

Tuesday, 17 March 2026

1
2 (2.00 pm)
3 **THE CHAIR:** Yes.
4 **MS LANGDALE:** Thank you.
5 Can we have please on the screen NGPF0007705. This
6 is a custody briefing inspector for 14 June 2023 and if
7 we can go, please, to page 3. We see there in relation
8 to VC:
9 "Not engaging with staff. Mental state not fully
10 understood. Possible risk to himself."
11 Were you aware at this point, on the 14th, that the
12 prosecution, the CPS, had contacted Professor Blackwood,
13 an expert in forensic psychiatry, about preparing
14 a psychiatric report, if required, in the criminal case?
15 **A.** No.
16 **Q.** Was there communication between the police and the
17 prosecution about that at this time?
18 **A.** If there was, it's not documented on the custody record
19 and it certainly isn't documented in any of the material
20 that I have reviewed for this.
21 **Q.** No doubt I can ask the senior investigating officer
22 tomorrow, but it looks like it was understood that the
23 issue of diminished responsibility may arise and that
24 forensic psychiatric examination was necessary?
25 **A.** I wasn't aware of that.

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1 **A.** In relation to this case, it was conducted via the CSI.
2 There was a body mapping process.
3 **Q.** CSI?
4 **A.** Sorry, Crime Scene Investigator. And it was part of the
5 forensic strategy. However, body mapping in general can
6 be obtained by an officer, it doesn't necessarily have
7 to be a crime scene investigator or a healthcare
8 professional.
9 **Q.** Indeed, we see that at page 94, same NGPF number,
10 page 94:
11 "...1050 hours. P[olice]S[ergeant] Oppon-Kusi
12 authorises the taking of a non-intimate sample..."
13 That's at 11.10, around then, yes?
14 **A.** Yes.
15 **Q.** If we can go please to NGPF0002697. This is the crime
16 scene investigation worksheet summary report. It begins
17 at the end of page 2, carries on to page 3, please. We
18 see there:
19 "Persons name: Tess BUXTON
20 "... Crime scene coordinator."
21 We see there what has been undertaken; can you just
22 take us through that?
23 **A.** Sorry, can you elaborate on -- in terms of what's
24 recorded in front of me?
25 **Q.** Yes, what do you understand is actually taken?

3

1 **Q.** Can we have a look then, please, at the evidence
2 recovery plan in relation to forensics, NGPF0008888,
3 page 1. So we see the "Evidence Recovery Plan".
4 I think it is referred in the documents as ERP, isn't
5 it, throughout? We see at the bottom:
6 "Body mapping
7 "Blood and urine."
8 It doesn't appear, going through the documents, that
9 VC was ever asked about a urine sample, was he? There
10 was reference to toxicology and bloods that we have
11 spoken about before, but no reference to urine being
12 requested?
13 **A.** I can't comment on whether it was requested. The only
14 thing I can confirm is that it doesn't appear in the
15 documents I have referred to.
16 **Q.** The process for taking a blood and urine sample is
17 different, isn't it, as far as the detained person is
18 concerned anyway?
19 **A.** So the process of obtaining blood and urine is
20 different. They are both intimate samples though.
21 **Q.** Can we have a look please at NGPF0007773, page 93. This
22 is the authorisation to conduct the body mapping of the
23 detainee. We were referring earlier to the inspector's
24 authorities. That's authority given to body mapping.
25 How is that conducted?

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1 **A.** So there's been photographs taken of VC, as it would
2 suggest, a full length photograph, head and shoulders.
3 The front and back of hand, it says, whether that's
4 hands, I assume it is, but I can't say for definite.
5 There's been swabs of areas that have got visible
6 blood-like substances. Hand swabs have been taken.
7 Nail scrapings taken and then there's been a sequential
8 recovery of clothing photographed but also taken and
9 seized.
10 **Q.** Nail scrapings, are you aware: are nail clippings able
11 to be taken at the same time?
12 **A.** Yes.
13 **Q.** What can you get from nail clippings that you can't get
14 from nail scrapings; do you know? Please don't say if
15 you don't, we have an expert forensic --
16 **A.** I don't know, sorry.
17 **Q.** But it looks -- in the exchange you listened to earlier
18 this morning, there was mention, wasn't there, of nail
19 scrapings and not clippings then as well. Was that
20 something, as far as you were aware, was ever
21 considered?
22 **A.** I can't recall whether it was nail scrapings or nail
23 clippings, but I do know that in many cases both are
24 considered.
25 **Q.** If we go over the page at page 4, we see what swabs were

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1 taken. "Clothing received" reflecting the earlier page.
 2 If we can go please to NGPF0007773, page 117. This
 3 is a follow-up note from Sergeant Cook at the top:
 4 "My last detention log was incomplete. I meant to
 5 type before I signed it off by mistake."
 6 Setting out:
 7 "I explained that a request was being made for
 8 a sample of his blood, that this had been authorised by
 9 a police inspector and that it would be taken by a HCP.
 10 I explained his consent was required. I asked him to
 11 consent and he replied with a clear 'No'.
 12 Is there anything suspects are told if they decline
 13 to provide samples about how that might be used later or
 14 not?
 15 **A.** Yes, there should be.
 16 **Q.** What should they be told?
 17 **A.** So they should be told that it could harm their case if
 18 it goes to trial.
 19 **Q.** We don't see that anywhere as being stated to VC, did
 20 you see that anywhere or know if that had been done?
 21 **A.** No, I didn't see that.
 22 **Q.** Difficult to say now what he would have said either way,
 23 but it does appear that he was engaging with his
 24 solicitor, wasn't he?
 25 **A.** In relation to this --

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1 question such as "Do you understand murder?"
 2 **A.** Yes, or what's your name, what's your date of birth.
 3 Some things he still refused to answer, for example, his
 4 address, but there was certainly engagement for personal
 5 information and other non-evidential related matter.
 6 **Q.** Can we just look, please, at the custody record again
 7 which is NGPF0007773, page 2. We see there the second
 8 entry:
 9 "Theft of a motor vehicle".
 10 There is a reference to drugs there. What are the
 11 drug flags around some offences that appear? Explain to
 12 us what that's about.
 13 **A.** Madam, that's very misleading because it's a pre-defined
 14 detention log entry. So just to put some context on the
 15 system, so NICHE is a national system, it doesn't just
 16 facilitate Nottinghamshire Police but also is used by
 17 other police forces, and these predefined entries would
 18 have been put onto the system and would have been part
 19 of NICHE when we had drug testing in existence.
 20 Since a lot of forces across the country, including
 21 Nottinghamshire, have gone through various stages of
 22 either having drug testing processes or not, but those
 23 predefined entries haven't changed.
 24 **Q.** And do they attach to some offences, some types of
 25 offences like driving offences where obviously being

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1 **Q.** Not this point, generally having consultations with his
 2 solicitor.
 3 **A.** Yes, absolutely.
 4 **Q.** And indeed you comment in respect of the interviews,
 5 again I'm going to deal with that with the senior
 6 investigating officer, but in relation to the interviews
 7 you make the observation that he does answer
 8 non-evidential questions but not evidential. Can you
 9 just elaborate what you mean about that in relation to
 10 his six interviews?
 11 **A.** It is difficult for me to remember the details now
 12 but --
 13 **Q.** I'm not asking for the details, the overview.
 14 **A.** So anything that was or some information that he was
 15 asked about himself and that wasn't necessarily about
 16 the offending, he seemed to be more comfortable
 17 answering. But there was certainly a lack of
 18 answering/engagement when it was evidential material
 19 that was put to him.
 20 **Q.** It was a "no comment" interview in respect of anything
 21 that would have been self-incriminating.
 22 **A.** Yes.
 23 **Q.** So he didn't give any answers other than "no comment" to
 24 something that was put to him, an image of him or part
 25 of the attacks, but he might answer a more general

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1 under the influence of alcohol or drugs is right up
 2 there, isn't it?
 3 **A.** I couldn't confirm whether drugs appears on a drug
 4 driving or another driving matter, but I can confirm
 5 that where it says "trigger" that would have been
 6 an offence that, initially, pre-2013 would have been
 7 an automatic drug testing offence. It slightly changed
 8 post-2013 but the trigger offence is more relating to
 9 acquisitive crime. There are a couple of other crime
 10 types, for example, possession of Class A drugs and
 11 I think begging was one of them. But certainly the
 12 trigger offences were predominantly acquisitive crime.
 13 **Q.** We will look at the one below, 14 June in terms of
 14 an acquisitive offence, burglary dwelling, we've heard
 15 from the caretaker of Seely Hirst House, assuming that
 16 refers to the episode when he is trying to gain entry
 17 into Seely Hirst House, does it?
 18 **A.** I assume so, yes.
 19 **Q.** So drugs aren't irrelevant to that place, are they,
 20 Seely Hirst House?
 21 **A.** Sorry? In what way?
 22 **Q.** Did you think about that at the time, that he had been
 23 to Seely Hirst House, whether his attempts to gain entry
 24 there might be drug related or not?
 25 **A.** Not me personally and there was nothing to suggest it

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1 was motivated by drugs.

2 **Q.** Again, we can return to the senior investigating officer
3 for that. But as far as you were concerned, at what
4 stage did you come into it? I know you were involved at
5 some stage in the custody process. When was that?

6 **A.** So I was a custody PACE inspector in 2023, and it was on
7 16 June that I was on duty, and really my only
8 involvement with VC was -- or direct involvement was
9 conducting one of the reviews. Obviously I had
10 an awareness of where we were with the investigation
11 because that was part of the review process, but
12 I played a very minimal part in the actual time that it
13 was occurring.

14 **Q.** Did you deal with him at all directly or were you doing
15 paperwork reviews?

16 **A.** So, I was based at Mansfield custody suite and when
17 I conducted the review with VC, it was done through the
18 Teltronic system. So we have an ability to ring
19 detainee's cells from one suite to the other. So when
20 I was based in the PACE inspector's office at Mansfield
21 I could dial the number for the cell that VC was in and
22 have a conversation with him, which is what took place
23 in relation to my review of him.

24 **Q.** And what was your experience of conversations with him?
25 How did he present to you?

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1 offending.

2 **Q.** DS Sanders' statement to the Inquiry says:
3 "Whilst VC was in police custody between 13 and
4 16 June ... I did not consciously turn my mind to the
5 potential partial defence to murder of diminished
6 responsibility. With hindsight, I wish I had directed
7 the taking of a head hair sample from VC whilst he was
8 in police custody, if necessary, by force."
9 Hair samples, how can they be taken and is consent
10 required?

11 **A.** So a hair sample, unlike blood and urine samples, are
12 classed as non-intimate samples except if they are pubic
13 hair, but head hair is classed as a non-intimate sample,
14 which can be -- it has a different level of
15 authorisation. So it's authorised by a sergeant and it
16 doesn't rely upon a suspect's consent. So, therefore,
17 even if the suspect doesn't consent, it can be taken by
18 force, if necessary.

19 **Q.** Given we have gone through how clothing was taken and
20 how else he was interacted with by many professionals at
21 the time, there's nothing to suggest that that would
22 have been particularly difficult actually, is there?

23 **A.** It is difficult to comment on that because taking
24 somebody's -- forcibly taking somebody's hair compared
25 to some of the interactions -- the other interactions

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1 **A.** He seemed to understand the conversation I was having
2 with him. He engaged with me. I think he asked as well
3 at the time whether he could have his pen and paper. So
4 there was definitely conversation there and at no point
5 did I believe that he was not understanding any of the
6 conversation between us.

7 **Q.** I think there's one reference in the notes to
8 an occasion when he had to be handcuffed in the cell but
9 that's the only occasion. Have you seen anything when
10 there was concerns about him being violent in the cell
11 to anybody?

12 **A.** The time of violence was when he first came into custody
13 and assaulted DO Stennett. He was handcuffed as
14 a prevention and he was kept in those restraints for
15 a while until it was appropriate to remove them and that
16 was during the CSI forensic strategy, but beyond that
17 I can't recall that he had to then be placed back into
18 handcuffs as a result of ongoing violence.

19 **Q.** That appears to be the case. What about any threats to
20 officers or anyone else as far as you were aware,
21 anything like that?

22 **A.** No, I'm not aware that he directly threatened anybody.
23 I am aware that his presence was felt to be
24 intimidating, but that may well have been purely based
25 on some of his behaviour and the gravity of the

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1 with VC is on a different level, so it would be
2 unreasonable of me to predict what his response would
3 be.

4 **Q.** But it is perfectly reasonable for you to say you would
5 have managed it, it wouldn't have been an issue?

6 **A.** We would put mitigation measures in place and have
7 appropriate numbers of staff. Whether that would have
8 resulted in somebody being injured as a result of that
9 or whether it would be classed as easy or difficult
10 would be difficult to predict, but there would certainly
11 be measures we could undertake to facilitate that
12 process.

13 **Q.** You must do so with people who are detained?

14 **A.** Yes, absolutely.

15 **Q.** Chair, those are my questions. I know there are a few
16 from Mr Moloney and Mr Beer?

17 **THE CHAIR:** Yes, thank you.

18 Questioned by MR MOLONEY

19 **MR MOLONEY:** Chief inspector, Ms Langdale asked you about
20 the distinction between evidential and non-evidential
21 questions.

22 **A.** Yes.

23 **Q.** May I just take you to one or two examples just to try
24 and illustrate what you said. VC understood the
25 caution, didn't he?

12

1 A. Yes, seemingly.
 2 Q. Could I take you to document NGPF0000306, and to page 2
 3 of that document, please. It starts right at the
 4 bottom:
 5 "What I'm going to do 'cause it is really important
 6 that you understand what it means for you. I'm just
 7 going to ask you 3 questions about the caution to make
 8 sure you have understood okay?"
 9 Because it had already been given further up the
 10 page, hadn't it, the caution?
 11 Anyway, and:
 12 "So do you have to answer mine and Steve's questions
 13 today?"
 14 Is what was asked. If we could just stuck on that:
 15 "Do you have to answer mine and Steve's questions
 16 today?"
 17 The answer given by VC was "No" and that's accurate,
 18 isn't it?
 19 A. It is.
 20 Q. And then:
 21 "If you go to court and you give an explanation in
 22 court that you didn't today whilst we were speaking to
 23 you, what could the court think?"
 24 The answer is:
 25 "That I am ... that I ... may have made it up."

