**Tuesday, 21 April 2026**

**(9.59 am)**

**THE CHAIR:** Yes, Ms Langdale.

**MS LANGDALE:** Good morning. May I call Dr Malik, please.

**DR KHURAM FRAZ MALIK (sworn)**

**Questioned by MS LANGDALE**

**MS LANGDALE:** Dr Malik, you have prepared a statement for the Inquiry dated 11 December 2025.

**A.** Yes.

**Q.** Subject to a date correction in paragraph 45, which you brought to my attention earlier, can you confirm the contents are true and accurate as far as you're concerned?

**A.** That's right.

**Q.** You set out your professional background and qualifications in your witness statement. Can you tell us what those are?

**A.** I hold MBBS, which is Bachelor of Medicine and Bachelor of Surgery. I completed that in --

**Q.** You might need to speak up a bit.

**A.** Okay.

**Q.** And probably a bit slower.

**A.** I completed that in 2001. I completed a post-graduate Diploma in Mental Health Studies from Nottingham University in 2011, and I am a member of the Royal



College.

**Q.** You started working as a Specialty Registrar in psychiatry in 2008, 2012; is that right?

**A.** Yeah.

**Q.** From 2012 to 2013, a Specialty Doctor in General Adult Psychiatry for Nottingham Health Foundation Trust; is that right?

**A.** That's right.

**Q.** And you undertook specialist registrar training in General Adult Psychiatry under the East Midlands Deanery from August 2014 to 2017, for the first two years working in Mansfield as a Specialist Registrar.

**A.** That's right.

**Q.** You achieved your Certificate of Completion of Training in August 2017 and have since worked as a Consultant Psychiatrist at NHFT in General Adult Psychiatry and remain in this role.

**A.** That's true.

**Q.** At the relevant time, you were involved in conducting Mental Health Act assessments and had been working as a Consultant Psychiatrist at NHFT for three years when you saw VC.

**A.** That's right.

**Q.** Roughly, you tell us you did about six to eight a week. How many Mental Health Act assessments would you have



conducted before the ones I'm going to ask you about later?

**A.** I can't give you in exact numbers, but it will be in the thousands.

**Q.** As a general psychiatrist in Nottinghamshire, when do you make referrals to forensic services? What are the criteria?

**A.** In the community, first of all, the patient's age, the patient needs to be between 18 and 65; the second thing is the need to have a mental disorder; and the third one is the offending history, and I think they look at GBH or GBH equivalent, you know, wounding with intent sort of, you know --

**Q.** So a serious criminal offence?

**A.** Similar --

**Q.** A conviction, it has to be a conviction?

**A.** Yeah. But in reality, if you're worried about risks, you can, you know, request an assessment.

**Q.** Have you ever done that, where there might not have been a conviction or not a conviction for GBH and something similar, and you've still referred?

**A.** My experience, forensic threshold is very high. So normally they are for 40 years, so one is that they might do advice and consultation just based on the referral. The second thing they might do is that they



might assess the person and then they'll advise you. The third thing they will do is that --

**Q.** How would they assess them? They would see them?

**A.** See them. They would see them jointly, and thirdly --

**Q.** With you, jointly with you?

**A.** Jointly with you, and then they will offer their advice.

The third thing is that they might do a joint working, and the fourth level is where they will do the case management, so they will be dealing with it mainly so the community team doesn't need to be involved. So, yeah.

**Q.** As a Consultant Psychiatrist, have you found, in Nottinghamshire, where you have sought that advice or assistance from forensics, you've been able to get it, or has there been a problem with that? I don't want details of any patients.

**A.** I have been able to get it a couple of times and there was a time before, before Covid, you know, we used to have this single point of access meeting in my patch, where we used to have a CPN from the forensic who used to come once a week. So we used to have a single point of access where we'd have people from different disciplines, and forensics were part of that and I found that very helpful, you know, then they can advise if they think that they need to take that referral back or

if they need to look into the PNC, you know. But that only continued for a couple of years and then it stopped.

**Q.** Why did it stop?

**A.** I can't recall, but I think it might be due to the pressures of the work, you know. But it was really helpful for us.

**Q.** Why was it helpful?

**A.** I think they being there in the single point of access meeting, and where we have got people, you know, we are worried about, you know, risks. You know, if we need more information, that can be sometimes very hard to get, you know, the *(unclear)* details and things like that and I think it was very helpful for us to get more details about somebody's offending history. And second thing is that that advice and if they think that they need to be jointly assessed, at least, they have assessed and then, you know, made a decision whether it is for them or not.

**Q.** Are they better able to get further information?

**A.** Yes -- *(overspeaking)* --

**Q.** You said it was helpful for them to get further information. Why was that information that you could not get as general psychiatrist?

**A.** It's not easy, you know.



**Q.** What's not easy, working with agencies to get information from them?

**A.** I think they are more -- I think they do this on a daily basis, you know, day in, day out. So I think most of their work is related to offending. That's the predominant, you know, work they do.

Before us, you know, it's getting the -- suppose somebody is in a prison setting and we receive a referral from, you know, somebody has been discharged from prison and they want us to see the person in the outpatient clinic, so their referral will come with very minimum information, so it wouldn't tell us, you know, why this person has been in prison, what was the offence, how long they have been. So with that information, it's hard for us to, you know, to decide where to go forward with the person.

So then you are trying to contact the prison and trying to speak to the right person and trying to get information, it's not that easy and straightforward. It's time consuming.

**Q.** What are the barriers to them sharing it with you?

**A.** Um --

**Q.** As far as you're aware?

**A.** I think in our team we had -- luckily we had somebody who previously worked in prison, yeah? So he was



an advanced clinical practitioner. So if we needed any information, we used to ask him and he used to get it for us. So that worked for us, you know.

