Southport Inquiry

Witness Name: Dr Nina Champaneri

Exhibits: NC/01

Dated: 31 July 2026

THE SOUTHPORT INQUIRY

FIRST WITNESS STATEMENT OF DR NINA CHAMPANERI

I, Dr Nina Champaneri, will say as follows: -

INTRODUCTION

1. I am a Consultant Child and Adolescent Psychiatrist, registered with the General Medical Council and included on the Specialist Register for Child and Adolescent Psychiatry.
2. This witness statement is made to assist the Southport Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 10 July 2025.

BACKGROUND

3. I have a medical degree from the University of Glasgow (MBChB) and am a Fellow of the Royal College of Psychiatrists (FRCPsych). I have a certificate of completion of training (CCT) in Child & Adolescent Psychiatry. I am on the General Medical Council Specialist Register in Child & Adolescent Psychiatry. I hold Approved Clinician status under the Mental Health Act.
4. I am a Member of the Royal College of Psychiatrists and have more than 20 years' experience in Child and Adolescent Mental Health Services (CAMHS), including community, urgent care, inpatient and forensic settings. My clinical practice has focused on the assessment and treatment of children and adolescents presenting with severe and complex mental disorders, neurodevelopmental disorders, trauma-related conditions, high-risk and offending behaviour.
5. I am employed by Birmingham and Solihull Mental Health NHS Foundation Trust as a Consultant Child & Adolescent Psychiatrist in the West Midlands Community Forensic CAMHS team, where my clinical practice is based. I hold a leadership role with NHS

England as Co-National Clinical lead for Community Forensic CAMHS which includes supporting the development of clinical standards and policy across Community Forensic CAMHS in England. Additionally, I hold a role via secondment with Birmingham Women's and Children's Hospital in the West Midlands CAMHS Provider Collaborative which includes the strategic oversight, commissioning, clinical and quality oversight of CAMHS inpatient units across the West Midlands.

6. I have expertise in the assessment of violence risk, formulation of offending behaviour, consideration of the relationship between mental disorder and offending, and the development of evidence-based risk management recommendations. My experience encompasses the assessment of young people with neurodevelopmental disorders, personality difficulties, trauma, psychosis, severe mental illness and complex safeguarding concerns, including those involved with the youth justice system, secure and custodial placements and secure hospitals.
7. I have extensive experience in the preparation of independent medicolegal reports and the provision of expert psychiatric opinion for criminal and civil proceedings, in addition to the Coroner's court. My opinions are informed by my clinical expertise, current evidence base, relevant professional guidance and current psychiatric practice.

Introductory matters

8. The term Violent Fixated Individuals (VFI) is being used within clinical practice in FCAMHS. There is no agreed definition however and this is not a recognised Psychiatric diagnosis in accordance with classification systems commonly used, such as the International Classification of Diseases (ICD 11) published by the World Health Organisation (2019) or the Diagnostic and Statistical Manual (DSM-5) published by the American Psychiatric Association (2022).
9. The term is used to describe a set of behaviours that an individual displays where there is a fixation with violence, causing harm to an individual or on a mass scale where there may not be obvious ideological thinking present.
10. There are challenges that arise from inconsistency or lack of clarity in relation to the use of language or definition. Clinicians may have a differing interpretation of what fixation is, leading to varying referral thresholds. From a psychiatric perspective, fixation could form part of a normal developmental trajectory or indicate a neurodevelopmental special interest, or be associated with obsessive or psychotic phenomena. From a multi agency perspective, inconsistent terminology can lead to miscommunication around risk and thresholds for specialist assessment.
11. I have not personally undertaken or contributed to any statistical analysis of the risk posed by VFI's. However, as part of my role as co-National Clinical lead for FCAMHS, NHS

England hold an annual review process. This reviews each FCAMHS service in England against the national FCAMHS service specification [NC/01-**DNC000001**]. In years 2024-2026 every team has been requested to record the numbers of children and young people under the age of 18 who present with these behaviours. Although there has been no statistical analysis performed on this data, each team has recorded seeing increasing numbers of children and young people with this presentation.

