Confidential

CHILD AND ADOLESCENT EXPERT WITNESS REPORT
FOR
SOUTHPORT INQUIRY

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DPA

Instructed By:

Jennifer Forrest
Assistant Solicitor to the Inquiry

on behalf of the Chair to the Southport Inquiry ("**the Inquiry**"),
Sir Adrian Fulford

Date of report: 14th October 2025

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1.0 INTRODUCTION

1.1 ABOUT THE AUTHOR

1.1.1 This report has been completed by Dr Tina Irani, Child and Adolescent Forensic Psychiatrist.

1.1.2 I am a medical practitioner fully registered with the General Medical Council since 2003. I graduated from University of Mumbai India with a degree in MBBS in 2001. I obtained my Completion of Specialist Training with dual accreditation in Child and Adolescent Psychiatry and Forensic Psychiatry from the Royal College of Psychiatrist in February 2012 having gained full Membership in 2005. I have worked as a Consultant Psychiatrist in NHS Child and Adolescent Inpatient and Community Forensic Mental Health Services since February 2012.

1.1.3 Clinically I have had the opportunity to work in a variety of community and inpatient mental health settings and as an in-reach psychiatrist at HMP YOI Werrington. Prior to December 2018, I was working in a Specialised Adolescent Forensic Inpatient Service which included a nationally commissioned Medium Secure Psychiatric Adolescent Inpatient Unit at Ardenleigh, accredited by the National Autistic Society (NAS) and I was working in the Community Child & Adolescent Forensic Service – Youth First, which covered the West Midlands. I was the Clinical Lead of these services from July 2016 until November 2018. In 2019 I worked in a Specialist Community Child & Adolescent Forensic Service and Community CAMHS service for neurodevelopmental disorders in Surrey and Borders. I started at Southern Health Foundation Trust as a Consultant Psychiatrist in the adolescent Low Secure Unit, Austen House and as a Clinical Lead for Austen house, Low secure adolescent services.

1.1.4 Nationally, I was the Co-Chair of the Clinical Reference Group for Tier four CAMHS services, Clinical Lead for the National Low Secure Network and an

elected member of the Child and Adolescent Faculty of the Royal College of Psychiatrists.

1.1.5 I have provided Expert witness psychiatric reports for both prosecution and defence, on a range of matter pertaining to young people. I have a keen interest in service development and reducing restrictive interventions in inpatient services. I have also conducted service and pathway reviews independently and as part of the Peer Review Quality Network, established by the Royal College of Psychiatrists.

1.1.6 I am an approved doctor under section 12 of the Mental Health Act 1983 (amended 2007).

1.2 DISCLOSURE OF INTERESTS

1.2.1 I have worked in community CAMHS services, Community FCAMHS services and Adolescent inpatient services. I was actively involved in developing the national service specifications for community FCAMHS services and all inpatient services for CAMHS in my role as a member and co- chair of the Clinical reference group (CRG) to NHS England. I would have met some of the clinicians involved in the matter, but I have not discussed the case or the details of the inquiry with them.

1.2.2 For the purpose of this review I have considered both CAMHS and community FCAMHS within the remit if the review.

1.3 INSTRUCTIONS

1.3.1 The purpose of the report is to provide evidence about matters within my expertise that may assist the Chair in fulfilling the Inquiry's Terms of Reference.

Key issues

1.3.2 To inform the Chair's analysis and consideration of the evidence which has been disclosed thus far, the Chair would be assisted by receiving a report discussing the following key issues (focusing on the time prior to the attack on 29 July 2024):

1.3.2.1 *'AR's engagement with Child and Adolescent Mental Health Services at Alder Hey Children's NHS Foundation ("**CAMHS**"); and*

1.3.2.2 *AR's diagnosis and treatment by CAMHS and the standard of the treatment and care provided to AR.*

1.3.2.3 *Whether there are lessons to be learnt from AR's treatment in terms of minimising the risks of attacks in the future.*

1.3.3 *You are being instructed on the basis that you will provide an expert opinion, entirely independent of the Inquiry and its CPs.*

Topics & Questions

1.3.4 *The topics and questions set out in these instructions are intended to provide a focus and structure to your work for the Inquiry. If you feel that they could helpfully be rephrased, or if there are matters that you consider should be added or omitted from those set out below, then please provide your suggestions to us as soon as practicable.*

1.3.5 *Whilst the main focus of your report should be AR's engagement with CAMHS and the adequacy of treatment provided to AR by CAMHS, you may also, insofar as you consider you are able to do so, comment on the accuracy / adequacy of diagnoses given to AR by CAMHS.*

1.3.6 *As far as possible, your report should consider the following topics/questions insofar as they are within your area of expertise, and it is possible to address them:*

1.3.7 ***Risk assessments***

1.3.7.1 *The adequacy of the CAMHS systems and processes for assessing risks and safeguarding concerns generally;*

1.3.7.2 *How CAMHS assessed the risks / safeguarding concerns posed by AR;*

1.3.7.3 *The adequacy of the assessments undertaken in AR's case in relation to the risks he presented and/or any safeguarding concerns;*

1.3.7.4 *The appropriateness of the levels of risk identified within those assessments.*

1.3.8 ***Escalation of concerns (in relation to risks and/or safeguarding issues)***

1.3.8.1 *Where risks and/or safeguarding concerns were identified in relation to AR, and intervention/escalation was sought, the appropriateness of the steps taken and the acceptability of the timeframe in which the intervention/escalation took place;*

1.3.8.2 *Any risks and/or safeguarding concerns which should have been, but were not, identified in relation to AR, and the steps which should have been taken as a result of those concerns.*

1.3.9 ***Diagnosis and treatment of AR***

1.3.9.1 *The adequacy of treatment provided to AR by CAMHS professionals (including the use of prescribed medication);*

1.3.9.2 *To the extent that you identify any inadequacy, the treatment(s) that you consider would have been more appropriate;*

1.3.9.3 *The appropriateness of the decision to discharge AR from CAMHS psychiatry in April 2024.*

1.3.10 Steps taken to engage/re-engage AR with treatment (including the taking of prescribed medication)

1.3.10.1 *The steps and/or processes that would have been available to CAMHS to try to engage/re-engage AR with treatment and his prescribed medication, and the adequacy of any steps in fact taken in that regard by CAMHS in relation to AR;*

