IN THE MATTER OF THE SOUTHPORT INQUIRY PHASE 1

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST'S (AH) CLOSING SUBMISSIONS

EXECUTIVE SUMMARY

A. **Introduction**. AH offers its deepest sympathies to the victims and their families. AH has fully participated in the Inquiry, listened to all evidence, and commits itself to learning and improvement.

B. **Acknowledgment of Failures**. AH accepts that its approach to risk assessment, interagency communication, record keeping, and care planning in relation to AR was inadequate. Failings included inconsistent and incomplete risk assessments, poor documentation, delays in Autistic Spectrum Disorder (ASD) diagnosis, and insufficient safeguarding responses. The Trust apologises unreservedly for these failures.

C. **The service provided to AR and the steps AH took to care for him and his family.** The level of service engagement, care and input from professionals that was provided to AR and his family went above and beyond what a CAMHS service would usually provide.

D. **The response to failures by CAMHS and actions taken**. AH has undertaken a comprehensive Internal Learning Review according to the national Patient Safety Incident Response Framework, identifying numerous areas for procedural and substantive improvement. Key actions already implemented include: integration and improvement of electronic records; mandatory structured risk assessments; enhanced safeguarding supervision and training; new protocols for information sharing across agencies; improved neurodevelopmental (ASD/ADHD) diagnostic pathway.

E. **Interagency and other failures**. AH further recognises that other key agencies might have identified the risk earlier in respect of crucial events, and

that AH's internal systems were not well equipped to address deficiencies in multi-agency working and that a lack of information sharing and absence of an agreed and recognised lead agency contributed significantly to the risk that eventuated.

F. **The Acute Hospital Response**. Treatment of the victims of the attack and improvements. AH provided exemplary care to AR's victims but has nevertheless identified learning and improvements where appropriate.

G. **Recommendations**. AH respectfully suggests that the improvements it has made to CAMHS services and the new neurodevelopmental diagnostic pathway may be of help in respect of the Inquiry's recommendations for future mental health service provision for children and young people whose risk to others may need to be observed and clinically managed.

A. INTRODUCTION

1. At the heart of the Inquiry are the victims of the events on 29th July 2024. AH extends its sincere condolences to those victims and their families. In July and September of 2025, this Inquiry received powerful testimony from many victims and witnesses, including the families of the children who were harmed or killed, and AH would like to begin its closing submission by acknowledging their evidence and by assuring them that they have been listened to and heard.

2. The events in Southport in July 2025 should never have happened; the impact of those events is immeasurable. AH is committed to learning and improving as an organisation from this Inquiry, and to making the changes necessary to help protect the public and help prevent such events from reoccurring.

3. AH has valued the opportunity to participate in this Inquiry and embraces this opportunity to continue to contribute to the Inquiry's investigation, understanding, analysis and review of the circumstances that culminated in the tragic events of 29th July 2024.

4. AH has listened to and participated in this public process as much as is practicable. Indeed, such is the seriousness with which it has taken the Inquiry, an executive officer of AH's board was regularly in attendance at the public hearings and key members of the Board have been kept informed of relevant matters. That is not

merely to keep itself informed of the important progress of the Inquiry, it also assists AH to focus and formulate real time responses to any issue that can be addressed here and now.

5. In that regard, and in addition to adopting the valuable guidance that will be received when the Phase 1 report of the Inquiry is published, AH will make specific submissions in respect of changes that it has identified to its Internal Learning Review (ILR) and from the evidence that has been received by the Inquiry. Those changes, AH suggests, are not mere window dressing but are sensible concrete actions that address gaps in the service highlighted by this case but also measures that the Inquiry may wish to consider as improvements to good practice in CAMHS services generally.

6. AH's closing submissions focus on the two matters from the Terms of Reference: (i) to examine whether there were opportunities to manage the risk AR posed to the public and (ii) recommendations for change. For completeness the AH major trauma response is dealt with briefly at section F below.

7. AH undertakes to acknowledge any relevant failings or shortcomings to ensure that lessons are learnt and to seek to assist in the shaping and implementation of comprehensive, sensible and achievable recommendations to ensure that our society is better equipped to identify, divert and prevent others who may contemplate any such appalling crimes.

