A. Yes, that's correct.
Q. Does that appear to be an error at the autism service end, that that wasn't done, as you'd intended?
A. Yes, unfortunately at the time, our letter system was quite different. So the clinicians would email letters to administrators to then upload onto the system. So, obviously, you are relying on information to be passed over, et cetera, whereas that's now been corrected and

that, obviously, is not how we work now but, at the time, that was the method that was used to send the report to an administrator to then upload and do the copies.
Q. Although one understands why you give us the detail about the systems then and the systems now, it's not unimportant because the system had changed, requiring two points of referral. You, as the clinician, were supportive of this and the letter was intended to be the request or the nudge to the school to make their side of the referral. So it's not an insignificant failure, is it, if the letter didn't ever go to the school, would you agree?
A. Yes, that's correct.
Q. Thank you. In terms of the overall time taken to diagnose AR with autism, we have looked at the early period and you have accepted that there seems to be a shortcoming there. The total period we calculate to be 77 weeks, I think --
A. Yes.
Q. -- from referral to diagnosis. How does that compare to national averages or national standards for the time?
A. I think at the time it was in comparison, there are significant challenges in terms of diagnostic services across the whole of the nation and waiting times are

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

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

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

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

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

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

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

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

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

A. Yes, that's correct.

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

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

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

A. Yes, that's correct.

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

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

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

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

Q. Support parents to be their own advocates --

A. Yes.
Q. -- you will forgive me -- I'm sure it's right that it is done in a supportive way and an informative way to tell parents of the sources of support -- but is the blunt reality of support parents to be their own advocates, that you give them the information in a supportive way and say, "Here's the menu", but the autism service at the time stepped away, having done that?
A. Yes, yes, because we are only part of the diagnostic process. We wouldn't have capacity, unfortunately, to follow up in that way.
Q. So if parents were thereafter struggling to get that support or -- and I'm not here referring to anything specific in relation to AR's parents -- but were ineffective in as parents in getting the support, is there any autism service in the local healthcare area who are there to help them, post-diagnosis at the time?
A. There is. But, again, it's not statutory. So it would be parents seeking that out.
Q. From whom? Who would they turn to?
A. So there was the small service that I mentioned earlier, the Sefton Nursing ASD and ADHD team. There is a small service that can offer some treatment -- not treatment, some intervention. So that would be some parent training and some individual work with the young person,

if that was required, but that would again still need to be sought out by parents.
Q. In a case such as AR's, where there was all this risk information of concern, is that process sufficient?
A. Sorry, can you clarify?
Q. Is signposting parents on to support for autism and then letting the parents advocate for themselves about that, is that sufficient, do you think, in a case in which there's lots of information of concern about risk to others?
A. I think in his case, though, he was open to the CAMHS services. So, from our perspective, as an autism diagnostic service, he was already open to a service that has a responsibility for managing risk. So, you know, the information was on the system and had been shared with parents, CAMHS were able to access the information and I think it is quite clear, you know, when I reviewed the records, that CAMHS did talk about the same signposting that we'd given, you know, throughout that journey. So they did have another agency involved at that time.
Q. All right. So, because of the resource, what the autism service was resourced and not resourced to do at the time, the baton then gets handed back to CAMHS, does it, to ensure that interventions that are now taking place

against the background of the autism diagnosis are sufficient to deal with the risk to others?
A. I think that would depend on a lot of factors. So, obviously, with AR's case, there was concerns around anxiety, isolation, socialisation. So mental health was considered, you know, as a possibility that he was struggling with mental health as a comorbid factor. So CAMHS, obviously, is important in that sense but, if it was another scenario, for example, where there might be domestic violence or something, or another -- or maybe mental health wasn't a factor, then we would refer onto social care or Early Help, for example.
Q. I understand but I'm focusing on the cases, including AR's, where the concern is not that the child may come to harm and is not, as such, that the child may have a mental health condition, such as an anxiety disorder, but that the behaviour of the child, now worsened because of a confirmed autism diagnosis, is a risk to the lives of other people.

You will understand it's not a criticism of you individually but I come back to the fact that the autism service wasn't resourced or expected to give ongoing support in that case. Notwithstanding the concerns about risk to others, the baton was passed back to another agency --

A. Yes.
Q. -- here, so far as you were concerned, CAMHS?
A. Yes, that's correct.
Q. Thank you.

You deal in your statement with the subsequent decision to discharge AR, presumably, for the reasons we have just been covering, from the autism service?
A. Yes.
Q. There is a particular point that I want to pick up with you about discharge because you have explained the reasoning and the resourcing of the autism service and what it was expected to do, but we do have on the records that indication from Forensic CAMHS, from back in March 2020, of an offer for them to become further involved if there was a significant change, and an indication that their ability input into the risk was limited by the fact that there'd not yet been a diagnosis.

So, against that background, prior to AR being discharged from the autism service, wouldn't it have been appropriate for the autism service to refer AR back to FCAMHS?
A. Yes, so unfortunately, as far as I can see, we didn't receive any communication with FCAMHS prior, so as discussed earlier, they didn't ask us to expedite or

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

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

A. Yes.

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

A. Yes. Yes.

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

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

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

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

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

Q. Thank you.

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

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

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

Is that quite accurate?

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

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

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

wanted to present matters?

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

Q. So that was a personal reflection by you?

A. Yes.

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

A. Yes.

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

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

A. Yes, that's correct.

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

background of the fact that the multidisciplinary panel had indicated that further assessment for ADHD would be warranted?

A. Yes.

Q. Is that a fair summary?

A. Yes.

Q. Could we look at paragraph 44 of your statement, please. It's on page 11. You deal, coming back then to matters after February, as to how things went forward, so we have looked at the autism diagnosis. A couple of months after that, you say that, upon reviewing the clinical records you can confirm that Sam Steed met with AR and his father during the CAMHS appointment, 9 April 2021, and that AR's father explained that he had requested a referral to the ADHD service for assessment and that AR was currently on the waiting list. You say:

"I am unable to comment on whether Ms Steed checked the records at that time to confirm if an ADHD referral was active on the system."

But you say it's possible that, given the referral process has changed, that "Ms Steed noted the active community paediatrics referral", and concluded that the community paediatricians were in the process of considering an ADHD diagnostic assessment.

You make clear helpfully that that's a supposition

on your part?

A. Yes.

Q. Can we just make sure that I've understood that correctly: are you saying that there is a risk there that Ms Steed may have been able to see that the community paediatrics part of the referral was there and may not have been aware that now it would need the school ones too. So, in simplistic terms, she may have been lulled into thinking this was all was on train?

A. Yes, that was my recollection when I read it. It was a little bit confusing at that time, during that transition period. So she may have seen that referral open on the system and thought that it was in hand and that she didn't need to take any further action.

Q. You go on in paragraph 49 of your statement to deal with the fact that, in the context of a meeting with Dr Sultan in July 2021, there is no indication that the family raised ADHD at that stage; is that right?

A. Yes, within the records and the notes for that appointment, I didn't see any discussion around ADHD from AR or his father. It wasn't documented.

Q. Understanding that that's the case and we think that you're right that it's not documented that that was specifically raised, but it is entirely possible, indeed perhaps likely, isn't it, that Alphonse R, at that

stage, would have just thought that AR was on the waiting list?

A. Yes, that's correct.

Q. Would it be fair that you can't read too much into it not being specifically raised on that occasion, in particular given the April conversation with Ms Steed, where he may have got the impression that he was on the waiting list?

A. Yes, that's correct.

Q. Could we look, please, at the bottom half of paragraph 49. You say that the ASD and the ADHD diagnostic services have been restructured to operate independently from the community paediatrics service at this time. You've helped us with that but you then say:

"... in my opinion, further justifying the case closure to the community paediatrics department at that time."

I'm not quite sure that I followed the logic of that. Given that the ADHD assessment was outstanding.

A. So, I think what I meant by that is the community paediatrics department then had a very clear remit around what they would deliver, which was regarding neurodisability, so physical health issues, medical issues, children with complex health needs, for example down syndrome, neurofibromatosis, so their criteria in

July 2021 was specific around health.

So AR, if it had been now -- and, obviously, I know it isn't -- but he probably wouldn't meet criteria for that service at all. So I think -- I mean, this again is just supposition, that maybe the paediatrician had looked and realised that there were no health issues, so they closed the case. But, unfortunately, obviously, the missing piece was the ADHD assessment because that referral was obviously not open to ADHD at that time.

Q. You go on to deal in paragraph 50, that it is not the case that Alphonse R had somehow accepted that ADHD was no longer relevant because, as you correctly and fairly point out in paragraph 50, he raised the ADHD issue again with Dr Elaine Weir, who was involved, on the dietician side, at this stage, as a general paediatrician?

A. Yes, that's correct.

Q. As a result of that, Dr Weir requested that either the GP or CAMHS investigate the concerns over ADHD and initiate an ADHD assessment, yes?

A. Yes, that is correct.

Q. So that letter is AHCH000096 at pages 27 to 28 and that was copied to the GP and Dr Molyneux as the psychiatrist at that time; what happened to that?

A. I think, as I have added really, I wasn't able to

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

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

A. Yes, that's correct.

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

A. Yes, that's correct.

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

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

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

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

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

A. Yes.

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

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

adding additional information that may have been helpful, so she may just not have seen that there was any risk presented but again that is a supposition.

Q. I understand the degree of reluctance to criticise and perhaps unfairly criticise Ms Hampson but does it really come to this, that you, with all of your expertise, looking at this and knowing what's in the notes, can now see that there was earlier information that would go to ADHD and a suspicion of ADHD, that doesn't seem to have been averted to in the rejection?

A. Yes. That's correct. Yes.

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

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

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

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

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

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

A. Yes.

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

A. Yes, that's correct.

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

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

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

I think you were there saying that, although you can't say definitively, you are flagging up to the Inquiry, are you not, that there may have been some contraindications to medication in AR's individual case?

A. Yes, I think I was asked to describe what would happen if he had have received an ADHD diagnosis. So I just wanted to make the Inquiry aware that it would have been quite complex to be able to prescribe for AR, due to physical health limitations, involvement with dietetic services, et cetera. There would have had to have been comprehensive reviews to look at it, really, and obviously unsure whether he would have met criteria or not but I just wanted to give some information in regard to that.

Q. Thank you.

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

A. Yes, that's correct.

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

A. Yes, that is correct.

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

A. Yes, that's correct.

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

A. Yes, that's correct.

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

A. Yes, that is correct.

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

A. Yes, that is correct.

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

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

A. Yes, that's correct.

Q. Thank you.

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

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

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

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

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

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

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

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

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

A. Yes, it would. Yes.

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

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

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

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

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

A. Yes, of course.

Q. -- if you would. Thank you.

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

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

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

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

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

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

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

A. Yes, I feel, yes.

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

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

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

A. Yes.

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

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

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

Does that reflect that that's a change that still

needs to come: more of the adaptive form of CBT and ACT?
A. Yes, I mean, I'm just -- just talking, I suppose, as a general term, you know, CAMHS services are not universally designed for neurodiversity and, although there are very skilled clinicians in Sefton CAMHS service and Liverpool CAMHS service, not all clinicians would have had a very, very high level of training in neurodiversity, which I feel is important.

So there is work going on in our Cheshire and Mersey partnership to develop a neurodiversity CAMHS pathway so we can make recommendations around what therapies, what support, what training needs to be embedded across all of CAMHS, so that any young person who accesses a CAMHS service is going to get the same level of support, and that work is currently ongoing as part of the Cheshire and Mersey neurodiversity recovery programme.
Q. Arising out of the issues that we have explored with previous witnesses, three further reflections should be added, yes? There was a delay in the first assessment for AR for autism?
A. Yes, that's correct.
Q. There was a failure to fast-track his autism assessment --
A. Yes.
Q. -- against the background of risk to others?