1.3.10.2 *Any other steps which you consider CAMHS ought to have taken to engage/re-engage AR with treatment and his prescribed medication;*

1.3.10.3 *The steps and/or processes that would have been available to CAMHS to assess and/or otherwise manage the risk of AR after he dis-engaged from treatment and/or was failing to take his medication as prescribed, and the adequacy of any steps in fact taken in that regard;*

1.3.10.4 *Any other steps which you consider CAMHS ought to have taken to assess and/or otherwise manage the risk of AR after he dis-engaged from treatment and/or was failing to take his medication as prescribed.*

1.3.11 Inter-Agency Working Arrangements

1.3.11.1 *The adequacy of the inter-agency working arrangements that were in place generally, including for information sharing and the effectiveness of communication, including the degree of openness between agencies;*

1.3.11.2 *The adequacy of inter-agency working, information sharing and communication between agencies in relation to the treatment and care of AR.*

1.3.12 Record keeping

1.3.12.1 *The adequacy of record keeping by CAMHS in relation to AR's treatment/care.*

1.3.13 Resourcing, training and guidance

1.3.13.1 *Your understanding of the availability of adequate resources within CAMHS at the time at which AR was engaging with CAMHS;*

1.3.13.2 *If known, the adequacy of any guidance or training available to professionals at CAMHS who engaged with AR.*

1.3.14 Improvements

1.3.14.1 *Any areas, not already covered above, where CAMHS did not follow or comply with relevant guidance, procedures, and/or expected practices in your view;*

1.3.14.2 *Whether you consider that CAMHS could have done anything more, or differently, to reduce the risk AR posed to the public;*

1.3.14.3 *If known, any improvements made since these events (including to training) and their effectiveness;*

1.3.14.4 *The Chair is tasked with making recommendations but ensuring, through engagement with relevant practitioners, that the recommendations are practicable. Please consider whether there are any improvements that could be made to CAMHS that would be practicable and make an effective difference.'*

1.4 ADDITIONAL INSTRUCTION RECEIVED ON 10TH SEPTEMBER 2025

1.4.1 On reviewing the following documents; the behaviour checklist completed by AR's mother on 17 December 2019 (**AHPH000090** – p.3-17), which indicated conduct disorder and an email on p.7 of **AHCH000162** from Stephanie Hallaran to Skott Morgan dated 17 December 2019 and the original referral by Stephanie Hallaran to FCAMS (**GMMH000002**) which they say demonstrates that concerns were being raised which may have related to a conduct disorder, to clarify a whether a diagnosis of Conduct disorder should have been made by FCAMHS and the impact of this.

1.5 SOURCES OF INFORMATION

1.5.1 I was provided with the following documents, via an Egress account, to peruse:

1.5.1.1 Letter of Instruction by Ms Jennifer Forrest, Assistant Solicitor to the Inquiry, dated 15 July 2025

1.5.1.2 All documents provided by Alder Hey Children's NHS Trust relating to AR, including AR's CAMHS medical records from 1 April 2019 - 23 July 2024;

1.5.1.3 The Rapid Review prepared post-incident as a result of the incident being notified to the Safeguarding Partners for Child Safeguarding Practice Review consideration (AHCH000165);

1.5.1.4 A combined chronology of multi-agency involvement disclosed by Alder Hey Children's NHS Foundation Trust (AHCH000172);

1.5.1.5 A draft chronology of contact and significant events prepared by Alder Hey Children's NHS Foundation Trust (AHCH000109) and;

1.5.1.6 A chronology created by Alder Hey Children's NHS Foundation Trust for this Inquiry (AHCH000193).

1.5.1.7 Witness statements by the professional involved in his care.

1.5.1.8 Corporate Statement from Greater Manchester Mental Health Services by Dr Sherman Imran, Child and Adolescent Psychiatrist and Lead Consultant for Forensic Child and Adolescent Psychiatric Mental Health Services and Miss Amanda Jane Brown, Head of Operations for CAMHS Division within Greater Manchester Mental Health Services.

1.5.1.9 Chronology of the record from Presfield High School dated 9th June 2025.

1.5.1.10 Record from Range High School chronology dated 30th June 2025.

1.5.1.11 CQC report on Alder Hey Children's NHS Foundation Specialist Community Mental Health Service for Children and Young People indicating an overall rating as 'Outstanding'.

1.5.1.12 Records from Greater Manchester Mental Health Trust with regards to Forensic CAMHS Consultation Services

1.5.1.13 Witness statement dated 23 August 2024, by David Fairclough, Police Constable of Lancashire Police in relation to the incidents on 17th March 2022.

1.5.1.14 Confidential Final Draft of Internal Learning Review into the care and treatment of 'AR' by Specialist Mental Health Services, Alder Hey Children's NHS Foundation Trust.

1.5.1.15 Virtual meetings with the Ms Jennifer Forrest, Ms Caroline Featherston on 1 July 2025, Ms Caroline Featherstone and Ms Jennifer Forrest on 19 August 2025, with Ms Harriet Wakeman, Mr Richard Boyle and Ms Jennifer Forrest on 9 September

2025 and with Ms Harriet Wakeman, and Ms Jennifer Forrest on 25 September 2025.

2.0 BACKGROUND AND ISSUES

2.1 According to the Letter of Instructions, on 29 July 2024, Axel Rudakubana (who I will refer to as "AR" in my report) carried out a knife attack at a children's dance club in Southport. He murdered 3 young girls, Elsie Dot Stancombe, Alice da Silva Aguiar and Bebe King, and injured 10 other people. Sixteen others survived the attack but live with the serious emotional scars.

2.2 According to the records provided, the parties/organisations involved in his care from 2019 (when he was first referred to Child and adolescent mental health services) to 2024 (when the serious incident took place) included, Alder Hey Children's NHS Foundation Trust, Mersey Care(school nurse), Roe Lane GP surgery, The Range High School, NSPCC, Lancashire Constabulary, Children and Family Wellbeing Service, Children's social care, Acorns PRU/School, Presfield School, Lancashire & South Cumbria Foundation Trust, Criminal Justice Liaison and Diversion Team, SENDIAS, CYJS, Lancashire SEND, HCRG Care Group, Virgin Care, Lancashire Education Improvement. Services consulted with, included Community Forensic CAMHS (Greater Manchester NHS Foundation Trust) and PREVENT in 2019/2021.

