

Thursday, 16 April 2026

1
2 (1.40 pm)
3 **THE CHAIR:** Yes, Mr Carr.
4 **MR CARR:** Chair, if I may call the next witness, Dr Dracass,
5 please.
6 **DR SARAH ELIZABETH DRACASS (affirmed)**
7 **THE CHAIR:** Yes, Mr Carr.
8 **Questioned by MR CARR**
9 **MR CARR:** If you can start, please, by giving us your full
10 name.
11 **A.** It's Dr Sarah Elizabeth Dracass.
12 **Q.** Dr Dracass, you have prepared a statement for the
13 Inquiry dated 3 February 2026. The URN for that is
14 WITN0387001 and, Chair, it's at tab 1 of the main
15 bundle.
16 **THE CHAIR:** Thank you.
17 **MR CARR:** Dr Dracass, is that true to the best of your
18 knowledge and belief?
19 **A.** Yes, it is.
20 **Q.** You have set out, from paragraph 4 to paragraph 14, your
21 qualifications and medical background.
22 **A.** Yes, that's right.
23 **Q.** I'm going to summarise that. You're a Consultant
24 Psychiatrist, you're currently the Deputy Chief Medical
25 Officer at the North East London NHS Foundation Trust.

1

1 Orders, to support treatment?
2 **A.** Yes, that's correct.
3 **Q.** The reason for you giving a statement to the Inquiry is
4 to explain your involvement in the Care Quality
5 Commission's Section 48 Review into the Trust; that's
6 right, isn't it?
7 **A.** Yes.
8 **Q.** That review was published in two parts; part 1 published
9 in March 2024 and part 2 published in August 2024?
10 **A.** Yes.
11 **Q.** Your work was relevant only to part 2 which focused on
12 the care and treatment of VC?
13 **A.** That's correct, yes.
14 **Q.** You weren't responsible for drafting the report?
15 **A.** No, I was not.
16 **Q.** But you undertook an analysis of VC's treatment from the
17 vantage point of an expert psychiatrist in order to
18 assist and inform the CQC in their drafting of the
19 report?
20 **A.** That's correct, yes.
21 **Q.** You state in your witness statement that you were
22 approached on 7 February 2024 in order to carry out this
23 work?
24 **A.** Yes.
25 **Q.** The scope of work you were asked to undertake is set out

3

1 **A.** That's correct.
2 **Q.** You explain that you've held section 12 approval since
3 2008.
4 **A.** Seven.
5 **Q.** Seven?
6 **A.** Yeah.
7 **Q.** You've been an approved clinician since 2011.
8 **A.** Yes.
9 **Q.** In the course of your career you've worked in community
10 adult mental health teams, an outreach team and in the
11 Tower Hamlets Early Intervention and Early Detection
12 Services.
13 **A.** That's correct.
14 **Q.** When working in the Early Intervention Team, you say you
15 worked with the Quality Standards for First Episode
16 Psychosis.
17 **A.** Yes.
18 **Q.** At the end of your paragraph 9, you explain that you
19 have wide experience of working with patients, both in
20 the community and in hospital, with a diagnosis of
21 schizophrenia?
22 **A.** That's correct.
23 **Q.** You have, in the course of your practice, initiated
24 treatment with antipsychotics including clozapine or
25 depot, and you have used CTOs, Community Treatment

2

1 in an email, isn't it, if we can look at that please, at
2 WITN0387004.
3 Chair, that's tab 4 of your bundle.
4 Yes, thank you. It's already gone to page 2 of that
5 document, and it's the email that's just towards the
6 bottom of the page. This sets out, doesn't it, the
7 scope of the work that you were tasked with undertaking?
8 **A.** Yes.
9 **Q.** So number 1:
10 "Review and report on the care, treatment and
11 services provided by the NHS from VC's first contact
12 with services to the time of the offence."
13 The point to make here, this is a focus on NHS
14 treatment, not treatment in the private sector?
15 **A.** Yes.
16 **Q.** Number 2:
17 "Review and report on the appropriateness of the
18 treatment of the service user in light of any identified
19 health needs."
20 So this required a judgement on the adequacy of the
21 care and treatment provided?
22 **A.** Yes.
23 **Q.** And number 3 was concerned with risk assessments,
24 number 4, care plans, and then number 5:
25 "Review, assess and report on compliance with local

4

1 policies, national guidance and relevant statutory
 2 obligations."
 3 **A.** Yes.
 4 **Q.** So that would involve comparing the care to policies and
 5 guidance that was in place.
 6 Then finally number 6:
 7 "Establish and report on if this incident was
 8 predictable and preventable."
 9 **A.** Yes.
 10 **Q.** Just underneath number 6 it reads:
 11 "Fyi - we also have a senior consultant psychiatrist
 12 from [I think that's southwest London and St George's
 13 Trust] joining us to help with the commission due to the
 14 tight timelines?"
 15 **A.** Yes.
 16 **Q.** That was a reference to Dr Mona Ahmed?
 17 **A.** That's correct.
 18 **Q.** I want to consider, before we look at the work that was
 19 undertaken, I want to consider just some of the
 20 constraints of the review. That email has just gone
 21 down, but the last point I read from referred to tight
 22 timelines?
 23 **A.** Yes.
 24 **Q.** In your statement at paragraph 19 you also refer to or
 25 describe, rather, the timeframe as being "tight"?

5

1 **Q.** If we can look at the full Terms of Reference and the
 2 URN is CQCM0006060.
 3 Chair, that's tab 3 of your supplementary bundle.
 4 You've seen this document for the purposes of
 5 preparing and giving evidence today --
 6 **A.** That's correct.
 7 **Q.** -- for the purposes of preparing your statement, but you
 8 say in your statement you're not sure that you saw this
 9 at the time that you were undertaking --
 10 **A.** I can't recall.
 11 **Q.** -- the review.
 12 This document sets out, doesn't it, the Terms of
 13 Reference for the entirety of the review?
 14 **A.** That's correct.
 15 **Q.** As you've explained, your focus was narrow: it was for
 16 part 2?
 17 **A.** Yes, and a proportion of part 2.
 18 **Q.** Yes. If we go, please, to page 3 of this document,
 19 under the heading "Resourcing", the third bullet point
 20 refers to a:
 21 "Minimum of 2 x Clinical Experts to be commissioned
 22 to review [VC's] care and the reviews of the 10 other
 23 patients. (Ordinarily this would be better for one
 24 clinical expert to review all patients for consistency
 25 but due to the time constraints more experts would be

7

1 **A.** Yes.
 2 **Q.** Is it right that, having been contacted on 7 February,
 3 you were working to a deadline of 16 February?
 4 **A.** That's correct.
 5 **Q.** So nine days.
 6 You explain in your statement you cleared the
 7 majority of your duties for that week ending
 8 16 February.
 9 **A.** Yes.
 10 **Q.** But was the time that you had, that tight timeframe, was
 11 it sufficient for you to consider adequately the issues
 12 raised in your review?
 13 **A.** I mean, the more time you have, the more detail you can
 14 use, and I guess the more careful your analysis would
 15 be, but I think the time that we had enabled us to go
 16 through the progress notes and the bits of the care
 17 record that we had access to, and to generate
 18 a timeline, understanding the care and the treatment,
 19 and identifying the issues that sort of stood out to us
 20 at that time.
 21 I don't know if that answered your question, sorry.
 22 **Q.** So you felt the time was sufficient?
 23 **A.** I mean, I think it would have been helpful to have had
 24 more time, but we were able to complete the task in the
 25 time that we had available.

6

1 required)".
 2 Did you understand the position to be that there was
 3 too much work for one expert, given the time constraint?
 4 **A.** I -- I hadn't considered that.
 5 **Q.** Do you consider that anything was lost by you not being
 6 able to undertake a comprehensive review of all the
 7 evidence?
 8 **A.** So we both -- so there were more than two experts.
 9 There was myself and Dr Ahmed and we both had access to
 10 the same information, and then there were some experts
 11 in community psychiatric nursing who were commissioned
 12 to look at the other ten patients who were also working
 13 at the same time.
 14 So we only looked at the care of VC, and then there
 15 were two other nurses, I think they were, who were
 16 looking at care from the same service but not VC's care.
 17 And then we worked together, we had one meeting when all
 18 four of us plus somebody from the CQC sort of talking
 19 about how we were -- that the work that we were doing
 20 was kind of in alignment, that we were finding the same
 21 issues.
 22 **Q.** Yes, we can take that down. If we can put up, please,
 23 CQCM0009697, and this is an email that you sent to
 24 Dr Ahmed a couple of days after, starting to work on
 25 this, and here you suggest a vision of the work, don't

8

1 you?

2 **A.** Yes.

3 **Q.** Do you recall what was ultimately agreed between the two

4 of you as to the division of labour?

5 **A.** Um ... *(Pause)* I can remember that we did agree on the

6 division of labour. I can't remember exactly what the

7 detail of that was without reference to the email. We

8 agreed that we would, rather than divide up across the

9 time, we would both cover the same time but divide up

10 the tasks, as I remember.

11 **Q.** So you both looked at the entirety of the records but

12 the --

13 **A.** Yes.

14 **Q.** -- analysis was of different aspects?

15 **A.** We focused on different aspects.

16 **Q.** Thank you. We can take that down.

17 The analysis was limited, wasn't it, to essentially

18 a desktop review, so it was looking at --

19 **A.** That's correct.

20 **Q.** -- records. You did not speak to any of the Trust's

21 members of staff.

22 **A.** We did not.

23 **Q.** Did you meet with the victims or families of victims?

24 **A.** No.

25 **Q.** You didn't speak to VC's family?

9

1 Chair, it's tab 1 of the supplementary bundle.

2 This describes, doesn't it, an attendance on VC by

3 paramedics on 23 May 2020.

4 **A.** Yes.

5 **Q.** We can see, we're on page 1, if we look at the box,

6 which is roughly in the middle of the page on the right,

7 next to the heading "Details":

8 "?/acute behavioural disturbance ?mental health,

9 [complaining of] chest pain and hearing mumbling."

10 If we move on now, please, to page 2 of this

11 document and if we go right to the bottom of the page,

12 the penultimate box:

13 "Medical/Surgical History".

14 "Other: [patient] admits to having mental health

15 problems in past but would not say what. Not currently

16 medicated for anything on questioning."

17 Do you recall whether you saw this document in the

18 course of carrying out your analysis?

19 **A.** I don't recall seeing it. But I may have done, but I

20 can't remember seeing it.

21 **Q.** Would either the two points that I've taken you to or

22 anything else in this document have impacted your

23 analysis, had you have seen it?

24 **A.** I mean, looking at the point about "patient admits to

25 having mental health problems in the past", because

11

1 **A.** No.

2 **Q.** So far as a desktop review of records, you didn't have

3 records from the police, did you?

4 **A.** I don't -- nothing that wasn't available to the NHS

5 record.

6 **Q.** So you worked only from the Trust records; you didn't

7 have a set of police records or records from the private

8 hospitals?

9 **A.** As I recall, that's the situation.

10 **Q.** At paragraph 21 of your statement, you make the point

11 there that you were able to access copies of the medical

12 records for VC from the Trust, you can't recall if you

13 had access to medical records from other providers or

14 hospitals.

15 In your analysis, there isn't, is there, an account

16 of records from other hospitals?

17 **A.** That's correct. Only what was sent through to the NHS

18 record from the other hospital, for example a discharge

19 summary.

20 **Q.** If we can put on the screen, please EMAS0000002, and

21 this is a document from the East Midlands Ambulance

22 Service, and you've been sent a copy of this in order

23 to --

24 **A.** Yes.

25 **Q.** -- prepare for your evidence today.

10

1 prior to seeing that, I would not have been aware that

2 there may have been a previous presentation to mental

3 health services, because from the information that we

4 had, we were under the -- or I was under the belief that

5 this was the first presentation to mental health

6 services.

7 **Q.** If there had been mental health problems in the past,

8 how would that have affected your analysis?

9 **A.** Well, the care that was delivered to VC was on the

10 assumption that this was a first episode of psychosis,

11 and therefore he was referred to the First Episode

12 Psychosis Service and, you know, we -- the guidance that

13 was followed or the care and treatment plan that was

14 followed thereafter was on that basis. I suppose if

15 there had been a history of previous episodes of mental

16 illness or psychosis in particular, then that might have

17 changed the way that you would have managed the care.

18 **Q.** In what way?

19 **A.** Well, he may not have been eligible for the First

20 Episode Psychosis Service.

21 **Q.** Thank you. We can take that document down.

22 Paragraph 23 of your statement, you say:

23 "I cannot recall if we were provided with policies

24 from any of the hospitals and/or NHS service providers

25 involved in VC's care."

12

1 And it's right to say, isn't it, the analysis
 2 carried out does not consider local policies?
 3 **A.** That's correct.
 4 **Q.** So is the position either the policies were provided but
 5 weren't considered, maybe because of lack of time, or
 6 they weren't provided?
 7 **A.** That's correct.
 8 **Q.** You can't recall which of the two it is?
 9 **A.** That's correct.
 10 **Q.** We looked at the first document I took you to, those
 11 Terms of Reference, the narrow Terms of Reference for
 12 you and Dr Ahmed, and one of them required consideration
 13 of compliance with local policies?
 14 **A.** *(no audible answer given).*
 15 **Q.** The analysis undertaken wasn't able to do that, was it?
 16 **A.** Well, no, not the analysis that we did, but I don't
 17 think I had interpreted the scope to just be related to
 18 the work that I was doing with Dr Ahmed. I thought that
 19 that applied to the wider scope of the work all of the
 20 experts involved were doing.
 21 **Q.** Can we move now, please, to consider the actual work
 22 undertaken by you and Dr Ahmed, the preparation work.
 23 You've described this in paragraph 28 of your statement,
 24 you refer there to a number of documents drafted by
 25 yourself and Dr Ahmed.

13

1 **Q.** Then the final document prepared -- and I will put this
 2 up briefly -- by Dr Ahmed, CQCM0010415, this is titled.
 3 "Summary of patient presentation/timeline of
 4 engagement"?
 5 The point you make in your statement is that this is
 6 a document that you worked on and you made contributions
 7 to?
 8 **A.** Yes.
 9 **Q.** It's a 25-page chronology essentially, isn't it?
 10 **A.** Yes.
 11 **Q.** Is it right to say -- we can just about see it on
 12 screen -- but there's some entries on this document
 13 which are in a different colour font?
 14 **A.** Yes.
 15 **Q.** Are those your contributions?
 16 **A.** It seems reasonable to assume that.
 17 **Q.** Thank you. We can take that down. Then the document
 18 that you worked on and you produced -- and if we can put
 19 this on screen, please -- CQCM0016210, and if we go to
 20 page 3, this is your document, isn't it?
 21 **A.** I drafted most of this document, yes, on the right-hand
 22 side. The points on the left-hand side were the
 23 structure that we were asked to follow.
 24 **Q.** Yes, so we can understand it, it's a template and, as I
 25 understand it, on the left that was pre-populated by the

15

1 **A.** Yes.
 2 **Q.** As I understand it, what's described there is as
 3 follows: Dr Ahmed prepared documents -- you don't need
 4 to put this up on screen -- CQCM0010414 and that's
 5 a review of risk assessments.
 6 **A.** Yes.
 7 **Q.** She prepared CQCM0010416, and that's titled "Incident in
 8 June and whether this was predictable".
 9 **A.** Yes.
 10 **Q.** Then the document ending 10417, whether the index
 11 offence of June 2023 was preventable.
 12 **A.** Yes.
 13 **Q.** Then the document ending 008 on risk formulation?
 14 **A.** Yes.
 15 **Q.** Did you review and agree those documents at the time of
 16 undertaking your analysis?
 17 **A.** Yes, I saw those documents before we submitted them to
 18 the CQC, and I broadly agreed with them. I may have
 19 made an edit to one or two of them, but they were mainly
 20 Dr Ahmed's authorship.
 21 **Q.** As for risk assessments, although Dr Ahmed carried out
 22 the analysis, as it were, of risk assessments, you say
 23 you also considered those because you considered all of
 24 the documents?
 25 **A.** Yes. And we met and spoke together, Dr Ahmed and I.

14

1 CQC --
 2 **A.** That's correct.
 3 **Q.** -- with you providing the analysis on the right?
 4 **A.** The right, yes.
 5 **Q.** You say you completed most of it; who else completed it?
 6 **A.** Well, I don't know whether I might have -- so we worked
 7 together, Dr Ahmed and I, and she, I think, started the
 8 analysis before I was able to do so. So she had got
 9 some of the timeline underway before I was able to
 10 attend to the task.
 11 So I built on the work that she did as well, and
 12 cross-referenced that with my analysis of going through
 13 the notes that we had available to us, sort of checking
 14 off whether or not things had been identified by the
 15 work that she'd already done. And then I took the kind
 16 of overarching view, from that, to populate this
 17 document.
 18 **Q.** Yes, I want to spend a little bit time on this, and if
 19 I am asking you questions about entries and you think
 20 they're not yours or you simply disagree with --
 21 **A.** I think it's fair to say most of this will have been
 22 mine, if not all of it.
 23 **Q.** Right. Well, if we start, please, on page 3, which
 24 we're on, we can see in the top-left corner, this is
 25 a section dealing with the review and report on the

16

1 care, treatment and services provided by the NHS to VC.

2 If we look under the heading "Analysis", first
3 entry, first line, it describes a:
4 "... slow collection of information to complete the
5 full history".

6 Can you expand on that? When do you say the
7 information should have been collected and the full
8 history completed?

9 **A.** Well, I mean, I suppose that what I meant by that was
10 that it took some time over the period of the admission
11 to collate all the information pertinent to VC's
12 history, as it was documented, and it might be
13 preferable, I suppose, where available, to do a fuller
14 assessment of the history and psychosocial sort of
15 background earlier on.

16 I think that, as I recall the sort of core
17 assessment or the initial clerking, as we call it, which
18 is kind of the detail of a patient's background when
19 they come into a service, was built up over time, rather
20 than from the initial interactions.

21 **Q.** Is it important generally to build that full history
22 early on?

23 **A.** It's helpful to build that history as early and as fully
24 as possible.

25 **Q.** Fourth line down, "MSE", is that mental state

17

1 **A.** Yes.

2 **Q.** Where it's not documented you can't be sure if it was
3 done.

4 **A.** Exactly.

5 **Q.** The next paragraph deals with diagnosis. You describe
6 it as "reasonable and accurate". You say:

7 "EIP [Early Intervention in Psychosis] often use
8 F23.2 before F20.0 -- but F20.0 supersedes later as
9 expected."

10 Now those numbers, are they to entries in the
11 diagnostic manual?

12 **A.** Yes.

13 **Q.** Can you tell us what you're referring and to the point
14 you're making there?