The Mental Health Act 1983 and other legal powers

12. The Mental Health Act 1983 (as amended 2007) offers the ability to detain an individual in hospital only where the individual is suffering from a mental disorder of a nature or degree for assessment (Section 2) for up to 28 days or for assessment and treatment (Section 3) for up to 6 months, which can be further renewed. A fixation on violence, attack planning, or a risk of serious violence does not, in itself, provide a lawful basis for detention under the Mental Health Act, in the absence of a Mental Disorder.
13. The Mental Health Act 1983 (as amended 2025) introduces no powers that are specific to VFI. However, there are changes around autistic individuals being detained. Under the reforms, autism alone will no longer provide a lawful basis for detention for treatment under Section 3 or for the imposition of a Community Treatment Order (CTO). Whilst detention for assessment under Section 2 remains available where the statutory criteria are met, longer-term detention will require the presence of a co-occurring mental disorder that independently satisfies the detention criteria. Accordingly, where an individual with violent fixation presents with autism but no co-occurring mental illness, the reforms reduce the circumstances in which compulsory detention under the Mental Health Act is available.
14. Where an individual is refusing engagement and there is concern about a risk of serious violence, the options available to psychiatrists are relatively limited unless the threshold for intervention under existing legislation is met.
15. If there is reason to believe that the individual may be suffering from a mental disorder, consideration can be given to an assessment under the Mental Health Act 1983. A Mental Health Act assessment may be appropriate where the available information provides reasonable grounds to suspect the presence of a qualifying mental disorder and the statutory criteria for detention are potentially met. However, the Mental Health Act does not provide powers to assess or detain purely on the basis of violence risk, in the absence of mental disorder.
16. In clinical practice I would seek to obtain information from other agencies which may include family, social care, other health based services such as CAMHS or Paediatrics, education, police and youth justice. This would allow all agencies to share their concerns which could be brought together into a shared narrative or formulation. If this suggests that

there is reason to believe that the individual may be suffering from a mental disorder, consideration can be given to an assessment under the Mental Health Act 1983. If the concerns relate primarily to public protection rather than mental disorder, referral to other agencies may be more appropriate. This may include police-led threat assessment processes, PREVENT/Channel arrangements where relevant, safeguarding procedures, youth offending services, probation services or multi-agency public protection frameworks, depending upon the individual's age and circumstances.

17. The current framework addresses this scenario to a degree from the aspect of; if there is a mental disorder then a mental health act assessment could be considered, and if there is an absence of a mental disorder then police led actions could be considered. The difficulties arise when an individual is refusing to engage with services and has capacity to do so, has not committed an offence and does not meet safeguarding thresholds. This then relies on voluntary engagement and potentially indirect monitoring despite concerns regarding risk, as there is no applicable statutory framework that can be applied.
18. The Mental Health Act was established to provide a legal framework for intervention where there is a mental disorder present. There is currently insufficient evidence to support the view that all individuals presenting with VFI have a mental disorder. Extending compulsory powers to those without a mental disorder would represent a significant expansion of the scope of mental health legislation beyond its original purpose. In the absence of mental disorder, the Mental Health Act does not provide a lawful basis for intervention.
19. Consideration could be given to a statutory multi-agency framework which would place duties on relevant agencies to share information, coordinate assessment and manage risk. If there are public protection concerns and non engagement, then consideration could be given to legislative frameworks which would support the engagement of the individual within the public protection arena.
20. I have personally not experienced a situation where I have assessed an individual who does not have a mental disorder, within the meaning of the mental health act but are assessed as posing a risk of harm to others. As my practice, both in the NHS and medicolegal capacity is focussed on forensic CAMHS, I see young people who have been referred due to a mental health need.
21. All Psychiatrists who have gained adequate experience, usually 3 years after basic training or following completion of Royal College membership exams (MRCPsych), are able to undertake Mental Health Act assessments under the Mental Health Act 1983. It would be expected that the presence of a Mental disorder, including neurodevelopmental conditions alongside risk would be taken into account during the assessment.
22. Neurodevelopmental conditions can affect how risk is understood, assessed and managed. Risk can arise from the neurodevelopmental condition itself, co-occurring

mental illness or situational aspects which can be related to a person's neurodevelopmental profile.