**Q.** So is it about having the right processes, a single point of contact, for example, someone who knew the system?

**A.** Yeah.

**Q.** Get up a liaison?

**A.** Yeah.

**Q.** Do you think your forensic service colleagues have that more established because they're doing it more often?

**A.** They were more established, yeah.

**Q.** But there's no reason why, in general psychiatry, that couldn't become established as well, where you're seeing patients in the circumstances you've described?

**A.** I think there is often reluctance to share the information.

**Q.** Sorry, say that again?

**A.** There is often reluctance to share the information.

**Q.** With you as general psychiatrists?

**A.** Yeah, yeah.

**Q.** Do you think that's different with forensic psychiatrists, as far as organisations are concerned, or you don't know?

**A.** I can't say that.



**Q.** So just to finish on that topic, the situation you were in pre-Covid you found helpful, where in effect you had someone from forensic services regularly assisting and discussing cases with you.

**A.** That's right.

**Q.** Would that assist you and colleagues in general psychiatry in assessing risk, risk assessment, because that's obviously what forensics do all the time, don't they?

**A.** Sorry, could you please repeat the --

**Q.** Would that assist you, in practice, having that as an ongoing arrangement as it was before with someone from forensics helping or discussing your caseload?

**A.** I think if there is more provision in the community about the threshold, that will be helpful, you know, if there's somebody we are concerned about and we think that they're going to benefit from forensic assessment, that will be helpful.

**Q.** You set out the role of the registered medical practitioner in your statement and indeed the role of everybody conducting a Mental Health Act assessment. Can you just tell us that? What do you do in a Mental Health Act assessment, how many doctors are there, who else is usually with you?

**A.** So the AMHP receives the referral, and he coordinates

the assessment, so depending on, you know, if it is during the daytime or if it is out of hours, you know. If it is out of hours, the AMHP will first -- obviously he needs two doctors for the assessment, so out of hours they will normally call the on-call registrar, and after arranging a time with on-call registrar they will contact the second doctor. The second doctor could be, you know, it could be another registrar; it could be a section 12 GP; it could be a section 12 doctor who might be working in the private sector or might be working for a neighbouring trust, you know, something like that.

So at that time, CT team had an arrangement with the NEMS doctor, so that's an out-of-hours GP service. So out of hours they used to call the GPs, you know, the GP on the rota for that assessment. So they need to arrange two doctors and in addition to that, they need to contact the Crisis Team. Because the Crisis Team at that time they were attending their assessment for the purpose of the gatekeeping.

**Q.** What does gatekeeping mean?

**A.** Gatekeeping means that Crisis, they manage the flow of beds. So it is an intensive home treatment team and they are alternated to hospital admission. So basically they are sitting in the assessment and they, they are trying to establish: can this person be safely and



effectively be treated in the community or does he need to come into hospital? So they need to make that decision, yeah, and if they --

**Q.** They need to?

**A.** Make that decision if the person can be managed safely in the community. Yeah? Or does he need to come into the hospital? That's the decision they make, you know.

**Q.** They make that decision? What are the doctors doing, then; aren't they making the decision around the Mental Health Act assessment and detention?

**A.** I will come to that, but their role is for the gatekeeping whether this person -- obviously when we're doing assessment, we're looking into the least restrictive alternatives as well, so one alternative is home treatment. So they'll look into that if the person can be safely and effectively managed in the community at their home, or do they need to -- because any admission needs to go through Crisis, so they are the gatekeepers. So yeah.

**Q.** But in terms of the assessment itself, two doctors, someone from Crisis, gatekeeping role --

**A.** Yeah.

**Q.** The AMHP --

**A.** Yeah.

**Q.** -- is it collective decision-making or can those people



disagree amongst them about detention?

**A.** How it works is that four doctors are independent of each other, and AMHP is independent as well. Yeah? So everybody does their assessment, yeah? And when we are doing the assessment, so we're look into the considering the least restrictive principle, you know, look at the alternatives to detention, can this person be safely managed in the community, yeah? So if doctors -- so for somebody to be admitted to hospital, AMHP needs two medical recommendation, yeah, either as an individual medical recommendation or joint medical recommendation, so he needs recommendation from both doctors.

So once those recommendations have been done and then AMHP needs to be satisfied that the criteria for the detention has been met, and then AMHP will make the application.

So it's three of us needs to be in agreement, you know, for somebody to be detained. But before we make a decision about detention, we'll look at the alternative, viable options which can be done safely.

So that's where the Crisis Team comes, you know, so if the decision is that this person can be safely treated in the community and then Crisis will provide the home treatment.

**Q.** You, I think, tell us you had a two-day training course



in November 2012 before receiving Section 12 approval in June 2013. It's a long time ago now, but what information were you being provided with on that training course for two days? Was it around the Mental Health Act codes, guidance, generally?

**A.** It's all about the mental health. Mental health Code of Practice and --

**Q.** Do you find yourself going to the Code of Practice? Do you look at it on a practical day-to-day basis when you need to?

**A.** We do.

**Q.** Can we have it on the screen, DHSC0000007, page 23, and if we have pages 23 and 24. You've referred twice now to the least restrictive option, and indeed it's set out at page 23 and also 24 if we can have that alongside it, please.

So we'd see at 1.2:

"Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained."

In your practice, do you expressly consider this principle at the point of assessing detention? Do you do that generally.

**A.** We do.

**Q.** And what factors are relevant for least restrictive

option, we see them here, but what things do you, in practice, consider at that point?

**A.** Obviously you want to have minimum restrictions, isn't it, so inpatient is a restrictive environment. So you are looking at alternatives, you know: can this patient be safely managed, either as an informal patient or can he be managed in the home treatment? So the most least restrictive out of the three will be home treatment so, you know, just maximising independence, you know, and seeing that can this person be treated in the home safely, and if the answer is no then you will look into admission.