15 **A.** So the point I'm making, F23.2 I have to be honest and
16 say I haven't looked at very recently because I'm not
17 working in that field at the moment, but F23.2 it's a
18 sort of shorter, it's a sort of schizophreniform-like
19 condition that is short lived, and F20.0 is paranoid
20 schizophrenia. And often when somebody presents with
21 a first episode of psychosis there is a disinclination
22 to diagnose somebody with paranoid schizophrenia very
23 quickly and, instead, there is a preference for using
24 codes that imply either that the diagnosis is not yet
25 certain or that it is potentially a shorter psychotic

19

1 examination?

2 **A.** Yes.

3 **Q.** "[Mental state examinations] are documented regularly
4 [but] ... often do not explore VC's delusional ideas
5 (related to AI technology, controlling his mind and
6 conspiracy to monitor him)."

7 Now again, what exploration was required here, and
8 by whom?

9 **A.** So when the doctor is doing a mental state examination
10 and you're thinking about what the contents of
11 somebody's mind might be, then exploring that in the
12 fullest amount that you can is -- gives you more
13 information about what's going on for that person. And
14 sometimes, for all sorts of reasons, the depth of
15 exploration into that person's content might not be
16 documented as fully as it could be. It might because it
17 wasn't explored as fully as it could be or it might be
18 that it wasn't documented as fully as it could be.

19 **Q.** It sounds like there are two points you are making:
20 firstly a need to explore in depth.

21 **A.** Yes.

22 **Q.** And by that you mean asking questions?

23 **A.** Yes.

24 **Q.** Then, having explored in depth, there's a need to
25 document it?

18

1 illness.

2 **Q.** Then if we go down to the line that starts
3 "Consideration of drug induced psychosis", you go on to
4 say:

5 "... not clear if UDS ..."

6 **A.** That's urine drug screen.

7 **Q.** -- thank you -- "completed", and the question I have is:
8 in what circumstances do you say UDS testing should be
9 taken?

10 **A.** So, often when a patient presents with a mental disorder
11 that looks like psychosis, it would be commonplace to
12 take urine sample to see if that could be explained by
13 intoxication with psychoactive substances. Obviously to
14 do that you have to have some collaboration with the
15 patient, for them to give a sample of their urine, which
16 is not always possible.

17 **Q.** Is it just at that presentation or is it something which
18 is undertaken throughout the course of care for
19 a patient presenting with psychosis?

20 **A.** It depends on the patient. You might think that there
21 is an indication to suggest that the patient uses
22 substances, in which case you might want to see if
23 there's any evidence of substance use in a urine drug
24 screen. Obviously different substances have different
25 periods of time that they stay in the body, so the

20

1 longer you leave it, the less helpful it is.

2 **Q.** You've raised the reference here to UDS. Is it your
3 view that VC's case met the criteria for a urine drug
4 screen? And if so, when?

5 **A.** It's probably something that, had VC had been my
6 patient, I would have asked for. But again, it depends
7 on whether or not it's possible to get that sample from
8 the patient. If they're not cooperative, it's not
9 possible.

10 **Q.** I want to deal now with the issue of admission, so
11 detention, and we're going to jump around the document
12 a bit because you deal with it in a number of different
13 pages. But sticking on page 3, we can see the third
14 paragraph counting from the bottom -- third paragraph up
15 counting from the bottom -- you refer there to "...
16 thresholds for detention ... and admission seeming very
17 high".

18 **A.** Yes.

19 **Q.** That's a reference for how they were applied rather than
20 the statute.

21 **A.** Yes.

22 **Q.** Then page 3 and into 4, so the very bottom line of
23 page 3:
24 "First Mental Health Act assessment did not result
25 in detention under the [Mental Health Act]: Surprising

21

1 **Q.** Then still on page 4, but if we go within the column on
2 the right, if we go to the final paragraph which reads:
3 "The decision not to detain on 18/01/2022 is
4 surprising given the incident precipitating [Mental
5 Health Act assessment], limited engagement with team,
6 lack of insight and minimisation of aggression."
7 Again, by describing this as "surprising" with the
8 caveats that you've already referred to, this being
9 a review of documents, is it your view that this
10 assessment should have resulted in detention?

11 **A.** I think -- yes.

12 **Q.** You go on -- I'm reading from the same paragraph, the
13 sentence that follows reads the:
14 "Rationale for not using Sec[ti]on] 3 on 28/2/22; 4th
15 admission is questionable - not adequate evidence of
16 psychopathology, so needs further assessment under
17 Sec[ti]on] 3."
18 Again, it's just the use of the word "questionable".
19 Is it your view that, at the time of this assessment, VC
20 met the criteria for a Section 3 detention?

21 **A.** Yes, and just that there was a typo there, so I meant
22 that "Needs further assessment under section 2" was the
23 bit that I thought was odd. I put Section 3 where
24 I meant Section 2.
25 But to answer your question, yes, the criteria were

23

1 decision given the clear description of psychosis with
2 profound loss of insight, persecutory ideation and
3 attempt to break into neighbouring flat in response to
4 psychotic symptoms."

5 Does it follow from those features of the
6 presentation that your view is that first Mental Health
7 Act assessment should have resulted in detention?

8 **A.** I was surprised it didn't. Obviously it's a clinical
9 decision made at the time after assessment of the
10 patient at the time and, you know, I wasn't the person
11 that did that assessment.

12 But I, looking at the information that was available
13 at the time, I thought it was surprising that they
14 didn't reach the conclusion to recommend for
15 a detention.

16 **Q.** Well, it's use of the word "surprising" and I appreciate
17 we've made the point that this is a desktop review,
18 you've not spoken to the clinicians, but based on the
19 desktop review, does it follow from the fact that you
20 were surprised that you think it should have resulted in
21 detention?

22 **A.** I mean, my clinical view, putting myself in that
23 position with all the caveats that we've already
24 discussed, I think I would have made a recommendation
25 for a detention.

22

1 met for detention under Section 3.

2 **Q.** Just on that point of clarification that you've made,
3 part of the reason at the time for justifying Section 2
4 was to carry out further assessment. But is your point,
5 actually, the diagnosis appears to have been reasonably
6 clear by this point?

7 **A.** So, I mean, I can understand -- like, I can understand
8 the logic of thinking that they haven't got a lot of
9 information about the current content psychopathology,
10 obviously at that point VC, I imagine, was sort of
11 guarded and not giving out much information about what
12 was going on in his mind.

13 So you could make an argument that you would want to
14 assess that further, but I don't think that that would
15 necessarily change the fact that he still meets the
16 criteria for detention under Section 3 and what he
17 needed, and I think it was clear at that point that what
18 he needed was treatment.

19 **Q.** You will have seen in the notes, the team undertaking
20 the assessment, they gave some consideration to the
21 possibility of depot medication; would that be a factor
22 that would point to Section 3 rather than Section 2?

23 **A.** Not necessarily. You can give depot anti-psychotic
24 medication on either section, under either section.

25 **Q.** If we can go back now to page 3, move away from the

24

1 issue of admissions, the penultimate paragraph on this
2 page describes:

3 "Poor communication and/or inaccuracies around risk
4 information evident throughout progress notes, core
5 assessments and care plans."

6 That's in response to a key line of enquiry asking
7 about risk assessments and care plans. Can you explain,
8 what is the "poor communication and/or inaccuracies"
9 that you picked up on in those documents?

10 **A.** Yes, so looking through the information, there was
11 information about the severity of the incidents that led
12 up to VC's contact with police prior to his admissions,
13 and the concerns that had been raised about his
14 behaviour on campus when he was not supposed to be
15 there, or around the accommodation when he was not
16 supposed to be there. But it felt that that information
17 wasn't being assimilated into the core assessments and
18 the care plans and the risk assessments in a sort of
19 comprehensive way and the communication between the
20 different bits of the service didn't seem to explain the
21 risks at the points of transition. So between coming
22 into hospital and leaving hospital, and between going
23 from one ward to another ward.

24 **Q.** So if there had been the proper communication, if the
25 information had been properly assimilated, how would

25

1 **A.** So that would be the practice that I was used to in the
2 service that I was providing in Early Intervention, that
3 we would, if there was a patient admitted to hospital,
4 although their care and treatment would fall under the
5 inpatient service, they would still make a referral for
6 the Early Intervention Service to do an assessment and
7 start engaging with that person while they're an
8 inpatient so you can improve the therapeutic alliance as
9 they improve and get better. So by the time they come
10 out of hospital, you've already got a relationship with
11 them.

12 **Q.** You also describe in that same passage, which was
13 highlighted on screen, referred to the benefits of
14 psychoeducation and, again, are there benefits of having
15 psychoeducation early in an admission rather than
16 waiting until post-discharge?

17 **A.** Yes.

18 **Q.** Which are?

19 **A.** Well, if you can help the patient understand the
20 connection between potentially an improvement in their
21 symptoms and the treatment that they're taking, if you
22 can explain to them what psychosis is, and how it can
23 progress in the future and the things that can sort of
24 improve outcomes at an early stage, then you can
25 sometimes improve motivation to engage with services.

27

1 that have changed the core assessments or the risk
2 assessment? What difference would it have made to the
3 management of VC?

4 **A.** Well, I think one would hope that it might have
5 increased the sort of balance between trying to be as
6 least restrictive as possible, and as collaborative, and
7 sort of as attuned to VC's views and opinions as
8 possible, with the need to mitigate the risk of him
9 getting very unwell and ending up in situations which
10 were causing significant harm.

11 **Q.** If we turn now, please, to page 4 of this document. The
12 second paragraph of your analysis on the right states
13 that:

14 "Might have benefited from earlier referral to EIP
15 and associated psychoeducation earlier in admission ..."

16 You're referring here, aren't you, to the first
17 admission?

18 **A.** Yes.

19 **Q.** That's the admission that you described earlier where
20 there was slowness to take a full history?

21 **A.** Yes.

22 **Q.** Is the point that you are making that EIP, although
23 a service in the community, can get involved in
24 inpatient care even during and early during a first
25 admission?

26

1 A lot of it is around reducing the sort of
2 associated stigma for the person of having a -- you
3 know, a severe and enduring mental illness, and kind of
4 working that through with them.

5 **Q.** I want to turn now to the topic of medication, and we
6 start with a few different pages in this document.

7 We're going to start with the page we're at, page 4,
8 and it's the next paragraph down from the one we were
9 just looking at, that starts "D/C".

10 So:

11 "[Discharged] from 1st admission on 5mg Aripiprazole
12 ... and reported as still having symptoms but meds not
13 reviewed by HTT medic."

14 HTT, is that Home Treatment Team?

15 **A.** Home Treatment Team, that's the Crisis Resolution
16 Service I think it's also called.

17 **Q.** So you're referring there specifically to the crisis
18 team?

19 **A.** Yes.

20 **Q.** Then if we go four lines down:

21 "Very low dose of antipsychotic medication in 1st
22 and 2nd admission with limited medical review in
23 community to review efficacy."

24 How frequently should there be reviews by medics of
25 medication efficacy?

28

1 A. So it depends on the patient, and the symptoms that
 2 they're reporting. And I think what was surprising in
 3 this case was that VC was complaining of ongoing
 4 symptoms, and -- but the medication sort of hadn't been
 5 sort of systematically reviewed.
 6 Q. Yes. Can I just deal with your use of the word
 7 "surprising" again.
 8 A. Sorry.
 9 Q. No, no, there's no need to apologise. But when you say
 10 it's surprising, are you describing there in your view
 11 that should have occurred, that's why you are surprised?
 12 A. Yes, and the reason that I use the word "surprising"
 13 I suppose is I'm conscious of the fact that there's
 14 a range of clinical views around this sort of thing.
 15 Q. Page 5, that same document. The entry right at the top
 16 reads:
 17 "Medical treatment is maintained at low doses,
 18 however VC does not achieve a clear remission in his
 19 symptoms in the community and there is a high index of
 20 suspicion that he is not taking the medication
 21 consistently."
 22 Then if we can go forward to a connected entry, it's
 23 page 11, please. And again, analysis column on the
 24 right, second line down:
 25 "Doses kept very low -- not always therapeutic
 29

1 "Medication reviews did not connect lack of response
 2 to treatment to adherence, dose, type of medication.
 3 Did not try alternatives except initial olanzapine
 4 (v[ery] low dose) and briefly haloperidol in seclusion
 5 [at psychiatric Intensive Care Unit]".
 6 In your view, should there have been a conclusion
 7 that aripiprazole was not effective and there was need
 8 for an alternative?
 9 A. I think it's difficult to say that because there wasn't
 10 a long period of VC taking, consistently taking
 11 aripiprazole. So it's possible that at a therapeutic
 12 dose and consistently taking, it may have been
 13 effective. But because he wasn't taking it
 14 consistently, you could have tried an alternative
 15 antipsychotic that he might have preferred or tolerated,
 16 or be willing to take more consistently, orally, before
 17 you then thought about whether or not you needed to give
 18 medications as an intramuscular injection.
 19 Q. Which would be depot injection?
 20 A. Yeah.
 21 Q. Well, before we turn to depot, we're going to come away
 22 from this document for a moment. We will be going back
 23 to it. But if I can have up on screen, please,
 24 RLIT0000013.
 25 And Chair, it's tab 4 of the supplementary bundle.
 31

1 levels".
 2 So firstly, what would the therapeutic dose be?
 3 A. So if aripiprazole, the kind of minimum therapeutic dose
 4 that I would expect is around 10mg. 15mg is common. It
 5 goes up to 30mg but sort of within the BMF limits. So
 6 5mg would be a, in my view, a subtherapeutic dose.
 7 Q. What are the potential reasons, in abstract, for
 8 treating someone at a subtherapeutic dose?
 9 A. In Early Intervention Services, one of the, I suppose,
 10 the ethos is that you start doses low and gradually
 11 increase them to the -- I think with the hope that you
 12 reduce the side effects, you keep the side effects to a
 13 minimum, that the patient can tolerate the medication,
 14 and that you achieve symptom control or an improvement
 15 in symptoms that is acceptable to the patient at the
 16 lowest possible dose.
 17 Q. So that relates, does it, to the point we looked at just
 18 a few moments ago on page 5 about VC not achieving clear
 19 remission?
 20 A. *(The witness nodded)*.
 21 Q. Where at a low dose, or a subtherapeutic dose, there is
 22 a remission, then that would be grounds to increase?
 23 A. If you are sure that the patient is taking the
 24 medication.
 25 Q. Still on page 11, the entry in the box on the right:
 30

1 Dr Dracass, you will see this is a paper published
 2 by the Royal College of Psychiatrists titled "Clozapine
 3 for treatment-resistant schizophrenia".
 4 It's dated January 2026 so it post-dates both the
 5 events we're concerned with and the analysis that you
 6 carried out. But I note and I read from your statement
 7 earlier, that you've had experience of prescribing --
 8 A. Yes.
 9 Q. -- clozapine.
 10 And if we can look at two paragraphs in this
 11 document. Firstly, if we go to page 3 please, and the
 12 first paragraph, part of the executive summary, under
 13 the heading "Context and rationale", it refers there to:
 14 "... convincing evidence that clozapine improves
 15 outcomes in patients with treatment (medication)
 16 resistant schizophrenia ... where other medications have
 17 been tried but have not been effective. [It describes]
 18 Clozapine is the only antipsychotic medication
 19 recommended by evidence-based national guidelines for
 20 this indication ..."
 21 And it says:
 22 "... [The] findings strongly suggest that the
 23 likelihood of response is maximised if clozapine is
 24 started soon after a diagnosis of [treatment resistant
 25 schizophrenia] has been made".
 32

1 Now if we go forward, please, to the next page,
2 page 4, and then under the heading "Evidence for the use
3 of clozapine in treatment-resistant schizophrenia", it
4 describes in the final three lines:

5 "In people with first-episode psychosis, almost
6 a quarter will warrant a diagnosis of [treatment
7 resistant psychosis] ... overall prevalence in those
8 with established illness has been consistently found to
9 be around 30%."

10 So it's a significant proportion, it appears to be,
11 based on this study, of people with psychotic illness
12 who will be treatment resistant.

13 **A.** Yes.

14 **Q.** In your view, would VC have met the criteria for
15 medication resistant schizophrenia, or does it go back
16 to what you say: that it wasn't clear if he was on
17 medication or not?

18 **A.** So it goes back to what I say that it wasn't clear that
19 he had an adequate trial of antipsychotic -- oral
20 antipsychotic first or second generation antipsychotic
21 medication for a period of time with the adequate
22 exploration of his psychosis symptoms.

23 **Q.** This is a document from 2026. What was the
24 understanding of the use of clozapine for
25 treatment-resistant schizophrenia at the time that --

33

1 consultant/clinical discussion regarding difference of
2 opinion between [community care coordinator] and
3 inpatient treating team about the value of depot and
4 [a] CTO."

5 Of course, it would have been necessary for that
6 detention to be under a Section 3 in order for the
7 discharge to include a CTO?

8 **A.** That's correct.

9 **Q.** Then dealing again with a similar point, if we go
10 forward, please, to page 20, the fifth paragraph down,
11 the request to consider depot and CTO. That paragraph
12 there. Is it your -- putting aside for a moment the
13 fact that this was not a detention under a Section 3, is
14 it your view that at this point there were grounds for
15 discharge on a CTO?

16 **A.** So I think a different approach might have been for the
17 treating inpatient team to consider the trial of a depot
18 medication. And to do that, they might have needed to
19 keep VC in hospital for longer, which would have
20 required a conversion of the Section 2 to a Section 3.

21 Obviously you can't detain somebody under a
22 Section 3 for the purposes of discharging them on a CTO,
23 but you could have used the argument that actually it
24 would have benefited VC at that point to have had
25 a trial period on a depot medication in the inpatient

35

1 **A.** Similar. I mean, this is not new.

2 **Q.** If we can take this down and if we can go back, please,
3 to CQCM0016210 at page 11, please.

4 Final entry in the column on the right, top
5 right-hand corner: "Depot discussed but not
6 implemented." Do you or did you consider, on your
7 analysis, that VC was a suitable candidate for depot
8 medication?

9 **A.** Yes.

10 **Q.** The benefit of it is that it ensures medication
11 concordance?

12 **A.** Yes.

13 **Q.** What are the options for clinicians where you have
14 a patient who would benefit from depots, a candidate for
15 it, but they are opposed to medication by way of
16 injection?

17 **A.** So if they're detained under the Mental Health Act, then
18 you have the opportunity to prescribe and administer
19 depot medication despite the fact that the patient might
20 not agree with that treatment plan.

21 **Q.** You refer, it's page 17 of this document, you make
22 a reference to Community Treatment Orders here when
23 describing the discharge from the fourth admission, so
24 it's the second line down. And you say:

25 "- no evidence of discussion with community

34

1 setting, and then, once you'd established them on that
2 depot and having had to put them on a Section 3 in order
3 to do that because you would have needed to keep him in
4 hospital for longer, assuming that he wasn't agreeing to
5 an informal admission at that point, or the treatment
6 plan at that point, and then you could potentially have
7 thought that that would be an appropriate point to try
8 discharging with the CTO if he'd had a good response to
9 the depot.