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1 this document and we see on -- I'm sorry, I have that
 2 wrong and I do apologise. I'm going to short circuit
 3 this. VC was given every opportunity to talk about
 4 motivations for his killing, wasn't he?
 5 A. Yes.
 6 Q. So in relation to that, can I just identify one passage
 7 which is at page 26, please. Sorry, no that's wrong.
 8 I do apologise for this, Chair.
 9 13, please. I won't deal with that, it takes too
 10 long. Page 29, please. He didn't give any indication
 11 as to why he committed the attacks, did he?
 12 A. Not to my knowledge, no.
 13 Q. Is it right that you gave him every opportunity to state
 14 anything he wanted to in relation to the questions that
 15 had been asked of him?
 16 A. I would say so, yes.
 17 Q. Just to clarify that, can we please go to NGPF0000311,
 18 and to page 31 of that document, please. It could be
 19 four zeros. It is three zeros in my reference but it
 20 could be four zeros, and it is page 31. We see at the
 21 end:
 22 "Okay, are you happy that you have had plenty of
 23 chance to view everything and have you understood all
 24 questions asked of you?" *(As read)*
 25 Again, a non-evidential question and he answers

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1 A. Yes.
 2 Q. That is a reasonable interpretation of what he had been
 3 told?
 4 A. Yes.
 5 Q. Then finally:
 6 "Okay and what could happen to the recording of
 7 today's interview if it goes to court?"
 8 He answers: "Could be used against me?"
 9 A. Yes.
 10 Q. Then if we could, please, in this document go to further
 11 down at 7.40. So it is the next page, please, at page 4
 12 actually, 7.40. It is asked:
 13 "So in relation to the offence which [you're] in
 14 custody and [you're] going to be interviewed for today.
 15 We want to discuss the murder that took place on
 16 Ilkeston Road, yesterday morning of Grace O'Malley-Kumar
 17 and Barney Phillip Webber. We're going to concentrate
 18 on those offences, you understand?"
 19 "I do.
 20 "Thank you. What happened?
 21 "No comment".
 22 That's the distinction between the evidential and
 23 non-evidential, isn't it, that you're referring to?
 24 A. Yes, it is, yes.
 25 Q. Then if we could just go down to page 11, please, of

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1 "yes". Then:
 2 "Any representations from yourself?"
 3 To the solicitor:
 4 "No, not at this time."
 5 Saying to the appropriate adult:
 6 "All good thank you."
 7 And then:
 8 "I'm going to bring this interview to a close."
 9 A. Yes.
 10 Q. Thank you very much, Chief Inspector.
 11 **THE CHAIR:** Yes, Mr Beer.
 12 **Questioned by MR BEER**
 13 **MR BEER:** Thank you very much, Chair.
 14 Chief Inspector, I ask questions on behalf of the
 15 Trust, and I want to ask questions about the L&D service
 16 and each side of it, the L bit of it and the D bit of
 17 it.
 18 A. Okay.
 19 Q. Can I start please with the D bit, the diversion bit.
 20 Can I take you to a document that you have been referred
 21 to before and just refer you to an additional part of
 22 it. NGPF0007755 and page 98. And if we can highlight
 23 paragraph 9.4.
 24 Thank you very much. Now Ms Langdale took you to
 25 paragraph 9.4 and she took you, if you remember, to the

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1 first part of it, the first big paragraph, yes?
 2 **A.** Yes.
 3 **Q.** And that included reading the last sentence, that's the
 4 healthcare professional "should assess whether or not
 5 a formal Mental Health Act assessment is required and
 6 advise the custody officer."
 7 Yes?
 8 **A.** Yes.
 9 **Q.** Can we look at the second paragraph as well, please:
 10 "Whilst mental ill health and learning difficulties
 11 do not preclude prosecution, particularly where the
 12 potential offence is serious, custody officers and staff
 13 are required to consider options for diverting mentally
 14 vulnerable offenders from the criminal justice system
 15 towards health and social care ..."
 16 Then this:
 17 "This may involve arranging a Mental Health Act
 18 assessment which may result in the detainee being
 19 admitted as a voluntary or involuntary patient or
 20 referral to community health support ..."
 21 You agree that from Nottinghamshire Police's custody
 22 policy it makes it clear that it is Mitie's
 23 responsibility to arrange, or its responsibilities
 24 include arranging for a Mental Health Act assessment?
 25 **A.** No, I don't. I don't agree with that. I agree that it

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1 criminal justice system of seeking a Mental Health Act
 2 assessment for the purposes of the inclusion in the
 3 criminal justice access; is that what you are saying?
 4 **A.** No. I think you are misconstruing what I'm saying.
 5 There is the liaison and diversion element of Liaison
 6 and Diversion, and in our training and in reality, the
 7 way that it operates in custody is that if Liaison and
 8 Diversion are on duty, they are the mental health
 9 experts, as opposed to Mitie who are the clinical
 10 experts. But outside of Liaison and Diversion's working
 11 hours, as the paragraph indicates, the healthcare
 12 professional will fill that gap and they will then
 13 liaise with Crisis and have a fundamental part in
 14 arranging that Mental Health Act assessment.
 15 **Q.** You say that L&D are the mental health expert.
 16 Presumably you know that lots of them aren't and that
 17 they are social workers?
 18 **A.** In terms of the function that Liaison and Diversion
 19 perform within custody, between healthcare professionals
 20 and the Liaison and Diversion team, we are under the
 21 impression, whether that's right or wrong, that they
 22 have primacy over mental health initially. That's not
 23 to say they work in silos, because they will also work
 24 in conjunction with Mitie, but in terms of that mental
 25 health facilitation function it would go to L&D first.

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1 is in there that they will do that. But it's
 2 an instruction to us that that will be when Liaison and
 3 Diversion are not available.
 4 **Q.** So where it says "They", that's the healthcare
 5 professional, "should assess whether or not formal
 6 Mental Health Act assessment is required and advise the
 7 custody officer," it doesn't mean that?
 8 **A.** It does mean that, but it means that when the Liaison
 9 and Diversion team are not on duty and not available.
 10 So, for example, in our training, at that time, that was
 11 part of the training. Now, I appreciate it is not
 12 reflected in this paragraph. However, our training was
 13 and is, still to the day, that Liaison and Diversion
 14 will play that role when they are on duty, and outside
 15 of that it will fall to the healthcare professional.
 16 **Q.** Do you know why it doesn't say what you say it should
 17 say?
 18 **A.** No, I don't, I'm afraid.
 19 **Q.** Do you know that the -- in practice it involves Mitie
 20 communicating requests to mental health professionals
 21 within Crisis?
 22 **A.** It does when Liaison and Diversion don't perform that
 23 role, but when Liaison and Diversion perform that role,
 24 it falls to them.
 25 **Q.** So, L&D you say performed the role as diverters from the

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1 **Q.** In any event, the gatekeepers for the triggering of
 2 a Mental Health Act assessment itself are the Crisis
 3 team?
 4 **A.** Yes. So Liaison and Diversion would do their assessment
 5 and they would then facilitate that communication with
 6 Crisis to consider whether implementation of a full
 7 Mental Health Act assessment and team was necessary and
 8 then arranged.
 9 **Q.** Or presumably Mitie if it was out of office hours, from
 10 what you are telling us?
 11 **A.** Yes, absolutely.
 12 **Q.** Thank you. And then it is for the Crisis team to act as
 13 gatekeepers to trigger the two doctors, one of whom is
 14 section 12 approved and the other AMHP to actually
 15 conduct the assessment.
 16 **A.** Yes.
 17 **Q.** Thank you. The second aspect, the provision of
 18 information, can we quickly have up NGPF0002378, and
 19 page -- in fact it is that page. Thank you. We looked
 20 at this briefly earlier. You will recall this as I
 21 think the Mitie note at 1.17 on the 13th. Yes?
 22 **A.** Yes.
 23 **Q.** And in short, is this a fair summary, that the Mitie
 24 nurses go to L&D to get some background information
 25 about VC's mental health?

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1 A. Yes, according to the notes.
 2 Q. That's good practice.
 3 A. Yes.
 4 Q. Do you agree?
 5 A. Yes.
 6 Q. Secondly, that the L&D service check RiO and provide
 7 information from RiO to Mitie?
 8 A. Yes.
 9 Q. You agree that's good practice?
 10 A. Yes.
 11 Q. No need to be suspicious.
 12 A. Okay.
 13 Q. The third aspect is, if you look at the detail of the
 14 information provided, it is quite detailed, isn't it,
 15 from the RiO records to Mitie?
 16 A. There is a fair level of detail within the notes, yes.
 17 Q. That's good practice as well?
 18 A. Yes.
 19 Q. It includes the diagnosis of paranoid schizophrenia?
 20 A. Yes.
 21 Q. So it is no doubt that, at least by this time, 1.15 on
 22 13th itself, that information had been at least provided
 23 to Mitie. It is up to Mitie to determine what
 24 information on there is provided to the police?
 25 A. At this point, yes, because that's formulating part of
 21

1 of the HCP tab within NICHE, then yes. If it forms part
 2 of the medical notes that don't appear within the
 3 custody record, then it has to go through the process
 4 that I have just described.
 5 Q. Thank you very much, Chief Inspector.
 6 A. Thank you.
 7 Questioned by THE CHAIR
 8 **THE CHAIR:** Yes. Can I just ask -- sorry, can we just put
 9 that back up again. Would you expect that to appear on
 10 the custody record, what's on the note there, that had
 11 been shared?
 12 A. Yes, I see no reason why paranoid schizophrenia doesn't
 13 form part of that care plan because it is relevant.
 14 **THE CHAIR:** So that would go onto the custody record and
 15 therefore could be shared from the custody record with
 16 others?
 17 A. Yes, it could do. So if it formulated part of the HCP
 18 notes that were put onto NICHE and part of that handover
 19 process, then yes, it could be.
 20 **THE CHAIR:** Mr Beggs, are you asking questions?
 21 Questioned by MR BEGGS
 22 **MR BEGGS:** Could we, following on from that, please, put up
 23 on the screen NGPF0007773, page 19.
 24 In fact, we see there, don't we, at almost 1.50 on
 25 the first day of detention the RiO check and the working
 23

1 their assessment. The information sharing between
 2 Liaison & Diversion would be ongoing but certainly
 3 leading up to and then following their assessment too.
 4 So the information sharing should be on all levels, but
 5 in relation to this, yes, I accept it is Mitie that
 6 would share that information.
 7 Q. Can they share that information to your knowledge with
 8 the police only if it is in VC's healthcare interests,
 9 I'm putting it broadly, or can they share it for police
 10 investigative purposes?
 11 A. They would do it with custody in relation to care, but
 12 then there needs to be some appreciation of the
 13 information that's available to then determine whether
 14 a Mental Health Act assessment is required.
 15 Q. I was talking about investigative, meaning evidential
 16 purposes, ie for the purposes of a police investigation.
 17 Are Mitie allowed to share the information they have
 18 been given about healthcare to the police to allow the
 19 police to conduct its investigation?
 20 A. Yes, with the required consent of the detainee or with
 21 the requisite court order if consent is withheld.
 22 Q. But not otherwise in your understanding?
 23 A. So, the sharing of information, if it forms part of the
 24 custody record, then it can be automatically disclosed.
 25 So if it is shared for care purposes and it forms part
 22

1 diagnosis, 17 February 2022, paranoid schizophrenia. So
 2 that's on the custody record, as I understand it; can
 3 you confirm that?
 4 A. It is, yes.
 5 Q. Following from that, Ms Langdale KC put to you: was
 6 there any thought given to a mental health assessment
 7 for evidential purposes -- and I emphasise evidential,
 8 so not a mental health assessment for sections 2 or 3.
 9 First of all, have you ever known such an assessment
 10 being conducted pre-charge in Nottinghamshire Police
 11 custody?
 12 A. No.
 13 Q. Secondly, does Nottinghamshire Police have, as it were,
 14 on tap a consultant psychiatrist for that purpose?
 15 A. No.
 16 Q. Thirdly, if Nottinghamshire Police did have such
 17 a psychiatrist on tap for that purpose, how would they
 18 access VC's medical records without his consent?
 19 A. I don't know how a medical person would access, but if
 20 it was part of the investigation process, I can surmise
 21 that it would possibly be via the same approach.
 22 Q. Finally, would VC have to co-operate with any such
 23 psychiatrist?
 24 A. Not necessarily. If the mental health assessment
 25 involved a psychiatrist, the assessment could take
 24

1 place, but it doesn't necessarily mean to say that VC
 2 would engage in that process.
 3 **Q.** He doesn't have to, does he?
 4 **A.** No.
 5 **Q.** Any more than he consented to give his blood during
 6 detention?
 7 **A.** Absolutely.
 8 **Q.** Yes, thank you.
 9 **THE CHAIR:** Yes. Thank you very much.
 10 **MS LANGDALE:** Chair, the next witness is Louisa Hagan and
 11 Mr Blake is going to take her.
 12 **THE CHAIR:** Thank you.
 13 **MS LOUISA HAGAN (affirmed)**
 14 **Questioned by MR BLAKE**
 15 **THE CHAIR:** Yes, Mr Blake.
 16 **MR BLAKE:** Thank you very much. You should have in front of
 17 you a witness statement with a URN of WITN0346001; is
 18 that right?
 19 **A.** Yes.
 20 **Q.** Can you confirm that that statement is true to the best
 21 of your knowledge and belief?
 22 **A.** Yes.
 23 **Q.** Thank you. You are a registered mental health nurse; is
 24 that right?
 25 **A.** Yes.

