Witness Name: Ms Amanda-Jayne Brown

Exhibits:

Date:13th November 2025

THE SOUTHPORT INQUIRY

SECOND WITNESS STATEMENT OF
MS AMANDA-JAYNE BROWN

INTRODUCTION

1. I am Amanda-Jayne Brown, Head of Operations for the CAMHS Division within GMMH. The Forensic Child and Adolescent Mental Health Services North West (FCAMHSNW), sits within the portfolio of the CAMHS Division. I am employed by Greater Manchester NHS Foundation Trust (GMMH), based at Prestwich Hospital, Manchester, M25 3BL.

2. I trained as a Specialist Child and Adolescent Social Worker qualifying in 1995, working with both statutory and voluntary organisations as a protected social worker. My Professional Registration number is SW42218. I specialise in Child and Adolescent Mental Health in 2004. In addition to my Social Work Qualifications, I hold a MSc in Organisational Development Management awarded in 2010. Throughout my 30-year career I have been a clinician, led and managed children's services at both a junior and senior level, before developing an Adult/Child mental health portfolio as Head of Operations. I have been a Head of Operations for 7 years. There has been no change in my role since this incident.

3. This statement has been prepared in response to the Inquiry's request for further clarification. It addresses points 1–3 set out in the correspondence dated 22 October 2024, which I will consider and answer in turn.

A more detailed account of the revised systems and processes now in place within FCAMHS, including:

a. The Criteria and mechanisms for transitioning from consultation to forensic assessment.

4. A transition from consultation to a full forensic assessment by FCAMHS clinicians, as outlined within the Standard Operating Procedure, may occur if one or more of the following criteria are met:

    1. The information gathered during consultation reveals a complex clinical presentation (e.g., multiple aggravating mental health, neurodevelopmental, and social factors), and the practitioner cannot develop a robust formulation of the young person's difficulties and forensic behaviours without a direct assessment.
    2. There is disagreement among professionals involved in the consultation, and a direct assessment is the only way to resolve this.
    3. The child or young person (CYP) requires a specialist assessment that only FCAMHS can suitably provide.

5. The process and mechanism for transition; moving from consultation to assessment is as follows:

    1. The practitioner presents the case at the weekly multidisciplinary team (MDT) meeting.
    2. The MDT reviews the case against the criteria above and considers:
        - Whether the CYP meets the criteria for assessment.
        - If additional information or further consultation could enable a formulation and recommendations without a full assessment.
        - Any barriers to assessment (e.g. ongoing court matters).
        - Specific risks associated with undertaking an assessment.
        - Whether FCAMHS is the most suitable service to undertake the assessment.
        - Whether the assessment requires a particular practitioner's skill set (e.g. psychiatric or psychological opinion).

- o If specific assessment tools or psychometrics are required.

3. If the MDT decides to proceed, the practitioner records this decision in the progress notes, informs the external lead professional, and begins arrangements for the assessment.

The transition is not automatic; it is based on clear clinical or systemic need

he MDT plays a central role in reviewing and authorising the transition. Documentation and communication with the lead professional are essential steps in the process. The revised SOP (yet to be ratified internally, scheduled for Governance SLT in January 2026) introduces that a transition from consultation to full forensic assessment may occur if there isa formal request from the local referring system indicating that a specialist assessment is warranted.

6.

b. The current approach to structured risk assessments, including the use of SAVRY and how responsibility for such assessments is determined and co-ordinated across agencies.

7. The SOP confirms that FCAMHS practitioners are trained in structured professional judgement (SPJ) tools to evaluate specific risks.

8. SAVRY (Structured Assessment of Violence Risk in Youth) is the most common tool used for peer-to-peer violence risk assessment. It is a national tool; it is not local to GMMH. However, SAVRY does not mention or pay particular regard to Autism Spectrum Condition (ASC). Newer tools such as FARAS and FARAH may also be considered.