A. Yes, that is correct.
Q. And there was a failure arising from poor record keeping to refer his case back into FCAMHS, which the autism service would have done, if it had known of FCAMHS' original recommendation?
A. Yes, it would have done.
MR MOSS: Just looking to my left.

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

Questioned by MR BOWEN

MR BOWEN: Thank you, sir.

I ask questions on behalf of the bereaved families. Just before I start, sir, could I just say that I have had specific permission in relation to question 14 of the Rule 10. I'm aware that quite a lot of it has been covered, so if I'm in danger of duplication, please -- I know you won't -- do not hesitate to stop me and I've set my timer.
SIR ADRIAN FULFORD: I won't hesitate, Mr Bowen.
MR BOWEN: I gather that.

The point that I'm looking at specifically is that, had the assessment taken place closer to what I call the hockey stick incident that you are aware of, aren't you, on 11 December, would that have altered both the timing, which I think we've covered -- it would and should have

been earlier -- but would it also have altered the appreciation of his risk to others, and that's what I think I want to just question you about a little bit.

You gave evidence -- for your note, sir, it was about 10.26 on the realtime transcript -- that, in a normal assessment, you wouldn't expect specific questions on risk to be asked, correct?
A. In a routine assessment, yes.
Q. But given -- and again, just assuming for the purpose of my question that there was enough information available following the various meetings, the strategy meeting on 17 December, where I don't think there was a member of the ASD team available, but there were enough inter-agency people there for the messages to get through, but at that meeting and then the meetings with FCAMHS later on in January, that had there been a true appreciation that on 7 October, the Childline incident, where we say was the active homicidal -- the murderous intent was clear, that that rather got lost in the wash; were you aware of that?

If that hadn't got lost in the wash and the hockey stick was looked on as the second major incident -- so you've got intent to kill followed by going equipped to kill -- so, when the professionals were thinking about a proper forensic examination at that stage in January

and not delay, can you conceive of any decision other than to expedite and fast-track, even given there was no fast-track official system in place?
A. Yes, I mean, I do agree that there shouldn't have been a delay. The risk was obviously very present at that time and the assessment should have been done then and there and I think maybe, if it had have happened, the practitioners involved talk openly about how they felt he was autistic and that is in the records, and so I think there were a lot of practitioners around that time that must have been very aware of the symptoms being quite significant. So if a diagnosis had been made then, at the time, then I assume that FCAMHS would have done the assessment that they refer to, if that makes sense, in the letters. They may have carried on and done that as part of that robust support package.
Q. Yes, so the assessment that they were prepared then to wait for, knowing that it could take up to a year, was really, in truth, given what they all suspected, more of a confirmation of what they thought was his presentation, rather than a genuine question of did he have it; is that fair?
A. I mean, that's how it seems from the records, is that people in their meetings very openly was talking about him as if he may already have been diagnosed because his

symptoms were so significant. So, yeah, I think the confirmation of diagnosis was just that: a confirmation of what people already thought at the time.

Q. Right. So, had it happened then much more quickly and had there been a true appreciation of risk, is it fair that the assessment itself would have maybe taken a month?

A. Yes.

Q. Probably no more than that?

A. Yes, that's correct.

Q. So by possibly the end of January, certainly into February, we would have had confirmation that he had ASD?

A. Yes.

Q. He is then in the system, they are talking to each other, there is a proper understanding of the risk. Would it then have followed that they probably would have got hold of the ADHD aspect as well, at that time?

A. I mean, it's hard to say but I would assume, I would assume -- yeah, I would assume so.

Q. Okay. Towards the end of Mr Moss' questions, he covered the possible use of lisdexamfetamine, Elvanse or something like that, assuming there wasn't a problem with diet and weight, can you just confirm that's a sort of -- I think it's called a dopamine-releasing agent --

A. Yes.

Q. -- and the four main things it does is reduces impulsivity, improves emotional regulation, less mental noise and distraction and better concentration and follow through?

A. Yes.

Q. So all the things that could have really impacted upon his behaviour and the way that he lived his life?

A. Yes, potentially, if he'd have met diagnostic criteria for ADHD, but we still don't know if he would have, but, yes, that is what the medication is designed for in young people who do have a diagnosis of ADHD.

Q. All right. The combination of high intelligence, lack of empathy, fascination with violence, a potential conduct disorder and ADHD all add up to a really toxic mix?

A. Yes, it is concerning, yes.

Q. It may be that you can't help with this last question: you were asked about the effect of delay on autism, do you know much about the effect of delay on any potential conduct disorder that he may or may not have had?

A. What I do know about conduct disorder is the recommendations for intervention are quite similar to, I think, what was offered anyway. So it relates to parent interventions, systemic family therapy support.

I think there is some consideration of medication when it's quite severe, but it's not my area of expertise so that's just sort of -- yeah.

Q. But would you agree that early intervention into that particular problem is essential?

A. Yes, I would. Yes.

MR BOWEN: Thank you.

SIR ADRIAN FULFORD: Thank you very much, Mr Bowen.

Questioned by THE CHAIR

SIR ADRIAN FULFORD: Just one area from me and then you are finished.

A. Thank you.

SIR ADRIAN FULFORD: You have given evidence, to an extent, about records and how things weren't always in the right place or weren't easily to be found, so the great example, in one sense, has been the FCAMHS letter, which was not on the autism service record. So on that, just focusing on that, what has happened since that has ensured that that won't happen again?

A. Okay. So following, obviously, the incident and the CQC inspection when they visited us, we have made significant improvements regarding the record keeping. So scanning, as it was, has completely gone. What would happen is that the information would be uploaded directly. So it is sort of hard to explain without you

seeing it but the session notes that we would go into one by one with the date, any external report that is received would now be there listed. So, for example, it would say "FCAMHS report" quite clearly and it would say "School information, ASD" quite clearly. So any external reports that are received are now directly visible on the record, you don't have to go through any additional apps and things like that.

The risk assessment information, as it was at the time, you had to go through one by one and find the risk document. Now, that has all been collated into one document on the very front screen. So we have a risk assessment for CAMHS, which, when that is updated, the historic info is kept on there, which I think is really good, but then you are able to update it with your new information, so you can clearly see this happened then, this happened then, this happened then, and it's all in one document.

We also have a neurodevelopmental risk assessment because I think obviously what was mentioned there, you know, we should be assessing risk in the ASD service. There are some cases where we are made aware of significant risks and we haven't really had anywhere to put that information or to make sure that that is shared appropriately. So now we have another document which

sits alongside the CAMHS one, which is clearly visible for anyone who goes on Alder Hey record. So they are the two main areas, and I think I mentioned earlier the referral form as well is a lot more comprehensive. So if another agency wanted to flag an urgent case for autism or ADHD assessment, they can, and they've got that place to write and that information so that can be shared.

SIR ADRIAN FULFORD: Are these systems user friendly?

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

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

A. Yes.

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

A. Yes.

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

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

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

SIR ADRIAN FULFORD: So very considerable changes, which in

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

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

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

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

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

can't do it with every person who has passed through the system -- but whether there's a sufficient investigation taking, as it were, some past examples to make sure that this is working as an end-to-end process.

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

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

A. Of course, yes.

SIR ADRIAN FULFORD: Thank you very much indeed.

So, 1.50 pm?

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

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

1.40 pm.

(12.49 pm)

(The short adjournment)

(1.40 pm)

JOHN HICKLIN (sworn)

Questioned by MS WAKEMAN

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

Yes, Ms Wakeman.

MS WAKEMAN: Would you start by stating your full name please.

A. My name's John Keith Andrew Hicklin.

Q. If we could have your witness statement on screen, it is GMMH000014. Is this your witness statement?

A. It is.

Q. Are the contents of that statement true to the best of your knowledge and belief?

A. They are.

Q. Just start with some questions about your background and experience, we can take the statement down thank you.

So as I understand it, you qualified as a mental health nurse in 1988?

A. That's correct.

Q. You have been working in adolescent forensic community service from 2000 --

A. Yes.

Q. -- and FCAMHS, Forensic Children and Adolescent Mental Health Service, that we have been referring to, started operating in 2017; is that correct?

A. I believe that to be correct, yes.

Q. At the time of your contact in relation to AR's case, in 2019 and 2020, you were working as a clinical nurse specialist within FCAMHS --

A. That's correct, yes.

Q. As I understand it, you have retired in May 2022. I think you returned to work for a few days a week for a short period but pretty much then you've been retired --

A. That's right.

Q. -- and you're retired now?

A. I am, yes.

Q. Thank you. So just to start by understanding the role of FCAMHS. Is it right that FCAMHS is commissioned by the Greater Manchester Mental Health Trust to operate its services in the North West?

A. Yes, I believe that to be correct. Yes.

Q. Putting it very simply, does FCAMHS have three key roles: firstly, consultation and advice?

A. Yes, that would be one role, yes.

Q. If you just keep your voice up, so it is picked up by the microphone.

Secondly, assessment?

A. Yes, I would think that's --

Q. We will come onto the detail of what it means later.

Thirdly, in some limited cases, it's some

intervention, as I understand it?

A. That's correct, yes.

Q. If we could bring on screen GMMH000015. This should be the corporate statement from FCAMHS provided by Dr Imran and Ms Brown. If we could have a look at page 3, please, and paragraph 2 there in the middle. So we said the first role was advice and they have explained here that the FCAMHS practitioner will:

"... engage with professionals closely involved with the young person to gather pertinent information."

It's utilised to form a structured narrative of the young person's difficulties, integrating information from various sources to elucidate the reasons for presentation development and maintenance and subsequently provide guidance and recommendations to professionals working with the young person to address areas of unmet need and mitigate high-risk behaviours.

Is that a summary of the advisory and consultation role?

A. Yes, definitely.

Q. If we could zoom out again and look at the next paragraph down which is "Assessment". Here they explain that:

"In complex high-risk cases, where it has not been possible to develop a formulation from consultation and

a specialist opinion is required, an FCAMHS practitioner will undertake a direct assessment. This involves interviewing the young person, their parents or carer and, if necessary ... specialist assessment tools."

Then an assessment report is developed which "provides recommendations to the professional network". Does that paragraph fairly summarise the assessment role?

A. Yes, it does. Yes.

Q. So you'd only be carrying out this assessment in high-risk cases where there is a need for a specialist opinion; is that fair?

A. Sorry, can you just say that again?

Q. So the assessment would only typically be done in complex, high-risk cases, where you need a specialist opinion; is that right?

A. I think where it hasn't been possible to gain a full understanding of risk and risk management strategies at a consultative level, then consideration of assessment then would take place.

Q. Within the FCAMHS statements, there is some reference to a forensic assessment; is that referring to this type of assessment?

A. I would say that arguably all -- both the consultation and this kind of assessment could be classed as -- well,

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

Q. Thank you.

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

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

Does that answer your question? Is that --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. That's fair, yes.

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

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

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

A. Yes, very familiar.

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

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

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

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

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

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

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

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

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

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

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

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

Is that right?

A. That's correct, yes.

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

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

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

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

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

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

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

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

A. Yes.

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

A. Yes.

Q. -- to the duty clinician at FCAMHS?

A. Yes.

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

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

A. Yes.

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

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

Which I understand to be Youth Justice Service?