10 There is a point at that point, he may not have
11 reached a remission on the depot medication, if indeed
12 he is or was treatment resistant, in which case you
13 would have then had the opportunity, whilst he was under
14 that Section 3 of the Mental Health Act, to have also
15 considered a trial of clozapine.

16 **Q.** Can you give clozapine by way of depot injection?

17 **A.** No, you would have to give that as an oral medication.

18 **Q.** Important points to make, you have been sent extracts
19 from the witness statement of Mr Ruck Keene King's
20 Counsel who gave evidence to the Inquiry this morning in
21 order to prepare for giving evidence today.

22 **A.** Yes.

23 **Q.** But even when a patient is on a CTO, it doesn't enable,
24 does it, medication to be given by force?

25 **A.** In the community, no.

36

1 Q. If a patient refuses to comply with the condition, such
 2 as receiving medication by depot, they can be recalled
 3 to hospital but it's not automatic, it's something that
 4 needs to be considered.

5 A. That's correct, and you sometimes have to go and get
 6 a warrant to recall them.

7 Q. Page 9 of this document, please, and this is dealing
 8 with the issue of capacity and capacity assessment, the
 9 penultimate paragraph describes:
 10 "VC having capacity frequently referred to but no
 11 evidence of structured approach or explanation of
 12 capacity assessments ..."

13 How might properly timed and undertaken capacity
 14 assessments have impacted or changed the treatment
 15 provided to VC, in your view?

16 A. Well, I felt that there was an assumption that VC had
 17 capacity and it was documented that he had, but the
 18 workings out was not documented, and had the -- his lack
 19 of insight and sort of inability to understand the
 20 implications of his sort of lack of adherence to the
 21 treatment on his mental illness that he didn't believe
 22 he had, you might have thought that the kind of weight
 23 on his preference for oral medication, or even his
 24 preference for, I'm assuming, aripiprazole, may not have
 25 carried as much weight because he didn't have full
 37

1 of VC's presentation, aren't they?

2 A. To the clinician, yes.

3 Q. So how serious was this, in your view, that the care
 4 plan doesn't address those issues?

5 A. So I think a sort of collaborative care plan with
 6 a patient would need to address the issues for the
 7 patient and the wider issues for -- that the clinician
 8 thinks is pertinent, and the fact that perhaps the -- on
 9 balance, the weight was given more to the kind of
 10 standard care plan content, rather than tailoring it
 11 specifically to the issues that were occurring in this
 12 case with, as listed here, meant that the care plan
 13 wasn't addressing meeting and mitigating these issues.

14 But these were needs that the clinician had
 15 identified rather than needs that the patient would
 16 identify.

17 Q. The final issue I'm going to deal with in this document
 18 is that of discharge, and specifically discharge from
 19 the EIP team. If we go to page 14, and we can see that
 20 some of the conclusions in these boxes are emboldened.
 21 Top-right box, you identify a number of features at the
 22 time of the discharge:
 23 "No documented consideration of the risks this
 24 course of action [ie, discharge] may pose.
 25 "The cold call was to the wrong address.
 39

1 capacity.

2 Q. So a more structured approach to the assessment may have
 3 resulted in a conclusion that there was a lack of
 4 capacity?

5 A. So by "more structured", what I mean is laying out the
 6 conditions for capacity: being able to understand,
 7 retain, weigh in the balance, and communicate.

8 Q. Just in -- we can take down the highlighting, keep the
 9 page up but take down the highlighting and look at the
 10 paragraph above. This is a slightly different issue to
 11 capacity; it's when you're setting out your analysis in
 12 respect of care plans.

13 You say in response to the question:
 14 "... evidence is there that the care plan has been
 15 written in a way the patient can understand".
 16 "This is all covered but did not address the issues
 17 ..."

18 And then you set out number of bullet points:
 19 "Poor adherence to medication.
 20 "Limited engagement with services.
 21 "Guarded and misleading information from VC about
 22 symptoms and circumstances.
 23 "Risk to neighbours.
 24 "Limitation to insight and thus capacity".
 25 Those issues, they're the most challenging features
 38

1 "No evidence that mother was consulted, no evidence
 2 that GP, police or university contacted ...
 3 "No proactive discussion with him or his mother
 4 [and]
 5 "No documentation about consideration of a [Mental
 6 Health Act] assessment ..."

7 Are those all steps that in your view should be
 8 taken, ought to be taken, prior to discharging a patient
 9 with VC's presentation?

10 A. Yes.

11 Q. At the bottom of the page, just above -- well, it's the
 12 penultimate paragraph, and this paragraph makes it sway
 13 to the CQC's final report, it says:
 14 "The evidence over the course of his illness and his
 15 contact with services and Police indicated beyond any
 16 real doubt that VC would relapse into distressing
 17 symptoms and aggressive/intrusive behaviour if not
 18 treated with antipsychotics and monitored in the
 19 community."
 20 Just pausing there, reference to
 21 aggressive/intrusive behaviour, that includes, does it
 22 acts of violence?

23 A. Not necessarily.

24 Q. Would that sentence, or would you include the risk of
 25 violence within that sentence, the same considerations
 40

1 apply?
 2 **A.** Sorry, can you repeat that?
 3 **Q.** So you've described that There was an Indication:
 4 "... beyond any real doubt that VC would relapse
 5 into distressing symptoms and aggressive/intrusive
 6 behaviour ..."

7 And my question is: is it beyond any real doubt that
 8 he would also relapse into violent behaviour in light of
 9 the evidence?

10 **A.** No, I don't think so.

11 **Q.** You go on to say:

12 "As such, the plan to discharge him when he
 13 disengaged from EIP services, before liaising with other
 14 agencies or doing a welfare check/cold call to his home
 15 address did not adequately consider or mitigate the
 16 risks."

17 **A.** Yes.

18 **Q.** The reason it didn't consider or mitigate the risks is?

19 **A.** Sorry?

20 **Q.** Why -- you say the plan to discharge him, when he
 21 disengaged from the EIP service before liaising with
 22 other agencies, didn't consider or mitigate the risks.
 23 How would liaising with other agencies doing a welfare
 24 check, carrying out a cold call, how would that control
 25 or reduce the risks?

41

1 into violence. I'm not entirely clear where I would
 2 draw that distinction.
 3 **Q.** Finally this, please -- we can take this document down,
 4 I have no more questions on your analysis document --
 5 the CQC's report at the part 2 report is documented, and
 6 we can put this up, CQCM0016518.

7 It's tab 18 of the main bundle, Chair.

8 So this is the review which focuses on the treatment
 9 and care given to VC, and this is the review to which
 10 your work contributed.

11 **A.** Yes.

12 **Q.** In your statement, you comment that you were given an
 13 opportunity to read and comment on the final draft, and
 14 you were asked to comment on report and recommendations
 15 prior to its publication. Did you comment on the draft?

16 Did you make any --

17 **A.** I believe I responded saying that I was -- there was
 18 nothing I had further to add, and I was in agreement.

19 **Q.** The summary of what you say in your statement about the
 20 report is essentially you agree with its conclusions,
 21 you consider the report reflects your analysis, and
 22 although you didn't contribute to the recommendations
 23 that are made in that report you are in agreement with
 24 them?

25 **A.** Yes.

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1 **A.** So it would have given a better indication of what was
 2 happening for VC at that point, which they did not know,
 3 whether he was relapsing at that point. It would also
 4 have enabled an assessment or a potential to find a way
 5 of reengaging with him if it was established that he
 6 was, for example, known to another, you know, he was
 7 still turning up at the University, for example, or if
 8 he was -- if you were able to access him at his correct
 9 home address, you might have been able to have
 10 a conversation with him about the next steps in terms of
 11 his care and treatment.

12 Equally with his family.

13 **Q.** You draw a distinction between the likelihood on the one
 14 hand of aggressive and intrusive behaviour on relapse,
 15 and violence on the other hand. Further up in this same
 16 box, the sentence starting "Despite this", you note that
 17 at previous incidents -- there had been previous
 18 incidents of violence, referred to
 19 "disturbing/assaulting the neighbours and associated
 20 with aggression or violence".

21 Why, in your view, was it likely that that would be
 22 aggressive and intrusive behaviour but not as likely
 23 that there would be violence, given the history of
 24 violence?

25 **A.** I suppose it's just about at what point aggression turns

42

1 **Q.** And if we just look at the summary, please, it's page 4.
 2 There are two bullet points in the middle of the page.
 3 The first one deals with the fourth admission. It says:
 4 "If the decision had been made to treat VC under
 5 section 3 of the Mental Health Act [...] during his
 6 fourth admission to hospital, further options would have
 7 been available for his care and treatment in the
 8 community."

9 Well, the further options being referred to there
 10 are CTO, aren't they?

11 **A.** Depot and CTO, yeah.

12 **Q.** It says "If the decision", your view, as you've
 13 explained, is that the decision should have been made to
 14 detain under Section 3.

15 **A.** Yes.

16 **Q.** Then the next bullet point deals with a series of
 17 errors, omissions and misjudgements. It lists three as
 18 being in the key area of omissions and misjudgements:
 19 risk assessment, the discharge from EIP in
 20 September 2022, and poor care planning and engagement.

21 Amongst the failures, shortcomings, that we've gone
 22 through in your analysis, do you consider that those
 23 three are the key failings?

24 **A.** I mean, I think, if we take a broader view of care
 25 planning as being kind of treatment planning in general,

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1 care and treatment planning, rather than just the sort
2 of care planning documentation, the actual act of
3 planning care, then yes.
4 **MR CARR:** Dr Dracass, thank you very much indeed. I have no
5 further questions, but others will have questions.

6 **THE CHAIR:** Yes, Mr Moloney.

7 **Questioned by MR MOLONEY**

8 **MR MOLONEY:** Good afternoon. I just want to ask you about
9 two things, really. Firstly, the third admission and,
10 secondly, the importance of accurate records.

11 Firstly, the CQC report notes that there's no
12 evidence of discussion around the value of depot
13 medicine or a Community Treatment Order until his fourth
14 admission.

15 **A.** Yes.

16 **Q.** We know that VC was detained under Section 3 for his
17 third admission.

18 **A.** Yes.

19 **Q.** Given his history of non-compliance and the
20 associated -- what has been described as extreme
21 violence with the admission on 21 September, would you
22 have expected, with that Section 3 admission there,
23 a rigorous consideration of the CTO during that
24 admission?

25 **A.** Well, the CTO would only be effective if the -- if it

45

1 not?

2 **A.** So again, because the patient is taking oral medication,
3 the power under a CTO is not particularly effective in
4 terms of improving the adherence in the community for
5 that patient, and in that way it would not mitigate the
6 risk.

7 **Q.** So I'm sorry to stay on this, but essentially, with the
8 CTO, could there be a provision for depot medication
9 which would ensure that medication was taken and they
10 could be recalled?

11 **A.** So it would be the other way round. The provision for
12 the CTO could support the treatment with the depot
13 medication.

14 **Q.** Yes, that's what I was asking. So if there's a history
15 of non-compliance on oral medication in a patient who is
16 refusing to engage with depot medication because they
17 don't like needles or something of that nature, could
18 there then be consideration, active consideration, given
19 to a CTO in order to ensure that depot medication was
20 complied with, and if not, they could be brought back
21 in?

22 **A.** So I would want to establish the patient on the depot
23 medication under detention of a Section 3 during the
24 inpatient admission, and then, depending on whether or
25 not that patient has a response to the depot medication,

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1 would have an impact on the adherence to the treatment
2 plan. So if the treatment plan was oral medication,
3 then a CTO probably wouldn't have been effective then
4 either.

5 **Q.** I'm not asking you about the efficacy or effectiveness
6 of a CTO; I'm asking you about whether or not there
7 should be, given the history of non-compliance and the
8 extreme violence, should there have been a consideration
9 of CTO at that stage?

10 **A.** So I think the consideration should have been at
11 a different way of delivering the antipsychotic
12 medication, rather -- in the first instance, before the
13 consideration of a CTO.

14 **Q.** If there was no alternative way of delivering the
15 medication, could a CTO have been thought about?

16 **A.** Under those circumstances, there wouldn't be much
17 benefit to a CTO. So it probably wouldn't have been
18 considered as an option.

19 **Q.** So to try to get some clarity on your answer, at that
20 stage, third admission, extreme violence, history of
21 non-compliance, no need to consider a CTO?

22 **A.** So I'm not sure what the added benefit of a CTO if the
23 patient was taking oral medication would be.

24 **Q.** But should that be considered to think about that and
25 document whether or not a CTO should be appropriate or

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1 they may gain some insight and decide to take their
2 medication without the need of a CTO, or they may
3 continue to say that they don't want to take medication
4 in the community, in which case you might consider
5 a CTO.

6 **Q.** Right, so if you'll just forgive me, just one further
7 question. With a history of extreme violence and
8 non-concordance with medication, this being the third
9 admission, would you consider at that stage the
10 potential for the use of depot medication?

11 **A.** Yes, I would consider the potential for the use of depot
12 medication.

13 **Q.** If the patient refused to engage with depot medication,
14 would you then think that it was necessary to consider
15 at least the use of a CTO?

16 **A.** If the medication, if the depot medication was being
17 given under the Mental Health Act and they had achieved
18 some clinical response to it, then yes.

19 **Q.** Yes. Thank you.

20 Just the second point, the accuracy of records.

21 There is a regulatory duty, is there not, under the
22 Health and Social Care Act 2008 Regulations of 2014, to
23 keep accurate, full and contemporary records in health
24 and social care?

25 **A.** I believe so.

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1 **Q.** Of course that's important because it ensures, when
 2 a patient transfers from one clinician to another or
 3 from one team to another, there is accurate information
 4 available to treating clinicians.
 5 **A.** Indeed, yes.
 6 **Q.** It's also important because if there is a tragedy and
 7 an alleged failing in relation to that tragedy, then
 8 having accurate records is very important for knowing
 9 what really happened.
 10 **A.** Indeed.
 11 **Q.** Thank you. Just on the same point, the treatment of VC
 12 proceeded on the assumption that 2020 heralded the
 13 emergence of his poor mental health, didn't it?
 14 **A.** Yes.
 15 **Q.** Yes. Did you see any pre-2020 records relating to VC,
 16 for example home GP records for --
 17 **A.** I did not.
 18 **MR MOLONEY:** No. Thank you very much.
 19 **THE CHAIR:** Yes, Ms Cartwright.
 20 **Questioned by MS CARTWRIGHT**
 21 **MS CARTWRIGHT:** Good afternoon, Dr Dracass.
 22 Can I briefly take you back to the Terms of
 23 Reference in the email that Mr Carr took you to, please,
 24 which is WITN0387004. Thank you. And if we can move to
 25 page 2, thank you, where we've got the Terms of
 49

1 a serious harm event for a member of the public whilst
 2 subject to crisis resolution home treatment and
 3 effectively before it's even got going?
 4 **A.** Yes, and I think I made a comment about the fact that
 5 there -- we did not get access to whether or not what we
 6 called Datix or Inphase, a sort of report of potential
 7 an incident had been created as a consequence of that,
 8 exactly that scenario that happened, where the patient
 9 presented, was assessed, the treatment plan was executed
 10 as crisis service, discharged and then readmitted
 11 following harm.
 12 That would, I would have thought, have met the
 13 threshold for to be reported as an incident, and it was
 14 not clear whether it was or not, and then from that duty
 15 of candour would have come out.
 16 **Q.** That's why I want to cover that with you because we
 17 don't see that in your report, and plainly a number of
 18 national guidance, in fact even the CQC guidance, comes
 19 into play here. Can we just look at those together.
 20 First of all, there is the incident reporting
 21 procedures and obviously there will be local policies
 22 that deal with that, but would you agree, depending on
 23 the harm event, there are different levels of
 24 investigations --
 25 **A.** Indeed, yes.
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1 Reference there.
 2 As has already been touched upon, point 5 was
 3 "Review, assess and report on compliance with local
 4 policies, national guidance, and relevant statutory
 5 obligations".
 6 You've already dealt with that the local policies
 7 had not been provided, but I want to ask you a question
 8 by reference to national guidance and statutory
 9 obligations, because you've already been taken through
 10 the report and the findings that were made about I think
 11 the first contact with mental health where VC was
 12 assessed, but not reached the threshold where he was
 13 detained -- and obviously we've already looked at
 14 together your comments that that was a surprising
 15 decision on the presentation -- but we know then that
 16 what happened was that VC was subject to crisis home
 17 treatment, and essentially within 11 minutes of being
 18 then released from custody, he went on to essentially
 19 have the further incident which resulted in an issue of
 20 harm. So this is now a patient who's subject and under
 21 the care of mental health services, against a background
 22 where you made a finding about a surprising decision.
 23 Can I ask: as part of the review, did you consider
 24 the obligations of the statutory duty of candour for the
 25 fact that this is a patient who has gone on to cause
 50

1 **Q.** -- that involve internal trusts?
 2 **A.** Yes.
 3 **Q.** To then be escalated to the Care Quality Commission?
 4 **A.** Potentially.
 5 **Q.** That would also go to the ICB if it meets a specific
 6 threshold?
 7 **A.** Yes.
 8 **Q.** Can I ask why that wasn't looked at and investigated
 9 bearing in mind this very serious incident had occurred
 10 of a harm event to a member of the public?
 11 **A.** Are you asking why we didn't focus on that in our
 12 review?
 13 **Q.** Yes, bearing in mind this arises out of a period of time
 14 of the investigation, and it engages local, national
 15 guidance of relevant statutory obligations.
 16 **A.** So I imagine the answer to that is that we did note, and
 17 I think I did note, although I can't lay my hand on it
 18 immediately, the fact that there hadn't been an incident
 19 raised around that outcome, but we didn't go into detail
 20 on that incident, I think, because of the time pressure
 21 across the amount of information that we had to cover
 22 over a short period.
 23 **Q.** Because -- so you think you noted it somewhere, but we
 24 don't see the product of that anywhere because, would
 25 you agree, the whole purpose of incident reporting could
 52

1 have been massively significant in the context of this
 2 incident because, would you agree, that incident
 3 reporting is to understand why something happened,
 4 understand the systems and processes that have gone
 5 wrong, to essentially correct those and if there's not
 6 been an incident reporting and that's not taken place,
 7 there was a significant lost opportunity here to
 8 investigate this matter by the Trust and maybe others;
 9 would you agree?

10 **A.** So the matter that would have been investigated would
 11 presumably have been the Mental Health Act assessment
 12 that led to the patient not being detained at that
 13 point.

14 **Q.** Yes.

15 **A.** Is that what you're referring to?

16 **Q.** Just more generally, this is a patient, a mental health
 17 patient, that assessment, but also that that patient
 18 went on to carry out a harm event while subject to
 19 services and actually very proximate to an assessment?