2.1.1 In October 2019, he assaulted a pupil at school, he contacted child line to talk about wanting to kill someone and talked about having taken a knife to school. Appropriate services were contacted but no lead services identified and despite multiple services being involved, a comprehensive structured Risk assessment, addressing his risk within a school environment and providing a risk management plan was not completed. Started attending The Acorns school 28 October 2019, with clear boundaries in place.

2.1.2 Whilst AR attended school he often made reference to international politics and his beliefs around this. He also expressed distress at being bullied by peers at school.

2.1.3 November/December 2019, Evidence of inappropriate online searches in school.

2.1.4 In December 2019 a PREVENT referral is made. There was a continued escalation in his presentation at school. There were further 2 referrals made to PREVENT, the 1st of February 2021 and 26 April 2021. All 3 were closed on the bases that his needs were met outside of PREVENT.

2.1.5 On, 11 December 2019, the following incident is noted. 'At approximately 0910 hrs, the Head Teacher of Range High School, Formby, was conducting a year 9 assembly. His attention was drawn to AR inside the school premises. He approached AR and repeatedly asked him to leave. AR ignored him and began to walk into the corridors of the school. The Deputy Head Teacher then saw AR and The Head Teacher walking down the corridor. AR has then started to run, producing a hockey stick from inside his coat as he did so. In the corridor was a group of around 6 Year 9 pupils. AR has swung the hockey stick above his head, and then towards the group, striking a male on his left arm. The event was captured on school CCTV. AR was restrained from behind in a 'bear hug' by the Head Teacher and the Deputy Head Teacher took the hockey stick from the grip of the accused. AR was escorted to the Head Teachers office and Police were called. Whilst waiting for police to attend, AR is said to have been very calm and insistent that his actions were not wrong. It is alleged that AR stated that he had attended the school to look for another pupil to attack. Upon Police attendance, AR informed the Officer that he had a knife in his Rucksack. He was arrested and in interview gave a prepared statement detailing that he had hit one male as he couldn't see that person who he intended to hit, DPA AR accepted he had a knife in his bag and that the teacher had mistaken his words when he said he told him he was there to kill DPA he stated that he just meant he was going to assault him because he used to bully him.' PREVENT was notified.

2.1.6 A referral was made by the Criminal Justice and Liaison team (CJL) to Community Forensic CAMHS. Community FCAMHS received the referral on 13 December 2019.The CJL team, appropriately noted concerns and risk in the referral. Following 2 consultations on, 21 January 2020 and 4 March 2020, AR was discharged from community FCAMHS on 9 March 2020.

2.1.7 Sefton CAMHS accepted the referral and strategy meeting held 17 December 2019 with Police, School, Children's Social Care, PREVENT, Health, CAMHS, CJLT. PREVENT was to complete an assessment and consider a referral to The Channel Programme.

2.1.8 Further strategy meeting held on 6 January 2020, PREVENT did not deem he met criteria for Channel/ Prevent program.

2.1.9 A professionals meeting was held with FCAMHS on 21 January 2020, attended by education, criminal justice and liaison team, social worker and family worker. Different views were held about who does the risk assessment and for what. FCAMHS advised a re-referral once ASD diagnosis confirmed and advised some interventions but unclear who was to carry out the interventions. CAMHS were not present at the meeting.

2.1.10 Initial risk assessment by Sefton CAMHS notes risk to others (in particular, the school pupil who he perceived bullied him). Reports from school regarding terrorism however PREVENT outcome is there is no evidence of radicalisation or anything malicious being found. Risk identified for Dion (Axel's sibling) from Axel should Dion hurt animals. This is not a comprehensive risk assessment with a clear formulation round the risk. What is likely to worsen the risk or improve the risks noted.

2.1.11 He received a referral order starting 19 February 2020 ending 24 January 2021 and to support the referral order an Asset Plus document was initiated, which addresses some of the risk factors but not all. However, following the conclusion

of the referral order, there was no process identified to continue monitoring risk and reviewing the action plan. I wonder whether this was impacted on by the Pandemic.

2.1.12 He had an Autism diagnosis confirmed in February 2021. A re-referral to FCAMHS was not initiated, as had originally been advised.

2.1.13 AR showed further deterioration in his presentation, particularly his reference to what he was watching on social media and how he felt about politics, and in his own physical health care, from January 2022.

2.1.14 In March 2022, Police created a missing person investigation at High Risk which was appropriate risk level owing to AR's vulnerabilities. AR was located on a bus by Police Officers and returned to his home address. At the time he was in possession of a small knife. He made concerning comments about wanting to stab people and make poison. When this was explored further, he reported knowing that 'if he commits a serious offence the police can help him delete his social media accounts'. He reported wanting this as there were historical, embarrassing video's on TikTok and Instagram of himself he wanted taking down.

2.1.15 At the time he stated that he had not harmed himself, and did not want to harm any particular person, but just wanted to get arrested. This did not prompt a re-referral to FCAMHS or to PREVENT.

2.1.16 In May 2022, there was a further deterioration in his presentation with increased violence towards parents, increased isolation at home and general disengagement. The police were involved, and a Mash referral was made, resulting in raising the level of his risk to 'High' and making a referral to Operation Encompass. However, there appears to be no comprehensive structured risk assessment completed at this stage and an absence of any SMART recommendations to be reviewed and followed through.

2.1.17 Early Help was recommended but took time to action. When the assessment took place AR refused to be seen. Children's social services are absent.

2.1.18 There were increasing safeguarding concerns within the family home and change in clinicians- both CAMHS case manager and consultant, as a result of them raising concerns. Children's social services are absent from these discussions.

2.1.19 February 2023 a deterioration in his presentation with him becoming non communicative and reducing food intake. Medication prescribed for Anxiety management

2.1.20 In 2023, Multiple appointments not attended at CAMHS. Welfare checks been attempted by school but he was not seen. Confusion between which local authority he falls under and lack of joint working.