A. I would think so, yes.

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

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

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

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

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

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

At the bottom:

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

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

A. Yes.

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

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

A. Yes.

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

Were you aware of that?

A. Was I aware of that?

Q. At the time?

A. I would have been, yes, yes.

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

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

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

A. Yes.
Q. "AR reports it doesn't bother him that he assaulted the boy as he didn't get hurt that bad."
If we could zoom out again. I'm not going to go through the letter but, if you can take it from me that it also mentions that Prevent were involved; is that right?
A. Yes, I think, from memory -- I'd have to look at the letter but I think from memory, I think by the time of the first consultation meeting they were no longer involved.
Q. Do you also recall it flagging that there were some serious concerns about his use of the internet and the material that he was accessing?
A. Yes.
Q. There are more features than that in the letter but those are some key features. Looking at those factors together, do you agree that there is a concoction there of really very concerning factors?
A. Absolutely, yes.
Q. Could we have a look at page 8, please, and the very bottom line. So there's a list of bullet points which are said to be the further risk management plan. One of the bullet points is:
"Discuss with band 7 Annie Kelly if a SAVRY

assessment is appropriate."
Are you able to assess us with who that is or what organisation she worked for?
A. Forgive me, but we are looking at the referral form from Stephanie Hallaron to our service?
Q. Yes.
A. I presume that Annie Kelly works for her service or with her service alongside. I don't know who Annie Kelly is.
Q. Do you remember what your understanding was when you received the referral as to whether somebody else was going to be carrying out a SAVRY assessment?
A. I can't say that I remember that, no. I have some further comments about the SAVRY assessment from my first letter, I think but that was following the professional consultation. So that was a little bit further along than this document that we are currently looking at.
Q. If we could just go over the page, please. The anticipated outcome is a possible assessment and risk-management plan. I understand this to be Stephanie Hallaron saying that was what she was anticipating being a potential outcome; is that right?
A. Yes, that sounds like what she was asking for, yes.
Q. What's your understanding of a risk-management plan? What is that and who would be doing it?

A. Well, that sounds like those two things are connected in what Stephanie was expecting from our service at that time.
Q. I understand. So would you understand that to be an expectation from her that you would be potentially carrying out a forensic assessment and also doing a risk management plan?
A. I think that -- I mean, I honestly can't remember what was going on in my head at the time of kind of accepting this referral and you know kind of setting up the meetings but I certainly would have been clear in our professional consultation meeting what the scope of that meeting was. As I think can be seen from the letters that I wrote, that included what I would say would be the elements of a risk management plan, as such, that was agreed with the professionals on that date.
In terms of the possible assessment, I didn't -- I certainly didn't give -- I mean, I think like we read out initially, you know, there was three elements to our service, professional consultation and then assessment by our service. So, clearly, that would have been out there for Stephanie to think and hope that that was what was going to happen in this case, perhaps. But I'm not -- I certainly don't think I gave her any indication that we would be doing an assessment and I wouldn't do

that at this stage before a professional consultation has taken place.
Q. I understand. So the risk management plan reference there, you would understand that to be essentially the steps that you did in AR's case and we will come to look at the letters later, but the making of recommendations after the consultation?
A. Yes, yes.
Q. So we know from your statement, of course, that the referral following this form, which we can take down now, thank you, was accepted and it was allocated to you?
A. Yes.
Q. As well as that referral form that we've looked at, what other information, if any, would you have from, for example, other agencies about AR?
A. Again, a slight difference in case by case. Sometimes the referral itself is accompanied by documentation from other agencies. I think if it was in AR's case to be that, then that would have -- they would be -- I'm sure they would have been known to this Inquiry. So if they are not, then they wouldn't have been attached.
Q. So you are not able to assist us with your recollection of any further records you were provided with in relation to AR at the start of your involvement?

A. I'm not, no.
Q. The Inquiry has received some evidence which initially appeared to suggest that one of the reasons for the referral to FCAMHS was a suspected conduct disorder.
I won't bring the document up but, sir, for your reference it's MERP000178 at page 12?
SIR ADRIAN FULFORD: Thank you.
MS WAKEMAN: So there was a record that did list the reason for referral as suspected conduct disorder. The Inquiry asked Ms Hallaron about that and she said in her statement, which again we don't need to bring up but the reference is MERP000026, page 19, paragraph 52, she said:
"I did not have any specific concerns around AR having a conduct disorder at that time and cannot provide any rationale for why this was listed as a referral reason."
I just wanted to check whether you were aware at any stage of the reason for referral being said to be a suspected conduct disorder?
A. Having reviewed my own letters and documentation that I've seen, I have not seen reference to conduct disorder. I have heard it, I think, in another statement but I have not -- at the time, I don't remember that being a factor.

Q. I understand. Just for our understanding, is a conduct disorder something that FCAMHS would have potentially been able to assess and diagnose for or would that not fall within your remit?
A. I think potentially, through the second part of the assessment of a young person and with full understanding, it would be possible for FCAMHS to make some comments around whether or not he would meet the threshold for what really is a formulation approach to looking at severe -- I don't know whether the right word is delinquent behaviour, and I'm sure that FCAMHS could comment.
If I'm honest with you, it was kind of like something that we, perhaps in early stages of my involvement of what was previously the FACS team, which became FCAMHS, we probably had more involvement with that kind of consideration of conduct disorder at that stage, I would say. I didn't come across it for a few years where that was an expectation or a question at referral or anything like that anybody was questioning in latter years.
Q. So are you able to assist us with whether, in AR's case, you ever gave any thought to whether he may have a conduct disorder or not?
A. I wouldn't have been given that as a specific thing,

a specific question, as to whether or not he had conduct disorder, no.
Q. So FCAMHS would be dependent on somebody flagging that as an issue in a referral for you to consider it; you wouldn't consider it of your own volition?
A. I think, unless in conversation, you know, that -- you know, kind of -- I suppose that was flagging any alarm bells that that was a specific issue. I think it didn't and, you know, even on reflection of my letters, I don't think that was what came out as a pressing issue, if that answers the question, sorry.
Q. All right. So back to the acceptance of the referral. I understand from your statement that you emailed Ms Hallaron the same day you got allocated to suggest a date to try and have a first meeting. We know there was a multi-agency meeting that took place on 17 December 2019 but I understand that you weren't able to attend that meeting?
A. Yes.
Q. Did you consider whether to arrange for somebody else from FCAMHS to attend; is that something you would usually do?
A. Not necessarily something we would usually do. I mean I guess that sort of once the case is allocated and other people are busy with their cases, that would be

unlikely that somebody -- somebody would have the ability to be able to sort of, with short notice, go to another -- a meeting about another case.
It may have been possible. I don't know whether I considered it at the time. I can't remember.
Q. All right. But we do know that the first multi-agency consultation meeting which you could attend was on 21 January 2020 and you have explained in your statement that, essentially, the purpose of this meeting was to gather information about AR's background, presentation, behaviour and risk --
A. That's correct, yes.
Q. -- and to use that information to develop understandings of his risks and needs?
A. Yes.
Q. Then also to provide recommendations to the local -- the professionals that were involved with AR?
A. That's correct, yes.
Q. Could we have on screen LCC000020, please. So this is a note of the meeting from that day. We see at the start we've got a list of attendees. AR's CAMHS case manager at that time was Mr Skott Morgan and we can see he's not on the list of attendees; is that right? He didn't attend that meeting?
A. That's in my letter as well, yes.

Q. Would you have expected him or someone else from CAMHS to attend a meeting such as this?
A. Yes, I guess so. Yes. Yes.
Q. If we could then look at the first paragraph. We can see there is some discussion about the hockey stick incident. Ms Hallaron was raising concerns that AR had assaulted a child that he said he liked and that the assault was severe. Two lines from the bottom, we've got:

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

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

At the bottom paragraph, it says, "John H then turned to Jo H", who I understand to be Joanne Hodson, the then Deputy Headteacher of Acorns School?
A. That's correct, yes.
Q. "John H then turned to Jo H and said, 'I've been thinking about what you said before, I don't have a crystal ball, none of us have. We can't say whether

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

Do you recall that exchange?
A. I certainly don't remember saying the -- saying all of that in the way that it is said. However, I wouldn't see what was said as being inaccurate. I think what is likely -- I can comment what I think I'm likely to have meant by those comments but these are not my notes.
Q. I appreciate they're not your notes. It appears to be a set of notes attempting to accurately set out what was said at the meeting though. I appreciate there may be some paraphrasing here and there.
A. Yeah, and I would have to comment that I don't think that is an accurate reflection of the context of that discussion at that time; which I felt was -- discussion, obviously -- you may come onto ask me this kind of question but we would start the meeting by asking all professionals to say -- go round the room and say what they felt were the risks and the needs of a young person and then probably go back around the room and ask people to contribute to what would be needed to manage those risk and needs and that's the way the discussion would

have taken place and information would have been gathered.

I would advocate that, you know, kind of there would have been a shared understanding of risk but I would have been keen to have a conversation primarily about how that risk was going to be managed. You know, kind of and I think these -- this discussion would have taken place in the context of him being outside of education at the time of this first meeting and that, in itself, is a known risk indicator. So I would have been keen for that to have been addressed and I think that's probably more the context of the conversation -- the discussion that was being had at the time.
Q. I appreciate, given it's a note of what was said at the meeting, that some of the context may have been lost. But it's quite a specific comment and it's a contemporaneous note of the meeting. Do you accept it is probably a more likely recording of what was said than perhaps how you might remember it down the line?
A. I think I understand your question. I would say that -- the letter that I wrote after this meeting is a fair and agreed summary of the meeting and, at the bottom of that first letter, I asked anybody who received it, if there was any disagreement with the letter, to come back to me.

This, however, isn't that. This is somebody else's notes that I didn't ask for and there was no opportunity for anybody to question these notes. As I said, at the beginning, I don't remember saying that comment or the other comment that -- where I'm quoted as saying specific things. I'm not saying I didn't say it and I would agree with it, I would still agree that nobody can predict the risk and I would still agree that none of us do have a crystal ball in that particular situation. But I don't remember saying those comments and I find the out of context-ness of them to be difficult to comment on really.
Q. All right. Well, the Inquiry has a witness statement from Joanne Hodson and she will be giving evidence so we will be able to pick that up in terms of her recollections of the meeting then.

If that is an accurate record of what was said, do you agree that that would be quite a surprising comment to make for FCAMHS, whose role is to gather information about risk and to develop an understanding about risk?
A. As I think I have said, no I don't, I think it's -- none of us do have the ability to predict the future and it wasn't the role of FCAMHS to predict the future. It was the role of FCAMHS to consider what risk management strategies need to be in place to manage the identified

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

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

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

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

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

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

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

Do you recall saying that?

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Possibly, yes.

Q. She says that:

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

But it's right, isn't it, when we look at this note of the meeting, that it wasn't agreed at this meeting who, if anyone, was going to be conducting a risk assessment in AR's case?

A. A risk assessment with regard to whether or not he could have a tutor at home?

Q. No, a wider risk assessment, looking at the risks he posed to others?

A. It wouldn't have been entirely clear at that stage, no.

Q. Right. Is it right that there was also no discussion about who was going to be the lead agency in AR's case?

A. At the stage of the first meeting, I think, that, as per the referral form, Stephanie Hallaron recognised herself to be the lead agency and coordinating person. So I think that I would have seen her as being the lead agency at this stage. But that's not necessarily saying that she had to do the risk assessment as to whether he could have a tutor at home. I think that may have fallen to education services to do that.