25

1 a Nottinghamshire-wide service, but it is based on
 2 a national model. Is it known as the Liaison and
 3 Diversion service throughout the country?
 4 **A.** I think largely it is, but I think there are some
 5 services which may be called criminal justice liaison,
 6 so CJ Liaison and Diversion. So I think there are a few
 7 different names for it, but it is essentially the same
 8 service model.
 9 **Q.** You have said you are physically based in custody suites
 10 at police stations and also at the Crown Court and
 11 Magistrates' court as well?
 12 **A.** Yes.
 13 **Q.** How about yourself; are you personally based at any of
 14 those sites or somewhere else?
 15 **A.** No, so I would be primarily based in our service
 16 offices, so that would be either in Nottingham or in
 17 Mansfield. So it would be an office base outside of
 18 custody.
 19 **Q.** We have heard from Mr Beer there is a L and a D and they
 20 have different functions. Very briefly, can you tell us
 21 what you understand about the L function, the liaison
 22 function?
 23 **A.** So that is about ensuring that we are sharing relevant
 24 and pertinent information across the criminal justice
 25 process. So if we have an individual who, for example,

27

1 **Q.** You have worked for Nottinghamshire Healthcare NHS Trust
 2 for the last 25 years?
 3 **A.** Yes.
 4 **Q.** Between 2019 and 2024, you were the service manager with
 5 the Community Forensic Services; is that right?
 6 **A.** That is correct.
 7 **Q.** Can you assist us very briefly with what the Community
 8 Forensic Services includes?
 9 **A.** So the Community Forensic Services is an umbrella --
 10 well, it has within it an umbrella of services, a number
 11 of different services. There is the Community Forensic
 12 Service which works with and supports patients within
 13 the community or within secure services; the ReConnect
 14 Service, which is a service that supports people who are
 15 transitioning from a prison sentence into the community;
 16 the Mental Health Treatment Requirement Service which is
 17 a community treatment order through the criminal justice
 18 process; the Notts MBT service which is a psychological
 19 therapy in the community service; and the Community
 20 Forensic Intellectual Disability Service which works
 21 with supporting people in the community with
 22 an intellectual disability.
 23 **Q.** Also the Liaison and Diversion --
 24 **A.** Yes, sorry, the Liaison and Diversion service team.
 25 **Q.** You said in your statement that is

26

1 is known to our mental health services or other services
 2 within our organisation, we would also share information
 3 that that person had been in custody, and details of
 4 that.
 5 We would also share information within the criminal
 6 justice system, so we complete criminal justice advice
 7 forms when we have had referrals and offered assessments
 8 and that is to support the courts and criminal justice
 9 process to ensure that they have got information that we
 10 know and that we have that we can then share that may be
 11 relevant for that individual.
 12 **Q.** How about the D, the diversion?
 13 **A.** So the diversion may be looking at more appropriate ways
 14 that aren't necessarily for a custodial sentence. So
 15 individuals, for example, who may be more suitable for
 16 community intervention, such as an MHTR, that may be
 17 something that is recommended.
 18 We would also liaise and divert service users into
 19 access and substance misuse services, for example, who
 20 are also based in custody. And it also may be diverting
 21 people who are remaining within the criminal justice
 22 process, diverting them to the most appropriate
 23 services. Say, for example if an individual is remanded
 24 to prison, that we would share information to support
 25 diverting into the most appropriate services there.

28

1 Q. We will get to what actually happened in respect of the
2 events of June 2023, but we have just heard evidence
3 from Chief Inspector Murray that it falls to Liaison and
4 Diversion to arrange a mental health assessment. Do you
5 agree with that or disagree with that?

6 A. A Mental Health Act assessment? If the Liaison and
7 Diversion service were to see an individual and were
8 concerned and felt that a Mental Health Act assessment
9 were required, then yes, Liaison and Diversion would
10 support that. It is not actually within the service
11 spec of Liaison and Diversion to be the intermediary in
12 Mental Health Act assessments, but we understand and
13 appreciate that Mitie perhaps don't feel expertise in
14 that particular area, so we may support, but ultimately
15 it is not directly in our service spec to do that.

16 Q. Could I take you to the Operational policy. It is
17 NHFT0000834. When you say the service spec, is that
18 something different to the Operational policy?

19 A. It is, yes. The service spec is the NHS England
20 overarching specification for the Liaison and Diversion
21 national service, so this here is the local delivery of
22 the Liaison and Diversion service.

23 Q. Thank you. If we could please turn to page 3, we see
24 there an introduction I will just read to you a little
25 bit from the second and fourth paragraphs. In the

29

1 first three:

2 "A comprehensive trauma informed screening ...
3 triage assessments ..." *(As read)*

4 Then it is the third one that I really want to ask
5 you about, the specialist assessment:

6 "... where indicated informing more complex health
7 needs". *(As read)*

8 So that specialist assessment, can you assist us
9 with what kind of assessment might be a specialist
10 assessment and does that include a Mental Health Act
11 assessment?

12 A. That is referring to -- so the assessments that we
13 undertake with individuals who are referred will all be
14 offered a triage assessment. The information that comes
15 from that triage assessment -- so that's a general
16 exploration with an individual regarding any needs that
17 they may have or may identify. That triage assessment
18 may identify that there are additional needs that
19 require maybe the assessment of one of our registered
20 clinicians. So the Liaison and Diversion service has
21 triage and support workers who are unregistered support
22 workers who can undertake any triage assessment.

23 It may be that in that triage assessment where
24 concerns are raised that that's then escalated to one of
25 the band 6 staff who may be a mental health nurse or

31

1 second paragraph it says:

2 "Diversion should be interpreted in its wider sense,
3 referring to both diversion out of, and within, the
4 youth and criminal justice systems. Access to Liaison
5 and Diversion services does not imply that individuals
6 will avoid appropriate sanctions but that the process
7 will be better informed, and access to appropriate
8 health and social care interventions will be improved."

9 *(As read)*

10 Then the fourth paragraph:

11 "Liaison and Diversion is a process whereby people
12 of all ages with health and/or social vulnerabilities
13 [then it lists the various vulnerabilities] are
14 identified and assessed.

15 "Needs identified at assessment are met through
16 supporting individuals to access relevant services as
17 early as possible, as they pass through the youth and
18 criminal justice systems." *(As read)*

19 Then it says:

20 "Liaison also involves sharing information about
21 an individual's needs and vulnerabilities with key
22 decision makers across the criminal justice pathway to
23 ensure that needs are considered." *(As read)*

24 If we could turn over, please, to page 4, there's
25 then a list of various objectives. I will just read the

30

1 a social worker, and so are qualified registered staff
2 who then will undertake what we call a core assessment,
3 so that is a much more detailed assessment looking at
4 an individual's background, their presenting issues. It
5 will consider risks much more -- in much more detail
6 than a triage assessment.

7 So the triage assessment is a standard assessment
8 that is dictated to us by NHS England. So it's about
9 capturing information but it is quite broad, whereas the
10 core assessment will be much more focused on what the
11 areas of concern are.

12 Q. Can that involve a Mental Health Act assessment?

13 A. If that were identified as an intervention that was
14 required from our assessment, yes.

15 Q. Can we please turn to page 8, the bottom of page 8 and
16 into page 9. It sets out there various duties and
17 responsibilities. It has a reference at the bottom of
18 this page to "service manager", and if we scroll over
19 the page it says "key role in developing strategic
20 direction."

21 Is that yourself?

22 A. It is yes.

23 Q. Then "Clinical lead: Psychologist". We are going to see
24 some emails from Dr Mark Taylor. Is he the clinical
25 lead or somebody else?

32

1 **A.** No, the clinical lead in this case is the psychologist
 2 who works across the service. Dr Taylor I think at the
 3 time was the clinical director across the low secure
 4 services.
 5 **Q.** I don't think we see reference there to clinical
 6 director.
 7 **A.** No. There's no medic involved in the Liaison and
 8 Diversion service.
 9 **Q.** So there's no medic who is a permanent member of the L&D
 10 team?
 11 **A.** No.
 12 **Q.** Thank you. Can we please go over to the bottom of
 13 page 11. I'm going to take you through this relatively
 14 quickly.
 15 At the bottom of that page there is the referral
 16 criteria:
 17 "Referrals can be made for any detainee identified
 18 with a vulnerability ..." (As read)
 19 And they can be referred by the police, custody
 20 healthcare providers, appropriate adults et cetera.
 21 Over please to page 15. There is a section there on
 22 "Service outcome & response times". I will take you
 23 over the page. It says there:
 24 "Where an MHA assessment is indicated following L&D
 25 staff assessment, staff will liaise accordingly with

33

1 **A.** If we were requesting a Mental Health Act assessment
 2 then, yes, we would do that via the Crisis team, they
 3 are the gatekeepers for our Mental Health Act process.
 4 **Q.** How do you decide whether it is yourselves or Mitie who
 5 contact the Crisis team?
 6 **A.** So if it was an assessment that we had completed we
 7 would be contacting the Crisis team. Out of hours that
 8 would be Mitie and they would follow the exact same
 9 process that Liaison and Diversion service would.
 10 **Q.** We will move now to 13 June and we will have a look at
 11 the RiO records. That is NHFT0000168. Could we start,
 12 please, on page 271.
 13 We have in the middle of our screen at 10.43,
 14 an entry there from the Street Triage Team and it says:
 15 "RiO check requested by Notts Police".
 16 Also underlined it says:
 17 "Not seen by the Street triage team. RiO check
 18 requested only. No further input requested from the
 19 Street triage team at this time."
 20 Can you assist us with what you understand that to
 21 mean?
 22 **A.** That the Street Triage Team were requested just to
 23 supply information to the police and that there was no
 24 active role for them.
 25 **Q.** The Street Triage Team do have access to the RiO system.

35

1 healthcare custody and the police prior to a request
 2 being made for a MHA assessment through the relevant
 3 Crisis Team and AMHP service." (As read)
 4 So is that exactly what you have just explained,
 5 that there is an initial triage process and then there
 6 is it seems liaison between L&D staff and healthcare
 7 custody, which in this case will be Mitie?
 8 **A.** Yes.
 9 **Q.** And the police prior to a request being made.
 10 **A.** Yes.
 11 **Q.** Is that the usual process?
 12 **A.** Yes. Following an L&D assessment, yes.
 13 **Q.** If you were, for example, of the view that somebody
 14 needed urgent attention, in particular with regard to
 15 medication, anti-psychotic medication or something like
 16 that, would it be possible for Liaison and Diversion
 17 therefore to have a role in that?
 18 **A.** We would be sharing that information with Mitie. In
 19 fairness I am not a clinician within that service so I'm
 20 not sure of examples where that may be the case. But
 21 certainly if we had information that was relevant for
 22 somebody's mental health or their safety in custody, we
 23 would share that in support care planning wherever we
 24 could.
 25 **Q.** You would involve the Crisis Team yourselves?

34

1 **A.** Yes.
 2 **Q.** Could we please -- we will come back to this RiO log but
 3 could we please first turn to NHFT0011435, and we are
 4 going to just look at some emails that were sent around
 5 midday. If we could take a look at the bottom email,
 6 please. In that bottom email, and over the page, at
 7 12.50, if we could perhaps scroll down, it is an email
 8 from Natalie Iles to yourself. Who is Natalie Iles?
 9 **A.** Natalie Iles is a mental health nurse, one of the band 6
 10 L&D practitioners.
 11 **Q.** And she says:
 12 "I just wanted to make you aware the suspect is
 13 [VC] ... I have been asked and provided some background
 14 information to HCP. Will note it on RiO and the log too
 15 but if there is any audit later I wanted you to know."
 16 (As read)
 17 In your statement at paragraph 11 you have said that
 18 you were first made aware of this incident by Natalie
 19 Iles, is it in this email or something else?
 20 **A.** Yes, so we had had earlier contact prior to really
 21 understanding who was in custody or the circumstances
 22 around that due to the nature of Nottingham having
 23 essentially been locked down, we had operational issues
 24 and, due to the absence of both team leaders within the
 25 service, I was the next point of contact, and so we had

36

1 conversations about the operational requirements of the
2 service, where we also had a discussion about how it was
3 in custody because obviously the custody suite itself
4 was also locked down for that period of time.

5 So I was aware that there was an incident happening,
6 and so this email then followed those conversations with
7 Natalie who then confirmed who the suspect was and the
8 RiO number.

9 **Q.** If we could please scroll up, we can see your response.
10 You say:

11 "Thanks, let me know if he is known to services as
12 obviously this is a big worry for the Trust." *(As read)*

13 What did you mean by that?

14 **A.** Because of the media attention and also I guess the need
15 to elicit -- well, to understand more about the
16 circumstances of how VC was known to the Trust, when his
17 last contact with(sic), et cetera. But because of the
18 media interest of this, that it would need escalating,
19 there would be the need to involve senior leaders as
20 early as possible so it was about escalating that
21 process.

22 **Q.** And I think you have said that it was escalated to
23 yourself and also Dr Mark Taylor.

24 **A.** Yes.

25 **Q.** Why Dr Taylor?

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1 dear" is a reflection of the sadness of the situation.

2 **Q.** It might be suggested by some that it is a concern for
3 the Trust and their reputation?

4 **A.** Yeah, I appreciate that's how it may sound, but I am --
5 reading it now, it does make me feel sad when I read it,
6 so that's my understanding of how it was when I sent it.

7 **Q.** Could we please bring onto screen NHFT0000168 please.
8 We are going back to the RiO log. Page 271 again. We
9 are just going chronologically now. So we are now at
10 12.50, the entry from -- one entry from the bottom. So
11 we are now in the afternoon of 13 June and there is
12 an entry there from Natalie Iles. Was she taking the
13 lead as far as activity on the ground is concerned?

14 **A.** Yes. So with Natalie being one of the band 6 nurses on
15 duty, yes, this would have fallen to her because of the
16 complexity of the situation.

17 **Q.** It says:

18 "RiO information check requested from [Healthcare
19 Professional] at Nottingham Custody Suite."

20 Just pausing there. We see the entry above is the
21 Street Triage Team.

22 **A.** Yes.

23 **Q.** They also have access to RiO.

24 **A.** Yes.

25 **Q.** Do you understand why there's reference there to the

39

1 **A.** I think because he was available. I had spoken to our
2 operational manager, so that's the senior person above
3 myself and it was then having that conversation with
4 Dr Taylor just to make him aware as the clinical
5 director, and for additional support for the service
6 really.

7 **Q.** And the answer came:

8 "He is. Disengaged from EIP September and
9 discharged back to GP. 2 previous admissions. Dx
10 paranoid schizophrenia." *(As read)*

11 What is the reference to DX?

12 **A.** Shorthand for diagnosis.

13 **Q.** Thank you. If we could scroll up, your response I think
14 was "Oh dear". The top email, it has a slightly odd
15 timing because the time on that email seems to be prior
16 to your response below. I don't know if you are able to
17 assist us with that at all?

18 **A.** No, I'm afraid I can't make sense of that.

19 **Q.** Can you assist us with the reference to "oh dear". What
20 was your concern at this time?

21 **A.** I think it was a very sad nature of the incident, that
22 we were -- we hadn't really fully known, I think, at
23 this point about what had happened and the charges.
24 I think we did know some of the charges, but we weren't
25 aware of any of the circumstances and I think that "oh

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1 healthcare professionals at Nottingham custody suite, it
2 appears, also requesting assistance from the Liaison and
3 Diversion team?

4 **A.** Yes. So the Street Triage Team would have provided
5 information to Nottinghamshire Police and wouldn't share
6 that -- well, there would be no process to share that
7 information with Mitie. I don't know how that
8 information within the police was shared, amongst the
9 police and the information that the healthcare
10 professionals have access to. So the healthcare
11 professionals have then since approached L and D to
12 request additional information which to me suggests that
13 they weren't fully aware of his history.

14 **Q.** So is there an unnecessary level of bureaucracy in that
15 respect, that the healthcare professionals don't seem to
16 be able to obtain the information from the Street Triage
17 Team directly?