9. FCAMHS supports the lead agency (referrer or lead professional) in refining overarching risk assessments and management plans, using evidence-based tools as required. FCAMHS does not independently complete or own the risk assessment for the locality-wide system.

10. FCAMHS facilitates forensic analysis and formulation in collaboration with local system partners, enhancing the risk assessment process through specialist input. Local

services are encouraged to maintain a single, overarching risk assessment for complex children referred to FCAMHS, promoting a system-wide ethos of risk sharing.

11. While FCAMHS practitioners may make recommendations and identify action owners during consultations or assessments, the responsibility for implementing and tracking these actions remains with the lead co-ordinating professional or the referring agency. FCAMHS does not assume responsibility for the actions or inactions of other agencies.

12. If recommendations categorised as immediate actions are not implemented and this poses a risk, FCAMHS practitioners are expected to escalate concerns through internal processes, ultimately involving senior operational leads, commissioners and external leads at Director level as necessary. This includes appropriate safeguarding referrals.

13. As stated above, SAVRY is the primary tool for youth violence risk, but other tools may be used depending on the case and practitioner expertise. FCAMHS acts as a specialist consultant, not the owner of the risk assessment; responsibility for risk management remains the concern of the lead professional and the local system. Collaboration and escalation are built into the process to ensure recommendations are considered and acted upon. FCAMHS does not have enforcement authority over other agencies, but does have clear safeguarding responsibilities and a duty of care.

The escalation procedures when key agencies do not attend multiagency meetings

14. The escalation process is stepwise, starting with direct resolution and moving up through management and commissioning levels as needed. The process is designed to ensure that risks associated with lack of agency engagement are identified, addressed, and, if necessary, escalated to ensure the safety and well-being of the CYP. All actions and escalations should be clearly documented in line with governance requirements.

15. When key agencies do not attend multi-agency meetings, the following escalation process is outlined:

1. **Identification of Concern:**

Non-attendance by system partners at pertinent meetings is explicitly listed as a significant concern that may impact the safety or outcomes for the child or young person (CYP).

2. **Initial Resolution Attempt:**

   Practitioners are expected to attempt to resolve the issue through the consultative process, engaging directly with the absent agency to encourage participation and address barriers.

3. **Formal Escalation:**

   If the concern cannot be resolved through informal means, or if the absence could lead to significant harm, the practitioner escalates the matter to the Team Manager.

   The Team Manager then raises the issue formally with their equivalent in the absent service.

4. **Further Escalation:**

   If the concern remains unresolved, the Team Manager escalates it to senior operational leads within the CAMHS Division (such as the Service Manager and/or Head of Operations) and, if required, to safeguarding leads.

5. **Commissioner Involvement:**

   If internal escalation within the CAMHS Division fails to resolve the concern, the Service Manager contacts the commissioning Quality Leads within the Lead Provider Collaborative, who can support escalation via locality commissioning pathways or contact the locality commissioners directly.

6. **Documentation**

   Throughout the process, practitioners are expected to document the concern and actions taken, including completion of an inPhase incident report if appropriate.

The post-discharge monitoring system now in place to ensure recommendations are followed up.

16. Pre discharge, the practitioner will be required give up to one month for all immediate actions to have been completed by the system, monitored and co-ordinated by the lead professional. If the withdrawal of the lead agency or failure to implement recommendations results in a safeguarding concern, the FCAMHS case manager (if still involved) will raise the matter via internal safeguarding and escalation processes.

17. During FCAMHS involvement, action owners for recommendations are identified and included in consultation and assessment reports. The lead co-ordinating professional is expected to track completion of these actions during and after FCAMHS involvement.

18. Currently, the service undertakes an audit of the standard of the discharge summaries. A further audit has been developed but not yet received formal governance approval. This audit proposes a biannual audit of open cases, including review of whether recommendations and actions have been followed up and documented appropriately.

19. At case closure, feedback is collected from the lead professional via a digital questionnaire, and from CYP/families via phone or questionnaire. This feedback is used to monitor the effectiveness of recommendations and the discharge process.