Q. All right. So your understanding was that Ms Hallaron was going to be the lead professional for AR's case at the time?

A. Yes, until her involvement was likely to come to a conclusion, yes.

Q. All right. Following this meeting, you sent a letter to

Ms Hallaron, basically summarising the issues that were discussed --

A. Yes.

Q. -- and making some initial recommendations?

A. Yes.

Q. If we could get that up on screen, it's GMMH000006. This is a letter dated 11 February, and we can see at the top it is addressed to Ms Hallaron.

I just want to pause there to ask you this: do you recall whether this letter and the second letter that you sent about AR was sent to CAMHS as well as Ms Hallaron?

A. Okay, my practice at the time would have been to send it to the case coordinator to send on to her colleagues. As she set up the meeting -- as I thanked her for setting up the meeting, I would have also made it clear that she would share the letter with professionals as she sees fit.

Q. So your understanding was that Ms Hallaron was going to distribute this to, for example, the CAMHS case manager?

A. Yes.

Q. Because the Inquiry has heard evidence from Dr Killen, the clinical lead at CAMHS, that essentially when she took over the file after the case manager left, and she was looking at it, she noticed that this letter and your

other letter were missing and she requested them to be sent over in May 2020. So it doesn't appear that the letters did make it to CAMHS but would you say that would be falling at Ms Hallaron's door?

A. I would, yes.

MS WAKEMAN: Sir, for your record, the email from Dr Killen chasing the records is at AHCH000234.

SIR ADRIAN FULFORD: Thank you.

MS WAKEMAN: So within the letter, you note that you discussed the case with Mr Morgan, the case manager?

A. Yes.

Q. You note that AR was open to Prevent at the time of the referral? That's the second paragraph.

A. It was closed by the time of the meeting but yes, yes, at the time of the referral.

Q. You note that AR had returned to his school, assaulted a boy and had been arrested for possessing a bladed article?

A. Yes.

Q. You also record that the assault was premeditated. You kindly provided the Inquiry with some handwritten notes from the meeting you took as well?

A. Yes.

Q. I can bring them up if you need to but the reference is GMMH000005 and you recorded in those notes that AR

wanted to kill the intended victim?

A. Right.

Q. Do you remember that?

A. I'm sure that if it's in there then it happened but if you want to bring it up, that's fine.

Q. You also made a note in those notes -- actually, if we could bring this up, so it's GMMH000005, page 5. It's the first bullet point at the top of the page:

"Pressure needs putting on the paed team [I assume that means paediatric team] due to the level of risk and need for specialist education provision."

Is that right?

A. Yes.

Q. So you clearly had a concern following that first meeting that things needed to move quickly, pressure needed to be applied; is that right?

A. Yes.

Q. If we could go back to the letter, which is GMMH000006. You explain at the bottom of page 1 that, at the time of the meeting -- could we look at the bottom of page 1, going to the top of page 2, please:

"The expected time for an ASC diagnosis is approximately two years."

A. That's what I was informed, yes.

Q. You then, at the top of page 2, say that liaising with

the paediatric team needs to take place, to ensure they are aware of the concerns and that they contribute. Is that because the community paediatric team is the service that does the ASD diagnosis?
A. I think that's what I would have been informed, yes.
Q. Then page 2, paragraph 5. You highlight that AR would benefit from psychologically informed interventions to address his high-risk, behaviour, taking into consideration his likely diagnosis of ASD; is that right?
A. Yes, correct.
Q. So your view at that time was that it was likely that he did have ASD?
A. Well, that's what I was -- that's what I was informed, yes.
Q. If we could then look at -- we know that a second multi-agency meeting took place on 4 March 2020?
A. Yes, that's correct.
Q. I understand from your statement that the purpose of that meeting was to review the progress that had been made since the first consultation?
A. Yes.
Q. If we could have the letter you sent following the meeting on screen. It is GMMH000007. It's a letter to Ms Hallaron, again dated 9 March 2020.

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

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

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

responsibility for conducting a structured risk assessment of AR?
A. No, not necessarily. Are you talking about a structured risk assessment as in the SAVRY?
Q. A structured risk assessment which could be in the form of a SAVRY?
A. The comment I was going to say before, in terms of the SAVRY, I had lots of training about SAVRY regularly and about -- in my time -- and certainly some caution needs to be considered when there is a diagnosis of ASC/ASD because, for obvious reasons -- well, not obvious reasons but for reasons such as, for example, you know, one of the factors might be a kind of empathic response, which young people with ASD -- some young people with that diagnosis may find those kind of things more difficult.

So they are kind of crucial factors in understanding the risk of violence but what I was going to say was, in my first letter, at the bottom of the first letter, the interventions that I highlighted as being psychologically informed interventions around managing risk, that will have been directly come from my understanding of the SAVRY and what the likely outcome of the SAVRY would have been. They are, in themselves, kind of informed by knowledge of the SAVRY as specific

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

priority, as that would further give some clarification to the risk, help with an educational healthcare plan and also, therefore, help with accessing specialist education provision. So I think all of those things would have been seen as a priority above our service doing another assessment, which was likely to have the same outcome as I have said, which would be that a full understanding of whether he met the diagnosis for ASC was of primary importance.
Q. All right. We know from the letters that your understanding was that the wait time for an assessment for ASD was about two years at that time and, in the meeting records, we see that there are some concerns raised about how long it was going to take.

Did you consider that by closing AR to FCAMHS at this time to wait for an assessment to be done, is that you were essentially leaving him without a proper risk assessment and exposing a risk to members of the public?
A. No, I wouldn't say that. I would say that we had done what we set out to do, which was to provide an understanding -- a response -- as in the remit of FCAMHS, a timely response to people's concerns about risk and a formulated -- what I hoped would be a helpful summary of the factors that would contribute to others' risk assessment.

As I said, we did not complete risk assessments but the information that would be helpful in those that are completing risk assessment and some guidance as to what would be helpful, and evidence based interventions to reduce the risk, that's how I would categorise it, not as you categorised it, just --
Q. Did you give consideration to whether FCAMHS should have requested an expedited ASD diagnosis assessment?
A. I did and I asked Scott Morgan to do that -- at the end of the first meeting, I spoke to Skott Morgan and asked him to expedite the concerns of the professionals to the ASD service.
Q. So your understanding was Mr Morgan was going to take that forward?
A. Absolutely, yes. Not necessarily to do that but he was going to liaise with his team, I think was how it was put.
Q. If we could just bring up your witness statement at page 9, paragraph 26. You say:

"... the only additional actions that could have been taken by me would have been to offer an extended consultation or undertake a forensic assessment which was not provided by FCAMHS by that time unless indicated."

We have already covered the forensic assessment

part, so let's leave that to one side, but, in hindsight, do you think that a period of extended consultation might have been helpful in AR's case?

A. I think, with hindsight, we clearly said that any agency could refer back to us and we had -- that was kind of in line with the practice that we had at the time, when I was involved in this case, to ask agencies to re-refer, and it was very easy for them to do that, possibly arguably easier than the first referral because a telephone conversation with us and a brief summary of the risk factors that had changed or the risk concerns that had changed at the time, you know, since our involvement, would have been enough to -- for us to reopen the case. So I think that would have been very easy for us to do that and I would say that was our way of operating, that was what people -- that's what I and others did at the time.

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

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

A. From other agencies?

Q. Yes?

A. No.

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

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

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

Q. So the Youth Offending Team?

A. The Youth Offending Team, yes.

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

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

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

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

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

A. No.

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

A. Sure.

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

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

the nuances of that diagnosis were.

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

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

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

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

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

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

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

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

A. Yes.
Q. Did you sit down and think, "It's been a year, no one has said anything, I should check in", or was it pretty much closed?
A. No, we wouldn't have done that.
Q. All right. You have helpfully provided some reflections in your statement which are mostly at paragraphs 20, 22 and 26. I won't take you to those now but they will be forming part of your evidence.

Just finally, I'm asked to ask you whether you felt that resourcing issues within FCAMHS affected the service that you were able to deliver?
A. I guess it's sort of -- any clinician would say you could also have additional resources but I don't remember there being any, for example, noticeable vacancies or anything of that sort, in staffing, if that's what you meant by that, if that answers that question.
MS WAKEMAN: Thank you. Just for completeness, the AssetPlus risk assessment, I will just give you, sir, Chair, the note for your records it's LCC000447.
SIR ADRIAN FULFORD: Thank you.
MS WAKEMAN: That was conducted in April 2020 and we will be hearing evidence about that in due course.
SIR ADRIAN FULFORD: Grand.

MS WAKEMAN: Thank you. I will just look to my left.

Thank you, Mr Bowen KC.

Questioned by MR BOWEN

MR BOWEN: Good afternoon.
THE WITNESS: Good afternoon.
MR BOWEN: I ask questions on behalf of the bereaved families.

I've got some general questions, sir, and I've also got specific permission in relation to one of the conduct disorder points under Rule 10. Do you know who Alexandra Chisnall is?
A. Yes, I do. Yes.
Q. Who is he?
A. She was an administrator with our service at the time.
Q. You worked closely with her?
A. Yes.
Q. You cc'd her in on documents, on certain letters?
A. No, I -- not from a clinical perspective. She would have perhaps been sending those letters out once they were -- you know, she was the administrator who would perhaps have sent the letters out.
Q. Could we have MERP000178. If we start at page 11, please, on the screen. We see there, at the top, there is a reference to Alexandra Chisnall. I think you've been taken to some of these documents. Could you just

identify what this document is. When you've had a look at that just if you go to page 12, please. You see that:

"Referral reason: conduct disorders."

You can see the referral closed 11 March, at the top. Again "Who received", reference again to "Chisnall", we've got the timing. Then page 15 of the document. Again, AR, FCAMHS referral form pdf; document type, referral forms; document date, 13th. This is the date that Hallaron makes the reference to you.

Again, Alexandra Chisnall, again time recorded. Then could you look at page 24, please. Again, this is AR's case. From John Hicklin, again it's later in the day, 3.38. Referral of AR to FCAMHS, cc'd to Alexandra Chisnall. You are writing to Stephanie Hallaron here:

"Thank you for your recent referral ... the case has been allocated to me. As you may be aware we ask referrers to arrange a meeting", et cetera.

We've heard about that when you were asked questions by CTI:

"Better understanding of the risk", et cetera.

Then you set up the meeting. Okay?

You've been told that Stephanie Hallaron, I think paragraph 52 of her witness statement said:

"I didn't mention conduct disorder."

The only person who could have possibly brought that in, as we see from all of these documents, is you.

A. It certainly isn't me.

Q. It isn't you?

A. No.

Q. Well, how does it get in?

A. I don't know. I have not seen that document that was there previously.

Q. Your name is all over it.

A. It is here, yes. On the previous document that you --

Q. Chisnall's name is all over it?

A. I guess it is an administrative document that's done --

Q. It's not an error.

A. I didn't say "error", I said administrative document.

SIR ADRIAN FULFORD: Let the witness finish his answer, Mr Bowen.

A. I thought it was an administrative document that looked like it must be a document that has been completed by admin staff on completion of the case.

MR BOWEN: We have to assume that the reference to conduct disorder is a contemporaneous entry on 13 December.

A. I can't make a further comment about it. I don't know where that comment has come from -- where conduct disorder has come from.

Q. I'm not trying to trap you --

A. I just don't know.

Q. I'm just slightly surprised that it calls for the best explanation that we can get for who brought in a clinical reference to something that might be suspected in relation to AR. Now, who are the likely candidates who could have brought it into your referral documentation?