18 **A.** They wouldn't necessarily have to because I think the
19 Street Triage Team have an open working relationship
20 just with the police, whereas the Mitie, the healthcare
21 professionals, are only based in custody. So street
22 triage may have more of an involvement where people are
23 in the community, rather than in custody. So I think it
24 feels quite appropriate that Mitie perhaps didn't know
25 that if it wasn't contained in the NICHE records.

40

1 Q. So it may be that the police are aware of information
2 because of their relationship and being embedded within
3 the Street Triage Team?

4 A. Yes.

5 Q. But the actual healthcare professionals on the scene are
6 not aware of that information?

7 A. No, and if it is not recorded in NICHE, I'm not entirely
8 sure how the police process is for information checks on
9 the Street Triage Team, but I would assume if it is not
10 recorded in RiO then the healthcare professionals
11 wouldn't have that knowledge.

12 Q. I will just continue in that entry. It says:

13 "Advised police have contacted both 136 - Acorn
14 Suite and Street triage. Brief overview of history
15 provided."

16 It says "police have contacted" and the Acorn Suite,
17 I think we have heard of before, is that the secure
18 suite where section 1(3) assessments are carried out?

19 A. Yes, that is correct.

20 Q. Is it usual for the police to contact the Acorn Suite or
21 do they usually request assistance with that?

22 A. I, unfortunately, don't know the answer to that.
23 I would have imagined that the street triage would have
24 been able to provide as much information as the Acorn
25 Suite. So I don't know whether that's based on

41

1 Q. Then there is a summary of the triage, and this is the
2 triage process we have just been talking about. It
3 says:

4 "L&D Assessment - Declined."

5 On the notes it says:

6 "Informed by the police he will only answer to the
7 name Adam. They report not seeing signs of responding
8 to unseen stimuli while in detention.

9 "I have spoken with Adam who has refused to engage
10 with our services. Spoken to in cell with 2 officers
11 present. Sat on bed with relaxed body language and
12 maintained eye contact. Would not verbally respond to
13 questions. Shook head when offered support. Asked if
14 he understood was responded with a nod."

15 Can you help us, he's declined any assessment. Do
16 you have any power to continue in circumstances where
17 somebody has declined your services?

18 A. Not in this as an example where someone appears to be
19 understanding what is proposed to them, at least being
20 able to suggest that they have an understanding with no
21 overt signs or concerns about his presentation. Then,
22 no, that individual will be able to make that decision
23 to decline and I -- what usual practice would be is that
24 we would close the referral and request a re-referral if
25 the situation changed.

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1 relationships that the police have with that service.

2 So I don't know, I'm afraid.

3 Q. Are you aware, as at that time, of any difficulties, any
4 unavailability of the suite or anything along those
5 lines?

6 A. No.

7 Q. It says:

8 "Brief overview of history provided."

9 Is your understanding that that is provided by
10 Natalie Iles?

11 A. Yes.

12 Q. Is that recorded somewhere?

13 A. I believe it is recorded, yes.

14 Q. Within RiO or somewhere else?

15 A. I believe it is recorded in RiO.

16 Q. We will continue down the RiO entries and perhaps that
17 might assist. If we go down to the next one, there is
18 an entry at 1.53. I will just read to you a little bit
19 of this:

20 "Liaison & Diversion - City.

21 "Contact type: Face to face.

22 "Intervention: Seen and refused."

23 So it seems as though by 1.53 Natalie Iles has seen
24 VC; is that right?

25 A. Yes.

42

1 Q. Is that a capacity issue? As in if she had formed the
2 view that he didn't have capacity, she could have taken
3 it further?

4 A. Yes, I think if there were -- if there was information
5 that suggested perhaps he wasn't as stable as perhaps he
6 presented. So if there were other signs through the
7 conversation with the officers who were observing him or
8 information from the Mitie staff who had attempted to
9 see him, if there was information that suggested there
10 were concerns about his capacity, then, yes, that could
11 be overridden and that could have been explored.

12 Q. Who would have carried out that assessment?

13 A. That would have continued to have been the Liaison and
14 Diversion practitioner.

15 Q. It has a section at the bottom of the current page it
16 says:

17 "RiO check entered onto NICHE."

18 It sets out:

19 "Known to ... mental health services."

20 It contains there the working diagnosis of
21 February 2022 of paranoid schizophrenia. Then there is
22 a Liaison and Diversion plan including, as you have
23 said, "No further action from L&D at this time".

24 If I could go on, then, to the next entry and that's
25 later -- it is the bottom entry on the page -- we are

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1 still on 13 June, we are now at 5.25.
 2 Is this an entry from the Liaison and Diversion
 3 team?
 4 **A.** Yes.
 5 **Q.** Can you assist us with who Kyla Fraser is?
 6 **A.** Yes, so Kyla Fraser is a social worker and is employed
 7 as a Liaison and Diversion practitioner.
 8 **Q.** Would she be working alongside Natalie Iles?
 9 **A.** I think, from recollection, Natalie may have been on
 10 an early shift and Kyla, I think, was on the late shift.
 11 **Q.** It says: "HCPs in custody" so that's Mitie?
 12 **A.** Yes.
 13 **Q.** "... Rosie Draper and Holly Bramley came to ask for some
 14 advice from L&D. Police have asked HCPs to take samples
 15 and complete body mapping, but they have been unable to
 16 do this as [VC] is not consenting. They have tried to
 17 speak with [VC] again and have asked questions. He has
 18 answered 'no' to questions asked but his responses were
 19 delayed. Based on history and current presentation HCPs
 20 believe [VC] is mentally unwell and is not fit to
 21 interview. Rosie advised that usually in these
 22 circumstances, she would request a Mental Health Act
 23 assessment by calling CRHT ..."
 24 Is that the Crisis team?
 25 **A.** Yes.

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1 significance in terms of risk to the public. Because of
 2 the nature of that, the Mental Health Act process that
 3 we would have available to us would be as described, so
 4 accessing the Crisis team and exploring a Mental Health
 5 Act assessment.
 6 That would only give us access to consideration for
 7 sections 2 or 3 of the Mental Health Act, which are
 8 civil sections, which, given the gravity of the offence
 9 and the potential risk to the public, it would be
 10 inappropriate for VC to be admitted to an acute
 11 inpatient bed, which is what that process would allow
 12 for us.
 13 So the conversation where it discusses "the Trust
 14 stance is he will not be admitted into a psychiatric
 15 unit" is more actually in relation to because of the
 16 beds that we had available to us as an organisation, he
 17 would not be suitable for admission there. So that's
 18 why we felt at that time that the pursuing of a Mental
 19 Health Act assessment was perhaps not appropriate at
 20 that point and --
 21 **Q.** Sorry. We know that VC ultimately went to a high
 22 security psychiatric unit?
 23 **A.** Yes.
 24 **Q.** Did you consider a high security psychiatric unit and
 25 would that have been available?

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1 **Q.** "... and AMHP but she was unclear whether to do this in
 2 these circumstances due to the nature of the alleged
 3 offence. Agreed to discuss with [yourself] ..."
 4 I'm just going to read to you what is written there
 5 it says:
 6 "Teams call to [yourself and] Rosie and Holly
 7 present and explained situation."
 8 You:
 9 "... agreed to seek advice and call back. [You] ...
 10 called back ... [and] advised the HCPs to follow their
 11 escalation process and that the Trust stance is that he
 12 will not be admitted to a psychiatric unit due to the
 13 nature of the offence, therefore no need for the HCP to
 14 call to request this."
 15 Just pausing there. Is that an accurate statement
 16 of the conversation that took place?
 17 **A.** It is a very brief summary of a conversation that took
 18 place, yes.
 19 **Q.** Did you say or give the impression within that call that
 20 there should be no assessment as to VC's mental health
 21 or no assessment -- no formal assessment under the
 22 Mental Health Act or something else?
 23 **A.** So from recollection the conversation that we had was
 24 related to the nature of VC's arrest. The offences for
 25 which he was currently in police custody were of huge

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1 **A.** So, to my knowledge that's not something that we would
 2 have available to us through the community to escalate
 3 immediately to high secure in those circumstances, as
 4 the criminal justice advice form suggests that we would
 5 share information with the prison to which he would be
 6 remanded and be requesting that they support
 7 an assessment of his needs so that he could be
 8 considered for an admission via the court process to
 9 a secure hospital.
 10 **Q.** Reflecting what's written there and the conversation
 11 that you had at the time, do you think that you gave any
 12 impression that there shouldn't be an assessment of VC's
 13 mental health?
 14 **A.** No, I think this was specifically regarding the
 15 pursuance of a Mental Health Act assessment. A mental
 16 health assessment is what L and D had offered to do and
 17 would be able to continue to offer as required. So this
 18 was more in relation to the nature of the offence and
 19 the requirement maybe for a section of a forensic
 20 nature, so through the criminal justice process.
 21 **Q.** What would you do, for example, if a medical, healthcare
 22 professional formed the view that VC was in need of
 23 medication in relation to his mental health, how would
 24 you have him assessed at that point in time in order to
 25 assist him?

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1 A. That's interesting because we don't have the
2 availability of a medic within the Liaison and Diversion
3 service, so we would not have been able to access that
4 through our own service. The Mental Health Act
5 assessment wouldn't be a process in order to ascertain
6 whether someone required medication. So I'm not sure
7 that we would have been able to support the prescription
8 of any medication on that basis.

9 Q. Whose responsibility would that have been?

10 A. In the absence of there being any mental health service
11 that VC was open to, I would imagine that would sit with
12 my team.

13 Q. Is there any assistance you could have provided in
14 relation to that kind of an assessment for medication
15 purposes?

16 A. I think the fact that we only knew historical
17 information and that we had information which was not
18 recent, I think we would have struggled to have been
19 able to offer support regarding any medication, if that
20 were appropriate.

21 Q. Can we turn to another log. I think this is the custody
22 log. It is CPSE0000005. If we could please turn to
23 page 16. We see there in the middle of the page, this
24 is a reference to the earlier assessment that we saw,
25 the Liaison and Diversion assessment that was declined

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1 "Healthcare Professional examination".
2 Rosie Draper has entered this and it says:
3 "Details of healthcare given: initially assessed in
4 cell, advice sought from L&D. Re-reviewed in cell post
5 consultation with solicitor, DP engaging with HCP -
6 deemed fit to be interviewed. DP stated may do body
7 mapping and samples later - to handover to night shift."
8 Were you aware at this stage, just before 6 pm on
9 13th, that VC had been deemed fit for interview?

10 A. Personally I wasn't aware of that. No, that wouldn't
11 have been shared with me.

12 Q. I would like to take you to an email chain around that
13 time. So it is WITN0388013. This is a chain that's
14 ultimately forwarded to you. But if we could look at
15 that bottom email on the page. It is from Mark Taylor
16 to Kasia Foster and Joanne John(?). Can you assist us
17 with who they are?

18 A. So Kazia Foster at the time I believe was potentially
19 a care group director within acute mental health
20 services, and I think she was copied in because she was
21 the on-call for silver, which is -- well, yeah, one of
22 the levels of on-call support that we have. I don't
23 know who Jo-Anne John is.

24 Q. So Kazia Foster is from L&D?

25 A. No, she is from adult mental health services, so she is

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1 and Natalie Iles has entered that.

2 Does Liaison and Diversion have the facility to
3 enter entries on the custody record?

4 A. Yes.

5 Q. If we could please turn to page 75 and we are back to
6 our chronology now. Three-quarters of the way down the
7 page, on page 75. So over the page please. We see
8 an entry from 5.31 pm. It says:
9 "L&D - HCPs Rosie Draper and Holly Bramley came to
10 speak with L&D for advice about a Mental Health Act
11 assessment concerning [VC] ... and whether this ought to
12 be requested. Agreed to discuss with L&D Service
13 Manager ..."
14 And that's yourself:
15 "Teams call to Louisa. Louisa called back and
16 advised that the Trust stance is that he will not be
17 admitted to a psychiatric unit, therefore no need for
18 a Mental Health Act assessment to be requested."
19 So that's the reference that we saw on the RiO
20 system as well.

21 A. Yes.

22 Q. A similar entry now on the custody record.
23 If we could go back then to page 18 of the
24 custody record. We are moving along in time, we are now
25 at 5.54, the bottom entry, please:

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1 care group director across all adult mental health
2 services, or I think she was at the time.

3 Q. Dr Taylor says:
4 "As discussed earlier the Trust L&D service ... have
5 asked the provider which undertakes medical
6 interventions in custody (private, understood to be
7 Mitie) to escalate their preliminary capacity assessment
8 such that they conduct this thoroughly likely by
9 a forensic physician with a view to advising police as
10 to fitness to be detained and to be interviewed (their
11 role) ..." (*As read*)
12 The reference there to a forensic physician, are you
13 aware in respect of Mitie's ability to conduct
14 an assessment using a forensic physician?

15 A. I am not aware that they have that facility.

16 Q. Do you think they do or they don't?

17 A. I believe they don't.

18 Q. So do you think this may be an error?

19 A. Yes, I think it may. I think historically they will
20 have had what we would have called FME, and I'm not sure
21 how long that's not been in their service model for.

22 Q. Was it your understanding at this point in time that
23 Mitie were conducting a thorough assessment of capacity
24 in some form?