2.1.21 Lancashire MASH involved in March 2023 and Children and family Wellbeing make contact in April 2023 but AR not seen and he refused to work with them. School attendance was reduced but there appears to be discrepancy in his actual attendance and what was reported to CAMHS. In June 2023, home visit by Deputy DSL and Safer schools officer completed a home visit and it was reported as all was well.

2.1.22 In September 2023 at a TAF meeting, it was discussed that AR has voiced that he does not want support from CFW or CAMHS. He was not attending CAMHS appointments and continued non-attendance at school. Parents have declined further direct work in relation to parenting. AR is continuing to engage in Family Therapy and no safeguarding concerns raised. (However, AR was not attending family therapy sessions) Parents report that AR is more engaged with them at home. Agreed that Lead Professional role will transfer to school who will continue to support attendance. However, AR was not attending school and was not being seen by any professionals. Risk assessment was not completed.

2.1.23 AR was prescribed Propranolol, then Sertraline, then Fluoxetine and Sertraline again for anxiety and Melatonin for sleep difficulties. He never really took the

prescribed treatment for long enough and discontinued them, himself each time. Whilst efforts were made to see him at home, when he did not attend the clinic, he still refused to be seen. No one had access to his mental state, or what he was doing in his room, to inform his risk assessment. Parents information was relied on.

2.1.24 AR was seen by Seftons Safer Schools officer and Deputy Head on 3 November 2023, at home.

2.1.25 Visit by Transitions Social worker was carried out on 9 November 2023 to complete a Care Act assessment- this was not recorded until after the serious incident. No further visit was arranged.

2.1.26 In 2024, AR was refusing to engage with education, health or social care. Not seen by services. February 2024, CAMHS note AR had not left home for 4 to 5 months. Parents reported he was visually health and gaining weight. No other corroborative information. No risk assessment.

2.1.27 February 2024, CAMHS review the Risk management Tool, along with Child and Adolescent Key Data Report and CYP current view but this is done without speaking to AR.

2.1.28 March 2024, EHCP ceases

2.1.29 April 2024 discharged by the CAMHS Psychiatrist but remained open to family therapist.

2.1.30 April 2024 Care Act assessment still not entered on the system

2.1.31 On 19 June 2024, his mother had emailed the consultant wanting to speak to him about Sertraline but the Consultant was on leave and AR had been discharged from the psychiatrist.

2.1.32 23 July 2024 discharged from community CAMHS

2.1.33 Unclear which services remain involved with AR and his family at the time of the serious incident.

3.0 ANALYSIS AND FINDING (TOPICS AND QUESTIONS)

3.1 Risk assessments

3.1.1 The adequacy of the CAMHS systems and processes for assessing risks and safeguarding concerns generally;

3.1.1.1 It has been noted that CAMHS have a risk assessment that was completed on Triage, but this is not standardised and did not inform decision making around intervention, supervision, discharge and transition.

3.1.1.2 CAMHS systems generally are adequate for assessing generic risks and safeguards but not in cases like this.

3.1.2 How CAMHS assessed the risks / safeguarding concerns posed by AR;

3.1.2.1 Whilst CAMHS carried out a risk assessment on triage, and there is some evidence of them raising concerns within the team and with other agencies, around the risks presented to AR due to the deterioration in his presentation and safeguarding concerns around his parents. This became less clear towards the end of their working relationship with him. With lack of clarity on who would still be working with him.

3.1.2.2 When working with young people who present a high risk to others, to aide with structured risk assessment, CAMHS services will refer the young person for consultation and if required, direct work with community Forensic CAMHS services. After the initial referral to community FCAMHS services, a re-referral was not made, despite a deterioration in his presentation and completion of the Autism assessment.

3.1.3 The adequacy of the assessments undertaken in AR's case in relation to the risks he presented and/or any safeguarding concerns;

3.1.3.1 CAMHS services in general would not have the skill set to complete a structured risk assessment using structured professional judgement risk assessment tools.

3.1.3.2 Following on from the consultation with community FCAMHS, the following was included in the ending letter:

'risk assessment will be complicated by his likely diagnosis of ASC. The known evidence in this field concurs with the discussion we had about Axel with professionals. The following aspects of young people with an ASC diagnosis should be taken into account when considering the risk

- *Disruption in routines and lack of motivation to change to adaptive behaviour*
- *Social naivety*
- *Specialist interests associated with the condition*
- *Experiences of being bullied/rejected and desire for retribution "this may lead to assault on a perpetrator or displacement onto another often completely innocent person" (as demonstrated by Axel)*
- *Hostility to parents*
- *Sensory sensitivities*
- *Following the lead of strong influencer*
- *Lack of awareness of wrongdoing*
- *Deficits in empathy or lack of recognition of fear in others*
- *Not seeing consequences*
- *Comorbid mental health diagnosis (although this has been not to be the case by CAMHS in Axel's case)*
- *Any combination of the above Bailey, Chitsabesan & Tarbuck (2017)*

3.1.3.3 Whilst I agree that a diagnosis of Autism Spectrum Disorder makes carrying out a risk assessment using standard tools more difficult, I do not agree that one could not have been carried out at this stage. In my opinion using a structured professional risk assessment tool like the SAVRY would have given a structure to the risk assessment of violence, would have helped identify historical factors, social/contextual risk factors, individual/clinical factors and Protective factors. It also encourages the use of caveats to describe the risk and mitigating factors. In addition, factors not included, like those specific to a condition like ASD can be articulated separately.

3.1.3.4 Using a structured risk assessment tool ensure the risk is described clearly, it helps identify who is meant to review it, it ensures SMART actions are considered which include interventions with the young person, family and wider systems. In my opinion Community FCAMHS services should have supported the system in pulling a more comprehensive risk assessment.

3.1.3.5 In my opinion, the assessments undertaken in AR's case by CAMHS, or community FCAMHS in relation to the risks he presented with and/or any safeguarding concerns were not adequate.

3.1.4 The appropriateness of the levels of risk identified within those assessments.

3.1.4.1 As the initial risk assessment was not adequate and an adequate tool was not used and appropriate level of risk towards others was not identified. This was not reviewed either with AR or his parents.

3.1.4.2 Latterly the focus of CAMHS services was around his anxiety symptoms and school refusal. There was no mention of his historical risk or review of what he was doing on his computer or how he actually felt about school.