20. All recommendations, actions, and their owners are documented in the EPR, which serves as a reference for the professional network post-discharge. At discharge, a copy of discharge information (including recommendations) is shared with the referrer, CYP, family/carers, GP, and other relevant professionals (with consent).

21. After discharge from FCAMHS, the responsibility for ensuring recommendations are implemented and tracked lies with the lead co-ordinating professional (or case manager) from the referring agency, not with FCAMHS itself. If, after discharge, there are concerns that recommendations are not

being implemented and this poses a risk, the lead co-ordinating professional is expected to use their internal escalation procedures.

22. FCAMHS does not retain ongoing responsibility for monitoring recommendations post-discharge; this is handed over to the lead co-ordinating professional. Systems in place include clear documentation, identification of action owners, structured handover, and escalation pathways for unresolved risks. Feedback and audit processes provide additional oversight and opportunities for service improvement.

2. Clarification on how FCAMHS now ensures that consultation letters and recommendations are distributed to all relevant professionals, not solely the original referrer.

23. Based on the revised FCAMHS NW Standard Operating Procedure, the SOP specifies that the outcome letter from a consultation is to be emailed to all professionals invited to the meeting, not solely the original referrer. This ensures that everyone who participated or has a role in the case receives the recommendations and summary.

24. Professionals listed in the referral document are invited to the consultation meeting. They are also advised to forward the invitation to other professionals who should attend but were not included in the original referral.

25. This approach helps to capture a comprehensive list of relevant professionals for both the meeting and subsequent correspondence.

26. The consultation report, including recommendations and action owners, is shared with all attendees and documented in the Electronic Patient Record (EPR). This report serves as a reference for the professional network and supports follow-up after the meeting or discharge. It is noted that the EPR is not a shared electronic system across all system partners and it is a potential system failure if all agencies do not upload the record/report on to their system.

27. The lead co-ordinating professional is expected to maintain communication with all relevant parties and ensure that recommendations are implemented and tracked, further supporting the distribution and awareness of consultation outcomes.

28. FCAMHS ensures that consultation letters and recommendations are distributed to all relevant professionals by emailing the outcome letter to all meeting participants, not just the referrer. The process is supported by careful invitation management, documentation in the EPR, and the ongoing responsibility of the lead co-ordinating professional.

3. Any additional governance, audit, or assurance mechanisms introduced since Ms Brown assumed her role in September 2023.

29. The service has undergone considerable change since 2023. This includes the development of a Divisional and Care Group Governance Framework through implementation of a series of senior leadership meetings enabling both oversight and assurance in practice, performance, workforce, risk, safety and financial balance. This has been supported by the development of a number of Quality and Governance roles that lead on oversight of patient experience and patient safety, collate themes and monitor the impact of improvement actions, creating a feedback loop for continuous learning. The governance structure also supports the implementation of effective risk management systems and ensures compliance with regulatory standards. This is aligned with the Trust's revised governance structure which creates a service to board assurance chain, integrates risk and safety oversight at every level, and embeds learning into practice. This reduces duplication, improves responsiveness, and fosters a culture of safety and transparency

30. Pertinent to the changes are that FCAMHS conducts a discharge audit as described by Dr Shermin Imran in her statement. This is a formal annual audit. FCAMHS is currently seeking governance approval for a further biannual snapshot audit of open cases, selecting a random sample of no fewer than 20 and no more than 50 cases which would explore the full standards set out within

the revised working SOP, this would include the auditing of the completeness of immediate actions recommended by FCAMHS by the system.

31. The audit reviews compliance with operational, clinical, and governance standards set out in the SOP. Outcomes from the audits are used to identify areas for improvement and inform the service quality improvement plan. Audit findings and improvement plans are presented to the Divisional SLT Governance Board, with ongoing monitoring at the Divisional Transformation Meeting.