**Q.** When Dr Gandhi was interviewed about the assessment in relation to VC, in 2025 -- and he'll give his evidence about what he did say or remember in due course -- he is recorded to have stated that the team of professionals considered the research evidence that shows over-representation of young black males in detention, and recalls that Annette Palmer was able to persuade us that CRT could provide a safe and reasonable alternative of supervised medication.

Do you remember, in respect of VC and discussing his detention, or not, whether representation of young black males in detention was discussed between you?

**A.** I don't remember this conversation happening.



**Q.** Has that kind of conversation happened? You say it's relevant to you to think about least restrictive option. Would that be --

**A.** I think when we are making decision, we do that based on the clinical presentation. So we don't, you know, take this into account. And as far as I'm aware of, based on my review of the notes, looking at Dr Gandhi's entry --

**Q.** We'll go to that soon.

**A.** Yeah, and the AMHP report and the crisis, there's no mention of, and I don't think this happened.

**Q.** You don't think the discussion happened or it didn't influence the decision-making either way?

**A.** The discussion did not happen and it didn't influence the decision.

**Q.** If we look on the screen, "Efficiency and equity" under the "Guiding principles", there's reference to services:

"... the quality of commissioning and provision of mental healthcare services are of high quality and given equal priority to physical health and social care services."

Do you think mental health services are given equal priority to physical health and social care services, in your experience?

**A.** I don't think so.

**Q.** Why do you think that is?



**A.** I'm not sure but maybe it's down to the resources, finances.

**Q.** And priorities?

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

**Q.** If you go to page 98, please, of the Mental Health Act Code of Practice, we see a reference to the Mental Capacity Act. Same document, page 98. It's DHSC0000007, page 98.

And we can have, please, 98 and 99 alongside each other. This is reference to the Mental Capacity Act:

"A person must be assumed to have capacity unless it is established that they lack capacity."

What do you understand by that, Dr Malik? How do you approach this issue of capacity?

**A.** I think I could say everyone is viewed to have capacity unless it's proven otherwise.

**Q.** You might have to go a bit slower, sorry.

**A.** Sorry, sorry.

**Q.** Everybody.

**A.** Everybody is assumed to have capacity unless it's proven otherwise. So if you have got, you know, during your assessment, if you've got concerns that somebody might be lacking capacity, then you will assess that. Yeah.

**Q.** And when you do assess them, how do you do that? Perhaps it's helpful to have page 94 and 95 on the



screen, where we see at 13.20, what to do when a person is unable to make a decision for themselves. Sorry, page 99 and 100. *(Pause)*

It'll come up in a moment, Dr Malik. Lots of different numbers at the bottom of it.

So we see there 99, please, and 100 next to it if we can. We see there:

"A person is 'unable to make a decision for themselves' if they're unable to do any one of the following".

So how do you assess what's set out there?

**A.** I think we try to see is the person able to understand the information regarding the decision. Is he able to, you know, retain the information? Is the person able to use or aware of the information, and the fourth bit is that is he able to communicate the same back to you? So if he lacks any one of these on these four, that means he lacks the capacity. But if you want to look at the Code of Practice, you know, they talk about stage 1 and stage 2 or a diagnostic test as a functional test, you know, the impairment of -- disturbance of the mind or brain, you know, yeah.

**Q.** How often do you find it to be the case that a person lacks capacity in respect of understanding and weighing the benefit of treatment?

**A.** If people are acutely unwell, you know, people who are psychotic, you know, people that's really depressed, you know, people manic, you know, so it's quite common, you know.
**Q.** What do you do then?
**A.** It varies from person to person, you know. Yeah.
**Q.** What do you do? What are your powers or your response if someone lacks capacity, doesn't understand how medication is going to benefit them, what do you do next, in terms of achieving that medication, if you think it's the right thing?
**A.** So what setting are we talking about?
**Q.** Community setting.
**A.** Community setting, yeah. So if somebody -- are we talking about in relevance to this assessment?
**Q.** No, no, I'll come to the assessment soon.
**A.** Okay, so obviously it depends a lot on the factors, you know, it depends about somebody's insight, yeah? That's very important. It depends on, you know, your therapeutic relationship or therapeutic alliance with the patient, it depends on, you know --
**Q.** Are they different concepts, therapeutic relationship and therapeutic alliance?
**A.** Same thing, yeah. And what sort of support network they have got. So ideally, you would like to involve the



patient in the decision making, yeah? But in this case, if somebody lacks capacity and if they need to be treated and if they are accepting, so it will be non-capacitous complying patient, you know. So if somebody is refusing, then it's another issue, you know.
**Q.** If they lack insight, even if they're not refusing, how can you be confident that they're going to take medication?
**A.** So they're lacking insight -- sorry, what was the second bit?
**Q.** They're lacking insight, but they tell you they'll take medication, but they might not believe they're ill and need the medication, so how do you work that one out?
**A.** I think you can try to ensure that somebody can monitor their compliance, if they are accepting. So we tend to ask if someone is living with a family, if family can ensure that the person is taking, and if somebody is under Crisis Team, then they will go and observe patient taking, and --
**Q.** Sorry, go on.
**A.** That's fine.
**Q.** What level of protective factor is living with a family member or a family member being present when someone is very ill?
**A.** It does play a very crucial role, yeah. So they can



provide a lot of information, collateral information, it is a reliable informing source. They can share with us if they've got any concerns, if somebody's getting unwell, if there's any change in risks, you know, if they're not taking their medication. Any concerns, you know. So it's really helpful.
**Q.** Page 115 of the Code of Practice: "Factors to consider - protection of others", and we see at page 115, at 14.10:

"In considering whether detention is necessary for the protection of other people, the factors to consider are the nature of the risk to other people arising from the patient's mental disorder, the likelihood that harm will result and the severity of any potential harm, taking into account:

"that it is not always possible to differentiate risk of harm to the patient from the risk of harm to others".