25 A. It was my understanding that yes, they would be

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1 considering capacity as part of their contact with him,
 2 yes.
 3 **Q.** Would you have understood that to have been by the HCPs
 4 themselves or by something else?
 5 **A.** By the HCPs.
 6 **Q.** So they don't have the level of qualifications of
 7 a specialist mental health care provider?
 8 **A.** Not that I'm aware of, no.
 9 **Q.** "If they are unable to conclude this process then my
 10 advice is that on call colleagues issue a containing
 11 response overnight pending further consideration
 12 tomorrow with appropriate expertise." (As read)
 13 Then there is the issue of custody time limits. He
 14 notes to Kazia that "it is worth ... making silver AMH
 15 aware in case of contact to the trust from the provider
 16 as they are 24 hours whilst L&D service discontinues."
 17 (As read)
 18 So it is lining up the possibility that there may be
 19 further Trust involvement at this stage.
 20 **A.** Yes.
 21 **Q.** The top email we can see is sent to yourself and he
 22 says:
 23 "I hope their position is resolved and there is no
 24 further approach with a view to diversion at this stage,
 25 if not we will need to pick up again tomorrow." (As
 53

1 where possible [VC] ... could be medicated ..."
 2 It appears as though question regarding VC's
 3 medication was put to Liaison and Diversion; is that
 4 correct?
 5 **A.** Yes.
 6 **Q.** Do you see that within Liaison and Diversion's remit?
 7 **A.** As I said, I think because he had been out of contact
 8 with services and, for all we know, not treated on any
 9 medication it wouldn't have been within our service to
 10 offer advice regarding that.
 11 **Q.** That's because you don't have a specialist clinician.
 12 **A.** Yeah, and no current information to support any
 13 prescription either.
 14 **Q.** The originator, Ms Bradley, she says at the bottom:
 15 "I will liaise with [yourself] ... for further
 16 advice."
 17 Then you have an update below that, at 11.10:
 18 "As [VC] ... is not currently prescribed
 19 medications, this is not a request we can facilitate."
 20 Just looking at that, reflecting on this now,
 21 wouldn't a Mental Health Act assessment or something
 22 other than a Mental Health Act assessment that assessed
 23 properly VC's mental health have been appropriate at
 24 that stage to quickly identify what medication may have
 25 been appropriate?
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1 read)
 2 Then he says:
 3 "Abdul, if forensic psychiatric assessment is needed
 4 due to no resolution I would likely be better placed
 5 overseeing this exercise and supporting the outcome at
 6 Trust level rather than conducting it myself." (As
 7 read)
 8 And then he asks to "think of other options."
 9 So as at the evening of 13 June, was it in your mind
 10 that you might need to become more involved in
 11 a psychiatric assessment.
 12 **A.** My recollection is that this was something that we had
 13 considered and would have available if there were
 14 escalating concerns regarding VC's presentation and
 15 mental health, yes.
 16 **Q.** If we could go back then to the RiO records. That's
 17 NHFT0000168. I'm just going to take you to a few quick
 18 entries on page 273. It seems there that on the next
 19 day, the next morning, 9.36, the police have contacted
 20 Liaison and Diversion in respect of establishing whether
 21 there were any recorded self-harm issues. That is the
 22 first box.
 23 Then the next box is "Liaison and Diversion service"
 24 confirming that the police:
 25 "[The] Sargent has requested our service find out if
 54

1 **A.** Erm I -- Erm, I think there is an element that he was
 2 offered an assessment he didn't wish to engage in. I do
 3 think that could have been re-offered. I think there
 4 was scope for further offer of assessment from Liaison
 5 and Diversion, if that was felt necessary. What I am
 6 aware of through reading the information to support for
 7 my evidence today is that there didn't appear to be any
 8 concerns regarding his presentation. There was no
 9 evidence to indicate that there were relapsing signs.
 10 So there was no evidence that the relapse indicators
 11 that we were aware of, such as experiencing auditory and
 12 visual hallucinations. There was no evidence that that
 13 was an experience of his.
 14 It was hard to engage because he wouldn't verbally
 15 engage in assessments so we were unable to identify if
 16 there was any evidence of thought disorder or any other
 17 symptoms, but based on the information that we had,
 18 there were no concerns about his presentation.
 19 **Q.** So you didn't at that stage have any evidence in your
 20 view that he was suffering from a mental illness that
 21 required medication; is that right?
 22 **A.** Yes.
 23 **Q.** That was based on his presentation?
 24 **A.** Yes.
 25 **Q.** If you did have such evidence, do you consider that it
 56

1 would have been your role to have taken that further
 2 step to involve a healthcare professional?
 3 **A.** I think if that were the case and was an issue we were
 4 presented with, I would have certainly taken that for
 5 further advice.
 6 **Q.** Could we please bring up on screen NHFT0002476. This is
 7 a criminal justice advice form that was filled in just
 8 one day after. If we turn to page 2, we can see at the
 9 bottom it was completed by Dominic Lloyd on 15 June.
 10 I would just like to read to you from that. Can you
 11 just tell us, what's the purpose of this kind of
 12 a letter?
 13 **A.** So the criminal justice advice form is a standard
 14 template form that we have that we use to share
 15 information following people that have been referred to
 16 the service that will follow them through their criminal
 17 justice process. So this will be supplied to the court,
 18 to the CPS.
 19 **Q.** It has been produced by the Liaison and Diversion
 20 service?
 21 **A.** It has. Dominic Lloyd is a mental health nurse and he
 22 was one of the team leaders.
 23 **Q.** If we scroll up, please, we can see above it says:
 24 "Verbal Consent to Share information received:
 25 "No - refused intervention, information based on
 57

1 witnessed by staff."
 2 There's then reference to August 2022, and then it
 3 says:
 4 "He refused to engage so police assistance was
 5 gained - he violently assaulted Police ...
 6 "Following this admission he disengaged with his
 7 community team and became non-compliant with
 8 medication."
 9 Then there is reference to an incident in
 10 January 2022 when "he trapped fellow students in their
 11 flat", and again it says:
 12 "... team attempted to engage him in community but
 13 this was very superficial, felt not to be compliant with
 14 medication."
 15 We have there on the first page not compliant with
 16 medication, and then over the page we have needed to
 17 have his medication witnessed by staff, the next one
 18 non-compliant with medication and again, the final
 19 paragraph of that section, "felt not to be compliant
 20 with medication".
 21 Was that not sufficient evidence? You said that
 22 there wasn't evidence, but we have here somebody who has
 23 committed a very serious significant and brutal attack.
 24 Your records say that you don't have sufficient
 25 information about his medication because he seemingly
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1 previous engagement with services."
 2 It sets out the reason for his arrest. Then it says
 3 there was a referral:
 4 "Due to the nature of the incident, [VC] requires to
 5 be seen regarding his mental health. There's also
 6 suggestion on previous records to suggest mental health
 7 issues."
 8 Then it says he:
 9 "... first came to the attention of mental health
 10 services in [May] 2020 ..."
 11 We have heard a lot about that. It says a little
 12 bit below:
 13 "Was admitted for 4 weeks and supported in community
 14 following this.
 15 "After around 2 weeks, his mental state was reported
 16 to be deteriorating and it came to light that he had
 17 been non-compliant with his medication believing that he
 18 was well and did not need this anymore ..."
 19 It then refers to the section 136 detention. Over
 20 the page, please.
 21 "Discharged on 31 July ..."
 22 And:
 23 "supported by community team, he was noted to be
 24 very good at masking symptoms of mental illness and was
 25 placed on a care plan to have his medication taken when
 60

1 hasn't been taking them for some time, has a history of
 2 not taking them and committing offences or serious
 3 violent acts. Surely that was the time to involve
 4 mental health professionals?
 5 **A.** Yes, so hence the conversation with leaders within the
 6 organisation. Because of the nature of his offence, the
 7 potential mental health issues that may be present that
 8 we weren't able to confidently confirm at the time, any
 9 medication would need to come from an assessment of his
 10 mental health and again he would have to consent to that
 11 and that's not something that we could actively enforce
 12 against consent in the police station. Again this is
 13 something that would be more appropriate to have come
 14 via the Mental Health Act process through the criminal
 15 justice, through the court process to ensure that he was
 16 admitted to a secure establishment.
 17 **Q.** But you have incident after incident where he is masking
 18 symptoms and not taking his medication and committing
 19 violence, and we have seen the notes from Liaison and
 20 Diversion relating to DP not currently prescribed any
 21 medication. It seems, certainly reading this today, to
 22 be quite clear that he required an assessment that could
 23 have led to medication.
 24 **A.** Which is what the (*unclear*) advice form requested that
 25 there is an assessment of his mental health upon
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1 admission to prison custody so that that could be
 2 established at the earliest opportunity.

3 **Q.** Do you think that something could have been done sooner
 4 in that respect?

5 **A.** I think, given the gravity of the offence, the
 6 significant risk to the public, it was my understanding
 7 that he required admission to hospital via the criminal
 8 justice process, which would ensure that he could be
 9 admitted to a secure establishment which would be much
 10 more suitable to the level of risk that he presented and
 11 ensure that he had access to a specialist forensic
 12 assessment through that process.

13 **Q.** Just looking back and reflecting on what occurred here,
 14 we have heard about issues with Mitie being able to
 15 access the RiO logs. We have heard about your level of
 16 access and information and you said that you don't have
 17 specialist clinicians available. Do you think that
 18 there is more of a role for Liaison and Diversion that
 19 could be possible in future cases?

20 **A.** I'm not sure that that does sit within the remit of the
 21 Liaison and Diversion service, that it is more about
 22 ensuring that people are either diverted within the
 23 criminal justice process, which in this case is what
 24 happened. I think if -- there are few cases -- these
 25 events are very rare, the nature of these events and

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1 their escalation process and that the Trust stance is he
 2 will not be admitted to a psychiatric unit due to the
 3 nature of the offence, therefore no need for HCP to call
 4 to request this."

5 Firstly, did you say or say words to the effect of
 6 the healthcare professionals should follow their
 7 escalation process?

8 **A.** Yes.

9 **Q.** If you had meant or believed that there should be no
 10 Mental Health Act assessment by anyone for any purposes,
 11 would you have advised Mitie to follow their escalation
 12 process?

13 **A.** No. It was an encouragement for them to ensure that
 14 they did, if they were concerned, that they did ask me
 15 that.

16 **Q.** Therefore, more openly, what did you envisage that Mitie
 17 would do when you were encouraging them to follow their
 18 escalation process?

19 **A.** I guess much like I did, which is to reach out to senior
 20 leaders to seek support and guidance where required;
 21 that would have been my expectation of that.

22 **Q.** Then the second aspect of the words that are typed up
 23 here, the very last sentence of that paragraph:
 24 "Therefore no need for [Healthcare Professionals] to
 25 call to request this."

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1 contacts with services are very rare, I do think a more
 2 robust approach to coordinating incidents such as this
 3 could be more helpful, but I'm not sure that that sits
 4 within the Liaison and Diversion role.

5 **Q.** Thank you, Chair. I don't have any further questions.
 6 I don't believe there are. Mr Beer has some.

7 **THE CHAIR:** Yes, Mr Moloney you don't have any questions?

8 **MR MOLONEY:** No, thank you, Chair.

9 **THE CHAIR:** Yes, Mr Beer.

10 Questioned by MR BEER

11 **MR BEER:** You know I ask questions on behalf of the Trust.
 12 Just two topics, please. To start with can we look at
 13 NGPF0000168 and page 272, please.

14 That is my fault, NHFT0000168, but still page 272.
 15 It is the bottom entry, please. If we can blow that up.
 16 It is an entry we looked at just a moment ago with
 17 Mr Blake. This is the RiO record and it records the
 18 various conversations with Rosie and Holly on the one
 19 hand, you and the other and Kyla in the middle and it is
 20 the penultimate paragraph:
 21 "Teams call to Louisa Hagan" that I wanted just to
 22 focus in on. Teams call between you, Rosie and Holly
 23 present, situation explained:
 24 "Louisa agreed to seek advice and call back. Teams
 25 call back from Louisa who advised that HCP to follow

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1 Does that mean no need for healthcare professionals
 2 to call you or L&D back to request a Mental Health Act
 3 assessment for the purposes of admission to
 4 a psychiatric unit?

5 **A.** I think that was probably what was meant by that, yes.

6 **Q.** So are you saying -- I'm speaking colloquially now --
 7 there is no need to call us back again to trigger
 8 an MHAA to get him into a psychiatric unit?

9 **A.** Yes.

10 **Q.** Because you have done that and I have told you the
 11 result already, yes?

12 **A.** Yes.

13 **Q.** Related to that you said on a number of occasions that
 14 you wouldn't trigger a Mental Health Act assessment for
 15 the purposes of diversion under section 2 or 3 of the
 16 Mental Health Act because that is the civil route?

17 **A.** Yes.

18 **Q.** Under part 2 of the Mental Health Act?

19 **A.** Yes.

20 **Q.** You said on a number of occasions that couldn't result
 21 in admission to a secure unit?

22 **A.** That's my understanding, yes.

23 **Q.** Then in other bits of your evidence, a little later, you
 24 said it would need referral through the criminal justice
 25 system?

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1 A. Yes.
 2 Q. Is that under part 3 of the Mental Health Act --
 3 A. It is, yes.
 4 Q. -- where that can result in admission, compulsory
 5 admission, to a secure unit --
 6 A. Yes.
 7 Q. -- needing the Secretary of State sign-off?
 8 A. Yes, so an individual on remand can be transferred for
 9 assessment or treatment, yes.
 10 Q. So that can occur under remand --
 11 A. Yes.
 12 Q. -- under section 48, 49 or indeed upon sentencing?
 13 A. Yes.
 14 Q. Is that why you were saying that's why the form that
 15 Mr Blake showed you, the criminal justice agency's
 16 advice form was really suggesting that or triggering
 17 that, dated 15 June, ie when he was remanded into
 18 custody?
 19 A. Yes, that's correct.
 20 Q. Thank you very much.
 21 **THE CHAIR:** Thank you.
 22 Yes, thank you very much. That completes your
 23 evidence.
 24 If we can start again at 3.50 pm. Thank you.
 25 **(3.37 pm)**

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1 Q. At the time you were employed by Mitie?
 2 A. Yes.
 3 Q. You say in your witness statement your background is as
 4 a paramedic; is that right?
 5 A. Yes.
 6 Q. Do you have, either as part of that role or as part of
 7 your role as a forensic healthcare professional, any
 8 specific training on mental health?
 9 A. So, with regards to my paramedic training, we get
 10 insight into certain mental health conditions. We have
 11 access and use the Crisis team if required as
 12 a paramedic on the ambulance service, and then upon
 13 joining the custodial role we get further mental health
 14 training again into potential presentations that you may
 15 see in custody.
 16 Q. So you would be comfortable generally identifying some
 17 mental health issues?
 18 A. Generally, yes.
 19 Q. In terms of your -- the role title -- what does the word
 20 "forensic" add to your job title of forensic healthcare
 21 professional?
 22 A. Essentially it means that we also provide a provision to
 23 the police which can include the taking of forensic
 24 samples and certain fitness assessments whilst in
 25 custody.

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1 **(A short break)**
 2 **(3.50 pm)**
 3 **THE CHAIR:** Yes, Mr Jones.
 4 **MR JONES:** Thank you, Chair. Can we please call Holly
 5 Bramley.
 6 **THE CHAIR:** Yes.
 7 **MS HOLLY BRAMLEY (affirmed)**
 8 **Questioned by MR JONES**
 9 **MR JONES:** Thank you. Ms Bramley, you have provided
 10 a witness statement for the Inquiry dated
 11 28 November 2025; is that right?
 12 A. Yes.
 13 Q. Can you confirm its contents are true to the best of
 14 your knowledge and belief?
 15 A. They are.
 16 Q. For the purposes of the transcript, the URN is
 17 WITN0017001.
 18 Ms Bramley, you are a forensic healthcare
 19 professional; is that right?
 20 A. Yes.
 21 Q. In June 2023, you were based in Nottingham custody; is
 22 that correct?
 23 A. I was.
 24 Q. You have since moved to a different area?
 25 A. I have, yes.