8. AH intends to structure its submissions in accordance with the themes set out in the Executive Summary above.

9. Nothing in these submissions is designed to nor should be read as seeking to sidestep or avoid acknowledging the shortcomings in CAMHS care in respect of AR that were made evident through AH's comprehensive Internal Learning Review (ILR), and the evidence given to the Inquiry by the witnesses called on behalf of AH.

10. Moreover, AH continues to reflect on the events and carefully consider what more it can learn. AH shouldered some of the greatest burden of Rule 9 statements with a very short deadline, so if any of the statements failed to deal adequately with reflective viewpoints on matters, any such deficiencies will be corrected by these

submissions on a corporate level. All have learned painful lessons from this matter; AH will continue to learn.

B. CAMHS FAILURES

General

11. AH acknowledges a series of failures within its provision of CAMHS care, including but not limited to:

Risk and in particular the risk to others

- The risk assessments conducted by CAMHS were not standardised and did not inform decision-making around intervention, supervision, discharge, and transition.
- The risk management tool used by CAMHS was neither filled out comprehensively nor regularly, and the updated detail following consultation from FCAMHS was not included.
- The CAMHS risk assessment tool was inadequate and the resulting risk assessments lacked detail, a proper understanding of AR's background history and an accurate record of the risk posed by AR and/or any safeguarding concerns.
- Historic risks and incidents should have been considered more fully in assessing AR's ongoing risk, greater scrutiny of AR's forensic history and a SAVRY-type risk assessment could have been beneficial.
- A referral back to FCAMHS should have been made after AR's autism diagnosis and in consequence of his conduct and disclosures made about his ideation in March 2022.
- The system within CAMHS for keeping track of risk information was inadequate, as important historical information was not readily visible to practitioners receiving responsibility for the care of AR across the period of his involvement with the service.

Record Keeping

- Record-keeping by CAMHS practitioners involved in AR's case was not adequate, which led to inadequate risk assessment.

Record Review and Information Sharing

- Dr Ramasubramanian acknowledged that she did not conduct a thorough review of AR's records and inform herself of the background when AR was admitted into psychiatry which caused her to miss crucial background information and acknowledged that she did not go into great detail about AR's previous behaviours during the handover, focusing instead on treatment and compliance issues. Dr Ramasubramanian recognised that a standardised format for handover would have been beneficial.
- Dr Molyneux recognised that the handover from Dr Ramasubramanian was not effective in highlighting the concerning risk information from 2019 and 2020, acknowledging that a good handover would have put him on notice about the risk information.
- Dr Molyneux acknowledged that he did not conduct a comprehensive review of AR's records, instead relying on the clinical letters.
- The cumulative effect of which meant that Dr Molyneux's understanding of the risk AR posed to others was minimal at the time he took over AR's care as he was not aware of several important risk-indicators which would have informed his assessment, such as AR's history of carrying knives to school and making concerning statements capable of evidencing an interest in extreme violence.
- Dr Molyneux accepted that the risk assessments conducted were inadequate and that the absence of a comprehensive risk assessment meant there was a lack of escalation in respect of AR's risk to others.
- Dr Molyneux reflected that the above inadequacies were likely compounded by AR's family's management of the presentation of information to professionals, which was only visible in hindsight.

Mental Health Assessment

- On reflection, AH agree with Dr Irani's expert opinion that a Mental Health Act assessment could have been considered given AR's historic risks and deterioration in his presentation. Assessment of AR for conduct disorder could also have been considered.

- AH also agrees with Dr Irani's expert opinion that it is unlikely that AR would have been detained in hospital, but the assessment may have triggered further referral to social care or other agencies.