How do you assess protection of others when making a decision to detain or not?
**A.** I think I will start that when I received the call from the AMHP, so they will provide me the available information they had. Then I will look at the patient's electronic records, and that I will be focusing predominantly -- I will look on other things as well, but my main focus regarding risk will be looking at



previous risk assessment, looking at forensic history, any previous involvement with the police, any previous convictions. I will know more about the substance misuse history, I will be interested in past psychiatric history, just to look at previous admissions, what's the trend like? Is it informal admission or formal? And what were the circumstances leading to admission, and what treatment did they receive? Were there any incidents during their admission like, you know, medication non-concordance, absconsion, you know, any seclusions or any risk to others.

So I will start from before I will assess the person trying to gather as much information as possible, and in addition to that, then it depends where the person is. So if I am assessing somebody in the custody, so when we go to the custody we normally do an introduction, so they take our names down, and then we ask them about what happened, why this person is here. And the next question is that where is it safe to see him? Yeah? So if we are concerned about somebody is very violent or aggressive, we wouldn't go into the cell, we will see him through the hatch from outside.

Then the next thing is that we might see him in the cell with the door open, but if somebody is settled, calm, and there are no concerns, then we'll see them in

the interview room. So throughout this process, so risk is an ongoing process, risk is dynamic, so we are assessing the time we receive the referral, and then obviously we are going to assess the person. We'll take the history. We will, if there is an incident, we will explore. We would want to know about the incident, we'll do their mental state, and we'll ask the person and try to get some collateral information, you know, from any reliable sources, you know. That's how it will be done, you know.

**Q.** Do you think detaining someone to prevent them committing aggressive or violent acts against others can be in their best interests? It's another factor that it's in their best interests that they don't commit criminal offences? Would that be a relevant factor for you?

**A.** Yes. But it depends on the whole -- a lot of other things, you know.

**Q.** Can we have page 116 up alongside this one, please, Amanda. "Alternatives to detention under the Act", Dr Malik. We see at page 115, 14.11:

"Informal admission to hospital based on that person's consent ..."

You referred to that earlier. Do you use informal admission for a day or two where necessary, just to take



the crisis or the acute nature of the event away, or is it informal admission not used for those purposes?

**A.** Not for a day or two. If somebody is in crisis and everything, that it can be the managed, we have got something called Crisis House. So these are managed by the Crisis Team and if I remember, they can only have five people, you know, at a time and people can only stay for seven days, you know.

**Q.** What's the benefit of them being in a house or with a host family that's referred to in the guidance?

**A.** Do you mean in the Crisis House?

**Q.** Yes, yes, what's the benefit rather than going back alone, so you're not being detained but you are somewhere with other people?

**A.** I think if it was felt that, you know, the patient is in crisis and can't be managed in the community and he does not really need to come into a psychiatric ward, you know, and he will benefit from the short stay, you know.

**Q.** Then you would use it?

**A.** Yeah.

**Q.** That can come down, please. Can we go to some Royal College of Psychiatrists guidance now around assessment and management of risk to others. NHFT0015099. Are you familiar, presumably, Dr Malik, with this guidance?

**A.** Yes.



**Q.** We see on page 7 "Tips for psychiatrists":

"Find out all you can to be prepared for the assessment."

Four bullet points up from the bottom:

"Learn to formulate risk."

What does "Learn to formulate risk" refer to?

**A.** I think there has been a lot of emphasis, you know, over the years that, you know, instead of categorising the risks, you know, do a formulation, it's more helpful and trying to understand, you know, risks better, you know, and to have a risk management plan, you know. So that's what they're talking about, you know.

**Q.** Do you think it's important to do that? Do you see the wisdom in that, learning to formulate risk within psychiatry, risk to others, risk to the patient?

**A.** I do agree. But sometimes it's not possible to do this in an emergency setting or in a one-off, you know; sometimes you need more information. Sometimes, you know, our psychologists within the team will do that after seeing patient over two or three occasions, you know.

**Q.** If we go to pages 8 and 9 on the screen, please, "General principles" of risk assessment, third bullet point on page 8 refers to:

"Preparation is crucial ... clinicians should try to



gather information from as many reliable sources as possible."

**A.** Yeah.

**Q.** Then if we go to page 9, "Mental state", what do you do during a mental state examination? How would you go about it? Again, I'm not asking about the specific one, but what do you do, what's important?

**A.** I think it's -- we start with, you know, somebody's appearance and behaviour, and we'll do it in more of a structured way, you know. So it's then we look at somebody's speech, you know, assess their mood, thoughts, you know, perception, you know, orientation to time in person, then there is the insight. So that's how we do it, in that order.

**Q.** If we go to page 10, please, "Risk formulation". 8 and 9 can come off the screen. Page 10 and page 11 at the same time, if we can.

This sets out risk formulation, relevant questions: How serious is the risk? How immediate is it? "Is the risk specific or general?" How volatile is it? "What are the signs of increasing risk?" "Which specific treatment and which management plan can best reduce the risk?"

Is that series of questions accurate, good practice?

**A.** *(No audible answer given)*.

**Q.** And we see general principles:

"A clinician, having identified a risk of dangerous behaviour, has a responsibility to take action with a view to ensuring risk is reduced and managed effectively."

Do you agree with that.

**A.** Yes.

**Q.** Is it always the case that there are management plans or care plans following Mental Health Act assessments?

**A.** Care plan?

**Q.** Yes, care plan, management plan, safety plan, whatever you want to call it; something to reduce these risks, mitigate them safely.