3.2 Escalation of concerns (in relation to risks and/or safeguarding issues)

3.2.1 Where risks and/or safeguarding concerns were identified in relation to AR, and intervention/escalation was sought, the appropriateness of the steps taken and the acceptability of the timeframe in which the intervention/escalation took place;

3.2.1.1 CAMHS Criminal Justice Liaison and Diversion Team appropriately raised concerns, and the risks AR presented with in 2019. However their role was temporary and after raising concerns and the initial period of consultation, they were no longer involved.

3.2.1.2 When CAMHS became involved, they were focused on his physical and mental health. When his physical health deteriorated, they escalated concerns and made recommendations for dietetic input and input from the eating disorder services.

3.2.1.3 They also raised concerns when AR went missing on 17 March 2022 but after the police were informed, there was little in the way of an action plan to address the reasons why he had gone missing or to challenge the rationale for why he wasn't processed through the criminal justice system. At the time, the police were of the opinion that he had 'severe Autism' and it would not be appropriate for him to be processed.

3.2.1.4 The Alder Hey Internal review concluded that, "*there were 11 occasions within AR's care when it may have been appropriate for practitioners to have sought safeguarding supervision. There have been potential missed opportunities to escalate safeguarding concerns and seek safeguarding supervision which may have resulted in the Safeguarding Team supporting practitioners to escalate concerns to achieve a better coordinated multi-agency response.*"

3.2.2 Any risks and/or safeguarding concerns which should have been, but were not, identified in relation to AR, and the steps which should have been taken as a result of those concerns.

3.2.2.1 AR was out with parental control, he had been presenting a risk in the family home, he was withdrawn and spending considerable periods of time on his computer, he was not looking after himself (he hadn't showered for more than a month). Right back in September 2023 when reviewing his attendance and parents inability to make him engage, these should have been escalated through safeguarding. Around the same time, when CAMHS were unable to meet directly with him, consideration should have been given to carry out a mental health act assessment and safeguarding concerns should have been escalated through children's services.

3.3 Diagnosis and treatment of AR

3.3.1 In addition, to the questions noted below I have included the additional instruction received on 10 September 2025 to address the question of whether AR met criteria for a diagnosis of Conduct disorder.

3.3.1.1 AR Was initially diagnosed with autism spectrum disorder (ASD). He also described feeling anxious and presented with social withdrawal and school refusal. The later were attributed to his diagnosis of Autism.

3.3.1.2 Further he had a history of repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms, rules, or laws are violated such as aggression towards people; destruction of property; deceitfulness and serious violations of rules which predated his first contact with CAMHS. In line the WHO International Classification of Disease 11th Edition (ICD 11), he would meet criteria for a diagnosis of Conduct -dissocial disorder.

3.3.1.3 However, Conduct disorder is a diagnosis of social construct and the interventions are primarily focused at supporting parents in developing parenting skills and supporting young people developing pro-social skills. Both originally recommended, when the youth offending services were involved.

3.3.1.4 A diagnosis of conduct disorder can be made by any trained CAMHS clinician and does not rely on Forensic CAMHS services.

3.3.1.5 A diagnosis of conduct disorder, in the absence of any other condition would have prompted an earlier discharge from community CAMHS services, and a risk assessment considering this would have supported social care to ensure the need for supervision and monitoring.

3.3.2 The adequacy of treatment provided to AR by CAMHS professionals (including the use of prescribed medication);

3.3.2.1 CAMHS primarily focused on symptoms of anxiety and poor sleep.

3.3.2.2 The pharmacological treatment recommended was in line with NICE guidelines and peer approved practices

3.3.2.3 Talking therapies which would be first line, were considered but AR did not engage.

3.3.2.4 Family therapy is also an evidence-based approach for young people with anxiety and school refusal and for conduct disorder.

3.3.2.5 Referral to Eating disorder services and dietetics when there were concerns around his weight.

3.3.2.6 In my opinion the treatment noted above was adequate for the conditions identified by CAMHS.

3.3.3 To the extent that you identify any inadequacy, the treatment(s) that you consider would have been more appropriate;

3.3.3.1 In the absence of a risk assessment that informed the management plan, there was no intervention carried out to review his risk of harm to others, with him and his parents and to consider other management plans, like supervision of his internet use, mental health act assessment etc.

3.3.4 The appropriateness of the decision to discharge AR from CAMHS psychiatry in April 2024.

3.3.4.1 Young people often will disengage from services as they near their 18th birthday and are discharged or referred to their General Practitioner as they do not meet the threshold for adult mental health services.

3.3.4.2 AR had historical risks, he was increasingly isolated, presenting with aggression and violence in the family home, there were concerns about the parents colluding with him and undermining professionals, it was reported he was not showering and was spending increasing periods on the computer. Professionals attempted to see him face to face at his home, but he would not come out of his room to see them. Parents reported improvement in his engagement with them and improvement in his physical health, but this was not consistent.

3.3.4.3 In my opinion, given his historic risks and the deterioration in his presentation, this should have prompted a mental health act assessment. It is likely that there would be no evidence to suggest he needed treatment in hospital but it would have given an opportunity to assess him face to face and assess his risk to self and others, with him.

3.3.4.4 In my opinion, if the above had been considered early in September 2023 and he was then discharged with a clear escalation in safeguarding concerns to social services, then that would have been more appropriate, rather than his care remaining open for as long as it did without him being seen or the risk being assessed.

3.4 Steps taken to engage/re-engage AR with treatment (including the taking of prescribed medication)

3.4.1 The steps and/or processes that would have been available to CAMHS to try to engage/re-engage AR with treatment and his prescribed medication, and the adequacy of any steps in fact taken in that regard by CAMHS in relation to AR;

3.4.2 Any other steps which you consider CAMHS ought to have taken to engage/re-engage AR with treatment and his prescribed medication;
Addressed both 3.4.1 and 3.4.2

3.4.2.1 CAMHS tried to engage with AR virtually, and in person. They did a home visit and tried seeing him at school.

3.4.2.2 They stopped medication appropriately when they became aware of his noncompliance.

3.4.3 The steps and/or processes that would have been available to CAMHS to assess and/or otherwise manage the risk of AR after he dis-engaged from treatment and/or was failing to take his medication as prescribed, and the adequacy of any steps in fact taken in that regard;

3.4.3.1 In my opinion the steps and or process taken to assess and/ or manage risks after he dis-engaged were not adequate. When AR was starting to disengage from services and when his risk was escalating in the family home, safeguarding concerns should have been escalated and a re-referral to FCAMHS services should have been triggered at the time, to support a risk assessment.