A. I've got to be honest, I don't know. I didn't -- the first document that you asked to be brought up, that's not a document that I use. I presumed that was an admin kind of document that was done either at opening of the case or closing of the case.

If you want me to speculate, I wonder whether there was some kind of dropdown options of kind of the reason why somebody would be referred. I don't know what that was and why conduct disorder was put there but it's not --

Q. Dropdown menu, which is clicked by accident?

A. Well, I don't know. I don't know the answer to that question.

Q. All right. Well, I can't take it any further. Okay.

Sorry, could you just bring up page 4, again. There is a code on there saying OV1 on page 4 of MERP000178. Do you know what that code is? It looks like "CCG"?

A. I think Clinical Care Group would be CCG, I would guess.

Q. Nothing to do with conduct disorders, a specific code for a specific problem?

A. Again, I'm really, really sorry but I don't know the answer to that question. Normally, in my working experience, CCG stood for Clinical Care Group. That was a shorthand for that but, in this situation, I don't know what it stands for.

Q. Moving on. It was suggested that you were reactive in the way you dealt with the referral. I have to suggest that, rather than being reactive, you were, I don't mean this rudely in any way, you were a bit dismissive?

A. Of the referral?

Q. Yes, you were a bit dismissive. I'm afraid I don't have it in my fingertips. I think it is in the minute, from memory, of the meeting on either the 20th or the 21st. You explained to the Deputy Head of Acorns, Joanna Hodson that she had to appreciate that you dealt with really heavy cases, and is there a danger that you were rather underestimating the risk that was inherent in the background facts to AR's conduct?

A. I think I would repeat the question I gave previously, that my letters in no way at all underestimate the risk or don't, in fact, highlight the risk that professionals highlighted to me at the time of taking into consideration absolutely everything, and I think the

summary of professional concerns is very clear in that letter and, no, I wouldn't agree --

Q. Sorry, I'm deaf I'm afraid, so I have to fiddle with the kit.

A. Did you hear?

Q. I can hear you if I press the headphones.

Sorry, could you say that again?

A. I would say that my letters entirely take on board the risk as highlighted by professionals at that meeting and risk management strategies, as I've clearly stated, and in no way at all did I underestimate the risk.

Q. But did the meeting get a little heated with Hodson: you had a bit of a bust up with her?

A. I don't recall the meeting. Meetings can get heated. I don't recall the meeting getting heated. I think some discussion and heated discussion is sometimes helpful but I don't recall that being any heated discussion or any overt falling out, or anything of that sort. Obviously, people -- I think everybody around the table agreed about the risk and the need for risk and mitigating strategies.

Q. So there's nothing between us on the seriousness of the risk because of the homicidal ideation in October, going equipped to murder on 11 December, you knew all of that?

A. Yes.

Q. You weren't lighthearted, you weren't dismissive, you thought it should be dealt with in a different way; that's your case?

A. Yes, I think that would be. I think that's a fair summary. I think I would just also repeat that there was no indication that this -- at the time, that AR was likely to be receiving anything other than a community -- it was all about risk management in the community. You know, despite --

SIR ADRIAN FULFORD: Sorry, two things, Mr Bowen. First of all, he doesn't have a case.

MR BOWEN: I'll withdraw that --

SIR ADRIAN FULFORD: Secondly, this is reasonably repetitive material we've already been over.

MR BOWEN: All right. If it's not helpful, I will -- okay.

Could I just move on then to the specific point and I will deal with it quickly. It's been accepted, I think, that you were pretty confident that he had all of the traits of autism: so no remorse, fixation on bullying, lack of empathy, as examples.

A. I was pretty certain that the professionals in the group were confident that -- all the professionals that I met were -- that had met him and met his family, were confident that he would likely meet a diagnosis, yes.

Q. So the assessment of ASD was confirmatory, rather than

something that there was a real doubt about?

A. To some extent but I think it was important that what's -- in particular, aspects of that diagnosis would have contributed to further understanding of the risk. So I don't think it is *per se* about a diagnosis, to say somebody has got something, it is about how that impacts on their behaviour, their thinking and the whole presentation, that could be very unique to each individual case.

Q. Just on conduct disorders. Do you have much experience of children with conduct disorders?

A. Well, I suppose arguably a significant proportion of young people within the Criminal Justice System and with kind of -- that would be referred to a service like ours, may well meet some criteria for conduct disorder, yes.

Q. Would you agree that, if it's only a conduct disorder then the likelihood would have been a discharge from CAMHS and a concentration on social care and behaviour management?

A. I guess that CAMHS themselves may be better able to answer that question than me but I think that might well have met some of my experience in the past, yes.

Q. All right, but that wouldn't be the case, would it, if it was comorbid with something else: here, significant

autism?

A. Yes, absolutely, I agree with what you are saying there, yes.

Q. So if you have -- because this is Dr Irani's view, it's at 3.3.1.5, sir, of the report -- this is the specific point that I have been given permission to look at. She says if it is comorbid then that's pretty significant with a conduct disorder?

A. Yes, I can understand that.

Q. So that would then not involve a falling away of support from CAMHS or FCAMHS, you are then very much in the driving seat because you need to assess forensically?

A. I think that's possibly taking -- that second step is a bit of a -- when it comes to the involvement of FCAMHS, I think that's taking it a little bit further than what I would like to agree with this statement. I think I agreed with you up until you talked about the FCAMHS involvement there.

I think it is -- the comorbidity that you're talking about is a very important factor, I agree with you. I would comment that the interventions that I highlighted in terms of the SAVRY, in the first letter, would also be interventions that would be probably indicated for somebody who was to receive a conduct disorder as well. I don't think that they're

inappropriate interventions from a psychological perspective as well.

Q. I'm almost there, sir. So with delay -- because, of course, we did have delay here, for reasons that have been touched on already -- toxic behaviour becomes more entrenched and early intervention is essential?

A. I think that's a fair point, yes.

SIR ADRIAN FULFORD: I think your time is up, Mr Bowen.

MR BOWEN: Yes. I have run out of prompts.

SIR ADRIAN FULFORD: Thank you very much.

MS WAKEMAN: Sir, just for completeness, Mr Moss has very helpfully informed me that it appears that the 01V code that the witness was just asked about is an organisational code within the NHS for data security purposes. It doesn't appear to be anything linked to a referral reason but, of course, Alder Hey will be able to correct that if we are mistaken.

SIR ADRIAN FULFORD: Thank you.

Thank you very much indeed for your assistance, you are now free to go.

THE WITNESS: Thank you, sir.

MS WAKEMAN: Thank you, sir. May we have a short break?

SIR ADRIAN FULFORD: 10 minutes.

MS WAKEMAN: Yes, thank you.

SIR ADRIAN FULFORD: I will sit again at 3.30 pm.

(3.19 pm)

(A short break)

(3.30 pm)

MS AMANDA-JAYNE BROWN (sworn)

Questioned by MR MOSS

SIR ADRIAN FULFORD: Please have a seat.

A. Thank you, sir.

SIR ADRIAN FULFORD: Yes, Mr Moss.

MR MOSS: Thank you, sir.

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

A. My name is Amanda-Jayne Brown.

Q. Thank you. If we could have on screen, please, GMMH000015. It is a copy of your statement that you provided to the Inquiry, dated 27 August 2025. Are the contents of that statement true to the best of your knowledge and belief?

A. They are true, just to add, the opening statement suggests that during the whole of the relevant period that I have contributed and held a senior leadership role. I have held a senior leadership role during that period but not necessarily directly for the CAMHS division, which included FCAMHS. I've been part the FCAMHS and the CAMHS division of the Greater Manchester Mental Health Trust since September 2023.

Q. Thank you. We can see from its face that it is a corporate statement that's jointly authored with your colleague, Dr Imran, yes?

A. Yes, that's correct.

Q. We've made arrangements, should it be required, for Dr Imran to attend later. She wasn't available today and we're grateful for you providing evidence. If at any stage during my questioning, we get into areas that are overly clinical and you feel uncomfortable answering, please just say so and we can then pick them up with your colleague later on.

A. Thank you.

Q. But please give us the assistance that you can.

So just briefly, by way of biography, you've touched on it a little bit, but you explain in paragraph 3, page 2 of your statement, that you are the Head of Operations for the CAMHS division within the Greater Manchester Health Foundation Trust; is that correct?

A. Yes.

Q. In terms of your own background, you qualified as a specialist child and adolescent social worker in 1995?

A. Correct.

Q. You have specialised in child and adolescent mental health from 2004 onwards?

A. Correct.

Q. The Head of Operations role is something you have carried for seven years with that caveat about the responsibility for the FCAMHS that you've indicated?

A. And adult services, yes, thank you.

Q. Thank you. The Forensic Child and Adolescent Mental Health Services North West, the FCAMHS that we're speaking of, I think sit within the CAMHS division for which you are Head of Operations?

A. Correct.

Q. Thank you.

Can I turn, against that background, then to the role and remit of FCAMHS and we've heard something about this from our previous witness. In terms of the advice and consultation, the first limb of the services that are provided, is there anything that you wanted to add to the working level description that Mr Hicklin gave of that?

A. No. I would say that most recently, and prior to this incident, the standard operating procedures and the systems and processes have changed within the FCAMHS arena. That was undertaken when I came into role, not just within FCAMHS but for the whole of the CAMHS division, and every service within there. So there have been some significant changes.

Q. I'm going to ask you to stick with how things were at

the time --
A. Okay.
Q. -- in late 2019 and 2020 but when we come to the end of your evidence, you can add in the significance of any changes.
A. Thank you.
Q. So in terms of how Mr Hicklin was describing the advice and consultation stages, would you broadly agree that what he said was accurate and it was a good indication?
A. Correct.
Q. Thank you. The second limb, the ability to give direct assessments, what can you assist us with in the circumstances in which FCAMHS would have thought it appropriate to do a direct assessment, rather than only giving advice and consultation to the professionals who were already involved?
A. It's my professional opinion that this would have been a MDT discussion back with the FCAMHS team and a decision would have been made whether it was indicated and appropriate to undertake a forensic assessment, whatever that might be. In this case, the SAVRY has been mentioned throughout.
Q. Thank you. But should we understand that that would only arise if, at the first stage, the advice and consultation limb, there was a sense by the FCAMHS nurse

or the FCAMHS worker that it wasn't possible to give an appropriate formulation of the mental health issue that was in play, or perhaps alternatively that it was so high on the seriousness scale that an assessment might be needed from FCAMHS?
A. Sorry, could you repeat the actual question?
Q. Yes. I'm really asking you, you say it would be a multidisciplinary panel, how would it get to the multidisciplinary panel: in what circumstances would the frontline FCAMHS worker say, well, actually, there's a problem here and we might need a direct assessment?
A. It's general that there is an MDT discussion with the FCAMHS service on a weekly basis and on an *ad hoc* basis, where there may be some contention within cases or there's complexity within cases that need a wider discussion and leading to a variety of further risk assessments.
Q. All right. So, the issues that would give rise to FCAMHS offering a direct assessment to the person referred in would be those sort of complexities or contentiousness identified in an FCAMHS multidisciplinary discussion?
A. Built on from the consultation that's been offered to the local system.
Q. All right. Would all cases be considered at the weekly

multidisciplinary discussion or would somebody in Mr Hicklin's position have to put it forward for discussion, saying this is potentially contentious or complex?
A. I'm unclear. That would have to be picked up with Dr Imran.
Q. Thank you. The intervention with the young person's professional network, the third limb, Mr Hicklin indicated, I think, some caution about the way that it had been described in your joint statement. If we could have your statement at page 4, please, that wording at the top of the page. In essence, I think he was saying that reflects the current way that FCAMHS might work to intervene, with an emphasis on supporting the practitioners, the professionals, who were already involved. But I think he was indicating that in his time, it might have been a bit more direct, that FCAMHS might be involved in some direct intervention with the person who had been referred.
A. In terms of direct intervention, it wouldn't be treatment as such, it would have been an assessment, a period of an assessment and extended assessment.
Q. So a time-limited period of assessment but would some of that be face to face with the patient or would that be assessment of what the other professionals were doing?