20 **A.** Yes, so it would have investigated the details of that
 21 assessment, because that was the contact that they'd had
 22 prior to the incident where the harm had occurred.

23 **Q.** Did -- as part of identifying it that it had not been
 24 incident reported, had that been escalated anywhere to
 25 understand why it hadn't been --

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1 the context of the attempted murders also of those that
 2 VC had attacked?

3 **A.** I don't know.

4 **Q.** No. And do you know at all whether there's any
 5 discussion about the engagement that was going to take
 6 place with the victims who were the survivors of VC's
 7 attack?

8 **A.** We weren't involved in those conversations.

9 **MS CARTWRIGHT:** Thank you.

10 **THE CHAIR:** Yes, Mr Straw.

11 **Questioned by MR STRAW**

12 **MR STRAW:** Good afternoon. I represent VC's family. Thank
 13 you.

14 In the table that we were looking at that you
 15 drafted, that we were looking at earlier, you explain at
 16 page 14 that after the fourth admission, attempts to
 17 liaise with VC's family petered out.

18 **A.** Yes.

19 **Q.** Did you then consider that there was a failure to
 20 properly liaise with VC's family after that fourth
 21 admission?

22 **A.** Yes.

23 **Q.** VC's family say that they weren't informed of the
 24 discharge after admission three.

25 **A.** Yes.

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1 **A.** No.

2 **Q.** -- incident reported?

3 Would you agree also -- I'm going to deal with
 4 another regulation -- but also pursuant to Regulation 20
 5 of the Health and Social Care Act 2008 (Regulated
 6 Activities) Regulations of 2014, that actually engages
 7 the very Regulation 20 that the CQC provide guidance on,
 8 as to the duty of candour to make apologies to the
 9 victim, but also to investigate thoroughly that harm
 10 incident; would you agree?

11 **A.** Yes.

12 **Q.** Bearing in mind this is a report commissioned by the
 13 CQC, was that raised with the CQC as to why -- how they
 14 were going to address the Regulation 20 issue linked to
 15 this issue that occurs in VC's care?

16 **A.** No, it wasn't.

17 **Q.** Can I ask you please, very briefly, just a general
 18 point, CQCM0016518 which is the report, essentially the
 19 CQC report.

20 **THE CHAIR:** It will come up.

21 **MS CARTWRIGHT:** Thank you. Dr Dracass, I omitted to say at
 22 the outset, I represent the survivors, and -- thank you.

23 We can see that the special review was in the
 24 context of the killings of Grace, Barney and Ian. Do
 25 you know why it was also not being considered also in

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1 **Q.** Should they have been?

2 **A.** Yes.

3 **Q.** The Part 2 report, with which you've explained already
 4 that you were in agreement with the conclusions, notes
 5 that there was a failure to respond properly to concerns
 6 raised by Celeste -- Celeste Calocane -- about VC's
 7 mental health on 11 July 2020, 9 October 2020, and in
 8 May 2021. Do you agree with that?

9 **A.** Yes. I think so. I can't see it, sorry. I'm not able
 10 to refer to it, so ...

11 **Q.** We have the report, but from your recollection, would
 12 you agree that there was a failure to respond properly
 13 to concerns raised by Celeste?

14 **A.** Yes.

15 **Q.** Late September 2021, VC began to refuse consent to share
 16 information with his family. I'd just like to briefly
 17 ask you about before that, so before he'd refused
 18 consent.

19 At that stage, would you expect the authorities to
 20 share with his family important bits of information
 21 about him?

22 **A.** Such as?

23 **Q.** The diagnosis of paranoid schizophrenia?

24 **A.** Yes, if that was something that he and they were, you
 25 know, involved in wanting to know.

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1 Q. And another example: details relevant to the risk he was
 2 assessed to pose to others.
 3 A. Yes.
 4 Q. Part 2 says this at page 31:
 5 "... VC required a much more robust package of care
 6 that included consistent and assertive interventions.
 7 More assertive engagement and restrictive measures were
 8 crucial to managing his illness and the risk he posed to
 9 others when unwell."
 10 I assume from what you said earlier, you agree with
 11 that?
 12 A. Yes.
 13 Q. Can you give any more detail, what in particular, what
 14 were the more assertive engagement and restrictive
 15 measures that were crucial?
 16 A. So I think that goes back to perhaps a longer period in
 17 hospital, trying a different antipsychotic medication,
 18 for example with a depot preparation if, you know, in
 19 the later admissions, certainly, thinking about the use
 20 of if a depot medication was useful, thinking about the
 21 use of Community Treatment Order to maintain engagement
 22 and adherence to treatment in the community. And
 23 I think following up on the things that may have caused
 24 an alarm, such as comments from the family that they
 25 were concerned, or unable to get hold of VC when going

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1 and then throughout his sort of increasing disengagement
 2 from the service.
 3 Q. I'm not going to ask you about after September 2022,
 4 just because that's not what you were asked to do --
 5 A. Even before -- even from the last contact they had with
 6 him, we don't know whether he was symptomatic
 7 thereafter. It's an assumption that he was.
 8 Q. There are comments, weren't there, in the notes
 9 indicating he was symptomatic, for example, the
 10 information from the neighbour Chris, who described him
 11 screaming in the night and going into other people's
 12 rooms --
 13 A. Yes.
 14 Q. -- saying "can you hear that screaming?"
 15 A. Yes.
 16 Q. Dr Manzar saying that VC said that professionals were
 17 interfering with his thoughts, that sort of thing?
 18 A. Yes.
 19 Q. Thank you.
 20 Another CQC document called "Key points in the
 21 Nottingham Investigation" states that VC's risk of
 22 violence was exclusively driven by deterioration in his
 23 psychotic symptoms; do you agree with that?
 24 A. I was not aware of any violent acts outside of that
 25 context.

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1 round to do visits, or him not turning up to pick up his
 2 medication. So all of those things having a bit more of
 3 a sort of reaction, and effort to try to sort of make
 4 contact and reengage.
 5 Q. Going back to your table that you drafted, you note in
 6 there on page 20 that the symptoms of his illness
 7 included "lack of insight, poorer adherence to
 8 medication, escalating violence when acutely unwell,
 9 complex and established paranoid delusions and
 10 intermittently very distressing auditory hallucinations,
 11 throughout his contact with services."
 12 When you say "throughout his contact with services",
 13 do you mean from May 2020 until September 2022?
 14 A. Well, in the contacts he had, there was often reference
 15 to the fact that he was still suffering from symptoms,
 16 and there was evidence that he was, you know, not
 17 gaining insight, not compliant with his medication, and
 18 not really wishing to engage with the services in a way
 19 that might have promoted his recovery, for example
 20 turning down CBT for psychosis, you know, not wanting to
 21 sort of have contact with the service, and asking them
 22 to keep it to a minimum.
 23 Q. So those symptoms you describe in your view continued
 24 into and during 2022?
 25 A. Well, from his discharge from hospital, in early 2022,

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1 Q. Two final questions. You were asked about the documents
 2 that you were given for the purposes of your review.
 3 Can we have on screen, please, CQCM0010415, and page 12
 4 of that. Towards the bottom there you talk about the
 5 third admission and can we go over the page a couple of
 6 pages, 13, you can see at the bottom "Discharge summary
 7 from cygnet"; then over to page 14, you can see there
 8 there's something:
 9 "7 Day notes
 10 "MDT ... Print record of MDT review
 11 "Care plans in Priory
 12 "Discharge summary from Priory"
 13 Towards the bottom.
 14 Did you have available to you documents from his
 15 time in the Cygnet and the Priory?
 16 A. So I can't recall the detail, but I think this was the
 17 information that had been sent to his NHS record.
 18 Q. Then finally, you mentioned that this was a very short
 19 period of time you were given to complete the review.
 20 A. Yes.
 21 Q. Obviously you've had time to reflect on it since then.
 22 Do you stand by the conclusions that you came to in your
 23 report and with those in the CQC part 2 report that you
 24 agreed with?
 25 A. Yes. I think that there has been other reports that

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1 have kind of gone into more detail and have given sort
2 of other -- given some emphasis to other parts of care
3 as well. But yes, in principle, I do.

4 **MR STRAW:** Thank you.

5 Thank you very much, Chair.

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

7 **Questioned by MR BEER**

8 **THE CHAIR:** Yes, Mr Beer, you're not scheduled, but you do
9 want to ask a question?

10 **MR BEER:** If I may, if I could have three or four minutes of
11 the Inquiry's time.

12 Three topics, please, Dr Dracass, I ask questions on
13 behalf of the Trust.

14 The first is that Mr Carr took you to the *pro forma*
15 document that had been pre-populated by the CQC with
16 your findings or comments on the right-hand side; do you
17 remember it?

18 **A.** And then summarised underneath, yes.

19 **Q.** Yes, exactly. You wrote in relation to the first
20 contact with the trust that VC had, in May 2020, that it
21 was not clear if urine had been screened for drugs. Can
22 we just quickly look at NHFT0000168. NHFT0000168,
23 page 13. Can we look at the top two entries; please.
24 So 28 May, you'll see this is dated 6.23 pm:

25 "VC has provided a urine sample and it all came

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1 **Q.** So do you think, even though you had some time, the
2 pressure of time that you were under compromised some of
3 the accuracy or reliability of the conclusions which you
4 reached?

5 **A.** It's possible, given the evidence that you've
6 produced --

7 **Q.** I'm not going to go through yours and Dr Ahmed's work to
8 highlight other issues such as this. You could be here
9 for a while doing that and it's not a profitable use of
10 time, but at a more general level, do you think the time
11 pressure you were under may have, if it was otherwise,
12 have aided greater accuracy and reliability?

13 **A.** It's possible.

14 **Q.** Do you think also that speaking to relevant clinicians,
15 if you'd had more time, would have allowed you to form
16 a more informed or balanced judgement as to why certain
17 views were formed or decisions taken or not taken?

18 **A.** So my understanding was that there was never
19 an intention for us to be speaking with the clinicians
20 or people involved in the incident. It was always going
21 to be a rapid review of the documentation.

22 **Q.** Okay. So they were the Terms of Reference under which
23 you were operating and you --

24 **A.** That was my understanding, yes.

25 **Q.** -- were constrained by that.

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1 negative apart from benzo[diazepine]s that tested
2 positive."

3 **A.** Yes.

4 **Q.** So it's clear that urine screening for drugs had been
5 carried out on the first contact with the Trust; yes?

6 **A.** Yes, some days later.

7 **Q.** Would you agree, as we've heard many times in the
8 Inquiry before, it's important before any clinician
9 draws a conclusion to take into account all relevant
10 information?

11 **A.** Yes.

12 **Q.** Do you think that the collective efforts of you,
13 Dr Ahmed, and those in the CQC reviewing your work,
14 missed this?

15 **A.** It's possible, yes.

16 **Q.** Even though you had the luxury of time, some time, to
17 review the notes and weren't doing so, for example in
18 the context of a busy ward round looking after dozens of
19 patients?

20 **A.** Sorry, I didn't catch the question.

21 **Q.** Yes, you missed this, all of you, even though you
22 weren't doing your review in the context of a busy ward
23 round.

24 **A.** Well, I was doing my review in the context of my
25 full-time job, but yes.

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1 Okay, thank you. Secondly, Mr Carr today has used
2 a template document, a 20-odd page document, to obtain
3 your views upon the care and treatment afforded to VC
4 rather than the published report of the CQC, you
5 understand.

6 **A.** Yes.

7 **Q.** You've said in your notes, again this is just by way of
8 example, in the template document, that it was
9 surprising that there was no detention after the first
10 Mental Health Act assessment on 24 June --

11 **A.** Yes.

12 **Q.** -- 24 May.

13 **A.** Yes.

14 **Q.** It was surprising that there was no detention after the
15 contact on 18 January 2022.

16 **A.** Yes.

17 **Q.** Neither of those sentiments, or anything like them,
18 appears in the published CQC report. Do you know why
19 that is?

20 **A.** I don't know what you mean, sorry.

21 **Q.** Well, ie a direct statement in the CQC's published
22 report that there should have been admission on both
23 occasions.

24 **A.** Because it's a clinical perspective, the people making
25 that decision are assessing the patient at that time,

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1 and I was not. And so whilst on paper it looks
2 surprising, it's a clinical decision made by qualified
3 professionals.

4 **Q.** Is that why you understand that the strength of view
5 that you've expressed on paper hasn't made it into the
6 final report?

7 **A.** I don't know what you mean, sorry.

8 **Q.** You used the same word "surprising" twice, it's quite
9 a striking word. Nothing like that strength of view,
10 nor indeed a direct statement, that there should have
11 been an admission on both occasions, appears in the
12 final report.

13 **A.** I see.

14 **Q.** I'm just asking is it because "Well, we didn't get the
15 chance to interview the clinicians", that that's been
16 omitted from the published report?

17 **A.** I don't know.

18 **Q.** You don't know why that's been missed out?

19 **A.** No.

20 **MR BEER:** Thank you very much. Thank you.

21 **Questioned by THE CHAIR**

22 **THE CHAIR:** I just wanted to check something with you
23 because I'm not sure that I've understood your evidence.

24 You were asked by Mr Carr about the view about
25 discharge on page 14. I wonder if we can get that up,

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1 **A.** Because that's what we said, that --

2 **THE CHAIR:** So if I was to ask you whether you considered
3 that there was a risk, or a likelihood, or a strong
4 likelihood, where would you have thought that came?

5 **A.** For violence?

6 **THE CHAIR:** Yes.

7 **A.** I mean I think it would have been a significant risk.
8 But I think it was inevitable that VC would relapse.

9 **THE CHAIR:** You've referred, just if we can go to page 20,
10 because this is why I was unclear, because you were
11 taken to this in fact I think by Mr Straw. "The balance
12 of least restriction", top of the page:

13 "It might have been prudent to take a more assertive
14 approach to medication given the history of lack of
15 insight, poor adherence to medication and escalating
16 violence when acutely unwell ..."

17 So you've taken that into account there --

18 **A.** Yes.

19 **THE CHAIR:** -- and I'm just interested to why you considered
20 that there was not -- you gave the evidence that you did
21 to Mr Carr about there not being a doubt or whatever
22 about violence.

23 **A.** I don't mean to mislead. I think I'm getting confused
24 about the term "violence" and the difference between
25 violence and aggression, and whether in fact there is

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1 of the -- so it's CQCM0016210. It's page 14.

2 And what you were asked about is the last paragraph
3 there:

4 "The evidence over the course of his illness and his
5 contact with services and Police indicated beyond any
6 real doubt that VC would relapse into distressing
7 symptoms and aggressive/intrusive behaviour ..."

8 And you were asked about violence, as well.

9 **A.** Yes.

10 **THE CHAIR:** You said you don't think he would relapse into
11 violent behaviour.

12 **A.** No, I said -- it's not that I didn't think he would
13 relapse into violent behaviour; I think that beyond --
14 it was not beyond any real doubt that he would relapse
15 into distressing symptoms, and the associated aggressive
16 or intrusive behaviour. But I stopped short of saying
17 violence, because as I said, I'm not sure where
18 aggressive behaviour becomes violent behaviour. So I'm
19 not -- so I don't know whether I've covered it in the
20 term "aggression" or whether I'm being asked about
21 specific acts of violence, in which case I don't think
22 we can say it's beyond reasonable doubt.

23 **THE CHAIR:** That's what I was going to ask you about. Where
24 did you get the test "beyond reasonable" -- "beyond real
25 doubt"?

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1 a reasonable difference.

2 **THE CHAIR:** Well, I think you've used "escalating violence"
3 here "when acutely unwell" -- (*overspeaking*) --

4 **A.** Yeah, so I've used the terms interchangeably.

5 **THE CHAIR:** So you have used them interchangeably?

6 **A.** Yes.

7 **THE CHAIR:** So just going back to where we were before, when
8 you were asked about whether he would relapse into
9 distressing symptoms and aggressive/intrusive behaviour
10 would that include violence?

11 **A.** It could include violence.

12 **THE CHAIR:** I see. But I think your point was that you
13 couldn't say with any doubt -- without any doubt.

14 **A.** Yes.

15 **THE CHAIR:** I see. I think I understand what you're saying.
16 Right, well, we'll take a break now until 3.35.

17 (3.22 pm)

(A short break)

19 (3.37 pm)

20 **MS LANGDALE:** Chair, may I call Dr Mona Ahmed, please.

21 **THE CHAIR:** Yes.

22 **MS LANGDALE:** Thank you.

23 **DR MONA AHMED (sworn)**

24 **Questioned by MS LANGDALE**

25 **MS LANGDALE:** Dr Ahmed, you have prepared a statement for

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1 the Inquiry dated 12 March 2026, and can you confirm
2 that the contents are true and accurate as far as you're
3 concerned?
4 **A.** Yes, I can.
5 **Q.** You also, along with your colleague Dr Sarah Dracass,
6 have had input into the CQC report that we were
7 referring to earlier.
8 **A.** Yes.
9 **Q.** You tell us that in your statement that as far as they
10 were concerned you didn't have time to comment upon the
11 draft report, but when the conclusions and the report
12 was produced you've had a chance to look at it since
13 then.
14 **A.** Yes, I have.
15 **Q.** You say various other matters today, which I'm going to
16 take you to, but as far as the report is concerned it's
17 not inaccurate in a particular detail in any way.
18 **A.** No. It's not inaccurate and it broadly reflects the
19 conclusions that we reached.
20 **Q.** To assist, because it was some time ago, and also for
21 everyone's benefit, I'm going to go to your original
22 notes that you put together, as your colleague did, and
23 to ask you a few questions arising from those before we
24 go to your statements.
25 **A.** Thank you.

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1 If we go over the page to page 4:
2 "[Repetition of] [VC] was arrested by the police for
3 criminal damage (kicked a door in of another flat)."
4 This was entered on 24 May at 6.19 before a second
5 event that the Inquiry has heard evidence about and you
6 read about where he goes back to the same property and
7 there's a further event where somebody jumps out of the
8 window.
9 So understanding why that might not be on 24 May
10 risk assessment, if we go to 26 May, please,
11 NHFT0000196, page 1. This is dated 26 May. It's
12 updated, as we see further along. If we go over the
13 page firstly to page 2, the top, exactly the same entry
14 as we saw on the 24th even though there's another event.
15 **A.** Yes.
16 **Q.** We do see cut and paste. Is this how risk assessments
17 are done, where it's just repetition of what's there
18 before?
19 **A.** Well, it is appropriate to take information directly
20 from previous risk assessments if there haven't been any
21 additional risk events, but certainly by then there had
22 been a further serious incident beyond just kicking at
23 the door and that doesn't appear to have been recorded.
24 **Q.** If we go to page 3, still criminal damage to a flat
25 door. Then over the page, page 4, we see there

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1 **Q.** You helpfully in your preparation did a summary of
2 patient presentation timeline of engagement. We can see
3 find that, please, at CQCM0010415, beginning at page 1.
4 Was this a record you made as you went through,
5 clearly analysing all your notes, and you put your
6 comments in the blue type I think; is that right?
7 **A.** So it's Dr Dracass's comments in the blue. I had
8 a headstart in putting this document together, and she
9 made the additions in blue.
10 **Q.** So when we look at this first page, the first
11 presentation, there is concern expressed by both of you
12 on this document about how risk to property has been
13 recorded and how risk is being recorded; is that right?
14 **A.** Yes.
15 **Q.** Would it help to have a look at some of those early risk
16 assessments, I'm not going to take you to many, but just
17 to see how they look in the Trust's documentation, and
18 if we can go, please, to NHFT0000197 page 1.
19 So if we see, this is a document dated 24 May 2020,
20 and if we turn over the page to page 2, we see there's
21 a recorded event here:
22 "Arrested for damaging a neighbouring flat door
23 after believing that his mum was inside screaming and
24 being raped. [VC] did not gain entry or harm anyone but
25 he was kicking the door".