Autistic Spectrum Disorder (ASD) Services

- Delay in diagnosis:
    i. There was a significant delay in diagnosing AR with ASD due to huge demand and the resulting lengthy waiting list for assessment.
    ii. This delay may have had a detrimental effect on AR, particularly in terms of social communication and emotional regulation and delayed the provision of supportive measures to help adaptations for AR and his family.
    iii. Concerns raised by the Acorns School should have triggered a prioritisation of AR's case through the assessment and diagnostic pathway which did not happen.
- There was no formal risk assessment pro forma in use in the EPR for documentation during AR's involvement with the autism diagnostic service.
- The discussion of risk was not a main characteristic of the autism assessment process, and the autism service did not have a formal process for assessing risk at every appointment.
- Further, risk information from CAMHS was not distilled into the autism service records, which was a shortcoming in the information provided to the multidisciplinary panel, who determined the diagnosis of autism.
- Concerns voiced by the Acorns School raised safeguarding issues which, at the very least, required a formal written response.
- The ASD service is commissioned for the assessment and diagnosis of autism but not to provide ongoing support, and the responsibility for managing risk was handed back to CAMHS.
- The ASD assessment and diagnostic process was suboptimal due to multiple deficiencies, including:
    i. The delay in diagnosis could reinforce maladaptive neural pathways, potentially worsening the condition.
    ii. The final outcome letter was not copied to AR's school.

iii. The process for a new referral lacked clarity.

C. THE SERVICE PROVIDED TO AR AND THE STEPS AH TOOK TO CARE FOR AR AND HIS FAMILY

12. Before dealing with AH's responses to the identified failures, AH wishes to set out some short points on the CAMHS service in order to provide context to those shortcomings:

12.1. The CAMHS service was not designed or specified to identify or manage risks to others, focusing instead, as it is commissioned to so do, on diagnosing and treating current presentations of service users requiring intervention. It is a therapeutic not a forensic service.

12.2. CAMHS has finite resources and an ever-increasing demand for its services not least arising from the pandemic, with many service users, like AR, exhibiting reclusive behaviour, particularly those with ASD diagnoses.

12.3. Practitioners faced challenges with AR, a specialist community mental health service user, who was highly anxious but did not have a clinically diagnosable mental health condition. His presentation was complicated by ASD with avoidant traits such as school non-attendance and agoraphobia.

12.4. AR's disengagement from CAMHS began with poor behaviour towards professionals and culminated in his decision to cease engagement, except for medication, by January 2023.

12.5. AH practitioners went beyond expectations in trying to work with AR, retaining involvement with him longer than required given his level of disengagement (other practitioners would have discharged AR long before July 2024 as Dr Irani told the Inquiry). Arguably, within the limitations of the existing CAMHS service, AR was over-serviced and not discharged early enough in the face of his deliberate non-compliance and repudiation of what CAMHS could provide (save for pharmacological interventions).

12.6. The reason why AR was kept open to CAMHS and not discharged in 2023 was because his parents were still receiving Family Therapy at their request up until April 204, even though AR had never engaged with that service.

12.7. That over accommodation by AH endured until Ms Morris completed the discharge paperwork for AR on 23rd July 2024, assessing him as presenting

no risk to others. This was an incorrect statement due to a lack of material event awareness; in effect it was a purely administrative process in line with AH's Standard Operating Procedure Sefton Child and Adolescent Mental Health Services ("CAMHS SOP") [AHCH000309 page 22]. Ms Morris completed the forms in line with her current view and knowledge of AR: the 'Current View' document is an internal document separate from the risk management form, which held the information relating to AR's risk factors including historical risks.

12.8. Systemic failures (as identified below) allowed AR's case to drift without any agency taking leadership responsibility, whilst CAMHS had ever diminishing contact with AR due to his disengagement from their consensual therapeutic relationship, leading to his discharge from psychiatry in early 2023 and his formal discharge from the service in July 2024.

D. LEARNING AND THE RESPONSE TO FAILURES: A NEW IMPROVED SERVICE

ILR [INQ AHCH000294]

The response to failures in respect of AR

13. In December 2024 AH determined to undertake an Internal Learning Review to produce a comprehensive analysis of the care and treatment provided to AR by CAMHS.

14. The ILR was conducted in accordance with the national NHS Patient Safety Incident Response Framework, a system designed to support organisations in drawing meaningful conclusions from the themes identified from recorded incidents, including learning that is relevant to and actionable by particular organisations and the specific risks in their area of work.