3.4.4 Any other steps which you consider CAMHS ought to have taken to assess and/or otherwise manage the risk of AR after he dis-engaged from treatment and/or was failing to take his medication as prescribed.

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

3.5 Inter-Agency Working Arrangements

3.5.1 The adequacy of the inter-agency working arrangements that were in place generally, including for information sharing and the effectiveness of communication, including the degree of openness between agencies;

3.5.1.1 There were a number of interagency meetings, not all were attended by all parties involved in AR's care consistently.

3.5.1.2 When other agencies like PREVENT were referred to, it was unclear how they carried out their decision making and how this was communicated to the services that were directly involved with AR. From the documents made available to me, his presentation at the time was attributed to his diagnosis of Autism and felt not to require threshold for a referral to Channel.

3.5.1.3 Minutes of the multiagency meeting were not always clearly documented and shared with all parties concerned.

3.5.1.4 Latterly, as he disengaged from education and CAMHS, it was unclear who remained involved and who was in communication with the transitions team that was meant to continue working with him.

3.5.1.5 In my opinion, whilst there were a number of meetings, in the absence of a lead agency, a clear handover process and an appropriate risk assessment, the interagency working arrangements were not adequate.

3.5.2 The adequacy of inter-agency working, information sharing and communication between agencies in relation to the treatment and care of AR.

3.5.2.1 Whilst a number of professionals were involved in his care and there were a number of multiprofessional meetings, it is unclear whether the different agencies knew who to approach for different aspects of his care and risk.

3.5.2.2 For example, on 17 March 2022, when the decision was made by the police to not proceed with charging him, it was unclear whether CAMHS service were consulted on the severity of his ASD diagnosis and his fitness to be interviewed. He was a bright young person who had been charged previously and received a 10-month referral order. It is likely that if he had been clinically assessed he would have been fit to be interviewed and processed through the criminal justice system.

3.5.2.3 **In my opinion, adequacy of inter-agency working, information sharing and communication between agencies in relation to the treatment and care of AR was not adequate.**

3.6 Record keeping

3.6.1 The adequacy of record keeping by CAMHS in relation to AR's treatment/care.

3.6.1.1 Alder Hey internal learning review, notes;

3.6.1.2 *"Record keeping was not consistently in accordance with the policies and procedures, or professional record keeping standards.*

3.6.1.3 *Inadequate record keeping practice resulted in an incomplete clinical picture of AR's care for other professionals accessing AR's Electronic Patient Record (EPR) and for the ongoing continuity of care.*

3.6.1.4 *The use of multiple EPRs (EMIS and Meditech) within community services has led to some practitioners not having a complete holistic picture of the whole physical and mental health clinical care of AR.*

3.6.1.5 *Not all minutes of multi-agency meetings are available in AR's EPR. CAMHS Case Managers did receive some multi-agency documentation (EHCPs and Early Help Plans) but did not upload these to AR's EPR. It remains unclear if all multi-agency minutes were shared with CAMHS Case Managers by Lancashire Children's Social Care."*

3.6.1.6 In my opinion, the record keeping noted above was not adequate, I have nothing further to add to the above.

3.7 Resourcing, training and guidance

3.7.1 Your understanding of the availability of adequate resources within CAMHS at the time at which AR was engaging with CAMHS;

3.7.1.1 At the time AR was first seen by CAMHS, the COVID pandemic was just emerging which had an impact on staff availability and how assessments and engagement was carried out.

3.7.2 If known, the adequacy of any guidance or training available to professionals at CAMHS who engaged with AR.

3.7.2.1 Clinicians working with AR were experienced clinicians who were working within their area of expertise and would have had the statutory training in safeguarding and risk assessment delivered through the trust. However, given AR's complexities, there wasn't a clear escalation process to seek a more appropriate risk assessment to inform his management.

3.8 Improvements

3.8.1 Any areas, not already covered above, where CAMHS did not follow or comply with relevant guidance, procedures, and/or expected practices in your view;

3.8.2 Whether you consider that CAMHS could have done anything more, or differently, to reduce the risk AR posed to the public;

3.8.2.1 A re-referral to community FCAMHS to support the system with an informed risk assessment.

3.8.2.2 Community FCAMHS to have completed a structured risk assessment with the agencies involved in AR's care when they were first consulted with.

3.8.3 If known, any improvements made since these events (including to training) and their effectiveness;

3.8.3.1 Both the community FCAMHS services with Greater Manchester NHS Foundation Trust and Community CAMHS services with Alder Hey Foundation Trust have list areas of Improvement since their involvement with AR.

3.8.3.2 Areas of Improvement noted in FCAMHS include:

3.8.3.2.1 Following an increase in funding the development of a learning disability and autism pathway in the service, FCAMHS has been provisioned to deliver autism assessments in those young people, where a diagnosis is suspected, and for the safety of the young person and others, it is not appropriate for the young person to wait.

3.8.3.2.2 *Additional funding has also allowed FCAMHS to recruit a speech and language therapist, and specialist learning disability nurse, to enhance the service offer for young people with neurodevelopmental variance.*

3.8.3.2.3 *A template for consultation letters/reports is in place which, through use of headings, makes risk information and recommendations clearer. Each of these recommendations is now allocated to an agency, allowing FCAMHS to check the progress of recommendations at review meetings. The template also includes details of all professionals in attendance at the meeting and who the report was sent to. Confirmation of receipt is requested from each recipient, which is then recorded in the clinical record. The quality of the FCAMHS letters is audited regularly, internally and by commissioners. This ensures our partners are receiving clear advice and recommendations, which can easily be incorporated into their care plans and local risk assessments.*

3.8.3.2.4 *The escalation process is now clearer when a service does not adopt critical recommendations, closes referrals, or discharges in ways considered unsafe.*

3.8.3.2.5 *Practitioner guidance for when a case should be assessed has been strengthened.*

3.8.3.2.6 *The service now has key performance indicators in place, with respect to triaging referrals in one working day, offering an initial consultation within four weeks, and sending the letter detailing the consultation within three weeks of the meeting taking place.*

3.8.3.2.7 *The decision to close a referral to FCAMHS has been made more robust. The practitioner now requires a colleague to scrutinise the clinical impression, recommendations, and decision to discharge, before providing their endorsement. If there is a difference in clinical opinion, the case is taken for senior review at the weekly FCAMHS multidisciplinary team meeting.*

3.8.3.2.8 *I am also aware that on a national level training has been rolled out across the FCAMHS national network to optimising the expertise on risk assessment within FCAMHS services and provide an online resource to inform services of how they are meant to function.*

3.8.3.3 Areas of Improvement recommended through the Alder Hey Enquiry include 39 recommendations. I have not included these here as it remains unclear as to which of these have been actioned.