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1 reference to a later event and that appears to have been
2 updated later on in July; is that right?
3 **A.** Yes, 14 July. Yes.
4 **Q.** We know -- and I don't know if you were aware -- there
5 had been another incident on 13 July where VC had been
6 restrained at the property by three residents. So in
7 effect there were three incidents by the time of this
8 review date and risk assessment of 31 August 2020 and
9 this risk assessment does not accurately reflect those
10 events or patterns of behaviour, does it, as far as VC
11 is concerned?
12 **A.** Yes, that's right and that's what I documented in my
13 report.
14 **Q.** You did. You are, I should have said at the outset,
15 a forensic psychiatrist, aren't you?
16 **A.** Yes, I am, yes.
17 **Q.** Your colleague a community psychiatrist. What different
18 expertise did you bring to this task?
19 **A.** So as a forensic psychiatrist, so I'm a doctor of
20 medicine and I specialise in the assessment and
21 treatment of mentally disordered offenders and as
22 a forensic psychiatrist we have specialist training in
23 the assessment and management of risk.
24 **Q.** You work, don't you, at south-west London and
25 St George's Mental Health NHS Trust?

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1 A. Yes.

2 Q. So what cohort of patients or people do you see?

3 A. So I work on a medium-secure unit, so those are
4 individuals whose mental disorder, quite often serious
5 mental disorder such as paranoid schizophrenia, has
6 caused them to carry out violent acts or bring them into
7 contact with the criminal justice system.

8 I have also worked as a forensic psychiatrist in the
9 community, so working with those individuals who have
10 transitioned from our secure wards into the community,
11 and I also am one of the consultant leads for court
12 liaison and diversion for the custody suites and
13 Magistrates' Court and Kingston Crown Court.

14 Q. Have you ever, I digress slightly, in your capacity in
15 the work that you do, been asked to go to a police
16 station to independently examine somebody who's in
17 custody and charged with serious offences or where such
18 serious offences are indicated? And they're not
19 suitable for Liaison and Diversion, but that's the
20 position they're in and they need assessment, mental
21 state assessment or examination?

22 A. So the Court Liaison and Diversion Service is
23 essentially a nurse-led service and it's only, as of
24 November last year, that the case was made that,
25 actually, there needs to be consultant cover, medical

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1 the medicolegal questions and provision of reports, for
2 example.

3 Q. They'd be unlikely to be referred to a hospital, an
4 ordinary hospital, wouldn't they, somebody charged or
5 pending charging for very serious offences or grave
6 offences?

7 A. For an offence like this, no. There wouldn't -- it
8 would be highly they would be diverted to hospital at
9 that point. They wouldn't be appropriate for our
10 medium-secure wards, certainly.

11 Q. Would you still -- if invited to do so, would you still
12 see the value in you providing an independent assessment
13 of that person on the day, not with a view to them
14 entering Trust services or anything like that, but to
15 understand; or is that something that would be difficult
16 for you to do?

17 A. I can't say that I would automatically go out and
18 provide a face-to-face assessment for every offence of
19 this seriousness, necessarily, but if there was a case
20 like this and it was somebody who has been known to
21 services, and there is a suspicion that the incident
22 could have been related to or arisen from their mental
23 state at the time, I think it is helpful, if only to
24 support the nursing team that are there, despite the
25 fact that we are unlikely to divert them.

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1 cover, for the Court Liaison and Diversion Service.

2 Even though I'm one of the consultant leads, we're not
3 expected routinely to go to the courts or to the custody
4 suites to provide assessments, but certainly there would
5 be cases where it would be appropriate to provide an
6 assessment. I'm thinking specifically about the gravity
7 of an offence, particularly given the importance of
8 having a snapshot of the mental state examination as
9 close to the material time as possible.

10 Q. It is important to have a mental state examination close
11 to the material time of offences, isn't it, to
12 understand the state of mind at that time?

13 A. Yes, the sooner that you can provide that assessment,
14 the more helpful it is.

15 Q. So in what circumstances would the nurse-led service
16 contact you, or where has that been considered to be
17 expanded? Because it's recognised it's a forensic
18 psychiatrist who would be better placed to do that?

19 A. Yes, so, as I say, it is a nurse-led service and they
20 would get in contact with me if they have any concerns
21 about a person's mental state, if they want support
22 around the decision making as to whether or not they're
23 going to divert that person to hospital, whether they
24 need support to refer that individual to the home
25 treatment team, whether they need support in terms of

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1 Q. Would you need, to do such an assessment, additional
2 information around the person? Assume they co-operated
3 with you, but that's not a given in such circumstances.
4 What other information would you need to be able to do
5 an effective mental state examination for a particular
6 day in time in those circumstances, someone with
7 a mental health history, and in a custody suite?

8 A. So gathering as much collateral information as possible
9 prior to seeing them. If they're not cooperating or
10 allowing you sort of access to their mental state then
11 you can rely on things like their -- the other aspects
12 of the mental state like appearance and behaviour,
13 whether their speech is coherent, evidence of them
14 appearing distracted or perplexed or responding to
15 unusual stimuli, and then that would be important
16 information to hand over to the mental health inreach
17 team in the prison because they would be the ones that
18 would then need to take over if we have concerns about
19 that person's mental state.

20 Q. If you had concerns about medication you'd be able to
21 ask about medication history if they needed medication
22 there and then or not.

23 A. Exactly, and that -- all of that information crucially
24 needs to go to the inreach team in the prison because
25 that's where that person is likely to be heading.

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1 Q. Going to. Mm-hm.
 2 Going back to risk assessment documents, please,
 3 NHFT0000168, page 17. You looked at the progress notes,
 4 and this is one of them -- there were many that you
 5 flagged up in your summary and your timeline -- pointing
 6 out that as we see underneath "Risk assessment", records
 7 in June referring to "there have been no incidents of
 8 violence yet."
 9 A. Mm.
 10 Q. What do you say about that? You picked that up as
 11 something that's recorded. What do you say?
 12 A. So -- sorry, what's the date of this entry?
 13 Q. June 2020, so after the events we've spoken about in
 14 the flat.
 15 A. So violence, as far as the HCR-20 concerned, is not just
 16 physical harm, it includes attempted or threatened
 17 violence. So certainly by that point there would have
 18 been incidents of violent acts with at least one person
 19 sustaining a physical injury as a result, and likely
 20 psychological harm to the people in whose house he
 21 entered.
 22 Q. You also, if we go, please, to NHFT0000168, page 58,
 23 note that some details should have been incorporated
 24 into risk assessment documentation but didn't; they just
 25 appeared elsewhere in the progress notes. So for

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1 mind being taken over and wanting to exact retribution
 2 on others for those responsible. So that was
 3 a motivator; is that right?
 4 A. I believe it was a motivator, yes.
 5 Q. And also on occasions, as you say, and certainly with
 6 this first episode, reference to his family being harmed
 7 as well.
 8 A. Absolutely. That's a running theme throughout all of
 9 the presentations, I think.
 10 Q. The retribution for those who have caused the harm and
 11 taking over his mind around him, that's a very real
 12 theme, isn't it, through the records?
 13 A. Yes.
 14 Q. You've identified it, the retribution point is
 15 significant, isn't it, in the context of assessing
 16 violence risk, why he wants to get to people --
 17 A. Yes.
 18 Q. -- that are around him?
 19 A. Yes, I think in assessing risk of violence, as I say,
 20 you think about the attitudes that they have, but you
 21 also want to explore the types of affects or emotions
 22 that accompany those delusional beliefs or hallucinatory
 23 experiences, and if they're associated with things like
 24 anger and wanting retribution, then that would be
 25 a concern that they might enact violence in response to

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1 example, here, where it's pointed out VC "minimised the
 2 potential risk to others ... did not fully acknowledge
 3 the risks of his actions to others especially when this
 4 had happened at his last admission", "concerning ...
 5 [VC] was unmoved or unfaced regarding his actions".
 6 Why do you say this sort of material should be
 7 contained within risk assessment documentation?
 8 A. Because it's important to explore the individual's
 9 attitudes to violence and whether there are antisocial
 10 attitudes in relation to that, so minimisation, so his
 11 referring to the incidents as "mild", for example.
 12 I just want to clarify that when I talk to
 13 antisocial attitudes I don't necessarily mean that's
 14 linked to an antisocial personality disorder, and
 15 I think his minimisation or rationalisation, which are
 16 these unhelpful attitudes, I think that can be
 17 understood in the context of how acutely paranoid and
 18 how distressing these paranoid delusions were. He felt
 19 he was taking these actions to save members of his
 20 family.
 21 But it is concerning that he isn't able to reflect
 22 on the impact that his behaviour has on other people or
 23 is being -- or that those attitudes aren't being
 24 challenged.
 25 Q. And you comment later that he was concerned about his

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1 the psychosis.
 2 Q. That can come down, thank you.
 3 You mentioned HCR-20, we had evidence yesterday
 4 afternoon about the value of that tool and it clearly
 5 takes some time; do you use that tool?
 6 A. Yes.
 7 Q. How long does it take for you to use it?
 8 A. So we try and complete HCR-20s as a team, it's an
 9 opportunity for people to come together and think it
 10 through together. One person might do the collation of
 11 the information in one area, somebody might look at the
 12 other items. It's often led by the team psychologist,
 13 and then we think through the formulation and risk
 14 scenarios together.
 15 Q. And the planning and risk management planning?
 16 A. Yes, and that's quite an involved process. It does take
 17 time.
 18 Q. Do most forensic services use that and have that
 19 available to them?
 20 A. Yes, yes, and it would be an expectation to complete
 21 HCR-20s, certainly as part of the admission process, so
 22 within the first few months of admission, and then they
 23 get updated usually at CPOs.
 24 Q. How would people in community psychiatry identify those
 25 who need to be referred to forensic services and to have

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1 such detailed assessment?

2 **A.** Yes, we have a forensic consultancy service, so there is
3 a policy for that which outlines what the referral
4 criteria are. If there's an individual where there are
5 concerns about risk to others, or offending, or there's
6 an offending history and it's believed that -- or it's
7 suspected that the violence is arising from a mental
8 disorder, then that would be the -- that would be
9 criteria for a forensic consultancy referral.

10 **Q.** In relation to the 2020 admission to hospital for VC,
11 first occasion he was released, of course, he was
12 detained on the second occasion -- what's your view
13 about him being released on the first occasion when he
14 then went out and committed another offence?

15 **A.** I think it's important to bear in mind that this was his
16 first presentation, and you want to avoid those more
17 restrictive interventions. I can't speak for the
18 rationale of the individuals who made that decision, but
19 you're essentially sending that person back to the
20 environment that was exacerbating their paranoia. Yes,
21 the Home Treatment Team were involved, but we already
22 knew that he was experiencing distressing voices, and
23 believed them to be real, and that there was a risk that
24 he could act on them.

25 So I think it could have been possible for that

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1 I mean VC's mother is a general nurse, she's not
2 a mental health nurse, but she raises it -- is that
3 common, that people around somebody where they are
4 worried about: well I've looked at that kind of thing
5 and you need to take it seriously?

6 **A.** It's not common, no. I mean, obviously we invite
7 suggestions and want to hear the views of family
8 members. It isn't common to have a suggestion like
9 this this early on in the presentation, but I guess it
10 speaks to the fact that she may have had concerns about
11 his -- him reliably taking medication.

12 **Q.** We see in the blue writing:
13 "Incomplete re: capacity & [patient] reported
14 scores."
15 Is that what PT is? But "capacity" I really want to
16 identify there:
17 "Incomplete re: capacity."
18 We've had evidence today about issue, specific
19 capacity issues around ability to understand the
20 implications of taking medication, for example. Is that
21 something you considered going through it: whether
22 anyone had actually assessed his capacity to understand
23 and weigh up the advantages and disadvantages of taking
24 medication?

25 **A.** There were references to having capacity or not having

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1 decision to have been a bit more risk informed.

2 **Q.** At that point, the risk, the person giving the
3 information about the risk was he himself, wasn't it,
4 and potentially, I suppose, those who had been around
5 him at the time of the first incident?

6 **A.** Yes, yes.

7 **Q.** Going back to your notes, please, to CQCM0010415,
8 page 6. You identify at page 6 in the third paragraph,
9 VC's mother joining a ward review. This was
10 21 July 2020:
11 "She queried [the] use of depot but VC replied he
12 didn't need to make [the] decision then."
13 First of all, the role of families, carers,
14 supporters in treatment and understanding a patient, how
15 would you describe that? How important is it, the input
16 of somebody in her position who knew her son and was
17 giving that information?

18 **A.** I think it's absolutely vital for all our patients, but
19 particularly those for whom there are concerns that they
20 are masking or not necessarily giving you the full
21 story, particularly when it comes to things like
22 compliance with treatment, and I think it is striking
23 that one of the first references to depot use did come
24 from VC's mother.

25 **Q.** In your experience, is that common, that patients --

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1 capacity but I didn't see very much evidence in terms of
2 an actual capacity assessment exploring the individual
3 limbs for the Mental Health -- Capacity Act, and I'm
4 thinking specifically about capacity to consent to
5 medication.

6 **Q.** Yes.

7 **A.** I think for somebody whose psychotic illness is
8 characterised by such limited insights, I think it is
9 important to focus down on the capacity assessment and
10 to think particularly about the individual's ability to
11 understand the need for treatment and their ability to
12 weigh up what would happen if they took it, what would
13 happen if they didn't take it, and the pros and cons and
14 being able to weigh that up. And I suspect that for
15 somebody whose insight remained so limited, who held on
16 to those beliefs with such conviction, I had concerns
17 that actually he didn't have capacity, at times.

18 **Q.** Dr Dissanayaka gave evidence yesterday. I don't know if
19 you heard any of that evidence or know about the Leeds
20 outreach work in the community, but his evidence was
21 that you would, in discussing taking medication, also
22 discuss and engage with the issues of the risk, the
23 risks of violence and the violence that had happened,
24 what significance it had. What do you say about that?
25 Would you address head on, I'm sure in an appropriate

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1 way, but would you address head on the incidents that
 2 had happened and their impact on others?
 3 **A.** You do need to address them head on and there are ways
 4 to do that sensitively and empathically and taking into
 5 consideration how distressing the paranoid psychotic
 6 symptoms are, but I don't think you're serving the
 7 individual well if you're not considering the risk of
 8 harm they might pose to others if they're not taking
 9 medication.
 10 **Q.** Why is that? Because we heard evidence him from Mr Alex
 11 Ruck Keene King's Counsel, a lawyer, who said best
 12 interests is generally determined to be best interests
 13 for the patient around what's happening, detention or
 14 being a patient.
 15 It sounds as though you would see best interests or
 16 potentially reflecting that their not committing acts of
 17 violence was also something relevant to the patient's
 18 interests? Would you say it was or not?
 19 **A.** You would certainly want to explore their thoughts and
 20 attitudes around the violence and what in their mind is
 21 driving that violence, and what, in their mind, might
 22 help them to avoid those sorts of incidents again.
 23 Part of a risk assessment, as I say, is exploring
 24 how the person understands their violence and what
 25 purpose it's serving, and also their ability to link the

1 So I think communicating in that way to the
 2 community team is crucial.
 3 **Q.** Page 8, please, "Concerns in [the] community",
 4 October 2020?
 5 Again, you flag up 24 October:
 6 "Mother called again to say that she was concerned
 7 [he] was not communicating with her or his father, and
 8 requested ... staff visit."
 9 That's on the 24th. Then underneath you've
 10 recorded:
 11 "... the inpatient Consultant who looked after VC
 12 during both admissions reported that VC had been in
 13 contact with him."
 14 This is at a point, of course, when VC is in the
 15 community.
 16 "He advised VC he could not be involved in his care
 17 and encouraged him to contact his community team ..."
 18 What did you take from that and what would you
 19 expect to happen following that, a patient contacting
 20 somebody in that situation in --
 21 **A.** I think it is significant that VC sort of makes his way
 22 back to hospital or tries to get in contact with the
 23 consultant that was looking after him. It suggests that
 24 he's struggling with his experiences, perhaps, or trying
 25 to make sense of them at least, and that would have been

1 violence to their mental state. But for -- in this case
 2 I think it is -- it would have been -- I think it would
 3 have been very challenging for the team, because VC
 4 never really I don't think bought into the idea that
 5 these experiences were symptoms of an illness.
 6 To him, this were -- these were things that were
 7 happening, that his family was in danger. This is the
 8 impression that I got from reviewing his -- the notes.
 9 So I think it would have been difficult to explore those
 10 things without having kind of a foundation of basic
 11 psychoeducation around the symptoms and their meaning.
 12 **Q.** Page 7, please, at the top. You refer to:
 13 "... no evidence of a handover meeting with the
 14 Crisis Team or with the EIP Team ..."
 15 What's the importance of handover meetings and
 16 communication?
 17 **A.** I think it's important to provide them with an
 18 understanding of the patient's current mental state and
 19 in particular what the risks would be. In these
 20 circumstances, this would have been the second
 21 discharge, so there would have been the experience of
 22 the medication non-compliance. So it would have been
 23 important for them to be aware of how the -- what kind
 24 of understanding VC had reached about his symptoms and
 25 his attitude to continuing medication.