15. The Internal Learning Review comprised seven Terms of Reference which considered AR's treatment pathway, his disengagement from the service and discharge.

16. Prominent amongst the detailed Terms of Reference (ToR) and underpinning sub-questions, which were also designed to frame the analysis of Sefton CAMHS

safeguarding systems and pathways with the aim of identifying any areas for improvements, were:

16.1. TOR 2 — Record Keeping and Communication; To establish the standard and timeliness of record keeping (including multiagency correspondence) and how effective information sharing was between AH's services and multi-agency partners.

16.2. TOR 3 — Electronic Patient Records; To explore how the Trust's current electronic patient records support staff in obtaining a holistic picture of the child and their family when providing care and treatment.

16.3. TOR 5— Safeguarding Supervision; To understand the agreed process and arrangements for safeguarding supervision across AH and whether staff involved in the care of AR accessed safeguarding supervision appropriately.

16.4. TOR 6 — Risk Assessment; To understand how services working with AR assessed the risk he presented and if this was communicated and shared with partner agencies.

17. AH has combined learning from the Internal Learning Review with the opportunity to participate in the Inquiry process to identify a wide range of areas of potential improvement.

18. AH has implemented substantial procedural, record-keeping, safeguarding, and digital infrastructure changes. In addition, the Care Quality Commission inspection of CAMHS undertaken in March 2025 as a consequence of the tragic events, has given AH still more learning and valuable direction in terms of service improvements.

19. Key objectives are to achieve sustained, consistent improvement, with continued monitoring, supervision, and audit to ensure the changes translate into frontline safety and high-quality care.

20. AH acknowledges historic inconsistencies and failures in record keeping, especially with uploading external documentation to the Electronic Patient Record (EPR), including vital multi-agency meeting minutes, care plans, and safeguarding information, which resulted in an incomplete picture for staff, particularly during transitions or staff absence. The previous structure of the EPR split records across services militated against comprehensive, holistic case management which contributed to communication failures. This has been addressed.

21. *Document management and information sharing protocols* have been improved, with focus on scanning external letters and making summaries more accessible to all involved clinicians.
22. Critically, *assessment of risk* was impeded by inconsistent review practices and poor formal documentation. Further, escalation protocols for patient non-engagement lacked both clarity and nuance, especially for adolescents with capacity. Risk assessment procedures have been updated to require more active recording and review of historical and background risk, not just present risk symptoms. There is now greater awareness of the importance of re-referral to forensic or specialist services, (e.g. after a new autism diagnosis, significant events, or disengagement) alongside explicit escalation pathways.
23. AH acknowledges that escalation and *safeguarding supervision* processes were used and/or documented inconsistently leading to missed opportunities. Specifically, AH recognises that there were 11 occasions within AR's care when it may have been appropriate for practitioners to have sought safeguarding supervision which may have resulted in the safeguarding team supporting practitioners to escalate concerns to achieve a better coordinated multi-agency response.
24. A range of improvements to the *EPR* were implemented across Community Mental Health, ASD, and ADHD services in mid-April 2025 to enable more effective, timely, and auditable risk assessment and care planning across the service and provide clinical leadership and practitioners with enhanced visibility of case complexity and risk, supported by easier escalation and oversight mechanisms. These steps will also ensure that information relating to children and young people accessing CAMHS, and their risk presentation is immediately visible to staff in both acute hospital and community services in the event that they require physical healthcare from the Trust.
25. The improvements include an *enhanced front page* for these services to highlight key risk data, make latest risk and care plans much more visible for all practitioners and list all clinical staff involved in a child's care to support an immediate understanding of risk. *Key risk documents* (including triage forms and risk/care plans) are now easily accessible and viewable on a single screen, enabling staff to track the full chronology of risk and care planning to promote timely and comprehensive risk review.