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1 Q. So when you say in your witness statement that your role
 2 is firstly to look after the health and wellbeing of
 3 anyone within the custody suite, and then, secondly, to
 4 perform certain forensic procedures at the request of
 5 the police. On the one hand it is to look after the
 6 healthcare of detainees, on the other hand it might be
 7 to assist with any forensic investigations?
 8 A. Yes, we have dual responsibility for both.
 9 Q. Just in terms of your ability to identify mental health
 10 issues, would you be able to identify signs of
 11 psychosis?
 12 A. I would be able to identify certain signs of psychosis
 13 in theory so -- but any kind of more advanced assessment
 14 I would gain further assistance from somebody else.
 15 Q. But you might know enough to know when to request that
 16 further assistance?
 17 A. Yes.
 18 Q. What kind of symptoms might you be able to look out for?
 19 A. Delusions, hallucinations either auditory or visual,
 20 that would be as far as I was comfortable with, with
 21 going off the bat. If the person would engage with
 22 a conversation I would be more comfortable if they
 23 weren't talking coherently we could use that as well,
 24 but initially for me personally it would be delusions or
 25 hallucinations.

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- 1 Q. So we will obviously come onto 13 June in particular in
2 a moment, but if somebody doesn't engage, do you feel
3 comfortable identifying signs of psychosis?
- 4 A. So, purely non-verbal engagement I would not jump
5 straight to considering psychosis. People can just
6 choose to not want to verbally engage, which is quite
7 common in custody as well. I would require some form of
8 either history or other symptom to be present for me to
9 just jump to psychosis.
- 10 Q. In terms of the information you can access within your
11 role, we have heard a little bit about that from some of
12 the witnesses today, but from your perspective what can
13 you access on the medical side in respect of a detained
14 person's history?
- 15 A. Without consent, very little. So with regards to
16 clinical notes, there's the summary care records, which
17 I believe is NHS throughout. We would need consent to
18 access that unless it was in an emergency situation,
19 clinically emergent; with regards to mental health we
20 don't have access to anything.
- 21 Q. So you can't access RiO; is that right?
- 22 A. No, we can't.
- 23 Q. What can you see in the summary care records?
- 24 A. If we can gain consent to access it, it again depends on
25 what that patient in this instant has consented for

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- 1 Q. Had you encountered detained persons who had been
2 accused of crimes that are really at the very serious
3 end?
- 4 A. Yes.
- 5 Q. So if we could bring up please the custody record and it
6 is CPSE0000005 and page 12, please. Right at the bottom
7 of the page, you can see your name, H Bramley, that's
8 you and then the date 13 June at 8.13. If we turn over
9 the record is on the following page.
- 10 These are the notes from your first examination of
11 VC; is that right?
- 12 A. Yes. On the custody record, yes.
- 13 Q. We know from the time it is just a couple of hours after
14 he had been brought into custody; is that your
15 recollection?
- 16 A. Yes.
- 17 Q. So can you recall at this point why were you asked to
18 see VC?
- 19 A. My recollection for this assessment was because he was
20 due to go on level 4 observations.
- 21 Q. Can you just tell us about those?
- 22 A. Yes. So within custody each detainee gets put on
23 a level of observations for the duration of detention.
24 It varies from level 1 to level 4. Level 4 is the
25 highest and that's a constant observation, which

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- 1 their GP to share. So it varies widely. Sometimes we
2 can see nothing, if they have basically said to their GP
3 that they don't want to share that information.
- 4 Sometimes it can be previous medical diagnosis,
5 medication that they have been on past and present. It
6 does vary hugely.
- 7 Q. On the police side we have already heard today you are
8 able to access the custody record; is that right?
- 9 A. Yes, that's correct.
- 10 Q. Anything else you can access on the police side, or is
11 it just the custody record?
- 12 A. Just the custody record.
- 13 Q. Turning to 13 June, you were involved in the morning
14 shortly after VC was arrested; is that right?
- 15 A. Correct.
- 16 Q. And then again later on in the day.
- 17 A. Correct.
- 18 Q. We will turn to each. I think you also did a welfare
19 check --
- 20 A. I did.
- 21 Q. -- a couple of days later on the 15th; is that right?
- 22 Just pausing there before we go into that, had you
23 encountered detainees with serious mental illness before
24 13 June?
- 25 A. Yes, I would have had during my time in custody.

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- 1 essentially means open door with officer or officers
2 present.
- 3 Q. Were you asked to perform any particular examination?
- 4 A. So it is local policy for anyone on level 4 to be
5 assessed by a HCP and in this case it was a fit to be
6 detained and level 4 assessment.
- 7 Q. The information you had before seeing VC, had you been
8 able to get access to any medical records by this point?
- 9 A. No.
- 10 Q. So can you recall what you were told about VC?
- 11 A. My recollection is very minimal as I was starting my
12 shift as he was being brought into custody. So the
13 night HCP that was on at the time that he was brought in
14 informed me that there was somebody in the holding cell
15 who had been brought in under an allegation of murder
16 and that I would be due to see him because he was being
17 put on level 4. That's what my recollection is.
- 18 Q. Is that the norm? Would you be told more or less than
19 that or is that about the standard when you're asked to
20 go and see someone?
- 21 A. (*overspeaking*) I don't believe there was any more
22 information known at that point, so that would be
23 standard for this situation.
- 24 Q. Did you look at the custody record before seeing VC?
- 25 A. I don't recall.

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1 Q. Can you recall if you spoke to anyone? Any other
2 healthcare professionals?

3 A. Just Kirsty who was the night HCP who handed that
4 information over to me. She will have been the only HCP
5 I spoke to at that point.

6 Q. So you weren't told of any particular concerns or
7 anything to look out for; it was just a routine review
8 of someone on level 4 observations.

9 A. I was informed that Kirsty had done a taser assessment,
10 that she'd seen him for that before the end of her
11 shift. But I don't recall being told anything else at
12 that point.

13 Q. Would you ever ask for information at that point, for
14 example from the L&D service, the Liaison and Diversion
15 Service or ...?

16 A. Not straight off the bat as I didn't have any, at this
17 point, anything to assume that he had mental health
18 problems. So I would see him -- I would see the
19 detainee first and then if I felt the need I would
20 involve L&D after.

21 Q. In terms of the recording, so we can see it says
22 healthcare professional examination, the word
23 "examination" suggests it is quite thorough; is that
24 right?

25 A. Again, that is quite -- that will depend on (1) whether

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1 asked if he had any medical problems. Handcuffed, on L4
2 ..."

3 That is level 4 observations?

4 A. Yes.

5 Q. "... sat on bunk. No immediate clinical concerns with
6 presentation currently."

7 So just in broad terms, what was your impression at
8 this point?

9 A. My impression at this point is that he was in for
10 a serious allegation but wasn't engaging with me. There
11 are multiple reasons that people can choose to not
12 engage. Whilst I didn't see any immediate clinical risk
13 to him being in custody, I wanted him to have a rest
14 period before we considered anything else whilst I tried
15 to gain more information.

16 Q. We will turn to the decisions in respect of fit to
17 detain, fit to interview in a moment. Just in terms of
18 non-engagement, is it common in your experience for
19 detained persons not to engage?

20 A. It can be, yes.

21 Q. Is that particularly common when they have just entered
22 custody or --

23 A. They can be.

24 Q. -- does it vary?

25 A. It varies hugely, yes.

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1 the detainee consents, and also what is being requested
2 of us.

3 Q. Can you recall whether you asked VC for access to his
4 medical records, for consent to access them?

5 A. I don't recall if I asked that, no.

6 Q. Do you think you would have done? Is that something you
7 would likely do?

8 A. Not at this point.

9 Q. Why is that?

10 A. So from what I can see on my notes and my recollection
11 of this specific event I -- after the minimal engagement
12 I got from VC I wanted him to be put on a rest period
13 whilst I considered getting further information. At
14 that point it was L&D that I involved rather than trying
15 to go through his medical records, as they have access
16 to RiO.

17 Q. Turning to what you have recorded, and we can see about
18 a third of the way down the screen:
19 "Details of care given".
20 These are your notes, are they?

21 A. Yes.

22 Q. You have written:
23 "DP [that is detained person] refused to engage with
24 me - did not speak, but made eye contact when I first
25 arrived, then bowed his head. Shook his head when I

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1 Q. What do you do? Do you get any training in respect of
2 getting them to engage?

3 A. Not directly, no. We would -- no, we don't get any
4 training on how to get them to engage. We would be
5 introducing ourselves, explaining our role there and why
6 we wanted them to engage, but ultimately it is their
7 decision on whether they want to consent to that
8 assessment and therefore engage. Obviously further
9 considerations down the line would have to be taken if
10 they had been in custody for hours and still wasn't
11 engaging, but initially it would be a case of
12 introducing myself.

13 Q. Can you recall whether you made any efforts to encourage
14 VC to engage with you?

15 A. My recollection is I made as much effort as I felt
16 comfortable doing at that particular time. So VC was
17 placed on level 4 and still in restraints because he was
18 violent on arrival to custody. I attended the cell to
19 see him to ensure that he presented as clinically well.
20 But I didn't feel comfortable nor would it be within my
21 remit to continue pushing him to engage at that point
22 when he had been so violent on arrival.

23 Q. In terms of what you recorded you are saying you got a
24 little bit of engagement but not anything --
25 (*overspeaking*) --

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- 1 A. No verbal at that point.
- 2 Q. -- (*overspeaking*) -- bowed his head, shook his head when
3 asked about medical problems. When you recorded no
4 immediate clinical concerns with presentation currently,
5 what did you mean by that?
- 6 A. So I was unable to take any observations due to them
7 wanting to preserve forensics, so I had to make
8 a decision on whether he was fit to be detained based on
9 what I could see. So with regards to that, I mean he
10 didn't appear to be in any respiratory distress, he
11 wasn't breathing fast, he didn't look cyanosed. It
12 would be clinical signs that we would quite quickly see
13 with somebody if there were any acute concerns.
- 14 Q. Albeit you haven't got immediate engagement, did you
15 detect any mental health problems at this point?
- 16 A. I wouldn't go as far as saying I detected mental health
17 problems. He was very calm in manner and appeared --
18 very calm in manner for what he had been arrested for
19 which was noted. But as far as mental health issue
20 goes, there wasn't anything detected at that point as
21 I had no engagement.
- 22 Q. The fact that he felt calm, this again being quite
23 recent in his time in custody, what did you make of
24 that?
- 25 A. I was very aware from when I saw him that more

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- 1 Q. So that's risk to themselves, I presume?
- 2 A. Risk to themselves and others, but predominantly for us
3 it is risk to themselves at that point.
- 4 Q. Below that entry we can see "AA recommended." Help us
5 with that, AA stands for appropriate adult; is that
6 correct?
- 7 A. Yes.
- 8 Q. You have selected "no". Why is that?
- 9 A. At that point, I had no immediate reason to jump to the
10 conclusion that VC required an AA. The lack of verbal
11 engagement by itself did not make me think that he
12 automatically needed an AA. However, as you can see
13 further in the custody record, once further information
14 had come to light, and the rest period had passed with
15 still no engagement, that decision I changed my
16 recommendation to him needing one.
- 17 Q. Just in terms of what an appropriate adult does and when
18 they might be needed, can you help us with that?
- 19 A. So an appropriate adult is somebody that acts as
20 an advocate for somebody during their time in custody to
21 ensure that they are understanding either what is being
22 told or what is being asked of them. There are
23 a variety of people who can require an AA where it can
24 be recommended. So it can be children under 18, people
25 with mental illness, certain people with learning

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- 1 information would be needed. So we would need to look
2 into whether it was mental health and why VC was
3 presenting in that way shortly after being arrested for
4 what he had been arrested for. So with regards to what
5 I made of it, I knew that I would have to do further
6 investigations into what potentially could be causing
7 that manner.
- 8 Q. What further investigations were those?
- 9 A. So I escalated it. So my management were involved and
10 I went to speak to L&D as they had access to the mental
11 health system.
- 12 Q. We'll come onto that in a moment. Just in terms of the
13 decisions here in terms of fitness to detain, fitness to
14 interview, starting with fitness to be detained.
15 I don't think we need to take you to the policy, but in
16 a nutshell what's your understanding of when somebody
17 will or won't be classed to be fit to be detained?
- 18 A. So to be fit to be detained in custody is to outline,
19 highlight any reason, be it medical or mental health,
20 that a detainee may not -- to outline the risk that may
21 be posed to the detainee during their detention in
22 custody. So if there is anything acute that needs to be
23 dealt with before we can deem that they are fit to be
24 there, we should do our best to facilitate whatever that
25 may be.

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- 1 difficulties if they struggle with understanding.
- 2 Q. So it follows, does it, that you didn't have any
3 concerns in that regard at this stage albeit you hadn't
4 had any meaningful engagement?
- 5 A. At this point, yes.
- 6 Q. Just briefly -- and again I do not think we need to go
7 back to the record -- we can see in the custody records
8 in another part that one of your colleagues, Ms Topham,
9 had earlier advised that an appropriate adult was
10 required. Were you aware of that?
- 11 A. No.
- 12 Q. At the time?
- 13 A. At the time, I was not aware that Kirsty had said that,
14 no.
- 15 Q. Would that have been relevant information?
- 16 A. Yes, if Kirsty had rationale as to why she believed that
17 he needed one, it would have been relevant. But it is
18 also predominantly the HCP that's making that decision
19 at that point. It is their call to advise the custody
20 staff whose final decision it is on the AA.
- 21 Q. Presumably you would have wanted to know the basis on
22 which someone in your position had advised that an AA
23 was required, is that -- (*overspeaking*) --
- 24 A. Yes, that may have been helpful.
- 25 Q. Would you have seen her entry in the custody record

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1 recording that an AA was required?

2 **A.** My recollection is that it wasn't there at that point.

3 **Q.** You didn't speak to her?

4 **A.** I spoke to her in the morning when she handed over, but

5 that wasn't mentioned.

6 **Q.** Do you think it should have been mentioned?

7 **A.** It could have been helpful, yes.

8 **Q.** What would you have done with that information? Would

9 you have been more likely to think that an AA was

10 required and might it have informed some of your other

11 clinical decisions moving forward?

12 **A.** It could have, yes, depending on what her rationale was

13 for it.

14 **Q.** You might not know her rationale now, but what -- how

15 would it have influenced any decisions you made?

16 **A.** This is unlikely as VC hadn't been in custody long, but

17 if she had more information than I had been told, which

18 made that decision for her to have put yes, then, having

19 known that information would have changed what I would

20 have said. Further than that, it probably wouldn't have

21 influenced as we have to make our own decision in the

22 moment that we see the detainee.

23 **Q.** Coming to the line below that, fitness to interview, and

24 again here you have recorded "no". What is the test

25 for -- what is your understanding of when somebody will

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1 assessment you had formed of his mental condition at

2 that point?