23. There is no pharmacological "treatment" for autism. The management centres around psychoeducation and supportive measures which may include psychological input to support relational difficulties and comorbid conditions, occupational therapy input around managing activities of daily living and speech and language therapy input to support communication needs. Although these supportive treatments are not specifically designed for an individual fixated on violence, they would be helpful in this context in managing behaviours that may lead to risk.
24. Regarding the management of children and young people under the age of 18 years, there is no single agency responsible for managing the risk posed by an identified individual with violent fixation where there is a co-occurring mental health need. This is usually managed with a multiagency approach, with each agency contributing to their area of specialism.
25. I am aware there is an overrepresentation in the number of referrals to PREVENT where the individual has autism. There is no causative link identified between autism and violent fixated individuals, however, some of the symptoms and vulnerabilities from having a diagnosis of autism can lead to a fixation with violence. Cognitive rigidity, perseverative thinking, having circumscribed and limited interests, social isolation and social communication difficulties may increase susceptibility, however, this is not the case for every young person with autism.
26. The Mental Health Act contains a number of safeguards designed to protect patients' rights and ensure that compulsory powers are only used when necessary. There are strict legal criteria for detention, requiring that an individual has a recognised mental disorder of a nature or degree that warrants detention in hospital and that detention is necessary in the interests of the person's health or safety or for the protection of others. Decisions around detention are subject to scrutiny by approved mental health professionals and responsible clinicians, regular review processes, rights of appeal to Mental Health Tribunals, and access to Independent Mental Health Advocates. These safeguards help to ensure that any restriction of liberty is lawful, proportionate and justified.
27. The accompanying Mental Health Act Code of Practice (2015) reinforces the principle of the least restrictive option, requiring clinicians to consider whether a person's needs can be met safely in a less restrictive setting before compulsory powers are used, which promotes patient autonomy and ensures that detention is not used unnecessarily.
28. The Mental Health Act provides a legal mechanism to intervene when a person lacks insight into their illness, refuses necessary treatment, or presents escalating risks that cannot be safely managed in the community. The ability to detain, assess and treat individuals in these circumstances provides a public protection function of the legislation.

29. This is particularly the case in forensic mental health settings, where the Mental Health Act provides additional powers and safeguards to manage individuals who may pose a serious risk to the public as a result of their mental disorder. Restrictions on discharge, oversight by the Ministry of Justice in restricted cases, and multi-agency risk management arrangements help to ensure that public protection considerations are given appropriate weight while continuing to uphold patients' legal rights and access to treatment.
30. The Mental Health Act (MHA) has evolved significantly since its introduction in 1959, through the amendments enacted in 2007, and the further reforms proposed in the forthcoming Mental Health Act. However, the legislation predates the concept of individuals with a fixation on violence (VFIs), although provisions relating to the protection of the public from harm have always formed part of the statutory framework.
31. The Mental Health Act permits compulsory assessment and detention in hospital only where an individual is suffering from a mental disorder and the relevant statutory criteria for detention are met. Consequently, a fixation on violence, in the absence of an identifiable or suspected mental disorder, would not in itself provide a legal basis for detention or intervention under Act.
32. This creates a potential gap in circumstances where an individual presents with significant concerns regarding a fixation on violence and an associated risk of serious harm to others, but does not appear to be experiencing a mental disorder that meets the threshold for compulsory intervention. In such cases, mental health practitioners may have limited powers to intervene under the Mental Health Act despite concerns about the risk posed. Management of such individuals may therefore require alternative legal, safeguarding, public protection, or multi-agency approaches rather than reliance on mental health legislation alone.

Risk assessment and management of VFI's

33. There is no single validated tool that accurately predicts the risk in violent fixated individuals. Psychiatrists would usually carry out these assessments as part of their role in a forensic team – either in an adult service or a child & adolescent service or in a medicolegal context. The assessment is often informed by multiagency information from police, health and justice services, other health organisations and social care. In these circumstances, Psychiatrists rely on structured professional judgement in assessing risk and a formulation is developed which integrates psychiatric, developmental, social factors and threat assessment principles.
34. There are structured professional judgement tools such as the Structured assessment of violence risk in youth (SAVRY) and the Historical Clinical Risk Management-20 Version 3 (HCR-20) used in adults that can provide a framework for the systematic assessment of

general violence risk, but they have not been specifically developed or validated for the assessment of VFI risk. The Forensic Assessment of Risk and Safety (FARAS) framework can provide a structured approach to formulation but is not an assessment tool.