A. Both, potentially.
Q. Thank you. I'm going to come on to aspects of risk in a number of places but, if we could just look at paragraphs 22 to 24 of your statement, please, page 9. I will come back to this but you say in paragraph 22:
"When FCAMHS accepts a referral for a young person, the responsibility for holding and maintaining the risk assessment remains with the referrer or lead coordinating professional."
I'm asked to explore this with you: would you accept that FCAMHS, given its experience, is the primary body with the most relevant expertise when assessing the risk of violence of young adults, where it may arise from a mental health condition?
A. It needs to be undertaken in partnership with the system, and the system being health, education, social care. Of course, the FCAMHS team have forensic expertise in undertaking specialist assessments that could also add to risk profiles.
Q. That forensic expertise, is that something over and above what "standard" CAMHS staff would have in assessing risk?
A. Generally, yes.
Q. At this time, 2019/2020, was the FCAMHS service in this region commissioned to provide any direct specialist

services for individuals with AR's sort of risk profile?
A. Sorry, could you just repeat the question again?
Q. Yes. Was the FCAMHS service in this region commissioned to provide any direct specialist services for individuals with AR's sort of risk profile?
A. Direct specialist services to AR or?
Q. To AR or somebody with AR's sort of risk profile?
A. Yes. Assessment.
Q. Okay. So we've got the assessment but, in terms of actual interventions, would there have been any potential for therapeutic services, for even inpatient care, matters of that kind?
A. They could make some recommendations but it is very unlikely because of the way that the service has been commissioned and resourced that treatments and therapy would be provided by the team. There would be an expectation that that would generally be undertaken by the wider system and the services in the locality --
Q. Yes.
A. -- which there are few and far between. There is a gap.
Q. So very unlikely that that would be provided by FCAMHS. You'd have to then make recommendations for the services offered by others?
A. Yes.
Q. Even if AR had been diagnosed with a conduct disorder,

would the same apply: that wouldn't make a change to the likelihood that there was any direct treatment that could be provided by FCAMHS?
A. During this time period, the FCAMHS service would not have provided ASC diagnosis but they do know. They would not have delivered direct intervention and therapeutic treatments. There would be an expectation, if there was a conduct disorder, that within the local system there would be services to support AR and/or his parents.
Q. All right. Can you try to be concrete in relation to this: which services provided by which agencies? Give us some examples.
A. So, for example, parenting support generally is provided by Early Help and social care, education, mental health support teams. Direct provision of support to AR could have been provided if there was a need for treatment directly from the YOT service and/or CAMHS service, generally.
Q. Thank you. The gap that you mentioned a moment ago in the provision at the time, you think is what? Can you just define it for us?
A. So, once somebody undertakes a very specific assessment and treatment, such as the SAVRY -- or AIM assessment, for example, but this is not relevant in this case --

you would need somebody who has got a repertoire of therapeutic skills to be able to deliver the treatment after. Therapy staff who hold those skills are few and far between across the system.
Q. Thank you.
A change in topic now. Could we just look at the process when somebody has been referred in and is open to FCAMHS. Paragraph 14 of your statement please at page 7:
"FCAMHS require the young person to be open to a lead coordinating professional for the duration of the service's involvement."
You go on to explain that:
"If the coordinating professional discharges the young person and no other service takes over coordinating responsibility ... FCAMHS will escalate concern within the local system at a senior level ..."
Should we take it from that that FCAMHS would never itself see itself as the lead coordinating professional?
A. Correct.
Q. It's always in a supporting role?
A. Yes. It's a collaborative.
Q. Thank you. Consistent with that, page 4 of your statement, with apologies for jumping around, but a link point, paragraph 5:

"During FCAMHS involvement with a young person, the referrer or other lead professional remains the responsible case coordinator."
Yes?
A. Yes.
Q. So from FCAMHS' point of view, there would always have to be at least one other professional agency involved; do you agree?
A. Correct.
Q. FCAMHS would never see itself as the lead agency; the person who would be the lead agency would be the person who referred to FCAMHS or another lead professional, presumably if they are allocated the role of lead professional?
A. Correct, and generally borne out of recommendations that have been made through consultation or assessments.
Q. At a general level, would you agree that, in AR's case, what one doesn't see on the documents is a clear statement of who the lead agency was at each time?
A. During this period of time, I would agree, yes.
Q. Do we take it from that that that's changed?
A. It has changed.
Q. Would you agree, in general terms, that the risks of that are obvious because cases could fall between the cracks?

A. Absolutely.
Q. In relation to the important aspects for this Inquiry of a structured risk assessment, would you agree that there is a risk that who is meant to be doing the structured risk assessment might fall between the cracks, if it wasn't clear who the lead agency was?
A. A structured risk assessment is a little different than a collective risk assessment. Within FCAMHS and with cases of this nature, I would expect, given the recent research and best practice, that there would absolutely be a risk share amongst the system providers. So that, whilst there will be a lead, the risk is shared amongst the whole of the community system.
Q. Yes, but somebody has to do the structured risk assessment?
A. The structured risk assessments are generally undertaken -- because the structured risk assessments are specialist forensic assessments. They are undertaken by FCAMHS alongside and in support of the information that's available from the rest of the partners in the system.
Q. At a general level, do you think, from the records, that that was done in AR's case?
A. No. Not to the standard that we would expect.
Q. Thank you. In general terms, the closure of a referral

to FCAMHS would be taken in what circumstances?
A. When there would be no further action required from an FCAMHS department; that there is assurance that recommendations are being carried out; there is a lead professional actively involved; and that the system are working closely together to make sure that identified needs are met.
Q. So, it would be appropriate, depending upon the individual circumstances, for FCAMHS to close the referral to it as an agency not when the person has been discharged from care and services altogether but when the FCAMHS role has been dealt with and other agencies are now satisfactorily taking the case forward?
A. Correct.
Q. So far as forensic assessments by FCAMHS are concerned, was there, at the time, any internal guidance on when that was appropriate to take place? You have said that it would be considered by the MDT but was there any guidance on that on which cases were appropriate for it?
A. The standard operating procedure, when I arrived in 2023, was very loose and that was refreshed and reviewed and approved at our SLT governance senior meeting in February 2024. It was felt that the standard operating procedure needed tightening up, this was before this incident occurred. So in answer to your question, there

was no specific evidence of detail when somebody would move from consultation to assessment. There was no standard set at that point.
Q. Again, I suppose one can't generalise as to the form that the forensic assessment might take but, if we could look at paragraph 17 of your statement, at page 7, please, you helpfully give us some examples of the skills that could be called upon. So specialist LD and mental health nursing, psychological, psychiatric, speech and language, neurodevelopmental assessments. There's quite a multidisciplinary range. So you could choose, or the MDT could choose, an appropriate clinician or a mixture of appropriate clinicians to do that sort of forensic assessment, with quite a lot of specialities covered?
A. Or a couple of professionals, really, to complement the assessments that were being undertaken, if there were gaps already within the system and the knowledge within the system.
Q. Thank you.
A. I think it is noteworthy to say there's been investment into the service, which has meant that the service now has a speech and language therapist and a specialist LD nurse.
Q. At the time, we appreciate from your statement that this

has changed, whereas Mr Hicklin was indicating -- my paraphrase -- the importance of an autism diagnosis being made, at the time, FCAMHS didn't have the capacity to see to those autism assessments being done themselves?
A. Correct.
Q. That is one area that has changed?
A. It has changed. It changed in March 2024.
Q. Thank you. If the now system, the post-March 2024 system had been in place at the time, with the sort of set of circumstances that you can see for AR, from your knowledge of the papers in late 2019/early 2020, would the FCAMHS-commissioned autism assessment have been put in place?
A. Yes.
Q. So I want to go back now to the question we touched upon a little bit of risk assessments. Can we go back to your paragraph 22, please.
That's the one starting at page 9. Can you help us just to understand now in a little bit more detail, the point that you raised that the structured risk assessment would involve FCAMHS but that would be done in partnership with others: can you just explain how that actually works on the ground?
A. I can summarise that. You may be better asking Dr Imran

for the micro-details surrounding that but, generally, a SAVRY for example is made up of very different components looking at history, current risks, background incidents in detail, and lots of other professionals obviously provide information to ensure that that's really comprehensive so that there can be a formulation and scoring system, which would then give outcomes in terms of a risk score and also opportunity for treatment.

Q. So you are going to have to pull the information in from different sources to inform the risk scoring?

A. Yes, including family and AR, if possible.

Q. Forgive me for descending to this, and if we have to pick this up with Dr Imran let us know, but at some stage somebody has to sit down with the scoring structure and assess that information to come up with the risk scores. Is that person going to be a nurse from FCAMHS or another professional from FCAMHS, or is it going to be somebody from one of the other agencies, for example, here, the CAMHS practitioners?

A. It is likely to be the FCAMHS service that does that.

Q. So when you say, "When FCAMHS accepts a referral for a young person the responsibility for holding and maintaining the risk assessment remains with the referrer or lead coordinating professional", does that

need to be read with the important caveat that, in appropriate cases, FCAMHS would go alongside the other agency and actively help score on a standardised type of risk assessment, yes?

A. Yes, and it wouldn't be used in isolation. You just wouldn't use the SAVRY, you'd use lots of other risk assessments that are undertaken by the individual services.

Q. I follow. You candidly said straightaway, when I asked you whether that had happened satisfactorily in AR's case, that you thought that it hadn't. Can you just expand on that answer and explain what you think should have been done that wasn't?

A. It's my professional opinion -- and I think that that needs to be with a caveat that I've not been in clinical practice for a period of time, I have limited experience of Forensic CAMHS, although I was able and trained to do some forensic risk assessments -- that a SAVRY could have been indicated earlier in this case and escalation could have been indicated earlier in the case, particularly with the CAMHS service sometimes not coming to the table during these very vital and important professional meetings and consultations.

Q. So let's break that down. A SAVRY could have been indicated earlier in this case. What does that mean in

practical terms? Who should have been indicating that a SAVRY would be an appropriate risk?

A. The FCAMHS service.

Q. So the FCAMHS service here, you would think, in your professional opinion, should have flagged up the desirability of doing that sort of standardised risk assessment?

A. Yes, because of the complexity and the high risk evident within this case.

Q. I follow. So that's the "could have been indicated earlier", and then you said, particularly with the CAMHS service sometimes not coming to the table during these very vital and important professional meetings and consultations: did you mean by that that CAMHS not having come to the two meetings in 2020, that it would have been appropriate for FCAMHS to flag to CAMHS the desirability of doing a SAVRY and really try to bring them more to the table?

A. Yes.

Q. Was there more to it than that or have I satisfactorily summarised what you think should have happened?

A. I think you've summarised it pretty well. There needed to have been an escalation that with CAMHS not coming to the table at the time, that there was a real push to ensure that they absolutely joined and contributed.

There may have been vital information that they had during that period that would have been missing from the risk assessment and they could have contributed greatly.