1 an opportunity to explore them with him. It sounds as
 2 though he wants to talk about something about his
 3 experiences.
 4 **Q.** One of the pieces of evidence we heard yesterday was the
 5 importance of having a larger team and not a single
 6 point of contact or single person for a patient, whether
 7 it's in the community with a care coordinator or
 8 a doctor. What do you say about that? Is it important
 9 that it's not a single figure that's identifiable to the
 10 patient?
 11 **A.** I think it is helpful, for very complex individuals, for
 12 there to be sort of multi-disciplinary team thinking
 13 around them and for people to have knowledge, but
 14 I think that is a challenge in a general adult community
 15 team, given the caseloads -- caseload sizes. It might
 16 be difficult to sort of familiarise yourself with
 17 everybody on the caseload. So perhaps by necessity you
 18 are allocated the one care coordinator but of course
 19 they need to be communicating with other team members,
 20 particularly, you know, if they're not around.
 21 So what you're describing would be helpful, but
 22 might be outside of what can be provided with the
 23 resources of a standard community team.
 24 **Q.** Page 10, please, "Concerns raised by mother May 2021".
 25 Three bullet points, you set out mother's concerns about

1 possible deterioration in VC's mental state. He's not
 2 making sense when she spoke to him.
 3 "Crisis Team called him and reported no concerns,
 4 denied hearing voices or any worrying thoughts. ...
 5 reported he was fully compliant with treatment."
 6 We see 2 June:
 7 "Seen by care coordinator and denied any concerns
 8 regarding his mental state or medication compliance."
 9 At this point do you consider it was becoming a bit
 10 familial, this report, report from parent, report from
 11 those visiting him, and most importantly what VC was
 12 saying himself in terms of not understanding the
 13 position he was in?
 14 **A.** Yes, and I think it does come across in the notes that
 15 there are concerted efforts from the family to raise
 16 concerns about both his mental state and their concerns
 17 that he might not be taking medication, because he was
 18 clearly giving the community team a different picture.
 19 I mean it's right that they met with him and tried
 20 to explore these things. It's difficult when you have
 21 an individual that's prone to masking their symptoms.
 22 But yeah, I agree. It is a concern that the individuals
 23 that do know him well with whom he is perhaps speaking
 24 a little bit more openly are raising --
 25 **Q.** Saying he's not making sense.

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1 didn't think it was going to make a difference.
 2 And evidence as well that he was suggesting in
 3 hospital that he was taking it in order to sort of
 4 effect a speedier discharge.
 5 **Q.** Pausing on that point, what's the significance of that
 6 when a patient is saying it? You recognise that they're
 7 just doing it to get out of hospital? Does that really
 8 give you any reassurance that they're going to comply
 9 when they are out of hospital?
 10 **A.** I think you'd need to look at the trajectory all
 11 together and to think about firstly their insight and
 12 what their understanding is of why they're needing to
 13 take medication. You'd need to look about episodes of
 14 them discontinuing it and why. And I think it's
 15 important to sort of stay curious when people are
 16 assuring you that they're going to take medication in
 17 the community.
 18 I appreciate that this might be easier to say now in
 19 retrospect but it's really not uncommon for individuals
 20 to mask their symptoms or to reassure teams that they're
 21 going to take medication.
 22 Being in hospital is distressing, it's highly
 23 restrictive, and I think it is understandable that
 24 people want to get out of hospital.
 25 **Q.** Third admission, page 12, set out, if we can have 12 and

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1 **A.** Yeah, yeah.
 2 **Q.** Dr Dracass gave evidence earlier. Did you hear her
 3 evidence?
 4 **A.** Much of it, yes.
 5 **Q.** Did you hear what she said about medication? First of
 6 all my question for you: did you get any real clear
 7 sense of when he was and wasn't on medication?
 8 The Inquiry obviously has more resources to examine
 9 that and more time but, as you were looking at this,
 10 what was your broad overview of his medication, both
 11 what he was prescribed, how often he was prescribed it,
 12 and whether you had any sense of how he was responding
 13 to it?
 14 **A.** Looking at the two years together, I think that with the
 15 exception of periods when he was in hospital, I don't
 16 think his medication compliance can be completely
 17 assured. I don't think we can be clear that he was
 18 adhering to medication in the community. There are --
 19 there is a lot of evidence of him retrospectively saying
 20 that "I stopped medication as soon as I was discharged
 21 from hospital."
 22 There's evidence of him talking to family and
 23 complaining about side effects or at least informing
 24 them that he wasn't taking medication. There's evidence
 25 that he was saying to his care coordinator that he

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1 13 next to each other, details of that admission:
 2 "... in seclusion ... guarded, hostile ... unwilling
 3 to engage."
 4 And the discharge summary you set out. What do you
 5 say about his discharge and the risk assessment level
 6 and risk of non-compliance noted?
 7 **A.** Sorry, which section?
 8 **Q.** Page 13.
 9 **A.** 13?
 10 **Q.** Do you agree, where was he, as far as you're concerned,
 11 at this point in terms of risk assessment?
 12 "[He's] ... noted to have extreme levels of violence
 13 and aggression on admission ..."
 14 This is after he's assaulted the police officer on
 15 3 September.
 16 **A.** Yeah, okay.
 17 **Q.** I think you comment in your report about where risk
 18 assessment does or does not refer to that.
 19 As a matter of interest, did you see the body-worn
 20 video footage of that assault?
 21 **A.** No, I didn't.
 22 **Q.** If you are treating patients, would you seek access to
 23 that kind of material? Because there was body-worn
 24 video footage of a number of events, certainly this one
 25 and the one referring to Christopher later. Would you,

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1 as a forensic psychiatrist, be interested in looking at
 2 that for yourself to see what you made of the behaviour?
 3 **A.** Yes, and we are usually able to access that sort of
 4 information, witness statements, transcripts from police
 5 interviews, CCTV or body-worn footage as part of the CPS
 6 bundle when people are first admitted.
 7 **Q.** He wasn't, of course, charged and prosecuted here at
 8 this point --
 9 **A.** Yeah.
 10 **Q.** -- so that footage wouldn't have been available as part
 11 of a concluded criminal case or one that was far enough
 12 ahead, frankly. But it was available. So is it
 13 something you would think to ask about whether, even
 14 pending proceedings, it might be something without
 15 prejudicing the trial you could look at for yourself to
 16 see what you needed to do in terms of treatment or
 17 something?
 18 **A.** It might be helpful. If I was on a busy, acute ward, it
 19 may not occur to me to ask for that information, but
 20 yeah, it certainly would be helpful, and the description
 21 of the incident and the sort of what was needed to
 22 subdue him as part of that admission process, it
 23 certainly shows that there was a significant amount of
 24 aggression. So, yeah. -- (*overspeaking*) --
 25 **Q.** I think somewhere you have referred to that event, you

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1 elicited during that period around his insight, his
 2 non-engagement, the medication refusal.
 3 I think if, during that period, that -- all of those
 4 concerns which had accumulated over that period had been
 5 taken into account by the admitting team during
 6 admission three, it may be that he wouldn't have been
 7 discharged still on oral aripiprazole.
 8 **Q.** Are you critical of the medication he was prescribed?
 9 **A.** I think, by -- I mean, I speak about this a lot in the
 10 risk formulation and the sort of preventability
 11 document. I think it's clear that -- so first thing to
 12 say is that it's, even now, it's very difficult to
 13 determine if his symptoms actually were resistant to
 14 aripiprazole treatment, because I don't think he was
 15 adhering to it reliably for long enough to be able to
 16 say, actually, aripiprazole is not working, we need to
 17 try something different.
 18 I think, despite that, there is evidence in that
 19 year in the community where the aripiprazole dose was
 20 gradually being increased, and yet he was coming back
 21 and saying, "The voices are there all the time, they're
 22 there all day without a break. It feels like things are
 23 worsening."
 24 So it would have been appropriate to consider an
 25 alternative to aripiprazole, explore that option with

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1 don't just refer to it as headbutting, you refer as well
 2 to using the handcuffs as a weapon or something. You've
 3 picked up the detail of that. Again, is that your
 4 forensic background, to look at the details, specific
 5 details and compare them with what is said elsewhere?
 6 **A.** I think that is significant, his opportunistic use of
 7 a weapon. He was clearly very distressed and paranoid
 8 during this incident, completely insightful, it would
 9 appear, in the weeks leading up to that. That comes
 10 across very clearly from the care coordinator's
 11 assessments. But yes, it is important information.
 12 **Q.** The fourth admission, you deal with that at page 18, 19
 13 and 20 and 21. Again, you are critical in the report of
 14 the discharge of that admission; is that right?
 15 **A.** The third admission?
 16 **Q.** Sorry, the third admission.
 17 **A.** Yeah, I think that third admission -- the discharge
 18 process for that, him being discharged without -- sort
 19 of being discharged on a Friday without the knowledge of
 20 the community team, I think even before that, I think it
 21 was important to gain the insights of the community team
 22 and get their steer on the discharge planning process.
 23 Ultimately they knew him the best by that point,
 24 especially in that year that he was in the community,
 25 there was a lot of really important information that was

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1 him.
 2 I think, by the point of the third admission, given
 3 what we call the revolving door nature of these
 4 admissions, so the repeated episodes of relapse of his
 5 psychotic illness or exacerbations of his psychotic
 6 illness, and the violent incidents that accompanied
 7 those relapses and therefore the importance of
 8 maintaining his mental stability in the community,
 9 I think it would have been important to consider --
 10 well, to think: how can we ensure medication -- how can
 11 we assure medication adherence in the community?
 12 Because that's clearly vital in terms of mitigating risk
 13 to others.
 14 At that point, one would start thinking about
 15 a depot antipsychotic. And it is evident that the care
 16 coordinator was, I think, at points trying to advocate
 17 for a depot during that third admission, and I think
 18 that view needed to have been given more weight.
 19 **Q.** That can come down now, please. And can we have
 20 CQCM0010414, page 1. This is your review of risk
 21 assessment. You do three more documents. This review
 22 of risk, other relevant factors, and then preventable.
 23 Did you give yourself the headings? How did you
 24 categorise this?
 25 **A.** I gave myself the headings, I think, and this was just

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- 1 a report on -- oh sorry, do you mean the 1, 2, 3?
 2 **Q.** No, not 1, 2, 3 here but within your headings of
 3 preventable, predictable -- (*overspeaking*) --
 4 **A.** Oh, so that was on the instruction of the CQC. Those
 5 were the specific questions that we were tasked with.
 6 **Q.** So if we look at risk assessment and we look at page 2,
 7 by the time of the second admission, what are you
 8 criticising in respect of what should have been
 9 formulated in overall risk?
 10 **A.** So I think there needed to have been clearer
 11 documentation of the seriousness of these incidents, and
 12 the physical harm that had resulted from some of VC's
 13 acts, both physical harm but also psychological harm, in
 14 relation to the second admission.
 15 The fact that some of the dynamic risk factors
 16 hadn't been captured, so the non-compliance with
 17 medication on discharge, and the fact that symptoms
 18 appear to have persisted during that time in the
 19 community. Yeah. So it was mainly the dynamic factors
 20 that I didn't think -- hadn't been captured, and also --
 21 **Q.** Page -- sorry, go on.
 22 **A.** Oh and also the -- sort of how distressing the psychotic
 23 symptoms were, which in turn led him to rationalise some
 24 concerning acts.
 25 **Q.** Page 3:

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- 1 the police, for you it would be presumably prisons and
 2 probation as well, how easy is it to share information
 3 between you and those organisations about events that
 4 may not have reached the courts but are significant in
 5 terms of what we're talking about?
 6 **A.** I think it can -- if the person -- it's different if the
 7 person has been charged and criminal justice proceedings
 8 are under way, and you're involved in the case, then in
 9 those instances it's not too difficult. Where I run
 10 into challenges is when I'm carrying out forensic
 11 consultancy assessments, and it's difficult, sometimes,
 12 to get an accurate picture of the full risk history.
 13 Sometimes it can be very difficult to obtain PNC
 14 records. We do have a security team and a police
 15 liaison who can help support with that, but it can be --
 16 it can still be difficult to get hold of that
 17 information.
 18 **Q.** Page 6, please.
 19 You set out at the bottom:
 20 "He [was] clearly non-compliant with medication even
 21 under home treatment ... he was avoidant ..."
 22 He was of course, you recognise, met by care
 23 coordinators "in public area/outside shops".
 24 **A.** (*The witness nodded*).
 25 **Q.** "... on ... occasion seen spitting medication out of his

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- 1 "The summary notes no forensic history, [and] in
 2 fact ... had been charged with criminal damage for
 3 attempting to gain entry to a neighbour's flat ..."
 4 Now it may be -- and we will find out of course from
 5 those who were doing the risk assessments -- they
 6 thought that criminal damage is an insignificant
 7 criminal offence in terms of other offences, and that's
 8 how it was recorded.
 9 One, it demonstrates the need for proper and
 10 accurate records, doesn't it? Because who's been
 11 affected, the impact psychologically and physically, is
 12 really important.
 13 **A.** Yes, you'd want to try to have a brief narrative of what
 14 actually happened.
 15 **Q.** Secondly, even if he hadn't been engaged in the criminal
 16 justice system at that time, as far as those treating
 17 him are concerned, these acts are to be taken seriously
 18 and, as they had occurred, and there's other ways of
 19 getting information about them to ensure their accuracy,
 20 isn't there?
 21 **A.** Yes, and accuracy is important when documenting -- when
 22 you're collating all the information into a risk
 23 assessment or an HCR-20.
 24 **Q.** In terms of a multi-agency working and getting
 25 information from the police in your role now, not just

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- 1 mouth as he walked off ..."
 2 Then if we go to page 7 under "Community consultant
 3 involvement", you record:
 4 "Much of the liaison with the inpatient teams and
 5 direct contact with VC fell to his care coordinator
 6 meaning this relationship came under pressure and
 7 ultimately broke down."
 8 How could that situation have been avoided with
 9 a single care coordinator? You've said what the
 10 pressures are on community teams, but how else -- he's
 11 in the community, there's no way he can be forced at
 12 that stage by the community team, at least, to engage
 13 him in medication -- how else should the community team
 14 have managed that situation, and the single care
 15 coordinator's pressure?
 16 **A.** I think, without a legal framework such as a CTO,
 17 I think it would be difficult. I think the first thing
 18 to say is that you do get the sense that the care
 19 coordinator worked hard to try and build a therapeutic
 20 relationship with VC. And I think it was around the
 21 third admission as part of her completing the social
 22 circumstances report which VC was very unhappy about, he
 23 felt that things had been misrepresented, and began to
 24 really mistrust his care coordinator and became a lot
 25 more guarded and unwilling to engage with her.

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1 I think it is important to have full
 2 multi-disciplinary team involvement for somebody as
 3 challenging as this, somebody who is as, I guess, so
 4 able to evade services and --

5 **Q.** Shall we go to page 8, because you pick both of those
 6 points up there? Page 8 in the bottom paragraph, and
 7 talking about the community team. You say:
 8 "... [they] discouraged discussion around his
 9 previous violence which is a crucial part of addressing
 10 future risk."

11 You touched on this earlier. Do you think that's a
 12 surrounding concern about having a complete breakdown in
 13 the relationship? So to hold onto the single thread
 14 that you have, you don't want to do that?

15 **A.** Yeah, I think if you are going to try and have these
 16 difficult conversations with patients, it needs to be
 17 after you've built a foundation of a trusting
 18 relationship, and that does take time. It takes a lot
 19 of time, and that may not have been a luxury that the
 20 community team members and a busy EIS team would have
 21 had, perhaps.

22 As I say, I think it is important to encourage
 23 people gently to reflect on their behaviours when
 24 they're unwell, and I don't think it's helpful to avoid
 25 those difficult conversations. But I appreciate they

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1 **Q.** You also -- that can come down, please, and can we have
 2 CQCM0010416, page 1. Incident in June and whether this
 3 was predictable. You say:
 4 "... it was almost certain he would discontinue his
 5 antipsychotic treatment ..."

6 Then paragraph 3:
 7 "Thus untreated, it was to be expected that he would
 8 experience further acute episodes of psychosis."

9 And on the last paragraph:
 10 "Based on his history of violence to others when
 11 unwell it was predictable that any future acute relapse
 12 of his psychotic illness would have been associated with
 13 threatened or actual violence to others ..."

14 Over the page at page 2:
 15 "Based on the above it is possible to therefore
 16 conclude that VC was highly likely to present again with
 17 violence to others in the context of his known untreated
 18 psychosis."

19 Do you want to add anything to that or anything that
 20 at this point leads you to have a different opinion to
 21 that?

22 **A.** I don't have a different opinion to that and I think in
 23 thinking about this, I didn't complete an HCR-20 scoring
 24 but I did lean heavily on the C&R items and also --

25 **Q.** C&R?

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1 are very difficult conversations to have.

2 **Q.** You also say in the paragraph above:
 3 "In the absence of criminal charges, a referral to
 4 Multi-agency Public Protection Arrangements (MAPPA)
 5 would have provided an appropriate forum for discussion
 6 and liaison with The Criminal Justice System."
 7 First of all, in your professional experience, how
 8 effective have you found MAPPA?

9 **A.** So because of the nature of the individuals that I work
 10 with, it's not difficult to make the case that they
 11 require MAPPA involvement. Again, when I involved in
 12 forensic consultancy assessments, and I encourage the
 13 team to make referrals to MAPPA, there can sometimes be
 14 resistance to that.

15 I think there is clear risk to the public that was
 16 posed, certainly by the point of the third admission, in
 17 the context of a mental disorder. So he would have met
 18 the criteria for MAPPA even though there hadn't been
 19 a formal conviction by that point.

20 **Q.** So in your view, by the third admission, come what may,
 21 the fact that the horrific events hadn't happened at
 22 that point didn't in any way eradicate or reduce the
 23 risk that he posed?

24 **A.** I think so, for MAPPA category 3, you wouldn't need
 25 a formal conviction for that.

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1 **A.** Sorry, so the current -- the current risks, so that's
 2 the C, the five items in the C bit of the HCR-20 and the
 3 R items, which is the risk management section, in
 4 combination with the kind of the full trajectory of the
 5 two years up until that point.

6 **Q.** Did that tool depend on knowing what had happened on
 7 13 June to describe the risk, or not?

8 **A.** I don't think so, no.

9 **Q.** No. So you were looking at what was known at the time
 10 in arriving at that?

11 **A.** Yes, and I think it's based on the fact that VC
 12 experienced four -- I don't know if we can call them
 13 relapses because perhaps the treatment wasn't -- the
 14 psychosis was never fully treated at any point but he
 15 certainly had four exacerbations of his psychotic
 16 presentation, and each one of those was not only
 17 associated with incidents of violence and either
 18 physical or psychological harm, but they also sort of --
 19 he presented with very similar themes. And by the time
 20 he was discharged from the community team, he would have
 21 been at least three months completely medication-free.