35. These tools were predominantly designed to assess the interpersonal risk of violence, rather than being sensitive in detecting the early stages of targeted violence or fixation. The tools can identify relevant historical risk factors such as previous violence and aggression, impulsivity, substance misuse, poor emotional regulation, emerging psychotic symptoms, personality vulnerabilities, poor treatment engagement and social stressors and destabilisation. These factors contribute to an understanding around an individual's propensity towards violence but do not take into account indicators of targeted violence including: intense fixation on a person/ organisation/ institution, any research undertaken by the individual around targets or attack methods, reconnaissance or online activity including interactions with ideological/ non ideological extremist groups or individuals. If the individual has not yet committed a violent offence, historical risk factors can be captured.
36. A specific threat assessment may provide a structured framework for evaluating the credibility, intent and immediacy of a threat but would be less useful if there is not an explicit threat made, particularly in the VFI cohort.
37. There is no validated or universally accepted threshold for undertaking a VFI risk assessment. A risk assessment should be undertaken if there are concerns from the information available that an individual is progressing towards targeted violence. This would ideally be undertaken with the involvement of the professional network around the individual.
38. In my opinion, there may be inconsistency in the threshold for undertaking specialist assessments of VFI's across services. This reflects the absence of nationally defined referral criteria or operational guidance, combined with differences in local commissioning arrangements, service models and workforce.
39. Establishing evidence informed guidance on referral thresholds and risk assessment standards would facilitate a more consistent approach to improve the identification of risk posed by VFI's, for all agencies.
40. In principle, a single assessment tool would be more practicable and accessible if it could be used across the public sector, however in practice, my experience is that each agency focusses on risk in a different context, e.g. health services are more likely to view risk with the lens of mental illness or neurodevelopmental difficulties and justice services may view risk with a greater emphasis on public protection. This challenges with this would be identifying the "owner" of the risk assessment and how this would be updated, shared and risks acted upon with relevant agencies. There may also be a particular skill level required

in completing an assessment and therefore a suitable professional would need to be identified.

41. Healthcare clinicians would have access to, and consider previous health information such as diagnosis/ previous illness/ hospitalisation/ interventions and treatment, which they have access to from health records, to inform risk assessment; and therefore would be beneficial to have a separate assessment tool.
42. All Psychiatrists are trained in carrying out risk assessments in the context of mental health and neurodevelopmental difficulties. Psychiatric training from trainee to consultant psychiatrist level is 7 years and follows the curriculum set by the Royal College of Psychiatrist. Options for Psychiatric specialisation include General Adult Psychiatry, Older Adult Psychiatry, Psychotherapy, Learning Disability, Child and Adolescent and Forensic Psychiatry. There are dual posts e.g. combining Child and Adolescent with Forensic training. Psychiatric training is predominantly centred around risk to self although risk to other is considered. Risk to others is considered further in Forensic training pathways. Trainees do not automatically rotate through forensic posts where risk to others would be more formally taught via training around structured professional judgment tools. There are opportunities for continued professional development (CPD) across trainee, middle grade and senior Psychiatrists and requirements to complete CPD relevant to their field, and therefore training opportunities and experience may differ. Psychiatrists can access training through their local NHS trusts post graduate medical education programme and the Royal College of Psychiatrists or via conferences and external training events.
43. To my knowledge, there is no specific training offered to Psychiatrists around VFI. There may be training offered locally around neurodevelopmental conditions and risk but I am not aware of any specific training around VFI.
44. Within the FCAMHS network there have been online sessions delivered around violence fixation to FCAMHS teams but this is not profession specific.
45. I believe that specific training around VFI would be beneficial, particularly around early identification, co morbid mental health conditions and neurodevelopmental disorders.
46. Clear information sharing protocols between health services, policing, education, social care and other relevant agencies are essential to support the assessment and management of individuals presenting with violence fixation concerns. These agreements should clearly define the legal basis for sharing information, the circumstances in which information should be exchanged, and the responsibilities of each agency in managing identified risks. Each local area will have differing policies around in addition to statutory data sharing policies such as information governance and GDPR .
47. Barriers to effective information sharing can include differing organisational thresholds for risk and intervention, incompatible data sharing systems, differing organisational

thresholds for risk, professionals understanding of risk and fragmented commissioning arrangements in different areas.