26. The *key risk documents* include a systemic *Risk Management Document* that enables staff to add details from other organisations directly and clearly display legal status/historic risk to assist staff to view and consider new information as it becomes available.
27. The *risk triage form* now includes mandatory fields for each risk domain, supporting risk stratification (high, medium, low, not known) to ensure consistency in initial risk evaluation. The risk formulation section is designed to strengthen the information used for planning and decision making.
28. The *Risk and Care Plan* forms mirror the triage forms' stratification criteria and allow practitioners to monitor risk scores over time in a structured way with mandatory documentation of clinical rationale at each step.
29. Enhancement of *risk metrics and outcomes* now automatically flow to the service waiting list and caseload management tools, enabling visible and colour-coded risk stratification.
30. Further the *CAMHS EPR Dashboard* enables clinical leads to audit appointments and note compliance on a 6-weekly basis to strengthen oversight and scrutiny.
31. The shortcomings identified in relation to *record keeping generally* and significant failures to upload multi-agency documents (including the FCAMHS letter dated 11 February 2020 [INQ GMMH000006]) have been addressed by the introduction of a *scanning solution* to allow CAMHS staff to upload external and internal paper-based documents directly into the EPR together with continued improvement of multi-agency information-sharing, including real-time risk sharing.
32. *Digital safeguarding supervision templates* in the EPR have been developed to support standardised documentation of planned and unplanned safeguarding supervision. Continued improvement of multi-agency information-sharing, including uploading and access protocols, as well as real-time risk sharing.
33. Additional *EPR training and updated induction* for new CAMHS staff has been introduced to highlight the importance of uploading/scanning documentation and using the improved record-keeping functions.

Delivery: Action Plan

34. An action plan addressing each of the recommendations in the Internal Learning Review has been drawn up and is in the process of being finalised with service leads. The Trust's Chief Nursing and Allied Health Professionals Officer will have

executive oversight of its implementation and will ensure rigorous analysis of its subsequent effectiveness.

35. The action plan will be *monitored by the Trust Board*. The key thematic recommendations and corresponding raft of detailed remedial actions have been designed with strong mechanisms for audit, future reflection and adaptation at targeted completion dates.
36. Lessons learned have been translated into corresponding actions which explicitly address methods of reviewing and updating Trust guidelines, policies, and SOPs including the Patient Access Policy, Consent Policy, Discharge Policy, Risk Management Tools (with explicit attention to multi-agency clarity of risk), and Medicines Management Policy, in direct response to identified failings or gaps.
37. Each *remedial action has been allocated an accountable officer* with responsibility for delivering the action and each monitored by evidence-tracking en route to completion by a designated monitoring and/or sign-off body.
38. Progress is monitored by *planned and structured evidence collation* and audit trails, including periodic, ongoing tracking or rolling reviews and audits.
39. *Local monitoring committees* and steering groups are in place to provide assurance that actions are delivered and embedded in practice. The Trust's Safety and Quality Assurance Committee will have oversight of the overall implementation of the plan and report progress to the Board.
40. Separately, the Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) pathways, which were previously managed independently, have been consolidated into a *unified Neurodevelopmental Pathway*. This integration allows for coordinated assessments of both ASD and ADHD within a single, efficient process when clinically appropriate, thereby reducing unnecessary repetition and duplication, particularly in instances where both conditions are suspected or identified during triage or assessment.
41. The *service has been restructured* so that families now receive support from two specialised teams: the Assessment Team, responsible for diagnostic evaluations, and the Treatment Team, which oversees ADHD medication management as well as post-diagnostic support for ASD. This restructuring aims to provide a more streamlined and equitable service; decrease waiting times and reduce the risk of incomplete or fragmented assessments across the neurodevelopmental service.