3 **A.** My recollection would be that it was to do with the

4 nature of the offence, the way he arrived into custody

5 and how calm he presented when I did attend the cell.

6 **Q.** Just before we move on, again I don't think I need to

7 take you to it, but we have seen in the witness

8 statement of Chief Inspector Murray that this

9 examination took around 2 minutes. Were you aware of

10 that? Does that sound about right in your recollection

11 of the time you spent with VC at this point?

12 **A.** Potentially, yes, I had no engagement and wasn't able to

13 do observation, so that could be the case, yes.

14 **Q.** Is that the norm, or would you expect it to take a bit

15 longer or --

16 **A.** Yes.

17 **Q.** -- does it entirely depend?

18 **A.** It is entirely dependent. For a full fit to be detained

19 assessment to be completed, it would take significantly

20 longer than 2 minutes, but again that is hugely

21 dependent on engagement from the detainee, the safety

22 for myself as an HCP and also what is being expected of

23 me within that period.

24 **Q.** If we could bring up, please, your decline notes and the

25 reference is NGPF0002377.

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1 be fit to be interviewed?

2 **A.** A fit for interview assessment is to determine whether

3 the detainee is physically and mentally capable of

4 withstanding questioning that's used in an interview

5 essentially and, if not, what needs to happen for that

6 to be changed to a "yes".

7 **Q.** In your witness statement you had said that it was

8 common practice in custody for an initial rest period to

9 be in place if a detainee presents with unusual volatile

10 or erratic behaviour; is that right?

11 **A.** That's correct, yes.

12 **Q.** We don't see at this point that you have identified any

13 unusual volatile or erratic behaviour; would you agree

14 with that?

15 **A.** In the custody notes, no.

16 **Q.** Sorry, I missed that?

17 **A.** Sorry, I haven't stated that in the custody record, no.

18 **Q.** But are you saying you did identify that type of

19 behaviour or was it based on something you had been

20 told -- (*overspeaking*) --

21 **A.** My recollection is it was based on what I had been told

22 about him during his arrest and his arrival into

23 custody.

24 **Q.** So was it, in reality, the nature of his offence and the

25 way in which he had arrived in custody rather than any

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1 It is right, is it, that these notes are in respect

2 of the same examination that morning; is that correct?

3 **A.** Correct, yes.

4 **Q.** What -- in terms of this document, what was the purpose

5 of this one in addition to the notes that you recorded

6 in the custody log?

7 **A.** So, we, as healthcare professionals, always document

8 clinical notes on our clinical system and then a brief

9 version of what we have encountered on the

10 custody record. So this was the clinical assessment on

11 the clinical system.

12 **Q.** We can see a bit more detail in this note in the top

13 box. It says:

14 "DP seen in cell due to volatile behaviour."

15 Again, was that volatile behaviour that had been

16 reported to you from others?

17 **A.** Yes.

18 **Q.** "Sat on bunk, handcuffed to the rear, in own clothing.

19 Appeared to be sat calmly, no erratic movement or

20 attempts to move when I arrived.

21 "Looked up and made eye contact with me on arrival,

22 then bowed his head and refused to engage verbally.

23 "Alert, no apparent SOB/DIB ..."

24 Is that shortness of breath?

25 **A.** Yeah, and difficulty in breathing.

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- 1 Q. "... no audible wheeze, no cyanosis.
2 "Appeared well perfused."
3 So these are your clinical observations to the
4 extent you were able to do them?
5 A. Correct.
6 Q. In terms of the plan that you formed, did you think at
7 this point it would be helpful to get further
8 information about his history?
9 A. Yes.
10 Q. Is that something you then went and did?
11 A. Yes.
12 Q. The box at the bottom which records that doesn't suggest
13 that that was part of your plan at that point. Can you
14 assist us as to why that might be?
15 A. I can't comment on why I didn't write it in there, no.
16 My recollection of this day was that due to the
17 presentation and what I wrote in here, more information
18 was needed, so the plan was to involve L&D and escalate
19 through my seniors.
20 Q. The plan you have recorded we can see at the bottom in
21 the second line:
22 "L4 to remain. No RA/violent behaviour."
23 RA, can you help us?
24 A. Risk assessment.
25 Q. At the bottom:

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- 1 A. Again, dependent, but I would say it was a red flag for
2 how calm he was appearing for what he had just been
3 arrested for and brought into custody.
4 Q. When you say red flag, can you expand on that; what do
5 you mean?
6 A. More just that I wouldn't expect somebody to be sat
7 there that calmly and seemingly -- just I wouldn't
8 expect somebody to be sat there that calmly with what
9 they had just been arrested for.
10 Q. Can you recall what you discussed with Rosie Draper?
11 A. As in just Rosie and I or with L&D?
12 Q. At that time when you went to seek her advice?
13 A. So Rosie came into custody and I don't have a complete
14 recollection of what we discussed as it is not
15 documented anywhere, but my assumption would be that I'd
16 just explained what he was brought in for and how he
17 presented so far.
18 Q. Your next contact with VC was to carry out a request of
19 complete body mapping and toxicology; is that right?
20 A. Yes, myself and Rosie were involved together at that
21 point.
22 Q. You set this out in your witness statement and perhaps
23 if we could bring up another document, it is
24 NGPF0002378.
25 So you hadn't seen VC between your earlier

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- 1 "H/SO PS Oppon-Kusi."
2 A. Handed over to Police Sergeant Oppen-Kusi.
3 Q. Now, you say in your witness statement that after this
4 examination, as you have alluded to, you sought the
5 involvement of your management due to the complexity of
6 the situation and the severity of the offence. Was that
7 Ms Rosie Draper who you spoke to about that?
8 A. Correct.
9 Q. What was it in your view that was complex about the
10 situation?
11 A. Due to what VC had been arrested for and the way that he
12 was presenting, I was aware that I would need further
13 support to ensure that all fitness assessments and
14 potential requests by the police moving forward were
15 conducted correctly. (1) to ensure that his health and
16 welfare was looked after during his time, but also to
17 ensure that any evidence we obtained was admissible.
18 Q. When you say the presentation and the offence, again, we
19 can see that you haven't been able to make many
20 observations in terms of his presentations, so was it
21 really more the offence or was it, in fact, both that
22 led you to -- (*overspeaking*) --
23 A. I would say it was both. VC was presenting extremely
24 calm for what he had just been arrested for.
25 Q. Is that unusual?

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- 1 examination and this point; is that right?
2 A. It suggests in my notes that I didn't, or the
3 custody record, I don't have recollection of seeing him
4 between, yes.
5 Q. We can see there in the progress notes:
6 "HCP has been asked to complete body mapping and
7 toxicology bloods. DP has not consented to this and no
8 assessment has been completed to assess DP's capacity to
9 consent as he has refused to engage."
10 Just breaking that down, we have heard a little bit
11 about body mapping, so can I just ask about toxicology.
12 What was your understanding of what you were being asked
13 to do at this point?
14 A. My understanding was that we had been requested to take
15 body mapping and ultimately perform toxicology bloods on
16 VC.
17 Q. When you say toxicology, what was your understanding of
18 the reason that that was requested?
19 A. I have no recollection of the forensic strategy being
20 explained to us, I just, with what's in my notes and on
21 the custody record, recall we were asked to take bloods.
22 Q. Are you normally told, for example, these are for drug
23 screening purposes or these are for forensic DNA
24 purposes? Do you normally get told that?
25 A. Yes.

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1 Q. Would that normally be recorded on the log?
 2 A. Yes.
 3 Q. But you can't recall which one it was on this occasion?
 4 A. My recollection from my notes is that we were asked to
 5 do toxicology bloods, as all my notes suggest that,
 6 I don't recall a verbal conversation with anybody.
 7 Q. So when you say your recollection is toxicology bloods,
 8 is that for drug screening purposes? Is that what you
 9 are saying?
 10 A. So toxicology bloods looks at whether somebody has drugs
 11 in their system, yes. There are also other bloods we
 12 can get requested to do but toxicology does look at the
 13 presence of drugs.
 14 Q. So it's your belief that that's what you were being
 15 asked to do?
 16 A. Yes.
 17 Q. Were you asked to take any other samples at all?
 18 A. Not to my recollection. Just body mapping and the
 19 bloods.
 20 Q. In terms of consent, we can see you have recorded that
 21 VC had not consented to that. In a nutshell, is it your
 22 understanding that forensic samples can't be taken
 23 without consent?
 24 A. These forensic samples cannot be taken without consent,
 25 no. That's my understanding.

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1 he was out of rest period.
 2 Q. Is that something that Mitie can arrange?
 3 A. With regards to capacity?
 4 Q. Yes.
 5 A. Yes, so we can assess capacity.
 6 Q. Did you take any steps to have that assessment done?
 7 A. So, at this point, VC was still in his rest period. So
 8 no, I didn't do a further capacity assessment at this
 9 point. The plan was to re-assess everything, including
 10 capacity, once he was out of rest period and had more
 11 information, so that was the plan moving forward.
 12 Q. Do you know what happened with that plan? Do you know
 13 when --
 14 A. Only through reading what's in the evidence bundle.
 15 Q. So in terms of whether and, if so, when a capacity
 16 assessment was done, can you assist us with that?
 17 A. It wasn't myself that completed that.
 18 Q. So turning to the part below that on the same document:
 19 "L&D checked RiO and were able to inform me that DP
 20 as of February 2022 has a working diagnosis of paranoid
 21 schizophrenia."
 22 Then we can see, the note has already been read out,
 23 a bit more detail as to VC's history. What did you
 24 consider to be the significance of that history?
 25 A. That he has significant mental health history that we

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1 Q. Do you recall what he said about that, when you asked
 2 him whether he would provide these samples?
 3 A. I don't recall that, no.
 4 Q. Do you recall how long the interaction was?
 5 A. No.
 6 Q. So you can't recall why it was that he wasn't giving his
 7 consent?
 8 A. I have since read further information that was provided
 9 in the evidence bundle and can see what Rosie
 10 documented, but I don't recall it personally, no.
 11 Q. We can pick that up --
 12 A. Yeah.
 13 Q. -- with Rosie. The note also says that you weren't able
 14 to assess his capacity to consent. Had you intended to
 15 perform a capacity assessment there and then? Is that
 16 something you are able to do as an HCP?
 17 A. I am able to perform a capacity assessment, yes. You do
 18 need some level of engagement from somebody to assess
 19 capacity. However, we are to assume someone has it
 20 unless we are given some reason to suggest otherwise.
 21 But due to him not consenting at that point and still
 22 being within the rest period, I was unable to assess.
 23 Q. So do you consider that formal capacity assessment was
 24 required?
 25 A. Yes. So, in general, re-assessment was suggested once

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1 were unaware of initially on him arriving.
 2 Q. Was this the first time you were aware of that?
 3 A. To my recollection, yes.
 4 Q. How was that relevant to any decisions that you had to
 5 make?
 6 A. At this point we would have to look at whether further
 7 assessments would be needed for VC, whether the
 8 presentation that we were seeing was due to mental
 9 health or something else, and also essentially what
 10 I said, anything moving forward, extra -- other people
 11 that we needed to get involved to assess this.
 12 Q. Was it your view that some kind of formal mental health
 13 assessment needed to be done?
 14 A. So, my role within custody is to put forward my concerns
 15 to the relevant professionals to enquire as to whether
 16 we should be requesting a Mental Health Act assessment.
 17 So any concerns that I may have I have to get escalated
 18 for somebody that understands that more to make that
 19 decision.
 20 Q. Who would you have escalated those concerns to?
 21 A. Within working hours, L&D. Outside of working hours, we
 22 can go through the gatekeeper Crisis team and so on.
 23 Q. So as far as you were concerned the next step was to
 24 speak to L&D about that?
 25 A. As it was within their working hours, yes.

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1 Q. Did you discuss with police staff at all?
 2 A. I haven't logged anywhere, but my assumption would be
 3 that I did. We kept them informed generally of
 4 everything we was doing.
 5 Q. So do you recall specifically talking about a mental
 6 health assessment with L&D?
 7 A. Yes.
 8 Q. Take us through that. From your perspective, what do
 9 you recall being discussed?
 10 A. Myself and Rosie went up to speak to L&D. We obviously
 11 asked for them to check RiO as we didn't have access to
 12 anything. Later on in the day we wanted to enquire as
 13 to whether they thought a Mental Health Act assessment
 14 needed to be requested and, if so, how we should go
 15 about doing that.
 16 Q. So was it the case that by this point, as you said, you
 17 brought in Ms Draper as your senior, on the managerial
 18 side. Was she leading on those decisions at this point,
 19 in terms of what happened next and liaising with L&D?
 20 A. I would say we was working together.
 21 Q. Just in terms of the discussions that were had, perhaps
 22 if we bring up NHFT0000168, please. It is page 272.
 23 I will take you through the note in a moment, but in
 24 terms of the message that you were getting from L&D,
 25 what is it you recall as to what they said about

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1 in circumstances where you had communicated to them that
 2 some assessment of VC's mental health was necessary?
 3 A. L&D are responsible also for coming down to assess the
 4 mental health of a detainee, especially one with
 5 history. So our remit is to assess mental health at
 6 each engagement with regards to an assessment, but that
 7 is also L&D's remit as well, whilst on site.
 8 Q. We can pick up some of the policy side of things with
 9 the next witness perhaps, but just looking at this
 10 particular note at the bottom, 13 June, 5.25. We can
 11 see it refers to you and Ms Draper:
 12 "HCPs in custody - Rosie Draper and Holly Bramley
 13 came to ask for some advice from L&D. Police have asked
 14 HCPs to take samples ..."
 15 So on and so forth. In the second paragraph down
 16 where it says "Teams call", you see the second line
 17 down:
 18 "Teams call back from Louisa who advised that HCP to
 19 follow their escalation process and that the Trust
 20 stance is he will not be admitted to a psychiatric unit
 21 due to the nature of the offence, therefore no need for
 22 HCP to call to request this."