48. I am aware of, but have not personally had any contact with the Counter terrorism clinical consultancy service (CT CCS) and therefore am unable to comment on co-working and information sharing between the NHS and counter-terrorism specialists.
49. Where the parents of under 18's withhold or withdraw their consent to information sharing, this can present problems in managing the case, sharing risk information with other agencies and for agencies being able to assess or provide intervention. This can be mitigated in part with raising safeguarding concerns with relevant agencies but this can be a slow process.
50. Psychiatrists (typically Child & Adolescent Psychiatrists, Forensic Psychiatrists or dual trained Psychiatrists) working within FCAMHS play a clinical advisory role within multi agency arrangements for the management of VFI. Their contribution may include the assessment of the presence of mental disorder, neurodevelopmental conditions and psychological vulnerabilities, formulation and using structured professional judgment and identification of appropriate therapeutic and risk management interventions where appropriate. Psychiatrists work as part of a multidisciplinary team in FCAMHS and would work collaboratively with MDT members in this.
51. Psychiatrists in FCAMHS would attend and input into the multiagency public protection arrangements (MAPPA) and the multiagency safeguarding hub (MASH) and may provide multi agency consultation and advice as detailed above. They can make referrals to PREVENT.
52. The strengths of MAPPA, PREVENT and MASH are that they provide a statutory multi agency framework with defined responsibilities for professionals from different agencies. These frameworks differ in that MASH is around protection of a child, MAPPA is around public protection and PREVENT around vulnerability to being drawn into terrorism.
53. Young people with violence fixation often fall under all of these categories and therefore as a clinician I am often navigating multiple structures and frameworks which don't always align. However all systems have a form of case management, in that there is an agency responsible for maintaining the particular framework and the systems require collaborative working across agencies. The referral pathways into the service can differ along with escalation routes.
54. I am not aware of the local arrangements for Psychiatry resource into these agencies and am therefore unable to comment on this.
55. MASH is primarily designed as an information-sharing and safeguarding hub, focused on the identification and triage of concerns rather than the ongoing assessment and management of complex violence risk. MAPPA provides a framework for the management

of individuals who have committed serious offences. Many individuals who present with concerning fixations on violence, grievance or mass casualty events may not have committed a serious offence and therefore may fall outside MAPPA's remit. PREVENT aims to identify and support individuals being drawn into terrorism with the Channel process providing a multiagency framework for supporting individuals, but on a voluntary basis. The threshold would have to be met to progress to Channel. Individuals without terrorism related interests but with violent fixation would likely not be accepted. These models offer valuable principles, particularly around information sharing and multi-agency risk management. Adapting these services would require significant operational changes including workforce and expertise, governance arrangements and potentially legislative changes, particularly if they are a designated lead agency.

56. A dedicated new structure could address this emerging cohort but would need to maintain strong interfaces with MASH, MAPPA, PREVENT and existing structures for cases that subsequently meet higher-risk or statutory thresholds.
57. In my opinion, it would be helpful to allocate a lead agency for each case, which in turn may include a lead professional. This would allow clear communication and accountability, however the challenges of having a named individual would be if the individual was absent due to leave, sickness etc then concerns may not be acted on or followed through.
58. Psychiatrists would not be the appropriate professional to undertake this role as not all cases of VFI would necessarily have a comorbid mental illness or neurodevelopmental need.
59. There is not currently an accepted definition of VFI and therefore no specific statutory framework addressing identification and management of this group. The existing safeguarding and mental health frameworks will only partially cover VFI's according to the remit of each agency i.e. health, social care, youth justice or health and justice. There is no dedicated pathway currently.
60. In my clinical practice I have seen interventions offered via the Channel process to be effective in some cases of reducing serious violence. These are offered via in Intervention Provider. I am unable to comment on if the interventions are accessible as I do not have any data around young people who have not been offered intervention via the Channel process. However, the young people offered intervention through Channel had some form of extremist ideology.
61. There are groups of young people who do not have a mental disorder and do not have fixed ideological beliefs but would still present with violent risk and it is unclear what intervention, if any they would receive.
62. There are examples of good practice from North America and Canada around behavioural threat assessment and violence prevention programmes. My limited understanding is that

these programmes focus on multidisciplinary assessment teams, structured professional judgment, early identification, case management and shared responsibility.

Improvements

63. Several improvements could strengthen the understanding around VFI and promote greater consistency across services. A nationally agreed shared definition of VFI that is adopted across health, social care, education, youth justice and other partner agencies. would improve communication, reduce variation in thresholds for referral and intervention, and ensure that individuals receive equitable responses irrespective of their home locality.
64. The role of agencies within the VFI pathway requires greater clarification, with clear guidance outlining referral criteria, consultation responsibilities, assessment expectations and interfaces with other agencies. Establishing a consistent model across regions would help reduce inequalities in service provision and support more effective multi-agency decision-making.
65. Development of a comprehensive training programme should be developed for professionals across the system, drawing from learning and evidence both nationally and internationally to improve understanding of VFI presentations, risk assessment, formulation, referral pathways and evidence-based interventions. Joint multi-agency training would enhance confidence, promote a common language and framework, and improve collaboration in managing complex cases.

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.

Signed: **Signature**

Dated: 31st July 2026

ANNEX B: EXHIBIT INDEX TEMPLATE

Index to the Witness Statement of Dr Nina Champaneri

Exhibit No	Inquiry reference no	Document Description
NC/01	**DNC000001**	NHS England FCAMHS service specification