42. Clinicians with *dual-specialist skills* are equipped to recognise how these conditions overlap, identify when they present differently across individuals, and distinguish them from other developmental, cognitive, emotional, or medical factors that may explain the presenting needs.
43. The introduction of a *neurodevelopmental risk assessment and safety planning tool* provides a structured, consistent way to identify, record, and respond to risk factors across all cases. By systematically evaluating areas such as emotional wellbeing, behaviour, vulnerability, environmental stressors, and safeguarding concerns, the tool ensures that any emerging risks are recognised early and addressed proactively. A clear safety plan enables clinicians to outline targeted actions, agree strategies with families, and coordinate timely support.
44. Significantly, it also strengthens communication with external agencies—such as education, social care, and mental health services—ensuring that risk is managed collaboratively and that the child or young person receives support across the whole system. This approach enhances safety, improves continuity of care, and promotes shared accountability for risk management.
45. *Safeguarding indicators* have been introduced on each child or young person's records Trust wide which clearly identify any risk presented and provide a clear and consistent method for highlighting cases where safeguarding concerns may be present, ensuring that risks are visible to all professionals involved and can be managed promptly and appropriately.
46. The introduction of a *Prevent flag* strengthens this approach by identifying children and young people known to the external Prevent team, enabling AH staff to track, monitor, and coordinate support where there may be risks related to exploitation, radicalisation, or vulnerability.
47. Together, these indicators enhance safety by ensuring early recognition of concerns, improving information-sharing with partner agencies, and ensuring that robust protective measures are in place throughout the assessment and intervention process.
48. The *updated EPR front screen* clearly displays any confirmed diagnoses such as autism or ADHD. It also shows whether risk assessments have been completed by the neurodevelopmental service or CAMHS, indicates who the CAMHS case manager is, and records whether a CNEST tool has been completed. The CNEST

tool is a structured clinical screening tool used to identify emotional, behavioural, or situational risks that may require additional support or intervention.

49. A *weekly complex case Multi-Disciplinary Team* has been introduced to bring together Mental Health Services, the Neurodevelopmental Service, Crisis Care, and the Safeguarding Team to review children and young people presenting with high or escalating risk. This multi-agency forum ensures coordinated care planning, early identification of unmet needs, and timely intervention when risks cannot be safely managed within existing resources.

50. Where concerns remain unresolved, an *internal escalation process* enables the Multi-Disciplinary Team to refer cases directly to the Director of Community and Mental Health Services for senior oversight and multi-agency problem-solving. This structure is designed to strengthen safety, enhance accountability, and ensures that complex or high-risk cases receive rapid, collaborative support across the whole system.

51. Additionally, *AH's Community and Mental Health Division complete a monthly audit* of all children and young people known to, or newly referred to, the Prevent teams to maintain clear oversight of this vulnerable cohort and ensure that robust safeguarding arrangements are in place. Regular auditing allows the service to monitor changes in risk, confirm that actions from Prevent or internal teams have been implemented, and identify any gaps in multi-agency support. It also ensures timely escalation where concerns are increasing and strengthens partnership working with schools, social care, police, and Prevent practitioners. This systematic review process enhances safety, improves accountability, and ensures that every child or young person linked to Prevent is receiving coordinated, appropriate, and proactive support.

52. A *'rapid-assessment'* offer has been developed to provide an expedited, trauma-informed ASD and ADHD assessments for highly vulnerable young people. The 'rapid assessment' is delivered through close Multi-Disciplinary Team integration with the Enhanced Support Teams, CAMHS, Social Care and Youth Justice.

An outline model for other CAMHS services?

53. The Inquiry is respectfully asked to consider the improvement made by AH as a potential best practice model for adoption by CAMHS and neurodevelopmental (ASD/ADHD) services nationally.

E. OTHER FAILURES INCLUDING INTERAGENCY FAILURES

54. AH accepts having contributed to a constellation of multi-agency limitations that resulted in a failure to adequately identify, assess and manage the profound risk of very serious harm that AR posed to others.

55. Evidence to the Inquiry revealed a continuum of events concerning AR that would have increased the risk index if information had been shared among agencies. All agencies, including AH, share blame, as do AR's parents.

56. The primary failure was the assessment of the level of risk that AR presented in 2019 which shaped the community mental health service's approach to the management of risk.