Q. Of course, not a question directed at any personal responsibility on your part at all, but would you agree that what seems to have happened instead is that Mr Hicklin in the March letter has given some indications of the potential risk complications that could arise because of autism, so sort of factors that might be coming out of a SAVRY assessment but in a letter that was on the face of it first of all only sent to Ms Hallaron --

A. Correct.

Q. -- and that that was also, in some senses, a cautious document because it wasn't giving a full SAVRY assessment, it was saying these could be the sort of issues in play but we can't contribute further without knowing the diagnosis?

A. Correct.

Q. Meanwhile, CAMHS, who it seems probably didn't have the skills to do the SAVRY type of standardised risk assessment, fell back on their own risk assessment tool, yes? Have you seen some of the CAMHS risk assessments?

A. I haven't seen Alder Hey's risk assessment but I would imagine it's not dissimilar to what is used against

Greater Manchester Mental Health Trust.
Q. So not really having a standardised method of assessing the risk and CAMHS have accepted they are neither as structured, nor as detailed, nor as frequent as they should have been, so that did here, on the risk assessment, would you agree, lead to again the proper standardised type of risk assessment falling between the cracks, here falling between the cracks of FCAMHS and CAMHS, principally?
A. Yes, there seems vital information missing.
Q. In terms of the complexity of different agencies thinking that others were in the lead, we don't perhaps need to have it up on screen, but Stephanie Hallaron -- sir, for your reference MERP000026, paragraph 61 -- she indicates that, so far as her organisation, CJYS, are concerned -- sometimes thought of as the YOT -- she says:

"I was advised that we were not best placed to complete a SAVRY and this could be considered by CAMHS or FCAMHS."

Again, that all points to different agencies thinking that other agencies were in the lead for doing the risk assessment, yes?
A. Well, that element of a risk assessment, yes.
Q. Can we pause on how matters were at the time and can

I invite you just to give a summary for the learned Chair of the ways in which you think that is now different, so that there is less risk of the same thing happening?
A. Thank you. The recommendations and changes that have been made to Greater Manchester Mental Health Trust FCAMHS service so far have been that there has been a LD specialist nurse, there is an autism pathway and assessment --
Q. I'm going to stop you, I'm so sorry. I think you're reading from a note. That's absolutely fine but could you, please -- I will come back to wider changes but can you focus on this issue because I'm particularly concerned that you should be able to explain to the Chair, in terms of risk assessments in this type of situation -- so not wider changes -- why would you be confident now that there wouldn't be this failure whereby the SAVRY type of risk assessment isn't done by FCAMHS, CAMHS are left to do their own type of risk assessment, meanwhile the YOT team think that it is either CAMHS or FCAMHS who are doing it but nobody, in fact, actually does it?
A. Okay. So, there are a variety of things that have changed in relation to the risk assessments. Within the standard operating procedure, which has been approved

and reviewed since this incident, there is very clear mechanisms to move from consultation to specialist forensic assessment, outlined within that standard operating procedure. There is also, as part of that standard operating procedure, the opportunity for audit to ensure that recommendations, where they have been made to the wider system, are audited across a system on a regular basis, via a random snapshot twice a year.

There are also multidisciplinary teams that discuss the potential for discharge and supervision is far more robust than previous.
Q. Thank you. I think what I'm going to do, Ms Brown, we may have Dr Imran along but I might ask you to take away that question, more specifically focusing down on ensuring that appropriate more advanced types of risk assessments and who is responsible for them are now carried out.

Yesterday, when Dr Killen gave evidence on behalf of CAMHS, and I put to her the substance of the corporate statement that you and Dr Imran have provided, paraphrasing paragraph 22, she indicated that they, CAMHS, would defer to the risk assessment by FCAMHS and they should do a full risk assessment.

When I put to her the essence of paragraph 22, that the responsibility for holding and maintaining the risk

assessment remained with the lead agency, she said that that wasn't quite how she understood it and she thought that there was still a lack of clarity around this and that she would like to see greater clarity in commissioning as well.

So that evidence tends to suggest, even now from a very experienced clinical lead, a lack of clarity about where the divisions of responsibility lie for this type of risk assessment.

Is that something you could take away and provide us with an update note on, the current state of play on understanding who bears what responsibility for risk assessments in this type of situation?
A. Yes.
Q. Thank you. Looking then at AR's engagement with the FCAMHS service. Much of this has been addressed by Mr Hicklin. Could I ask this: he wasn't able to attend the strategy meeting on 17 December. What would the expectation be in that case? One appreciates it was at relatively short notice. Is that just an operational risk that sometimes you can't field somebody or would FCAMHS have expected to have sent somebody to attend in Mr Hicklin's place?
A. There would be an expectation that there would be attendance. I think it needs to be borne in mind that

the FCAMHS services are small services. There are just 12 members of staff within that service. They cover a very wide area but we do also now have a safeguarding lead that could have attended a strategy meeting on behalf of FCAMHS to feedback some of that information.

Q. Thank you. In terms of the recommendations that Mr Hicklin made in his two letters, other than the aspect of risk assessment, which I have touched upon already, what is your observation on the type of advice and recommendations that he was giving in those two letters?

A. We've moved to more of a SMART action recommendation and being very clear about what needs to happen, why it needs to happen, who are we keeping safe by undertaking a piece of work and who is responsible, and potential timelines for work for completion, who will be the lead professional to undertake and ensure that this is monitored. It feels a lot more structured, in terms of the correspondence that is forwarded out. There's also a greater emphasis and assurance surrounding who receives a copy of the recommendations, either from consultation or assessment.

Q. Yes, because, would you agree, that one downside of the letters is that being addressed only to the person who had referred into FCAMHS, when there were quite a few

agencies involved, and relying that other agency to copy it round, was not ideal?

A. Not ideal.

Q. You have indicated that now there would be an emphasis on the structure, so that it was SMART compliant, so measurable, time limited, and so on, one understands that, but looking at the substance of the recommendations that Mr Hicklin made, were they generally within the sort of standard that you would expect, albeit that they could have been structured and headed better --

A. Yes.

Q. -- and appropriate for FCAMHS type of advice?

A. Yes.

Q. You will have heard my learned friend, Ms Wakeman, asking Mr Hicklin himself about the 21 January meeting notes; obviously not his note. Could we just have that back on screen, it is LCC000020. Could we have enlarged the very last paragraph on the first page.

So:

"Mr Hicklin then turn to Ms Hodson, the Deputy Head, and said, 'I've been thinking about what you said before, I don't have a crystal ball, none of us have. We can't say whether he's likely to offend again. There are kids who have carried out serious offences, they

still have a right to an education'. Ms Hodson replied, 'That might be so', but she wasn't prepared to explain to a parent why a child at our school has been seriously injured."

In fairness to Mr Hicklin, he was keen to explain that the context to this was that, at this stage, AR had been permanently excluded from his old school and was not yet attending his new school, the referral unit, while the risk was being looked at. So, at that stage, he was out of education and it's not his note of this.

But, against that background, do you have any observation on an indication that he may have said something to the effect of "I don't have a crystal ball, none of us have, we can't say whether he is likely to offend again"?

A. I wasn't in the meeting. I understand that this is a note. This is not how I would expect one of our professionals within FCAMHS to communicate with the wider system. It doesn't fit the organisation's values and standards of expectations.

Q. On page 2, in the middle of the page, if we just go over, it's the very middle paragraph:

"John H repeated that there were no crystal balls and that he would offer a £5 bet to anyone who could say what was going to happen next. He said that [AR]

clearly needed some sort of specialist provision with ongoing therapy and social stories 'but unfortunately, you've been left holding the baby'."

Even if one makes allowance for this being a note, not verbatim, and for the context that Mr Hicklin may have been appropriately seeking a re-entry into education and pressing the need for specialist provision, and even in the absence of AR or his parents, would you expect to see reference to offering a bet of £5 as to what could happen next?

A. No.

Q. We know that after the second meeting and the letter that followed from Mr Hicklin, AR was discharged from FCAMHS' services or FCAMHS' case load. In relation to that, can you just give us your assessment of whether that was appropriate or whether there was a different course open at that stage?

A. My own professional opinion is that a professionals meeting should have been called to ensure that that was a safe discharge. There were key players who were missing from the meeting, including CAMHS, and it wasn't very clear who was going to take on the roles and responsibilities outlined within the recommendations.

Q. Thank you. If we see your paragraph 21 at page 9, please. GMMH000015.

That's the essence, isn't it, of what you are seeking to communicate there, the benefit of delaying discharge, a further multi-agency professional meeting. First of all, they could have got CAMHS along to that and the purpose, on the face of the FCAMHS understanding, would have been in part to try to encourage CAMHS to keep the case open, yes --

A. Yes.

Q. -- because it was FCAMHS understanding that it was going to be closed. But, in any event, I think you indicate also to give clarity around who was going to take forward the recommendations, yes?

A. Yes.

Q. Also, a formal designation of which the lead agency was going to be?

A. Yes.

Q. You are, of course, both more experienced and more senior, and you are also looking at this now with the knowledge of current practice that has improved and your knowledge from reading the papers. Can you assist us to try to gradate this a little bit: do you think the closure to FCAMHS was a poor professional decision at the time, with what was known, or do you think it's more the case that that was understandable at the time but now there would be a different approach.

A. The latter.

Q. So you wouldn't be saying that the decision to close it at the time was outside of reasonable professional practice for FCAMHS at that time?

A. At that time. However, I do still maintain that a SAVRY should have been undertaken.

Q. I was going to come onto that, and you correctly predicted my next question, but what you would say is that the way in which the SAVRY was dealt with or not dealt with was poor practice?

A. Yes.

Q. Thank you.

AR, having been discharged from FCAMHS' involvement -- Mr Hicklin was asked about this but at the time that the formal diagnosis of autism was made at a meeting in December 2020 and communicated on across January and February 2021, would that have been an appropriate time to re-refer AR to FCAMHS?

A. Yes, I feel it's a missed opportunity, particularly because assessment for ASC doesn't only give a diagnosis, it gives lots of information about how somebody functions.

Q. Thank you. I don't need to go through them all but, after the diagnosis of autism, there is a series of further events. So there are more Prevent referrals.

There was attendance by the police at his home for incidents involving a level of violence, some to property, some to parents and there was the bus incident in March 2022. Again, I'm not going to list them all but, certainly, with those events on top of the autism diagnosis, it would have been appropriate to refer back into FCAMHS?

A. Absolutely.

Q. Would you go so far as to say it is not just appropriate but that he should have been referred back to FCAMHS?

A. Yes, by all system partners because that list involves lots of agencies from health, social care, the police --

Q. Yes.

A. -- education.

Q. So, that would be, as it were, the push of referrals coming back to FCAMHS?

A. Yes.

Q. What about any pull from FCAMHS: was there any system at the time to monitor post closure or to monitor -- there was a sort of quasi-recommendation from Mr Hicklin, "If things change or you get the diagnosis, come back to us" -- was there any post-closure monitoring?

A. No, not at the time. That has subsequently changed.

Q. How does that work now?

A. Through the audit system that is now in place within the

service, and by much more robust discharge from the service and expectations being spelled out of the system and the risk share across the system.

Q. It is, of course, extremely difficult for practitioners and for lawyers alike not to use hindsight with knowledge of the most awful events of 29 July. I'm going to ask you to try not to use the knowledge of the events and how awfully matters turned out.

But just with the information about AR's risk that was known in 2022 and 2023, against what had already happened in 2019, 2020 and 2021, how surprised are you that AR wasn't referred back to FCAMHS?