3.8.3.4 The Alder Hey CQC report for 2025 highlights the following improvements:

3.8.3.4.1 *The service was recruiting a psychological wellbeing practitioner who would sit in adult services and case manage individuals making the transition. There was a Transition Lead based within the local mental health trust that provided adult services. The Transition Lead was not routinely involved in every transition of care but was involved in more complex cases and was able to provide advice ,guidance and a means to escalate concerns.*

3.8.3.4.2 With regard to safeguarding alerts, *"At the time of our inspection staff had to contact the Trust's central safeguarding team and request that they put the alert on. However, following our inspection the Trust took immediate steps to change this. Staff were now able to place a temporary safeguarding alert on the system. A daily report was sent to the Trust safeguarding team who could then validate the alert or, it was deemed appropriate remove it."*

3.8.3.4.3 With regards to Risk, *"Service user risks were initially recorded and considered at the referral and triage stages of the care pathway. Following our inspection the service made changes to the triage form, including the introduction of mandatory text fields for each key risk domain and a requirement to score risks as high, medium, low or not known. The triage form was also updated to incorporate a formulation section that utilised the 5 P's framework (presenting issues, precipitating factors, perpetuating factors, predisposing factors and protective*

factors). This supported staff to better gather information about the needs of the child or young person, the level of concern, the impact of the problem and contextual factors informing each risk.

3.8.3.4.4 *A Risk and Care plan function had been developed which gave staff easy access to key risk documents and which provided a clearer overview of service user risk. A Systematic Risk Management Tool had been introduced to provide easier access to documents provided by other organisations and providers. The Special Indicators function had been altered to enable staff to add risk flags directly to the system and they were now more prominently displayed onscreen."*

3.8.4 **The Chair is tasked with making recommendations but ensuring, through engagement with relevant practitioners, that the recommendations are practicable. Please consider whether there are any improvements that could be made to CAMHS that would be practicable and make an effective difference.**

3.8.4.1 Several recommendations have been made for both FCAMHS and CAMHS services through their independent reviews which include more robust, risk assessments, escalation systems, safeguarding review and supervision, documentation and transitions.

3.8.4.2 In addition to those recommendations, in my opinion, the following will be useful when multiple agencies are involved with a young person with a diagnosis of ASD and who presents a risk to others.

3.8.4.2.1 The system ensures that a lead organisation is identified to hold the risk assessment and to ensure that the other agencies are accountable for their actions.

3.8.4.2.2 A comprehensive structured risk assessment is commissioned when local risk assessments do not fulfil the need.

3.8.4.2.3 When external agencies like PREVENT are referred to, they need to work collaboratively with the agencies involved and share their risk assessment with the wider system and receive feedback from services before concluding their assessment.

4.0 CONCLUSION

4.1 On 29 July 2024, Axel Rudakubana "AR" , carried out a knife attack at a children's dance club in Southport. He murdered 3 young girls, Elsie Dot Stancombe, Alice da Silva Aguiar and Bebe King, and injured 10 other people. Sixteen others survived the attack but live with the serious emotional scars. He was 9 days away from his 18th birthday at the time of the serious incident.

4.2 The purpose of this report is to provide an expert opinion on the CAMHS provision for AR. This includes both community CAMHS and community FCAMHS.

4.3 Both service lines have carried out internal reviews and considered recommendations for improvements to be made. They are extensive and detailed in their reports.

4.4 My summary of key learnings include:

4.4.1 Identifying a lead organisation who holds the risk assessment for the young person and through it holds others accountable for their actions. This also ensures that the risk assessment is reviewed on a regular basis and actions amended/updated accordingly. This does not have to be CAMHS services.

4.4.2 A structured risk assessment is carried out using an structured professional judgement tool like the SAVRY which is a structured professional risk assessment tool for violence in young people and in young people with Autism this can be further supplemented with Framework for the Assessment of Risk & Protection in

Offenders on the Autistic Spectrum (FARAS), which is a recent development in the world of risk assessments.

4.4.3 Specialist services like community FCAMHS are consulted with who should be supporting the completion of the risk assessments noted above.

4.4.4 There have been several recommendations made around documentation, escalation and liaison between services, within the internal reviews. In my view, key clinicians involved should ensure clear documented handovers of the young person, the systemic issues and their risk.

4.4.5 When a young person disengages and clinicians are worried about risk and safeguarding, due consideration should be given to the use of the Mental Health Act to assess the young person.

4.4.6 A diagnosis of Autism does not preclude a young person from being processed through the criminal justice system or be fit to be interviewed and tried and to develop skills to address their risks.

4.4.7 Further, in my opinion, a diagnosis of Autism in someone who does not have a learning disability and is of normal intellect increases the risks, particularly if the risk is associated with their area of special interests and is accompanied with a lack of empathy.

4.4.8 In my opinion it would be useful to commission training that is nationally accessible for all statutory bodies, including organisations like PREVENT, and the police.

4.4.9 One of the factors, whilst not referenced in this report, would probably be useful for the chair to consider, is the absence of a legislative framework on monitoring the use of the internet by a young person with known risks but no legal premise.

5.0 DECLARATION

5.1 "I Dr Tina Irani, confirm that:

I have made clear which facts and matters referred to in this report are within my knowledge and which are not.

Those that are within my knowledge I confirm to be true.

The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer."