57. The Inquiry has undertaken to review the decision-making and information-sharing by all local services and agencies which interacted with AR prior to 29th July 2024 and to examine whether there were opportunities to manage the risk he posed to the public. AH does not seek to deflect blame on to any other agency but rather to assist the Inquiry's review by highlighting key events:

- Neither the criminal justice system nor the Youth Justice Board seem to have fully understood AR's propensity for violence when he was prosecuted in 2019.
- If FCAMHS had conducted a structured risk assessment that might have revealed AR's troubling ideation.
- If Prevent's assessment had been more focussed on risk to others on the three occasions of referral, AR could have been assigned to Channel and an appropriate process followed.
- The key strategic leadership agency for AR was Lancashire County Council not least in respect of Lancashire Children's Safeguarding Assurance Partnership (LCSAP). LCSAP had the lead strategic role for all matters pertaining to Safeguarding in Lancashire.
- The key significant interagency failure was the missing from home and bus incident on 17th March 2022 and the reactions thereto. This event which revealed an alarming ideation in relation to poison, indicated that the events of 2019 were not isolated and, if anything, the danger AR posed to the public was increasing. AR's accumulation of weaponry, his curation of a poisonous substance, his profound family dysfunction

(including his isolation) would have alerted relevant agencies, including criminal justice and Prevent to intervene to assess and manage the risk he presented.

- AR's procurement of weapons was at best unmonitored and possibly tolerated by his parents, allowing him to accumulate deadly paraphernalia.
- The failure of AR's parents to report the events of 22nd July 2024 to social care, mental health or criminal justice agencies.

58. On a more general level, multi-agency failures included but were not limited to:

58.1. The absence of a clearly identified and agreed lead agency.

58.2. Inconsistent attendance by all parties involved in AR's care at interagency meetings.

58.3. Inadequate documentation of minutes of multi-agency meetings which were not consistently shared with all parties concerned.

58.4. Ineffective interagency communication.

58.5. Lack of clarity regarding who was responsible for conducting structured risk assessments, leading to potential gaps in risk management.

58.6. Inadequate interagency working arrangements, resulting in handover processes that lacked clarity.

58.7. Critically, a structured risk assessment should have been conducted by or on behalf of an identifiable lead agency with 'ownership' of the results and responsibility for ensuring that risk was measured, monitored and managed.

F. THE ACUTE HOSPITAL RESPONSE AND IMPROVEMENTS

59. In addition to its response in respect of CAMHS provision to AR, AH was required to provide the Inquiry with evidence in relation to its involvement in the major trauma incident caused by AR's horrific acts, that required detailed statements from witnesses from AH's Emergency Department, Paediatric Surgery, Cardiac Surgery and PICU.

60. Their evidence described in detail how, in the aftermath of the egregious crimes committed in Southport on the 29th July 2024, clinicians from AH collaborated with colleagues from the wider Northwest Children's Major Trauma Network (CMMTN) and the North West Children's Major Trauma Network (NWChMTN) to

undertake a review of the clinical response to the incident, to make recommendations and to identify opportunities for shared learning.

61. The key objectives of which were to:

- Collaborate with relevant major trauma network stakeholders to obtain the necessary information required to conduct the review.
- Identify and disseminate lessons learnt regionally and nationally.
- Review the care of patients from initial triage through the major trauma pathway.
- Ensure that any identified learning is used in the development of future guidance and incorporated in the Clinical Response to Major Incidents.

62. Although the Terms of Reference focused on clinical care rather than the wider emergency response, it included recommendations on communication and coordination of the pre-hospital response and the different capabilities of enhanced pre-hospital teams in the UK.

63. The Review addressed (i) the complexity of decisions as to how and where patients in major incidents are transported and (ii) the potential improvements in the support that could be afforded to local teams through better communication including teleconferencing.

64. This review culminated in the publication of the Northwest Children's Major Trauma Network Report (Exhibit BM/02: INQ AHCH000244), an examination of the clinical care of all the patients treated during the major incident response across the organisations involved.

65. In July 2025, AH was informed that the Inquiry intended to examine the timeliness and quality of the clinical treatment of Alice da Silva Aguiar and to determine whether or not the injuries to Alice may have been survivable.

66. Accordingly, the treating AH clinicians responded to a raft of Rule 9 requests to assist the Inquiry to determine whether, individually or collectively, the clinicians 'could have done more or done things differently', both with the knowledge possessed at the time and with the benefit of hindsight and/or wider understanding of the events and to assist a consideration of whether there are any improvements that could be made that would be practicable and make an effective difference.