22 So there would have been a high likelihood of him
 23 having a further exacerbation of these psychotic
 24 symptoms. And based on the trajectory up until that
 25 point, I felt that there was a significant risk of

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1 further relapses being associated with violent acts.
 2 Just because of the nature of the psychosis, his
 3 attitudes to his psychotic experiences, which he never
 4 acknowledged were psychotic experiences, and the
 5 distress that this caused him --
 6 **Q.** When you say he acknowledged psychotic experiences,
 7 because he could hear the voices, he just thought it was
 8 different cause?
 9 **A.** Sorry, what do you mean?
 10 **Q.** Would you say he'd acknowledged psychotic experiences?
 11 **A.** I don't think at any point did he truly understand and
 12 accept that these really distressing experiences that he
 13 was having, I don't think he ever understood that these
 14 could be, or -- I don't think he was ever convinced of
 15 the fact that these could be symptoms of a mental
 16 illness for which medication had an important role.
 17 **Q.** Understood. That can come down, please, and if we can
 18 have CQCM0010417. "Whether the Index Offence of
 19 June 2023 was preventable".
 20 Could you expand please on --
 21 **A.** Sorry, did we -- I just want to add that the final line
 22 in the predictable --
 23 **Q.** Do you want to go back to that?
 24 **A.** Yes.
 25 **Q.** So that was, sorry, CQCM0010416, page 2.

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1 paranoid psychosis, the crucial intervention for
 2 minimising the risk he posed was ensuring assertive and
 3 consistent medical treatment of his psychotic illness
 4 and close supervision of his compliance with treatment."
 5 So how do you say that should have been done? What
 6 should have happened?
 7 **A.** So on the basis that it is psychosis that is the
 8 principal driver of violence in VC, I guess the most
 9 important intervention to mitigate risk to others would
 10 have been assertive consistent treatment of the
 11 psychotic symptoms. And given the fact that he had
 12 demonstrated challenges, challenges with adherence in
 13 the community, so despite the efforts of the community
 14 team to engage him on an informal basis with oral
 15 treatment, that had still resulted in four exacerbations
 16 of his psychotic illness.
 17 I think, by admissions three and four, I think that
 18 the rationale or the criteria for -- the indications,
 19 rather, for a depot antipsychotic, that was clearly
 20 necessary by that point. It would be difficult to see
 21 how his psychosis could be assertively treated, given
 22 his limited insight without a depot antipsychotic.
 23 **Q.** When you say: "On the basis his violence was motivated
 24 by paranoid psychosis", when you see patients with
 25 paranoid psychosis, do you assess or consider

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1 **A.** So I believed that there is a high risk of violence
 2 associated with future episodes or exacerbations of his
 3 psychosis because those were circumstances where
 4 violence was known to emerge. But I certainly don't
 5 believe that it was predictable that the violence he'd
 6 ultimately enact would be of this nature, this
 7 catastrophic, or involve fatal attacks. I don't think
 8 any risk assessment could reliably predict that, and
 9 outcomes such as this are extremely rare, which makes
 10 them difficult to predict.
 11 So the violence would have been more akin to what we
 12 had seen up until that point. There was no way to
 13 predict that the events of June 2023 were going to
 14 happen.
 15 **Q.** But you're clear that the violence and the risk of
 16 violence was significant enough, without knowing of the
 17 actual events of the 13th, to require different
 18 treatment, different response.
 19 **A.** Yes, yes, and I guess I come on to that more in the
 20 preventable.
 21 **Q.** Yes, so if we go to that please CQCM001417, page 1, and
 22 that's paragraph 3. Can you expand on that for us,
 23 please?
 24 **A.** Sorry, could we have --
 25 **Q.** "On the basis that his violence was motivated by his

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1 personality disorder or traits as well at the time?
 2 **A.** Yeah, that's part of the --
 3 **Q.** Part of the --
 4 **A.** Part of the assessment, yes.
 5 **Q.** Can you find co-morbidities?
 6 **A.** Yes, particularly in the forensic population, yeah. You
 7 can. I didn't see, if I'm honest, I didn't see
 8 convincing evidence of precursors of an antisocial
 9 personality disorder in the personal history, or
 10 features of anti-sociality in his interactions with the
 11 team.
 12 **Q.** Is it possible in any event that paranoid psychosis
 13 could mask any underlying personality issues in -- or
 14 not?
 15 **A.** I think it's about trying to understand the meaning of
 16 the violence for an individual, and the circumstances
 17 and scenarios where you're seeing it arise. If you are
 18 seeing it arise in the context of these psychotic
 19 illness exacerbations and not outside of that, and not
 20 preceding the first onset of psychosis in 2019, 2020,
 21 I think it would be very difficult to make the argument
 22 that there were antisocial personality traits.
 23 **Q.** Can we go then, that can come down, to your statement,
 24 please, and have that on screen. WITN0425001, page 9,
 25 paragraph 34, and you, dealing with formulation, say at

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1 paragraph 34:

2 "This reflects the core formulation set out in my
3 report on risk formulation, which identified untreated
4 paranoid psychosis as the primary factor mediating
5 violence risk ..."

6 Why was this your core formulation of untreated
7 paranoid psychosis?

8 **A.** That paranoid psychosis was the primary --

9 **Q.** Driver?

10 **A.** -- driver?

11 **Q.** Mm-hm.

12 **A.** The nature of the paranoid psychotic symptoms and the
13 very clear link between the distress that they caused
14 him and the content of them with the actions that he
15 took. I mean, he wasn't, from the description that he
16 provided, he wasn't assaulting people at this point
17 during the two years I'm thinking about. In the
18 two years that he was under services, there wasn't
19 evidence of him assaulting people at random or outside
20 of these distressing paranoid convictions that he was
21 being controlled or that his -- or the hallucinatory
22 experiences that he was having.

23 You would -- there could be other drivers of
24 violence, like substance misuse, antisocial personality
25 traits, instabilities and the person's affect or

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1 "... collective multi-disciplinary team
2 thinking/risk formulation bringing together .. [those
3 with] experiences and concerns ..."

4 Who would be the lead convener for that kind of
5 discussion?

6 **A.** So I guess in stating that, I was thinking about case
7 formulation -- formulation meetings or case management
8 meetings. For individuals as complex as VC, who by this
9 time had displayed a lot of challenges around
10 non-adherence, poor insight, the disengagement from the
11 team, the incidents of violence, you'd -- you would
12 expect that there would be sort of the team coming
13 together to think through what was going on with this
14 individual and what we could be doing a little bit
15 differently to stop these repeated cycles of admission.

16 Perhaps it wasn't -- perhaps it was documented
17 elsewhere, but I couldn't see a risk formulation meeting
18 or an MDT meeting discussing VC, and in terms of who
19 would convene that, it would be -- the clinical
20 leadership would come from the consultant, but it might
21 be convened by the care coordinator or the team manager.

22 **Q.** He was a university student. Is it the sort of meeting,
23 multi-disciplinary meeting, where you'd expect
24 a university representative to be there as well, when
25 assessing --

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1 behaviour.

2 It's significant, as I say, that the nature of the
3 violence or the scenarios of the violence were informed
4 so closely by the content of the delusions that he was
5 having and the hallucinatory experiences that he was
6 having, certainly at this point in his illness.

7 **Q.** Do you think he should have been referred to forensic
8 services by the community treatment teams or even
9 inpatient teams?

10 **A.** I think somebody whose presentation and illness is
11 repeatedly associated with incidents of threatened
12 violence or actual violence, I think that would be
13 meeting the threshold for a forensic consultancy
14 assessment. And I think that could have gone some way
15 in supporting the team to think through these difficult,
16 finely balanced, decisions around depot, around CTO,
17 around coercive interventions versus least restrictive
18 safe interventions.

19 And, yeah, to have the decisions be made with risk
20 to others informing the plan a little bit more. And
21 it's just helpful to have somebody from outside of the
22 team just to take a fresh look and see it through
23 a slightly different lens.

24 **Q.** You say at paragraph 60, which is page 15, you speak
25 there of, at the top of the page:

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1 **A.** You'd want to gather certainly information from them,
2 but I'm thinking more about what are we -- let's look at
3 our management plan as a team and think about what we
4 might be doing differently to support him to stay in the
5 community, and stay well and stay safe for longer
6 periods.

7 **Q.** You also note in your timeline that he refuses
8 alternative psychological therapies, occupational
9 therapy and the like. With somebody with his illness
10 and the nature of it, what can be said or how can that
11 be encouraged, access and using those routes?

12 **A.** I think intervening early and offering these sorts of
13 interventions early is important. I think before
14 anything else you'd want to stabilise the mental state.
15 I think there was a reference in one of the Mental
16 Health Act assessments that even though he was very good
17 at masking symptoms, when his mental state was improved,
18 he actually did speak a little bit more openly about his
19 experiences and his symptoms.

20 There was evidence that he was trying to make sense
21 of some of his experiences by going to his consultant in
22 hospital, but also times where he asked to speak to
23 doctors in the community team. So I think there was
24 a part of him that was possibly curious about what was
25 going on with him.

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1 But yeah, it's very difficult, and while somebody is
 2 mistrustful of the team and is actively incorporating
 3 the team into their paranoid psychotic symptoms, it is
 4 going to be difficult to sit down with that person and
 5 to explore their insight and challenge their views about
 6 what might be going on.

7 **Q.** And page 21, please. "Recommendations", finally.
 8 Paragraph 91. You say:

9 "An appropriate body, such as the Department of
 10 Health and Social Care, NHS England or CQC, should
 11 produce guidance or minimum standards for NHS Trusts and
 12 other providers to incorporate in order to increase the
 13 robustness of their local disengagement policy and
 14 strengthen their processes for the discharge of
 15 patients, particularly those with Severe and Enduring
 16 Mental Illness."

17 You recommend or suggest that, do you, in the light
 18 of this case and others, in your general experience?
 19 Tell us why you say that.

20 **A.** I think it's also from my general experience, working in
 21 forensic psychiatry, this is not an uncommon consequence
 22 of events that you see at the point of somebody coming
 23 in to the forensic service following an alleged offence,
 24 there is a consequence of events that quite often
 25 includes disengagement -- discharge from a community

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1 management plans formulated where necessary -- whether
 2 this is in the context of MAPPA or not."

3 What are you envisaging there? There are sharing
 4 arrangements, or should be, aren't there, between Trusts
 5 and the police, sharing agreements. Is there some kind
 6 of monitoring or regular information sharing about those
 7 you're concerned about? What you're thinking about?

8 **A.** Information sharing for community teams who are trying
 9 to collate information for risk assessments, I think
 10 that can be more forthcoming.

11 I think the liaison with police, what I'm referring
 12 to here is the challenges that a lot of teams
 13 experience, both inside and outside the forensic
 14 service, in getting prosecutions progressed where it's
 15 appropriate and where it might actually help risk
 16 management in the long term. Sometimes that can be
 17 a very difficult, arduous process. Particularly if --
 18 I'm thinking of assaults on a ward, for example. It can
 19 be very difficult to progress those sorts of incidents
 20 to a criminal prosecution, even though they can be
 21 serious incidents.

22 There is often a suggestion that we need to be
 23 providing information on patient's capacity, capacity in
 24 quotes, I guess.

25 **Q.** What do you mean, "capacity in quotes"?

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1 team due to disengagement. And I think specifically for
 2 people with severe and enduring mental illness, where
 3 lack of insight is -- or it's symptomatic of what's
 4 going on, the decision to disengage from services,
 5 that's not being made by a rational capacitous choice.
 6 In fact, when people disengage, that might be when alarm
 7 bells should be going off rather than when they're
 8 discharged. And I do appreciate there were attempts by
 9 this team to engage him in the community before the
 10 discharge.

11 But where severe and enduring mental illness is
 12 concerned I think there needs to be clearer, more robust
 13 guidance around how you go about that process, and
 14 really thinking about the fact that people with this
 15 kind of disorder aren't -- they're not making that
 16 decision to disengage from a place of -- it's not
 17 a rational decision; it could be a symptom of the
 18 illness.

19 **Q.** And lastly:

20 "There should be a formal memorandum of
 21 understanding between the NHS and policing bodies to
 22 establish and/or strengthen police liaison functions
 23 with mental health providers. This should identify
 24 roles and responsibilities for ensuring that people who
 25 present with risks are appropriately discussed with risk

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1 **A.** So we are sometimes asked that question by the police:
 2 does the person have capacity to --

3 **Q.** Commit a criminal offence?

4 **A.** Yes, to carry out this assault. And there can be a --
 5 there can be a resistance to getting involved --

6 **Q.** Because you think, if you say, "Yes, they are able to
 7 understand what they're doing," you're making it
 8 difficult for the patient?

9 **A.** Well, I think it's not appropriate to pre-empt those
 10 sorts of decisions at that moment. Those are
 11 considerations for expert evidence further down the
 12 line. And I don't think the fact that somebody has
 13 a mental disorder should preclude police involvement in
 14 it, and that can be a difficult argument to make,
 15 especially for the community teams and for the general
 16 adult teams.

17 **Q.** Yet policing guidance makes that clear: that mentally
 18 disordered offenders, it doesn't mean -- doesn't excuse
 19 offending. There needs to be investigation. So do you
 20 think that works both ways: that the community teams, as
 21 well, there's a reluctance to get involved in that one
 22 way or the other, but if they do they're effectively
 23 saying, in quotes "no capacity, no ability" to commit an
 24 offence because of mental health difficulties?

25 **A.** Possibly and I guess you have to consider that the

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1 priority of a care coordinator in the community is
 2 trying to maintain the relationship that they have with
 3 the individual. But if there were processes where that
 4 didn't necessarily need to involve proactive sort of --
 5 the push isn't coming from the treating team to progress
 6 those sorts of prosecutions, that might be helpful too.

7 **MS LANGDALE:** Thank you. Those are my questions.

8 There will be more, Dr Ahmed.

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

10 Mr Moloney.

11 **Questioned by MR MOLONEY**

12 **MR MOLONEY:** I'll try to be brief, Dr Ahmed.

13 Can we look at CQCM0010414. It's a document that
 14 Ms Langdale has referred you to a number of times
 15 already, and to page 6 of that document, please, the:
 16 "Lack of corroborative evidence regarding illicit drug
 17 use" at the top of the page.

18 **A.** Yes.

19 **Q.** Do you remember this, Dr Ahmed?

20 **A.** Yes.

21 **Q.** You said you saw much of the evidence of Dr Dracass.

22 **A.** Yeah.

23 **Q.** Did you see Dr Dracass questioned about how it was that
 24 this may have been missed?

25 **A.** Yeah, I did.

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1 the same day and he was admitted on 24 May 2020?

2 **A.** Yes.

3 **Q.** So the relevant events had arguably started 30 minutes
 4 past midnight or just after midnight on 23 May.

5 **A.** Yes.

6 **Q.** Okay. So, arguably, some five days or so before the
 7 urine test, but we don't know when the urine test was
 8 precisely.

9 **A.** When -- yes, I was about to ask. When was the urine
 10 test?

11 **Q.** We don't know, we only know that it was provided, I
 12 believe.

13 **A.** Okay.

14 **Q.** Now, I'm not suggesting that this admission was
 15 drug-related, but given the way drugs degrade in the
 16 system, would it be best to test a urine sample as close
 17 to admission as possible just in case we can find out
 18 when the drug -- the urine sample was provided?

19 **A.** Yes, it is helpful for it to be measured as soon as
 20 possible. I think cannabis, for example, would still be
 21 evident during that period. But --

22 **Q.** Well, the Chair has good evidence on this.

23 **THE CHAIR:** I have had evidence --

24 **MR MOLONEY:** Absolutely. So that's why I don't want to ask
 25 you about it, but would it be useful in your view to

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1 **Q.** Can I take you to the document that was shown to
 2 Dr Dracass, which is NHFT0000168, because in that
 3 paragraph whilst we're doing that, you say:

4 "[It] was suggested on occasions based on progress
 5 notes entries but there was no evidence that this was
 6 carried out."

7 **A.** Yes.

8 **Q.** Yes, that's the one. We see at the top of that page,
 9 reference to a urine test. Sorry, did you see the
 10 reference to a urine test?

11 **A.** I saw it in Dr Dracass's evidence, yes.

12 **Q.** That was on 28 May 2020 at 6.23 pm?

13 **A.** Yeah.

14 **Q.** Yeah. Now, what we know of events around that time is
 15 as follows: that an ambulance had gone to VC's address,
 16 and he was in the ambulance complaining of chest pains
 17 and being taken to A&E at 30 minutes past midnight on
 18 23 May 2020, okay?

19 **A.** Okay.

20 **Q.** Then he was in custody of PC Eustace by 36 minutes past
 21 midnight on 24 May?

22 **A.** Okay.

23 **Q.** So that's a day later, roughly?

24 **A.** Yeah.

25 **Q.** He was released, and then he broke Feven's door down on

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1 have --

2 **A.** Yes, it would be useful but it's also about consistent
 3 testing.

4 **Q.** I was going to say, was your concern that there was
 5 a need for consistent screening on admission across each
 6 of the admissions?

7 **A.** Yes, and also in the community when there were concerns
 8 around his lack of response to the aripiprazole. So
 9 when you're not -- this is in my witness statement right
 10 at the end, in thinking about the question of treatment
 11 resistance, before you make that conclusion you want to
 12 rule out that substances might be playing a part. So
 13 you would want to see slightly more consistent testing
 14 of substances.

15 **Q.** Absolutely. And essentially it's therefore able to
 16 understand his history and risk and provide appropriate
 17 services and report?

18 **A.** Yeah.

19 **Q.** Yeah. Now, can I just ask you, as a forensic
 20 psychiatrist, have you encountered people with
 21 cannabinoid psychosis on a number of occasions?

22 **A.** Individuals whose psychotic illness has been exacerbated
 23 by that, yes.