Signature

Dr Tina Irani MBBS MRC Psych

Consultant Child and Adolescent Forensic Psychiatrist

Approved under Section 12 (2) Mental Health Act 1983(amended 2007)

APPENDIX 1

Abbreviated Curriculum Vitae

Tina Irani

Contact Details:
Austen House
Tatchbury Mount
Calmore
Southampton SO40 2TA
E-mail: DPA

GMC Registration No: 6036816

Royal College of Psychiatrists Membership No: 810939

Medical Defence Union Membership No: 438231E

Approved under Section 12(2) of the Mental Health Act 2007 2016 (renewed)

Undergraduate Education

Padmashree Dr D Y Patil Medical College 1995-2001
University of Mumbai, India

Qualifications

MB BS 2000

MRC Psych (Part 1 and part 2 passed at first attempt) 2005

CURRENT APPOINTMENT

JANUARY 2020: CONSULTANT CHILD AND ADOLESCENT FORENSIC PSYCHIATRIST

Southern Health Foundation NHS Trust
- Consultant Psychiatrist for Low secure Adolescent inpatient unit Austen House.
- Clinical Lead for General, Low Secure, and Medium Secure Adolescent Inpatient services.

National Posts
- April 2019 to June 2022 - Co-Chair of the Clinical reference Group for Child and Adolescent Mental Health Services to NHS England,

- 2019- Elected Member of the Royal College of Psychiatrist, Child and Adolescent Faculty

Appointments to date:

01.12.18- 06.01.20	Consultant	Community FCAMHS and CAMHS Surrey and Borders Partnership Trust
10.07.16-30.11.18	Clinical Lead	CAMHS services within the secure directorate, Birmingham Solihull Mental Health Foundation Trust
02.04.13- 30.11.18	Consultant	Inpatient and Community FCAMHS services Birmingham Solihull Mental Health Foundation Trust
01.02.12-31.03.13	Locum Consultant	Inpatient and Community Adolescent Forensics West London Mental Health Services
01.02.07- 31.01.12	Specialist Registrar	West Of Scotland Adolescent Forensics Training Scheme
03.08.11- 01.11.11	Acting Consultant	LAAC Mental Health Glasgow
22.05.06– 31.01.07	Locum Specialist Registrar	Forensic Psychiatry Oxford Clinic, Littlemore Hospital, Oxford
15.02.06– 22.05.06	Locum Staff Grade	Assertive Outreach & Psychiatric Intensive Care Warneford Hospital, Oxford
08.08.02– 07.02.06	Senior House Officer	Oxford Psychiatry Training Scheme

CLINICAL EXPERIENCE

- My expertise is working with young people who have complex mental health needs, in particular neurodevelopmental conditions such as autism and high-risk behaviour.
- I have worked in inpatient mental health setting at different levels of security, as an in-reach psychiatrist in custody and as a community Forensic CAMHS psychiatrist and as a specialist within a community Autism diagnostic service.

MEDICO-LEGAL EXPERIENCE

- Expert witness in criminal proceedings concerning adolescents. This includes preparation of reports in relation to Fitness to Plead, and sentencing/disposal issues and giving evidence in crown court.
- Experience in preparing reports for courts in criminal proceedings concerning young people in the inpatient setting.
- Preparation of reports and giving evidence in Mental Health Review Tribunals.
- Expert witness reports in care proceedings both in Scotland and England including assessments of impact of contact on the child's mental state and development and assessments in secure care proceedings.
- Expert witness in Litigation cases for Young People

APPENDIX 2

SELECTED REFERENCES

- Borum, R., Bartel, P., & Forth, A. (2006). Manual for the Structured Assessment of Violence Risk in Youth (SAVRY).

- The SAVRY (Structured Assessment of Violence Risk in Youth) has been used to assess and guide opinion regarding risk of physical violence. The SAVRY is a structured risk assessment of violence risk in youth (Borum, Bartel & Forth, 2003). It was founded on the research evidence relating to violence in adolescents.
  This SAVRY is composed of twenty-four risk items, ten historical, six social/contextual and eight individual and six protective factors. Each risk item is coded low, moderate or high and each protective factor is coded present or absent. The historical risk factors are mainly static in nature. The social/contextual individual risk factors are dynamic in nature and indicate potential opportunities for therapeutic interventions to reduce the risk of violence. Protective factors are similarly dynamic and represent strengths that mitigate against the adverse risk factors and can be built upon to reduce the risk of violence. Critical items of those items that seem particularly relevant to the risk of violence in individual cases. Additional risk factors can be added if they are relevant to the risk of violence in particular cases

- Allely CS, Jouenne E, Westphal A, Staufenberg E, Murphy D. Autism spectrum disorder, extremism and risk assessment. Crim Behav Ment Health. 2024 Apr;34(2):182-196. doi: 10.1002/cbm.2330. Epub 2024 Feb 11. PMID: 38341798.

- National Resource on Community FCAMHS https://integratedcare.gomocentral.com/content/20a7dccfcc38f2806bdeaaba2c21f065c7e8/web

APPENDIX 3

Diagnoses according to the ICD 11 Classification of diseases

6C91 Conduct-dissocial disorder

Conduct-dissocial disorder, adolescent onset is characterised by a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms, rules, or laws are violated such as aggression towards people or animals; destruction of property; deceitfulness or theft; and serious violations of rules. To be diagnosed, the behaviour pattern must be enduring over a significant period of time (e.g., 12 months or more). Isolated dissocial or criminal acts are thus not in themselves grounds for the diagnosis.

6A02 Autism spectrum disorder

Autism spectrum disorder is characterised by persistent deficits in the ability to initiate and to sustain reciprocal social interaction and social communication, and by a range of restricted, repetitive, and inflexible patterns of behaviour, interests or activities that are clearly atypical or excessive for the individual's age and sociocultural context. The onset of the disorder occurs during the developmental period, typically in early childhood, but symptoms may not become fully manifest until later, when social demands exceed limited capacities. Deficits are sufficiently severe to cause impairment in personal, family, social, educational, occupational or other important areas of functioning and are usually a pervasive feature of the individual's functioning observable in all settings, although they may vary according to social, educational, or other context. Individuals along the spectrum exhibit a full range of intellectual functioning and language abilities.