23 Does that reflect your recollection of what was
 24 being discussed?
 25 A. The part that states "the Trust stance is he will not be

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1 a mental health assessment?
 2 A. My recollection was that the lady in L&D that we spoke
 3 to escalated it to her manager who responded with it was
 4 the Trust's stance that a Mental Health Act assessment
 5 wouldn't need to be requested.
 6 Q. Was it your understanding that that meant a formal
 7 assessment under the Mental Health Act or any assessment
 8 of VC's mental health?
 9 A. Just a formal Mental Health Act assessment.
 10 Q. So you could have gone on to perform further assessments
 11 of his mental health within Mitie within custody?
 12 A. Yes. So Mental Health Act assessment is standalone to
 13 a mental health assessment. As HCPs, we can conduct
 14 mental health assessments at every engagement with a
 15 detainee, as they're fluid, so we can reassess at each
 16 point. But with regards to this, it was the Mental
 17 Health Act assessment.
 18 Q. So was it your understanding, then, that the L&D team
 19 were encouraging you to do that within Mitie to carry on
 20 doing some assessment, if not a formal Mental Health Act
 21 assessment?
 22 A. I don't recall any conversation of that nature, just
 23 that they were advising that a Mental Health Act
 24 assessment would have been completed.
 25 Q. Do you think it is likely that they might have said that

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1 admitted to a psychiatric unit" does reflect my
 2 recollection, yes.
 3 Q. What about the bit concerning the HCP to follow the
 4 escalation process within custody in Mitie?
 5 A. I personally don't recall that.
 6 Q. When you say you don't recall it, are you not able to
 7 recall the conversation fully enough, or you do recall
 8 the conversation and you can't remember that particular
 9 bit being mentioned?
 10 A. I would say I don't recall the conversation fully enough
 11 with how long ago it was.
 12 Q. Do you think it is likely that that is correct, then,
 13 given that this is a note from the time?
 14 A. I would suggest that if we were told to follow our
 15 escalation process, I would remember it because that
 16 would involve us having to do something else following
 17 this meeting, which I don't recall.
 18 Q. What would that be? What would your escalation process
 19 have been in those circumstances?
 20 A. If I'm honest I'm not sure in this context because we
 21 would go to L&D to get their assistance with what it is
 22 we went for. Our escalation process with regards to
 23 a Mental Health Act assessment tends to occur when they
 24 are not on site, or we can't get help from them on site,
 25 which would be calling a gatekeeper, calling a Crisis

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1 team which is the same process that they would do.

2 **Q.** So it sounds like there is a bit of a difficulty here in
3 that you have gone to request a Mental Health Act
4 assessment. It seems like that's not going to be taken
5 any further and you are not sure what would happen next
6 on the Mitie side?

7 **A.** Mitie aren't the ones who deal with the Mental Health
8 Act assessment. So we would highlight any concerns that
9 we have and ask if we felt that one needed to be sought
10 or if they felt that one needed to be sought with
11 information they had. In this instance, they could
12 assist with that. Mitie doesn't have an escalation
13 process other than what I have explained for a Mental
14 Health Act assessment.

15 **Q.** Did you continue to think that a mental health
16 assessment was necessary at this point?

17 **A.** As previously stated, a mental health assessment is
18 fluid in the fact that we assess mental health at
19 each -- it is part of our clinical note. So we assess
20 the way he is presenting with regards mental health at
21 each engagement where we can, as HCP.

22 **Q.** But at this time did you continue to think it was
23 necessary?

24 **A.** Yes.

25 **Q.** Why is that? I mean, for example, if we look in the
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1 only engaged as minimally as he had by this point, and
2 with the mental health history combined, it was
3 a consideration that he -- it could be due to mental
4 illness.

5 **Q.** When you say it could be --

6 **A.** All of those things combined.

7 **Q.** We know, and perhaps we can pick this up with the next
8 witness, that there was a further examination of VC at
9 about 4/5.30 later that day; is that right? Do you
10 recall being at that?

11 **A.** I don't have recollection of that, but I have read in
12 the notes that I attended with Rosie, I believe.

13 **Q.** Do you recollect much from that?

14 **A.** No.

15 **Q.** We know that you saw VC on 15 June. Did you see him in
16 between those --

17 **A.** I didn't, no.

18 **Q.** -- dates at all? No. On the 15th, what can you tell us
19 about that? What do you recall?

20 **A.** So I saw him I believe when he was being returned from
21 interview for a welfare check due to him having been in
22 custody for a prolonged period of time.

23 I saw VC in the medical room at this point as he was
24 walking through the custody block, and it was to touch
25 base to see whether there was, at this point, anything
99

1 paragraph above, four pages up from the top, we can see
2 it says -- four lines up from the -- sorry, back to the
3 box below that.

4 Top paragraph within that box, four lines up says:
5 "... [VC] ... is mentally unwell and is not fit to
6 interview."

7 Pausing there. Why was it you thought that he was
8 mentally unwell?

9 **A.** So by this point a significant rest period had passed,
10 so the likelihood of it being, for example, due to drugs
11 is lower. So that's one reason that we request a rest
12 period. So the rest period had passed. He was still,
13 from my recollection, giving us very minimal verbal
14 recommendation and we had the mental health history to
15 back up the fact that this could be due to him being
16 mentally unwell again.

17 **Q.** So just breaking that down. You have the non-engagement
18 and you have the mental health history. What is it
19 that's telling you at this point that he is unwell?

20 **A.** It's not a case of at this point we thought he was
21 unwell; it was just the consideration of all those
22 things together. So the rest period has passed so we
23 are no longer necessarily considering that it is due to
24 something else. It would be unusual for somebody to
25 have been in custody for this period of time and still
98

1 that he wanted to talk to me about, whether he wanted to
2 engage further or anything, that I could be of
3 assistance with, and my recollection is that I still had
4 very minimal verbal engagement from him.

5 **Q.** Just one final question: records. The fact that you are
6 not able to access medical records without consent, is
7 that a frustration in your role?

8 **A.** It can be. Consent runs through all of healthcare
9 though, regardless of the setting. It's not just a case
10 of we can't do it in custody; it is healthcare-wide and
11 it is there for a reason. It is frustrating as we do
12 have dual responsibility to the criminal justice system
13 and the health and wellbeing of the detainee.

14 However, it is there for a reason and, short of
15 an emergency, we can't access it.

16 **Q.** Chair, those are my questions.

17 **THE CHAIR:** Yes, thank you.

18 **Questioned by MR BEER**

19 **MR BEER:** Good afternoon, Ms Bramley. I ask questions on
20 behalf of the Trust.

21 **A.** Good afternoon.

22 **Q.** You said on a number of occasions that you considered
23 undertaking a capacity assessment and explain why you
24 did not do so. You have to say "yes" --

25 **A.** Sorry, yes.
100

1 Q. Thank you very much. You understand that there's no
2 such thing as a generalised capacity assessment.
3 A. I do.
4 Q. Capacity is always issue or subject-specific.
5 A. Correct.
6 Q. A capacity to consent to x, y or z, capacity to refuse
7 medical treatment, the list can go on.
8 A. Correct.
9 Q. When you were considering conducting what you described
10 as a capacity assessment, what issue or subject were you
11 intending to assess for?
12 A. That will have been dependent at each time that I would
13 have been wanting to assess his capacity. So, for
14 example, if it was to do with the forensic sampling that
15 was requested of us, it would have been his capacity to
16 consent to those samples. Prior to that, when I was
17 assessing his -- when I deemed him as not fit for
18 interview it will have been did he have the capacity at
19 that point to engage with the interview? So it would
20 have been specific to what I was being asked to assess
21 at each time.
22 Q. Is capacity relevant therefore to fitness for interview?
23 A. If somebody doesn't have the capacity to understand what
24 is being said, weigh up that and answer appropriately
25 whilst retaining the information, then yes. Yes.

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1 A. No, I don't.
2 Q. Why was that? Had you forgotten those?
3 A. No.
4 Q. You say that L&D were on site and that's where you went
5 to, you and Rosie, to gain some support. Why would you
6 not go to the AMHPs?
7 A. Because when L&D are on site we go through them
8 initially and they will go to the AMHPs --
9 Q. In circumstances where you said that you go to the AMHPs
10 to gain advice as to whether they think it would be
11 appropriate to conduct an assessment, is that a mistake?
12 A. Yes, that's the way I have wrote it in the statement.
13 That is correct.
14 Q. Did you become confused between the AMHPs, the Crisis
15 team and the L&D?
16 A. No, that's just the way I wrote it in the statement.
17 Q. You have re-read your statement before signing it,
18 presumably?
19 A. Yes.
20 Q. So when we get to the call at 5.30 on the 13th --
21 calls -- is this right, the sequence of events is:
22 number 1, you and Rosie Draper approach Kyla Fraser, the
23 L&D member of staff, in the custody suite?
24 A. I can't recall off the top of my head. I would have to
25 look at the custody record for timings.

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1 Q. You tell us in paragraph 4 of your witness statement --
2 in the interests of speed I'm not going to draw it up on
3 the screen:
4 "As a healthcare professional I have no direct
5 involvement with the MHAA other than to gain advice
6 whether the AMHPs think it would be appropriate to
7 request one." *(As read)*
8 A. Yes.
9 Q. I think you are saying there that you do have a role,
10 because --
11 A. What I meant in my statement was that I have no direct
12 involvement in conducting the Mental Health Act
13 assessment.
14 Q. Got it, and that's agreed. You say there you would gain
15 advice from the AMHPs about whether they think it would
16 be appropriate to request a MHAA; is that right?
17 A. Yes.
18 Q. But there are no AMHPs habitually in custody?
19 A. No. So when writing my statement that was, if we are
20 out of hours and we call the gatekeeper, we go through
21 the AMHPs and the mental health professionals, if we
22 call them out of hours. When it is within hours, you
23 are correct, there isn't anyone in custody.
24 Q. I do not think you mention the gatekeepers or the Crisis
25 team in your statement, do you?

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1 Q. Maybe if we look at NHFT0000168 page 272. It is the
2 bottom entry.
3 A. Yes.
4 Q. If we can blow that up. So, this is written by
5 Kyla Fraser, you can see that?
6 A. Correct, yes.
7 Q. And it says Rosie Draper and Holly Bramley came to ask
8 for advice from L&D. So I'm suggesting that's stage
9 one?
10 A. My recollection from what I have read in the evidence
11 bundle is that we approached L&D in the morning to gain
12 history from RiO and then approached them again later in
13 the afternoon with regards to the sampling.
14 Q. I'm only asking about this ie, the discussion over the
15 need for a Mental Health Act assessment?
16 A. Yes.
17 Q. So stage 1, we agree I think?
18 A. Yes.
19 Q. You and Rosie approach Kyla?
20 A. Yes.
21 Q. Second stage, Kyla suggested a Teams call with Louisa
22 Hagan, agreed?
23 A. Yes.
24 Q. Stage 3, you and Rosie, along with Kyla, join the Teams
25 call with Louisa?

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1 A. Correct.
 2 Q. Stage 4, Louisa says she is going to go away and get
 3 some advice from seniors?
 4 A. Correct.
 5 Q. Then stage 5, Louisa calls Kyla back, and only Kyla
 6 back, on the phone?
 7 A. That's what it states, yes.
 8 Q. Then the last stage, she, Kyla, speaks to Rosie and
 9 Rosie alone, ie not you?
 10 A. Correct. That's what it states here, yes. I have no
 11 recollection of that part, only the parts that I was
 12 involved with.
 13 Q. So the sum is, when the advice is actually given, you
 14 are not a party to the call as well?
 15 A. According to the notes, no.
 16 Q. I think you have got no notes at all, have you?
 17 A. No.
 18 Q. Why is that?
 19 A. If I wasn't present when those conversations were had
 20 I wouldn't have written the notes.
 21 Q. But you were party to some or all of this, weren't you,
 22 because we can see your name all over it?
 23 A. Yes.
 24 Q. How come you haven't got any notes -- or indeed Rosie
 25 hasn't got any notes either I don't think.

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1 that's correct, why is Rosie saying that usually in
 2 these circumstances she would request the Mental Health
 3 Act assessment?
 4 A. That was incorrect then, we can call to gain advice on
 5 whether a Mental Health Act assessment needs to be
 6 conducted as well as L&D.
 7 Q. And when you say that was incorrect, you mean the
 8 evidence you gave earlier, Mitie has no role in
 9 requesting a Mental Health Act assessment, that was
 10 incorrect?
 11 A. If that was the way I worded it, then yes.
 12 Q. Have you become confused whether Mitie can or cannot
 13 request a Mental Health Act assessment?
 14 A. HCPs in my team can call to ask whether a Mental Health
 15 Act assessment needs to be requested, yes.
 16 Q. Have you any reason to doubt the accuracy of the note
 17 here where it is recorded that Louisa advised that you,
 18 the HCPs, follow their escalation process?
 19 A. I don't recall Louisa advising us of that, no.
 20 Q. You don't have any written notes from two and a half
 21 years ago?
 22 A. No.
 23 Q. Thank you very much indeed.
 24 A. Thank you.
 25 **THE CHAIR:** Thank you very much.

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1 A. I thought Rosie had notes~~~
 2 Q. About this conversation?
 3 A. About the Mental Health Act assessment.
 4 Q. In any event, they are the stages. It is only Rosie
 5 that's spoken to to get the advice back, we are agreed
 6 on that?
 7 A. According to this, yes.
 8 Q. You will see in the first paragraph, four lines up from
 9 the bottom it is recorded that Rosie advised that
 10 usually in these circumstances, "she would request
 11 a Mental Health Act assessment by calling CRHT gate
 12 keeping ..."
 13 A. Correct.
 14 Q. You have told us that when L&D were on site you would
 15 normally ask L&D. Do you know why Rosie is saying that
 16 usually in these circumstances when L&D are on site, she
 17 would still ask for an MHA from Crisis?
 18 A. So L&D can assist us with the Mental Health Act
 19 assessment, it doesn't have to be L&D when they are on
 20 site. Historically, if they are on site when something
 21 happens, when a Mental Health Act assessment is being
 22 queried, they have made that call for us. However, we
 23 can be the ones that call the gatekeepers also.
 24 Q. You said in evidence earlier today that Mitie has no
 25 role in requesting a Mental Health Act assessment. If

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1 A. Thank you.
 2 **THE CHAIR:** Just looking at the time, and I know we have one
 3 more witness to hear, that would probably take, I would
 4 think, until about 5.45 pm on the current timing. So
 5 I think it is probably not possible to hear that witness
 6 today, unless we are prepared to go on that long.
 7 I know it is quite difficult for the shorthand writers
 8 and so on, so I think what I'm going to do is to see
 9 whether we can re-schedule that witness. It would have
 10 to be after Easter, I'm afraid.
 11 All right. I will rise now and we will see if
 12 there's anything that can be done to shorten the
 13 witness, but I think it is unlikely, so thank you.
 14 (4.44 pm)
 15 (A short break)
 16 (4.48 pm)
 17 **THE CHAIR:** Yes, having done as much as we can in terms of
 18 re-scheduling, I think we are going to start at 9.45 am
 19 tomorrow with Rosie Draper if you are able to come.
 20 **THE WITNESS:** Yes, ma'am.
 21 **THE CHAIR:** Thank you. We will start then.
 22 (4.50 pm)
 23 (The hearing adjourned until 9.45 am the following day)
 24
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