67. In turn, this evidence was considered by Professor Richard Lyon MBE as part of his expert Medical Report of 2nd August 2025 which included an evaluation of the quality of the clinical decisions taken and the standard of the treatment provided to Alice da Silva Aguiar at the scene, on transfer to Southport and Formby District General Hospital and at AH and whether there are any lessons that can be identified from Alice's treatment in terms of preventing future fatalities even from such significant injuries. [INQ PFL000005]

68. In Professor Lyon's expert opinion, the quality of service provided by AH staff was of the highest standard, particularly having regard to the rarity and severity of the wider circumstances within which the treatment was provided.

69. Nonetheless, AH and its clinical staff welcome the opportunity to contribute to the learning derived from these exceptional events and any consideration of whether there are any practicable and effective improvements that could be made.

70. The recommendations below are drawn from a combination of:

- North West Children's Major Trauma Network Report (INQ AHCH000244)
- The Medical Report of Professor Richard Lyon MBE dated 2nd August 2025 (INQ PFL000005)
- The reflections of treating clinicians as expressed in the corresponding Rule 9 Witness Statements.

Recommendations

71. The list of recommendations is not exhaustive but is intended to reflect core learning points and collective recommendations:

Bystander and First Responder Equipment

- There were no bleed control kits available at the scene.
- Increased provision of publicly accessible layperson 'bleed control kits' warrants further consideration and potential expansion, particularly in venues of higher risk.

Major Incident Declaration and Communication

- A lack of urgency, delay, or reluctance to declare a major incident may inhibit the mobilisation and allocation of resources. Early declaration is essential.
- Recommendations call for a regional review of major incident alerts and communications protocols, including the deployment of Hospital Advice and Liaison Officers (HALO).

Initial Scene Management and Triage

- Recommendations suggest a national review of triage tools (particularly MITT) in incidents with penetrating injuries to improve effective prioritisation and deployment of limited resources (such as blood products and advanced care teams) and the adoption of robust systems for triage marking.

Rapid Allocation of Enhanced Pre-hospital Resources

- Prompt dispatch of consultant-level pre-hospital responders (HEMS, advanced/critical care paramedics) can aid decision making and bring advanced interventions (such as thoracotomy and blood transfusion) to the scene early.
- It is recommended that regional teams configure remote clinical support options and review pathways for deployment where in-person support is delayed or challenging
- It is recommended that consideration should be given to ensure the wide availability of such enhanced care-providers with a capacity to respond rapidly, and to review whether their capabilities should be standardised nationally.
- Effective and rapid role allocation, as well as communication regarding which advanced resources (e.g., HEMS) are available and their arrival times, is essential.
- The major trauma networks should have a formalised role in coordinating regional response and supporting communication and supply management in major incidents.

Pre-hospital Blood Product Administration

- Early administration of blood/blood products at the scene may offer benefit, but limited supplies require careful triage and prioritisation, especially in multi-casualty incidents.
- National guidance is needed regarding prioritisation of limited blood products and clarifying supply lines during incidents.

Casualty Distribution and Trauma Centre Capabilities

- All Trauma Units and Major Trauma Centres should ensure availability of paediatric-sized equipment and access to paediatric trauma guidelines.
- Paediatric experts may need to support Trauma Units with limited experience.
- Training providers should review and standardise training in damage control surgery, paediatric trauma care, and mass casualty procedures for all relevant clinicians.
- Further, when distributing casualties, efforts should be made to keep families/siblings together where possible.

G. RECOMMENDATIONS

72. AH hopes that the improvements it has made to CAMHS and its new Neurodivergence Service model will be of use to the Inquiry in forming recommendations in this field.

73. On a general level:

- The identification and removal of barriers to assessing and managing risks caused by the complexity of the Social Care, Health Care, Education and Youth Justice System apparatus.
- Reconfiguration of systems for interagency communication and collaboration to establish a readily identifiable leadership with ultimate responsibility for assessing risk and determining what action needs to be taken to minimise the risk of serious violence.

74. AH looks forward to the publication of the Inquiry's report with interest and remains at the Inquiry's full disposal should further information or evidence be of assistance.

24th November 2025