**A.** I don't know how to answer it. It depends. We have got Crisis Team most of the time for gatekeeping. There might be occasional times when they're busy, they can't do it. So normally when they attend these, they do a risk assessment, and care plan is included in that, you know.

**Q.** Because in your area of expertise --

**A.** Yeah.

**Q.** -- you don't just have obligations to the patient, do you, you have obligations to the wider public the people that you don't know --

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



**Q.** -- but the impact of your decisions one way or another may be felt?

**A.** Yeah.

**Q.** How do you take that into account when you're looking at risk and management plans?

**A.** I think you do the -- based on the available information and what's in front of you, you know. So it's -- it all -- obviously you take everything into account. And when you're doing assessment, risk is an essential part of the assessment. But it's how much information you have got, what do you see at the time, you know. And based on your assessment, you want to make the right decision, you know, what do you think at the time? It's because if you see that this is not just one person doing the assessment, Mental Health Act assessments, there are four people from three different disciplines; you've got two doctors who are Section 12 approved; you've got an AMHP who has got a social worker background; and you've got a senior clinician from the Crisis Team. So it is like a multi-disciplinary, you know, four people.

**Q.** In terms of making the right decision, the Inquiry has heard evidence about the patient autonomy, the concept of patient independence --

**A.** Yeah, yeah.



**Q.** -- you've referred to least restrictive practice.

**A.** Yeah.

**Q.** Do you think risk to others, risks of violence to others is appropriately weighed in the balance by psychiatrists such as yourself, making these assessments?

**A.** Yes.

**Q.** Why do you say yes? You seem confident about that. Are you confident about that?

**A.** I think, if you're saying that somebody is posing risk to others, so the Act doesn't say just about the risk to self; Act is very clear about risk to self and risk to others. So we take that into consideration.

**Q.** With the information you have, do you think that psychiatrists often need more information than they have got when making risk assessments?

**A.** I think the more information you have got, the better it is. But sometimes you have to work on what's available in the emergency settings, you know.

**Q.** That can come off the screen, please. I'm going to turn now to the assessments you undertook of VC, and you were involved in two Mental Health Act assessments, weren't you?

**A.** That's right.

**Q.** The first and the second one. The first one, you tell us at paragraph 45, based on your "usual practice acting



as a second doctor, I would have been aware of the patient's background pertaining to the arrest before conducting the [Mental Health Act assessment] ..."

And we know that he was recorded to have been responsible for criminal damage, and kicking a door. Did you ever see a picture of that door or a photo of that door or have it in your mind what that was?

**A.** I think we had very limited information. Like you said, all the information we had at the time was that there was a call for a burglary, they found VC who lives in a block of flats, and it's for alleged criminal damage, for kicking a door. That's all the information we had at the time.

**Q.** Who got that information? Which of you spoke to a police officer?

**A.** Obviously I can't recall, this incident happened six years back.

**Q.** Just to be clear, you're doing everything from records now?

**A.** On the records, yeah. So I can tell you what my normal practice is, but apart from that, normally we look on the patient electronic records. So by this time he had already been seen by Liaison and Diversion, so we will have been aware of the information. And normally, Liaison and Diversion, they take information directly

from the police, they will have received a referral.

And -- but when we do come to the custody, we normally speak to the officer on the desk, because we need to make sure the safety. We don't know, so we have to ask them "Why is this person here? How has he been and where is it safe to see him?" So it's -- I think looking at, there are times, even when we're seeing people in the medical room, we'll ask the officer to either stay in the room with us, or stay outside the room. I can't see any evidence of that.

**Q.** No, no, you didn't do that here.

**A.** No, we didn't do that here.

**Q.** Let's have a look, please, at NGPF0000072, page 1. This is a photograph of the door that had been kicked in. You didn't see that. Have a look at it now. You can see the handle has been taken off the door, by the looks of it, the door, hasn't it? And a number of items of post, and we know no one was in this premise *(sic)*.

**A.** Yeah.

**Q.** Were those two factors brought to your attention, first of all the degree of force that that would have required, we see splintered wood, we see the handle's not there. Did you understand what force was required for that or not? Would you have asked about that?

**A.** I think if we had more information, we would have



definitely explored it, and we would have challenged him, as well.

**Q.** When you say challenged him, challenged him about what?

**A.** I think ideally you want to try to ask the patient about the incident, what happened, you know. So you want to know from the patient and what the patient tells you, and sometimes the patient is not coming forward and you've got the information, then you need to try to, in that context I'm saying, yeah.

**Q.** It doesn't appear in the documents, that we know from the officer he continued to try to pull back and so she had handcuffed him, restrained him. So he kicked in this door, and had been restrained. Would you have recorded that if you had those pieces of information?

**A.** It's relevant information, it's important information.

**Q.** Why is it important?

**A.** If somebody has been restrained, that means he's acutely disturbed. So it's relevant to know.

**Q.** That can come down, please, and can we have NHFT0000168, page 1. You say your usual practice would be to look at the medical records, and we've got here the RiO records, setting out at the top, Liaison and Diversion Service, police called to a burglary in progress, DP located at a block of flats, DP resides in one of the flats. Is that the information, in essence, that you had?



**A.** That's right.

**Q.** When you say the Custody Sergeant, usually there's a conversation between one of you, is that who you normally speak to to get further information if it's you?

**A.** It's not one of us. Normally we go together. When we get there, we wait for the others to come, and then we go as a team, we introduce ourselves. And then whoever is the officer on the desk, so we'll be having the conversation, yeah.

**Q.** We see the recording here, Liaison and Diversion record:

"Prior to this referral he was seen by custody healthcare, following this he was sent to ED in order to rule out organic causes to his presentation, I understand that he had bloods taken there which came back clear of substances." *(As read)*

You didn't have -- we refer to the EMIS records on 23 May. You didn't have any other records than this, did you?