24 **Q.** Yes. Now can I just ask you, can people develop
 25 cannabinoid psychosis through heavy use of cannabis and

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1 then have psychotic episodes later without having any
 2 further drugs?
 3 **A.** It's usually in the context of very heavy use within
 4 that timeframe.
 5 **Q.** Yes.
 6 **A.** But there's also evidence that very heavy use whilst
 7 your brain is developing, so when you're a teenager, the
 8 exposure to THC will then further increase your risk
 9 further down the line of developing severe illnesses
 10 such as schizophrenia.
 11 **Q.** A psychotic disorder?
 12 **A.** Yeah.
 13 **Q.** Just to be clear, your analysis was based on records and
 14 you didn't have any records from before the onset of
 15 psychosis in 2020.
 16 **A.** No. There was evidence of what's called the past
 17 personal history, which would talk about his
 18 developmental history, his education, past history of
 19 substance misuse. So we did see that in the clerking
 20 but obviously not from that time period.
 21 **Q.** And not indeed, based -- no records from that time, of
 22 school records or GP records from his time South Wales
 23 or anything of that nature.
 24 **A.** *(The witness shook head).*
 25 **Q.** No. Thank you. Secondly, very quickly, can I just take
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1 layer of risk management for him in the community (that
 2 would have aided in the prevention of future violence)
 3 was lost".
 4 Is that what you mean, in a sense: for this to be
 5 confronted?
 6 **A.** Yes, and that if criminal jurisdiction proceedings do go
 7 ahead, if there was a conviction, that opens up the
 8 availability of other services for the individual to
 9 help manage the risk in the community, and that's -- or
 10 it's helpful to have that for an individual that the
 11 community team were clearly struggling to support.
 12 **MR MOLONEY:** Thank you very much, Dr Ahmed.
 13 **THE CHAIR:** Yes, Ms Cartwright.
 14 **Questioned by MS CARTWRIGHT**
 15 **MS CARTWRIGHT:** I just have two very short matters, please,
 16 Dr Ahmed. Can we just briefly look at your witness
 17 statement, please, WITN0425001. I'm going to ask if we
 18 can go to page 13, please.
 19 Thank you. Just to clarify, Ms Langdale has taken
 20 you through your notes, but I think you clarify in the
 21 witness statement, essentially the report that was
 22 published by the CQC, there are matters of distinction
 23 that you take in respect of how that report is detailed;
 24 would you agree?
 25 **A.** I think the report by the CQC broadly does reflect the
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1 you back to CQCM0010414, which is the first document
 2 I showed you, and this time to page 7.
 3 And where you deal -- sorry. That essentially where
 4 you deal with harmful attitudes towards his own
 5 violence. Can you see that?
 6 **A.** Yes.
 7 **Q.** Under "Progressing Criminal Charges"?
 8 **A.** Yes.
 9 **Q.** "... VC had little appreciation of his violence
 10 [et cetera] ... These harmful attitudes towards his own
 11 violence were reinforced by the fact criminal charges
 12 were frequently not progressed."
 13 **A.** Possibly. Possibly, yes.
 14 **Q.** Yes, that that was a concern of yours, that that may be
 15 the case?
 16 **A.** So I think, quite often, police action didn't reflect
 17 the seriousness of some of these incidents, and the harm
 18 that was caused potentially. I'm thinking about the
 19 second break-in ahead of the first admission and also
 20 the incident that was described as hostage taking before
 21 the fourth admission.
 22 **Q.** Can I go very briefly to how you might elaborate upon
 23 this on the next page where you say:
 24 "Apparent failure to progress these incidents
 25 appropriately by the police meant that an available
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1 conclusions that were reached in my reports and I go
 2 into some detail picking out what the CQC's conclusions
 3 were and then cross matching that with what's in my
 4 reports.
 5 I think broadly they do match. I have gone into
 6 quite a lot of detail in the witness statement, just,
 7 really, to kind of outline my thinking and my rationale
 8 a little bit more, more than I was able to when we were
 9 producing the report.
 10 **Q.** Thank you. And I think we see that concession, you've
 11 just said, at paragraph 40, that it broadly reflects
 12 your work.
 13 **A.** Yeah.
 14 **Q.** But then if we look at paragraph 52 you go on to say:
 15 "More fundamentally, the CQC Report concludes that
 16 there was no single point of failure. In my opinion
 17 there were a number of failings which include the
 18 following ..."
 19 Then you go on to detail those.
 20 **A.** Yeah.
 21 **Q.** Because of time I'm not going to take you through those.
 22 **A.** Yes, I think the CQC instead of using the word
 23 "failures" they used "errors", "misjudgements" and
 24 "omissions", and I'm happy to use that terminology as
 25 well. It's probably more accurate and has better
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1 specificity.
 2 **Q.** Then just finally, please, just to complete the point
 3 that I explored with Dr Dracass, and I'm grateful to
 4 Ms Price. Can we display CQCM0016260, I think. I think
 5 it's 60, I do apologise if it's not. Sorry, it's 10.
 6 I do apologise. 0016210.

7 Thank you, and can we go to page 7, please.

8 Dr Dracass records that did think she had identified
 9 that she'd raised the issue of there being no Datix
 10 incident report, and I think we can see on page 7
 11 exactly that:

12 "No evidence that the decision not to detain on
 13 [24th of May] .. and subsequent arrested, with harm
 14 caused to person in flat (due to jumping from window in
 15 fear) leads to a datix related to the outcome or any
 16 learning."

17 Can you recall that?

18 **A.** Yes, I do recall that.

19 **Q.** Thank you. And so would you agree -- I mean I'm not
 20 going to go over the issue of candour in the
 21 regulations, but essentially the purpose of Datix
 22 incident and incident investigations is to learn and
 23 investigate the issues that have resulted in that, and
 24 so it is key to identifying failures but also changing
 25 what went wrong to resulting that issue?

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1 assertively treating those. If that was done, I think
 2 that would have, in my opinion, significantly reduced
 3 the risk of violence going forward. But having said
 4 that, I think it's important to note that there was
 5 a period between the discharge in September 2022 and
 6 June 2023, where we don't -- or Dr Dracass and I didn't
 7 have knowledge of his progress during that time, he
 8 could have accumulated other risk factors that could
 9 have been more difficult to mitigate.

10 There could have been the addition of substance
 11 misuse, further social isolation and withdrawal from
 12 family and support network. So there's a period that we
 13 don't know enough about.

14 **Q.** Sure. So we can't have absolute certainty --

15 **A.** No.

16 **Q.** -- but it's a probability?

17 **A.** Yes, yeah.

18 **Q.** You mentioned earlier his illness made him genuinely
 19 think hallucinations, et cetera, were real. Did that
 20 impact on his compliance with medication?

21 **A.** I believe it would have done. He didn't recognise that
 22 medication had a role in managing these experiences.

23 **Q.** Was another factor that impacted on his compliance with
 24 medication his delusions that medical staff were
 25 involved in a conspiracy against him?

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1 **A.** Yes, and I think there would have been helpful learning
 2 from that incident, yes.

3 **MS CARTWRIGHT:** Thank you very much indeed.

4 **THE CHAIR:** Yes, Mr Straw.

5 **Questioned by MR STRAW**

6 **Q.** Dr Ahmed, I represent VC's family.

7 Paragraph 34 of your witness statement, you were
 8 taken to that is it your view that the offences were
 9 preventable if VC's paranoid psychosis had been properly
 10 treated and managed?

11 **A.** I don't think it's possible to say that there's
 12 certainty to that preventability. But I do think that
 13 there -- by the time he was discharged from services
 14 after two years under the EIP team, I think there is --
 15 there is a rationale to say that it could have been
 16 preventable. There are caveats to that which I can go
 17 into and, as I say, I don't think it's possible to
 18 assert preventability with absolute certainty.

19 I think the key point is that -- I think I've spoken
 20 to this a lot -- that the principal driver of the
 21 violence, based on what we know of him during the
 22 two years that he was under services, the principal
 23 driver of those violent assaults were very distressing
 24 paranoid psychotic symptoms.

25 So the most important intervention would have been

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1 **A.** Yes, and I think that made it very difficult for him to
 2 open up to the team and be more clear about his
 3 psychotic experiences.

4 **Q.** So those factors led him to be more guarded, disengage
 5 from the team?

6 **A.** (*The witness nodded*).

7 **Q.** Thank you. You mentioned earlier that, I think, a depot
 8 in the framework of the CTO was, by admission three or
 9 admission four, clearly necessary?

10 **A.** Yes.

11 **Q.** There are three key reasons why: firstly, he was almost
 12 certain by that stage to be non-concordant with
 13 medication in the community?

14 **A.** Yes.

15 **Q.** Second, medication was vital in preventing a relapse?

16 **A.** Yes.

17 **Q.** Then thirdly if he relapsed he would be at high risk of
 18 harm?

19 **A.** Based on what we knew of his trajectory for those
 20 two years, yes.

21 **Q.** In your witness statement you note that inappropriate
 22 emphasis was placed on VC's autonomy, that that was
 23 misjudged.

24 Can you -- we are short of time -- so very briefly
 25 explain what you mean by that?

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1 A. I mean these are very difficult, finely balanced
2 decisions, and I think it's absolutely right that the
3 principle, the guiding principle, is around least
4 restrictive interventions, but that needs to mean the
5 least restrictive intervention that's most likely to be
6 effective and safe.

7 And I think by those third and fourth admissions, it
8 was evident that the reassurances that he was giving to
9 inpatient teams, that he was going to adhere to
10 medication in the community, that that wasn't reliable,
11 based on a more longitudinal view of his presentation.

12 It is very difficult to enforce medication on
13 patients and it's very -- it's coercive, it's
14 distressing, and you would understand why a team would
15 want to avoid that to maintain the relationship, but
16 ultimately that meant the important interventions to
17 manage his illness and his risk, that that wasn't done
18 assertively enough.

19 Q. So in short, the high risk of harm that he would pose to
20 the public if he wasn't properly medicated outweighed
21 those considerations.

22 A. Yes, exactly.

23 Q. In admission four, I think is it your view that he
24 should have been transferred or detained under Section 3
25 of the Mental Health Act at that stage?

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1 mentioned earlier, and you explained that it was your
2 view that at that stage it was highly likely that he
3 would present again with violence to others in the
4 context of untreated psychosis; is that right?

5 A. *(The witness nodded).*

6 Q. Discharge to a GP meant that he essentially had no
7 monitoring management of his psychosis.

8 A. Yes.

9 Q. That's right, isn't it?

10 A. Yes.

11 Q. So that was the wrong decision, wasn't it?

12 A. I think everything that was known about VC by that
13 point, and the fact that by that point he'd been free of
14 medication for some months, it was likely that he was
15 going to have an exacerbation of his psychotic symptoms
16 or a relapse, and that that had in the past been closely
17 associated with incidents of actual or threatened
18 violence.

19 Q. So by that stage rather than discharging him to his GP
20 there should have been a face-to-face assessment and
21 consideration of the Mental Health Act; would you agree?

22 A. I think that there did need to have been an assessment
23 of his mental state prior to that discharge to the GP,
24 and a clearer understanding of the risk formulation and
25 what the interventions needed to be to help manage the

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1 A. I think that while he showed some response to the
2 aripiprazole, I think even towards the end of that
3 admission, so he's an inpatient and medication adherence
4 is hopefully a bit more assured. I think he was still
5 experiencing residual psychotic symptoms. Around the
6 period that he was discharged, he was still talking
7 about beliefs that his mind or that he was being
8 controlled by an outside force. That's the first rank
9 symptom of schizophrenia. He was still talking about
10 the computer mapping -- of the remote mapping of his
11 brain and the fact that he had been doing research about
12 that and it was familiar to what was happening in his
13 own life.

14 So I don't think he was fully treated by the end of
15 that admission. I think it would have been appropriate
16 to have kept him in hospital for longer, and sort of
17 give weight to the recommendations of the community team
18 who were saying he needs to be on a depot, we also need
19 to consider a CTO.

20 Q. By that stage his underlying psychopathology, so he had
21 a permanent condition of schizophrenia, was known, and
22 therefore the criteria for Section 3 were satisfied.

23 A. Yes, yes.

24 Q. Final issue, please, which is about September 2022. So
25 the point at which he's discharged to the GP. You

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1 risk.

2 Q. When you say an assessment of him, that would include,
3 wouldn't it, importantly, a face-to-face assessment?

4 A. Yes, yes.

5 MR STRAW: Thank you very much. Thank you chair.

6 THE CHAIR: Yes. Mr Beer.

7 Questioned by MR BEER

8 MR BEER: Just two topics, please, Dr Ahmed. I ask
9 questions on behalf of the Trust.

10 You say in your witness statement that by the time
11 of the later admissions there was a very clear
12 indication for depot medication in conjunction with the
13 use of the Community Treatment Order; correct?

14 A. The depot would have needed to come first, yes.

15 Q. Yes. I'm just reading paragraph, I think 31, of your
16 witness statement.

17 A. Yes.

18 Q. Do you agree that in the community, a patient on a CTO,
19 whether or not they have capacity to consent to
20 antipsychotic medication, cannot be given medication by
21 force as part of the CTO arrangements?

22 A. They can be given the medication without them having
23 capacity to consent to it with the support of a Second
24 Opinion Approved Doctor.

25 Q. Sorry, with?

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1 A. The support of a Second Opinion Approved Doctor, SOAD.
 2 Q. By force?
 3 A. No, not by force.
 4 Q. Which was my question.
 5 A. No, no, it can't be enforced. In those circumstances,
 6 the responsible clinician would need to make a judgement
 7 as to whether or not the defaulting on the medication
 8 had resulted in a deterioration in the mental state,
 9 that that was associated with risk to others, and then
 10 they would recall them to hospital to administer the
 11 medication.
 12 Q. Do you agree, therefore, that if a patient on a CTO
 13 stops taking medication, recall to hospital is not
 14 automatic; they'd need to form a judgement about whether
 15 the conditions for recall were met --
 16 A. Sorry, that's --
 17 Q. -- with it being more difficult to justify the recall if
 18 a risk of harm to the patient or others was not
 19 imminent?
 20 A. Yes, it's not a question of defaulting on medication,
 21 automatic recall. You do have to demonstrate that the
 22 risk of harm arising from the potential relapse is
 23 sufficient to justify the recall.
 24 Q. Thank you. In what circumstances, if any, would it be
 25 appropriate to just discharge a patient on a CTO with

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1 additional work that's needed around psychoeducation or
 2 exploring their insights. But by the time -- if you've
 3 established somebody on a depot and they are responding
 4 to treatment, and gaining insight, you would anticipate
 5 that they may be starting to consider that actually
 6 medication is -- might be a helpful thing.
 7 Q. Yes. My question is to the other effect: namely if
 8 there was a continuing refusal?
 9 A. Then there would be no way to enforce the medication on
 10 the CTO but you would need to -- you would want to
 11 explore why that person is still refusing their
 12 medication, medication options.
 13 Q. Thank you. Lastly on this topic, we've heard some
 14 evidence that a patient under a CTO who lacked capacity
 15 to decide whether or not to agree to the treatment under
 16 it can in theory be given treatment in the community if
 17 an attorney requests it, a Court of Protection-appointed
 18 deputy approves it, or a Court of Protection judge
 19 consents on their behalf.
 20 Have you any practical experience, either personally
 21 or through knowledge of the work of other colleagues, of
 22 anyone ever having done any of those three things?
 23 A. No, I haven't. But I have had experience of individuals
 24 on CTO in the community not being able to capacitously
 25 consent. They're agreeable, they're not actively

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1 depot medication as a condition if the patient had
 2 already said that they did not agree to taking
 3 medication by injection, and so non-compliance with the
 4 condition of the CTO had already been predicted in
 5 advance?
 6 A. So I think we need to give individuals with these sorts
 7 of illnesses opportunities to recover. I think
 8 a slightly lengthier admission with establishing him on
 9 medication that he was responding to. As I mentioned
 10 earlier, we knew that when his psychosis was better
 11 managed he was able to talk a little bit more openly
 12 about his experiences, perhaps with a little bit more
 13 insight and curiosity.
 14 If an admission --
 15 Q. Sorry to interrupt --
 16 A. Go on.
 17 Q. -- even at that stage, if the patient was saying they
 18 did not agree to take medication once discharged by
 19 injection, in what circumstances would it be appropriate
 20 to discharge them on a CTO with depot medication as
 21 a condition of it?
 22 A. So if they are actively refusing, and saying, "I will
 23 not be taking the depot," then you would need to
 24 consider -- you would need to reconsider why, and
 25 explore why that is. Perhaps that's indication of

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1 refusing, but they do lack the capacity to provide
 2 consent and that's when the help of a SOAD, a Second
 3 Opinion Approved Doctor is needed.
 4 Q. But none of the enforcement mechanisms that I've
 5 mentioned, you've got no experience of that ever having
 6 happened?
 7 A. No, no, I don't have any experience of seeing
 8 Court of Protection input for that, no.
 9 Q. Thank you. And then lastly on the second topic, you
 10 said earlier that by the end of the third admission,
 11 I think, in your view VC clearly fitted the criteria for
 12 admission to MAPPA under category 3.
 13 Have I understood that correctly?
 14 A. So category 3 enables referrals for individuals who
 15 haven't had convictions, yeah.
 16 Q. Are you sure about that?
 17 A. I think so.
 18 Q. How familiar are you with the MAPPA guidance?
 19 A. Fairly familiar.
 20 Q. Isn't category 3 where, you've got two conditions,
 21 essentially: one, the person is a person who has been
 22 convicted of any offence, or they've received a formal
 23 caution for any offence, or they've been found guilty of
 24 any offence by reason of insanity, or they're found to
 25 be under a disability unfit to stand trial, and the

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1 offence for which they've received any of those four
2 disposals indicates the person may be capable of causing
3 serious harm to the public?
4 Which of the first four categories did VC fit into?
5 **A.** So he would -- he didn't have a conviction but he had --
6 **Q.** Did he have a caution, a finding of not guilty by
7 insanity or be found to be under a disability so he was
8 unfit to stand trial?
9 **A.** No.
10 **Q.** So -- which of those four criteria did he satisfy?
11 **A.** So he would have been appropriate for MAPPA level 3.
12 **Q.** Yes, but that's what I'm asking you. I've read out the
13 guidance, the two conditions, the four elements to it,
14 and the person may be capable of causing serious harm to
15 the public, ie the disposal indicates that, and I'm
16 asking you which of the four categories VC satisfied?
17 **A.** Could you repeat the four categories?
18 **Q.** Yeah. A conviction for any offence, current or historic
19 within the UK or abroad.
20 **A.** Yes.
21 **Q.** Or they've received a formal caution either as an adult
22 or a young person.
23 **A.** So he would have met that condition.
24 **Q.** So the caution?
25 **A.** He had a caution, yes.

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1 **THE CHAIR:** That's not the reason I'm stopping you, Mr Beer,
2 it's because I think it's something that really needs to
3 be followed up separately if at all.
4 **MR BEER:** I can show the witness the relevant document, but
5 it's maybe something we can do in writing.
6 **THE CHAIR:** Yes, thank you.
7 **MR BEER:** Thank you very much.
8 **THE CHAIR:** Thank you.
9 No other questions. Thank you.
10 Right, we'll start again at Monday morning at 10.00.
11 **MS LANGDALE:** Thank you.
12 **THE CHAIR:** Thank you.
13 (5.17 pm)
14 (The hearing adjourned until 10.00 am the following Monday)

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1 **Q.** And that disposal indicated that they were capable of
2 causing serious harm to the public.
3 **A.** Yes.
4 **Q.** So you're saying that the caution, his caution,
5 indicated that he may be capable of causing serious harm
6 to the public?
7 **THE CHAIR:** I think it's rather difficult for the doctor to
8 follow what you're saying without actually seeing what
9 you're looking at, Mr Beer.
10 **MR BEER:** I was trying to do it quickly, so I was on the
11 horns of a dilemma.
12 **THE CHAIR:** I know you are. But is it actually within the
13 bank of materials that are on the system or not?
14 **MR BEER:** It is, I think it's under the 2012 MAPPA guidance,
15 or --
16 **MS LANGDALE:** Chair, it's complicated further by the fact
17 that the conditional caution was never accepted. The
18 point was being made by the witness about the
19 multi-agency referral, I can look at the details of
20 where and how, but I'm not sure if it adds anything in
21 the greater picture.
22 **THE CHAIR:** Well, certainly if any issues arise, I can
23 follow them up.
24 **MR BEER:** Certainly at 5.15 on the last day of the sitting
25 week, yes.

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