A. There were many missed opportunities.

Q. I appreciate that it's difficult and you may also say that Dr Imran may be able to assist on this but let's take some of the key points: with AR having had an autism diagnosis, if you took the fact that there had been some further internet activity of concern which Prevent had looked at but hadn't taken forward, some instances of violence in the home and then perhaps, most particularly, AR found with a knife on a bus saying that he wanted to stab someone and that he had thought about poison, if that had come to FCAMHS at that sort of stage with that profile, are you able to help us with the sort of process that might then have been followed by FCAMHS?

I appreciate that it is hypothetical and speculative to some extent but can you help us at all on that?
A. There shouldn't have been a regurgitation of information that was already available and within the system but the new information should have been shared via consultation and there would absolutely have been a very specialist forensics assessment undertaken.
Q. So you are confident that that would have got beyond the advice and consultation phase and would have gone to assessment?
A. Yes, because of the complexities. They are very clear. The risk is very high.
Q. Potentially by what: a forensic psychiatrist?
A. By the whole of the MDT, potentially.
Q. Thank you.
SIR ADRIAN FULFORD: Just before you move on, can we stay with that just for a minute.
A. Yes, sir.
SIR ADRIAN FULFORD: So reviewed by the whole of the MDT.
A. The right professionals within the MDT.
SIR ADRIAN FULFORD: Absolutely. To what potential end? So with what -- what might have come as a result of that? So beyond people sitting around a table thinking about it, what practical results?
A. There would have been a greater formulation of what was

occurring, a bringing together of all the information that was available in terms of the violence and aggression and risk and extremism that was at play within this case. From that formulation, there would have been plans made in terms of supportive treatment for the family, for the community, and also for AR.
SIR ADRIAN FULFORD: Thank you very much.
Sorry, Mr Moss.
MR MOSS: Not at all.
Thank you. Have you had the opportunity to see Dr Irani's report?
A. I have.
Q. Thank you. She concludes, in terms of multi-agency working that, in her opinion, rather a number of meetings in the absence of a lead agency, a clear handover process and an appropriate risk assessment, the inter-agency working arrangements were not adequate; do you agree?
A. Yes.
Q. Can I ask you, just in terms of your own reflections on matters, can we look at page 11 of your statement, please. You repeat there the point about the benefit of holding another consultation meeting and the involvement of the Criminal Justice Liaison and Diversion Team and Sefton CAMHS having discharged AR, and the risks that

that gave rise to, but that Anna Croll of the Sefton YOT had become involved.
You say this meeting could also have been used to explore who would be contacting the neurodevelopmental pathway to request that AR's assessment be expedited and to consider what service could have taken on the recommendation of delivering psychological interventions. So should we understand from that that you also candidly accept that, although there was the recommendation for the autism to be expedited, or the assessment to be expedited, there was a lack of clarity about exactly who was going to take that on?
A. Yes, it wasn't clear within the letter, the actions weren't SMART.
Q. Thank you.
I should give you an opportunity to comment on Dr Irani's assessment of the risk assessment process but what it comes to is that, in her opinion, the assessments undertaken in AR's case by CAMHS, community FCAMHS or in relation to the risks that he presented, or any safeguarding concerns, again, were not adequate, and should we understand from your previous answers that you would agree with Dr Irani in that respect?
A. Yes.
Q. Thank you. Paragraph 30 of your statement, please. You

deal there with the rapid review of care that was conducted by GMMH. Sir, for your note, it's GMMH000008.
SIR ADRIAN FULFORD: Thank you.
MR MOSS: Just taking those briefly, I think in terms of timescales this is not perhaps the most significant one but I think, by the current key performance indicator, the offer of a first consultation meeting was slightly outside current expectations on timetables; is that correct?
A. Yes.
Q. Thank you.
A. I think it's worthy to note that there was a Christmas period in between but, absolutely, there was that strategy meeting that occurred a couple of days after the referral was made too.
Q. Thank you. Then second bullet point:
"The clinical record for AR does not reveal whether letters detailing the consultation were sent to all professionals ..."
That's a point that we've touched upon, I think you've said, that has changed since?
A. Yes.
Q. "The consultation letters are well written [so the third bullet point]; however the clarity and readability of the letter could be made clearer ..."

That goes to the point about now being SMART compliant; would you agree?
A. Yes.
Q. The fourth bullet point:
"The consultation suggested that AR may be displaying traits indicative of autism, and it was recommended to Sefton CAMHS that they refer AR to the local neurodevelopmental pathway."
Then there is reference to the fact that, subsequent to that, with NHS England increasing FCAMHS funding, FCAMHS now has a greater capability in that regard to take autism assessments itself?
A. Yes.
Q. Accepting that this was a rapid review, we note within that that -- and it was a very rapid review -- that it doesn't seem to have identified the very significant issue around shortcomings in risk assessment that you've helped us with today. When did those shortcomings around the risk assessments first become apparent to FCAMHS?
A. I can't be precise with the actual date. My understanding was I reviewed all of the systems and processes from September 2023. I would imagine it was in the fourth quarter of 2023/24 where the SOP was asked to be revised and reviewed to be far more specific.

Q. But what about in AR's specific case? I think you're kindly there indicating about when you noticed a need for improvements but when in relation, after the events of July, when there was a rapid review in AR's case, it hasn't identified the shortcomings over risk assessment. Do you know when that was first identified?
A. After a rapid review has been completed, there is a patient safety panel within the trust and within the division, it would have been discussed at that point and within that forum. Also the LPC, the local provider collaborative took over and delegated responsibility from NHS England and they had conducted more regular contract reviews and quality reviews, in partnership with Greater Manchester Mental Health Trust. It's helped greatly.
Q. The reason why I'm asking this, Ms Brown, for your assistance, is that it might be thought that it's up there as a key identification of a shortcoming in this case and I'm keen to understand from you how that was first spotted and what was then done about it specifically seeing that things had gone wrong in AR's case on the risk assessment, the lack of SAVRY.
Can you help us with --
A. I can't help you, I'm sorry.
Q. Thank you. We might pick that up with others.

In terms of improvements, we have picked on several of those. So we have covered the fact that autism assessments can now be done, and I think you wanted to give an indication of some earlier on and I said that I would come back to that at the end, so do you want to give your high-level summary now. If we could have on screen paragraph 33, it's at page 14.
I think you prepared some notes possibly on just highlighting some aspects to the Chair. Please feel free to do so.
A. Okay, so the highlights that were detailed within the reports are the LD and autism pathway and new workers LD and speech and language therapists. We are also going to look for an OT to join the team at some point, which will help greatly. We have a safeguarding strategic lead that works across the CAMHS division, that helps to support safeguarding concerns and escalations across systems. They would do this with the FCAMHS service.
There has been a requirement for clearer recommendations in a SMART way, also indicating public safety issues and personal safety issues and responsibilities.
An audit has been devised and highlighted within the revised standard operating procedure. This also covers distribution of consultations and assessments. The

escalation process requirements, where things are not being picked up quickly by system partners, also forms very much part of the SOP and that is now in detail.
Where assessments are indicated, these are undertaken and there is very clear standards that are set surrounding when to move to assessment.
Lead professional forms part of that SOP and how that is identified and what to do if there is an out of area move and/or a need for a different provider to take the lead.
The discharge is in a lot more detail, in terms of requirements of MDT and supervision discussions. There is a new SLT governance assurance framework within the CAMHS division and across Greater Manchester Mental Health Trust. There has been a revision of systems and processes within the service.
An example of that, Chair, would include the information that was shared earlier, the CCG was actually the local care commissioning group. So that was the responsible commissioning group for AR, at the time, on the referral form, and also the indication of a conduct disorder in logging a referral was logged, basically, because that's how a referral is logged and the nearest definition of a requirement for a FCAMHS case, rather than it actually being identified as

anxiety or depression.

And all system changes have been made. There are now KPIs, so the service is reviewed against those KPIs, within regular contract meetings with the LPC and also within SLT governance, not just within the CAMHS division but within the care group and wider within the organisation, to ensure that standards are being met that have been set, such as timeframes.

Q. Thank you. You provided information on that in your statement.

A. Yes.

Q. With all of those changes and improvements, which I know you have only summarised, could we look at paragraph 34, page 15, because, even with those improvements, against the invitation from the Inquiry to outline any recommendations, you said this -- it comes back to this issue of the gap:

"There appears to be a gap in service offer for children and young people who display high-risk and high-harm behaviours, in the absence of a mental health disorder, who would benefit from a structured psychological intervention. Currently the FCAMHS service model, as described in the NHS England FCAMHS Service Specification, sets out no provision for this, and currently there would be feasibility issues to

offering this within a regional model, due to insufficient resources, and distances would be prohibitively large for young people to attend a central clinic, or practitioners to regularly travel to a venue local to the young person."

Yes?

A. Yes.

Q. Should we read into that your assessment that, for AR and for others in his category, where there may not be an apparent treatable mental health disorder but there are still very harm risk behaviours and a risk of violence to others, they would benefit from structured psychological intervention -- yes --

A. Yes.

Q. -- which at the moment FCAMHS is not commissioned or resourced to provide?

A. Yes.

Q. Should we also understand that, in your experience "standard" CAMHS is also not able to provide?

A. Not always. There is a provision within the local integrated care boards to approach for specialist care. I don't think that that has been utilised across all of our regional trusts to its full capacity with these cases.

Q. Is that on a case-by-case approval type of basis?

A. Yes.

Q. Thank you. Sir, I was going to turn to my left but I have had a question come in by email from Mr Nicholls, who, Ms Brown, is junior counsel representing the injured adult victims, and he goes back to the question that I asked you about Mr Hicklin and the comments about the £5 bet and, when you answered that those sort of comments do not reflect FCAMHS value standards and expectations, Mr Nicholls would like to ask: why those comments do not reflect FCAMHS' values, standards and expectations?

A. They don't reflect the standards and values because they seem very flippant. They don't seem to acknowledge the gravity of the concerns and risks evident.

MR MOSS: Thank you. I'm just checking with the other teams.

Sir, do you have any questions for this witness?

SIR ADRIAN FULFORD: No questions, one request: first of all to thank you for some extremely helpful evidence, Ms Brown, I'm very grateful to you.

A. Thank you.

SIR ADRIAN FULFORD: In your fairly lengthy list of things that have changed, you dealt, I'm reasonably confident to say, with a number of things which are not within your paragraph 33. You went beyond that. You also

explained them in a rather high-level way. You've already had to put in a lot of work in relation to this Inquiry but I'm going to ask one last request that you set it out in greater detail and submit that in writing by mid-November.

A. Okay, thank you.

SIR ADRIAN FULFORD: Is that all right?

A. Yes, of course.

SIR ADRIAN FULFORD: Thank you very much.

A. Thank you, sir.

SIR ADRIAN FULFORD: You are free to go.

MR MOSS: Thank you, sir. We resume, with your permission, at 10.00 tomorrow with Dr Irani.

Also, sir, with your permission, may I give advance notice that because of the realities of the timetable for Thursday, with your permission we propose to sit with a 9.30 start on Thursday morning.

SIR ADRIAN FULFORD: Certainly, there was also some reading this afternoon?

MR MOSS: Sir, because of the timescales that was, in any event, going to be pushed back but it's not forgotten and we will come to a summary of other psychiatric evidence in due course.

SIR ADRIAN FULFORD: We've got time for that on a future day?

MR MOSS: We will make time.

SIR ADRIAN FULFORD: Thank you all very much. 10.00 tomorrow.

(4.42 pm)

(The Inquiry adjourned until 10.00 am the following day)

I N D E X