**A.** No.

**Q.** What did you think that was referring to, bloods taken, came back clear of substances?

**A.** I think my understanding is that, reading the notes, that after this arrest, you know, on the night of 24th, you know, after midnight, after the arrest he was sent



to -- he was seen by the -- because what happened is that, in the custody, the Liaison and Diversion only works from eight until eight during the day. So he would have been seen at nighttime by the healthcare practitioner and they would have sent him to QMC due to concerns about this being physical health related. And he's been seen and had bloods done. That was my understanding.

**Q.** He's recorded here:

"... delayed in his responses, sometimes forgetting what has been asked of him, appears distracted, eyes dancing around - appears to be responding to internal stimuli, when eventually he did response gave a rational response. Asked directly about voices, more obvious responding and eventually said no but I was under the impression he wanted to tell me otherwise."

So that's the L&D, Mr Lloyd's record. When you read that, you say you read this before you assess the person, what did you assess from that or consider from that?

**A.** To me it appears he's presenting with psychotic symptoms.

**Q.** Further down in the note:

"Telephone call from Dr Malik

"requesting community card for Zopiclone and

Olanzapine ..."
Did you request that or did Dr Gandhi request that?
**A.** I did that. I was trying to be helpful to make sure that because the Crisis Team were planning to go and see him in the evening the same day, and I just wanted to make sure somebody has done a community card and meds are ready for him to be --
**Q.** Where would the medicines be ready for him?
**A.** So the Crisis Team are based at Highbury, Bullwell in Nottingham. So it's -- and the doctor would have completed a medication card, and they would have sourced the medication for it to be ready on time for somebody to deliver and observe him when taking it. So I did that. It's definitely me calling the on-call doctor.
**Q.** Can we have, please, NHFT0000168, page 2. And this is Dr Gandhi's note of the assessment, and we see four paragraphs down:
"[VC] is seen in the medical room ... dressed casually and had [a] face mask."
What was the impact of face mask on the assessment?
**A.** I think it was quite difficult time in a sense, you know, when we were only just coming off the restriction and, you know, it was just, you know, lockdown, and I think it's -- you struggle to read somebody's facial expression, you know, if somebody has got a face mask



on. But sometimes, you know, it doesn't help if you're trying to establish a therapeutic relationship with, you know, somebody who is paranoid, you know. People like to see who they are talking to, you know.
**Q.** Using this note, can you tell us what questions you asked and what questions Dr Gandhi asked?
**A.** I can't tell you.
**Q.** Not attributing each, what between you did you ask --
**A.** I think what normally happen is that it's the AMHP does the introduction, and explain the role and purpose of the assessment, and then normally one of the medics take the lead, yeah.
**Q.** He's taken the note. Does that mean you might have taken the lead? You haven't done a note for either assessment, have you?
**A.** No.
**Q.** Is there a reason for that? Why don't you do any notes?
**A.** I will explain that. Dr Gandhi was on call for the south side covering where the assessment happened, and as a part of the on-call duty, one of the duties is the on-call to conduct a Mental Health Act assessment and complete the relevant documentation after that.
So both doctors don't need to make an entry. It's like, you know, you've got a ward round and the ward is an MDT, you've got consultants, reg, junior, people from



other disciplines, not everybody makes, it's only one entry. That's how it happens, it's a standard practice.
**Q.** The note says:
"... it was quite clear that [VC] was very distracted and guarded [and] ... struggled with his attention and ... questions [had to be repeated a] number of times."
**A.** Yeah.
**Q.** So did that complement your initial assessment of what had been observed earlier by Mr Lloyd, in the RIO notes?
**A.** Yes.
**Q.** You asked him about his background and he told you he was born in Africa, raised in Portugal. When he was 16 he moved to the UK; gave you the occupation of his mother; said his father was retired; one younger brother and younger sister. So he gave you familial information, and one of you telephoned, didn't you, his mother?
**A.** Yes, there was afterwards, yeah.
**Q.** Very important to get information from his family at that point, wasn't it?
**A.** It was.
**Q.** Again, can you remember now, having refreshed your memory from the documents, what information you got from his mother?



**A.** I think his mother mentioned that, you know, over a period of a week she has noticed a change in his behaviour. I think we specifically asked about -- whoever did the call specifically asked about she denied him having any past history of mental health difficulties, she denied VC having any history of risk to self or others, and denied any history of violence and aggression. So that's what we were told, you know. I don't think Mum shared anything more than that.
**Q.** Were you aware that she had asked the police whether they could keep him at the police station until she could get there? She was five hours away, wasn't she, and she came to Nottingham and wanted to be there?
**A.** I wasn't aware. Normally these conversations, AMHP, they do, normally call the family or the carers after the assessment. We don't do that.
**Q.** You set out earlier it's a crucial role, and here you had a mother, not a mental health, but a nurse, asking to be there before he was released from custody, and we know the next day she was saying he should be detained, right? So that was where she was coming from.
**A.** *(The witness nodded)*.
**Q.** Wasn't it relevant, even if you hadn't made the call, to ask what's her view? Does she want to see him? Does she want to be here?

**A.** It would have been helpful to -- why she wanted that, what were her concerns, you know.
**Q.** I think the concerns were clear, weren't they, she had said, "I'm five hours away" and it was obvious she was coming to Nottingham?
**A.** To Nottingham, yeah.
**Q.** Did you, as group of practitioners, consider the significance of that, that it was important she should be there --
**A.** We weren't aware of this conversation.
**Q.** You weren't aware of the call?
**A.** No, this call wasn't done by us. So what I'm trying to say is that after the assessment, I went to make a phone call to the on-call doctor to make arrangements for the medication. So this call would have been done by the -- in normal practice when an assessment is done, after that AMHP normally calls the patient and let them know the outcome of this. So this would have been when he's explaining the outcome to the mum.