32. Strict standards are set for referral management, including electronic submission, triage within one working day, and timely initial consultation offers. Referrals are held for up to three weeks while awaiting further information before rejection, ensuring transparency and accountability.

33. Consultation outcome letters must be emailed to professionals within three weeks of the meeting. Standardised headings are used for reports, and assessment venues are risk-assessed for safety and accessibility.

34. Assessment reports must be returned to system partners and care co-ordinators within 14 days of assessment completion.

35. All young people must have one direct or indirect contact within 28 days of referral. Routine outcome measures (e.g., HONOSCA) are completed at first contact and case closure, and interventions are SNOMED-coded for data reporting. Routine outcome measures systematically demonstrate a person's progress, providing evidence of change, effectiveness and experience over time i.e. whether symptoms, distress or functioning are improving, worsening or stable or quantifying impact of intervention/treatment.

36. Mandatory safeguarding training for all staff, with compliance tracked and reported weekly within service and monthly within the Divisional SLT People/Performance meeting. Safeguarding concerns are recorded in the

electronic patient record and an inPhase incident report is completed if FCAMHS are the referring agency for the safeguarding concern.

37. Line management supervision is required at least every eight weeks, with documentation uploaded to the Learning Hub. Clinical supervision must also occur at least every eight weeks, and annual appraisals are mandatory for all staff.

38. Feedback is systematically collected from CYPs, parents, carers, and lead professionals at case closure via telephone or questionnaire. Feedback response rates are reported quarterly and monthly, and immediate concerns are escalated as formal complaints if necessary.

39. All direct CYP appointments are conducted in twos for safety, with practitioners required to check in and out using the Duty Channel and Outlook diary.

40. Managers monitor practitioner safety and escalate concerns as per policy, with vehicle safety and registration requirements enforced.

41. Regular engagement events are held with agencies and services, and practitioners are expected to liaise effectively with other services. The lead co-ordinating professional must retain overall clinical responsibility and ensure recommendations are implemented, with decisions and actions recorded in the EPR.

42. The SOP introduces structured, recurring audits, clear performance standards, robust safeguarding and supervision protocols, and systematic feedback collection. These mechanisms are designed to ensure high-quality, accountable, and transparent service delivery, with continuous monitoring and improvement. The SOP is in its first cycle of formal review since implementation in Summer 2024, this revision takes account of learning from best practice and incidents and development and investment into the FCAMHS provision. The revised working SOP, is to be formally ratified through GMMH Governance

Procedures January 2026, after a period of consultation with the internal workforce, the wider workforce and commissioners.

43. GMMH are participating in a formal research study which aims to understand why young people are having difficulty accessing forensic mental health support. This research study will help the system to understand how to improve access forensic mental health services for young people in the future. This research has been approved by the Research and Innovation Department at Greater Manchester Mental Health NHS Foundation Trust who are sponsoring the study. The study has been reviewed internally by members of the Applied Research Collaboration Greater Manchester (ARC-GM) who are funding the study. This study has received Approval from the NHS Health Research Authority. Dr Heather Law, will lead the research study, Heather is based at the Youth Mental Health Research Unit. The research will be carried out alongside a team of researchers from Greater Manchester Mental Health NHS Foundation Trust and the University of Manchester.

44. Further to the internal assurance mechanisms the commissioners of the service, NHS England, has delegated responsibility to the Local Provider Collaborative (LPC) in 2024. This change has brought about positive transformation, GMMH and FCAMHS have worked collaboratively with the LPC to develop service Key Performance Indicators ensuring that standard expectations are set, implemented and monitored for quality and safety. The LPC have undertaken biannual quality reviews which have added objectivity and richness to the quality improvements seen within the service. There are also robust quarterly contract meetings in place and a developed escalation clinical activity panel to offer objectivity and scrutiny of the commissioned expectations set out in the service specification.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a

false statement in a document verified by a statement of truth without an honest belief in its truth.

Signature

Signed:

Full name: Ms Amanda-Jayne Brown

Dated: 13th November 2025