So I don't think anybody, even the Crisis Team or the other doctor, might have been aware of this. That's my understanding.
**Q.** Wouldn't it have been really important to, pending your decision, get the information, even if it meant you took the decision a bit later, find out what she had to say



before you made it?
**A.** I think they might be two separate calls, you know. So it might be one call, obviously one call to try to find the information, yeah? To gather more information, and once we have made the decision, because -- and then he would have called again, you know. That's my understanding.
**Q.** You set out, or it is set out in this report, halfway down:

"When questioned about what happened last night. [VC] ... was confused but then told us ... [he'd] heard someone screaming and went to investigate. On further questioning he revealed he heard his mother screaming and people were screaming telling him that his mother was being raped and she was in pain."

So any notion of it being about a burglary, you knew at this point this wasn't about a burglary --
**A.** No.
**Q.** -- and theft, this was --
**A.** This was his mental health. He was not well.
**Q.** Yeah.

"[VC] stated earlier in the evening his mother had texted him and told him she wanted to visit him but he told her not to travel. [VC] could not tell who these people were who were screaming and how they knew it was



her mother who was screaming in pain."

So you knew in the property he was living, he was hearing that in an adjacent property; hearing his mother scream? That's what he was describing to you, as professionals.
**A.** That's right.
**Q.** "When questioned about hearing voices he initially denied but then described hearing two voices talking to each other (third person hallucination)."

What's the significance of it being a third person hallucination?
**A.** The third person is saying that they are talking about him, referring to him, you know. So it's --
**Q.** One of you asked him about:

"... thought insertion, broadcasting or withdrawal .."

Do you know what those questions were about? They were directed at paranoia, presumably.
**A.** Yeah, these are delusions of, you know, control, you know, so formal authorities trying to explore, you know, sometimes people can feel like, you know, somebody is interfering with their thoughts, putting thoughts or taking thoughts away or thoughts being broadcast, you know. So I think what we were trying to do is we were trying to elicit other psychotic symptoms, you know.



**Q.** Did you find them?
**A.** I think later on, I think towards the end then he become a bit more guarded, you know, so I think he engaged reasonably okay, you know.
**Q.** Well, he started talking about being observed and bugged.
**A.** Yeah, and then his -- yeah, from there on, you know, he became more guarded, you know.
**Q.** "[He] acknowledged he [hadn't] ... slept for a week ..."

That's a long time, isn't it?
**A.** Yeah, he -- yeah.
**Q.** "He described being stressed due to coursework and upcoming exam."
**A.** That's right.
**Q.** Again, you don't remember that, you're just taking that from the record?
**A.** The information, yeah.
**Q.** It's recorded:

"[He] had limited insight into his current presentation ... described his mood to be fine but he was guarded and ambivalent."

I mean, it clearly wasn't fine, was it? He had being tearful, he was hearing voices, hadn't slept for a week?
**A.** That's right.

**Q.** The conclusion in the next paragraph:

"Even though we were asking him questions he appeared to be muddled and struggled to concentrate ... speech low in volume with numerous pauses ... described his mood to be okay but appeared very bewildered."

It's recorded:

"... he lacked capacity to consent for treatment[s]."

Why did he lack capacity to consent for treatment, if it's not obvious?

**A.** It's clearly documented that he lacked capacity to consent to treatment.

**Q.** Would that be a conversation between you? It's an important finding, isn't it?

**A.** It would have been picked up during the conversation, yeah.

**Q.** When you say picked up on the conversation --

**A.** When you're trying to -- obviously when you're trying to talk about the medication, so you're trying to explain, you know, what's this medication for? You know, what are the side effects? You know, so in a way you are assessing the capacity when you're having those conversations, you know. So during those, it would have been picked, you know ...

**Q.** We see the history here recorded from his mother, and



that's where it's set out what you said earlier: no "family history of mental illness", VC having mental health issues, or VC "having mental health issues in the past."

**A.** Yeah.

**Q.** And noticed change in his behaviour. This doesn't record that she wanted to come and was coming?

**A.** No, I think what happened was that -- I think what my understanding in reading the notes is that when we went there, we didn't have VC's mother's number, you know, because it wasn't known to the services. So I think we have seen him, and then we wanted more information. So we went to the Custody Sergeant and we got the number, and I think that's when we called. So this is a conversation trying to gather more information, and then there would have been another call after the decision and outcome to let her know about the outcome.

**Q.** "Impression:

"First Episode psychosis due to sleep deprivation and stressors.

"Following the review the team agreed that least restrictive option needs to be offered ..."

That does suggest the least restrictive as a concept or an option was discussed in the meeting, even if you don't remember how.



**A.** I can't recall, you know.

**Q.** But do you agree, referring to "least restrictive option needs to be offered", however it was discussed, you don't remember, but it looks as though that was something --

**A.** I think it's in reference to the Code of Practice in considering the least restrictive principle, you know, I think it's talking about we considered both the options and the patient was considered as well in community, you know, and taking -- based on the available information, his presentation and, you know, least restrictive principle it was decided, you know. That's my interpretation here.

**Q.** Here we have: "He was consenting to home treatment". So a direct contradiction to the lacking capacity to consent for treatment; do you see?

**A.** I think my understanding is that, as you know, the capacity is decision-specific and time specific. So my reading of this is that Dr Gandhi is talking about here two different things. So when he's talking about the capacity to consent to treatment, generally with doctor, we talk about the consent to medication. So he's referring to olanzapine above, and down below, he is saying that he agrees that he's unwell and in his health, you know, and so he's consenting -- he's



consenting to seeing the Crisis Team, so they're two different things. I'm sure Dr Gandhi will be the best person to further elaborate and the Crisis Team will be able to -- and that's my reading, the capacity for two different things here. So he lacked capacity to consent to olanzapine, but he had capacity to consent to see the Crisis Team.

**Q.** So what was your understanding, then, what was going to happen to him when he left?

**A.** Okay, so Crisis offered that they normally see people once daily. When people go on the red RAG, normally see them on once daily. They can see them more than once, but that's how normally they will see, once daily.

So this said they can see him twice daily, they're going to monitor him, observe taking medication, and they are planning to visit him the same day. So based at that time, you know, based on the available information, I think it felt an appropriate and a safe plan to do that, you know. It's -- there are alternative to hospital admission, and what they were offering, it seemed quite a robust, you know, plan, so that's what --

**Q.** He was going to go back to the same place, wasn't he, as where he had just --

**A.** Yeah.

**Q.** -- committed the offence --
**A.** Yeah.
**Q.** -- and where he was hearing voices --
**A.** Yeah --
**Q.** -- that were distressing him?
**A.** -- yeah.
**Q.** Why did you have any reason to believe that if he went back there the same wouldn't happen again?
**A.** I think the information we had that he's not been well for a week, and in that week there has been only one incident. That's all the information we had. So by the time we assessed him, he has already been in the cell for 14, 15 hours. There hasn't been any further incidents, and --
**Q.** Well, he's not in the house where he's hearing the voices, is he?
**A.** Yeah, but the Crisis Team were planning to go and see him the same day, and observe medication, and provide twice daily. And if they would have felt that, you know, that they can't manage him safely, if there is any further incidents or any further deterioration in his mental health or escalation of risks, they would have considered admission.
**Q.** You knew he was living on his own, did you?
**A.** Yeah, we were aware of that.



**Q.** So who was going to tell you if there was any escalation of risk or if he was doing badly when he got home?
**A.** He did mention Mum coming, you know, I think, during the interview, his mum was coming. Something like that.
**Q.** You said earlier that you didn't know that, otherwise you might have waited. Could you have waited if you knew Mum was coming?
**A.** He mentioned about -- obviously I can't recall all the conversation, but he did mention that he received a text from his mum in the evening, and Mum said that she wanted to visit him, but he told Mum not to come. So that's he's talking about the day before.
**Q.** Yeah, that's the day before. So that didn't give you any reassurance that she was going to come; your evidence earlier was that you didn't know she was going to come or wanted to come.
**A.** I don't remember, I don't recall it.
**Q.** But it's significant, isn't it? You need scaffolding around somebody in this situation if they're going to be in the community and there was none for him when he went back to Brook Court?
**A.** I think at the time he had some insight. He was talking about that, he's -- he started talking about some of his difficulties, you know, feeling stressed, not sleeping, he acknowledged that he's not well, he needed help. He



was even talking about, you know, I think I have read somewhere that he mentioned about some of his experiences being abnormal and he wanted help.

So he had some insight. It wasn't like, you know, he had no insight at all. So he had some insight, he was willing to see the Crisis Team and he was willing to take medication and, I think, based on the available information and, you know, after discussion amongst four of us, it was felt at the time that, you know, it's the right decision.

**Q.** But in terms -- irrespective of insight, in terms of risk assessment to others, you were required to understand what had happened and what the triggers were for it happening, and the risk that he posed going back, weren't you? That's what the guidance suggests is necessary, formulate the risk, look at the triggers, what's happened, how are you going to stop it happening again?
**A.** Yeah, so we tried to identify that, you know, he's not well, he's experiencing psychotic symptoms, and he is acting in response to this. And the treatment would have been to treat his psychotic symptoms and that would have mitigated the risks, you know.
**Q.** The scenario of violence or, however it was described at that stage, criminal damage, the scenario was him being



adjacent to somebody and hearing, in neighbour's flat, his mother being harmed.
**A.** *(The witness nodded)*.
**Q.** That was the scenario given to you.
**A.** Yeah.
**Q.** Was it necessary to consider whether that specific scenario, that unique risk, was something that you needed to manage?
**A.** To be honest with you I can't recall what we considered at the time. It happened six years back, you know.
**Q.** That can come down, please, and can we have NOCC0000044, page 1. It's the AMHP report which you've read subsequently. You say you wouldn't have read it at the time. And we see medical psychiatric history. We'll hear from the author of the document at another time. If we see there:

"No previous mental or physical health issues

"First presentation".

If we go over the page, page 2 at the bottom:

"[VC] ... seemed to struggle to follow the thread of conversation -- it would often take him a number of seconds to respond to a question."

If we go to page 3, please:

"When asked about ... voices, [second paragraph] [he] said [he'd] ... been hearing them for a few days

now."
Your colleague asked:
"... whether [VC] feels he is being watched in his apartment -- whether he feels there may be cameras or microphones listening and watching him. [VC] asked how we know this in a defensive manner."
So he was exhibiting signs of paranoia, wasn't he?
**A.** *(The witness nodded).*
**Q.** Sorry, you nod. It doesn't get picked up if you nod.
**A.** That's right, sorry.
**Q.** "When asked, [VC] was unable to pinpoint any social stressors."
Dr Gandhi's notes refer to his university studies but here no social stressors.
**A.** I think it talked about, if I read the Dr Gandhi's entry, he was talking about the stress of exams and coursework, you know. Yeah.
**Q.** He gave you permission to contact his mother.
"[VC] said ... his experiences were abnormal and he would like help with them."
You referred to that with insight, he would like help.
It's very important at a moment that patient wants help to give that help, isn't it?
**A.** That's right.



**Q.** While they're engaging?
**A.** That's right.
**Q.** "It was agreed ... [VC's] experiencing a psychotic episode. What was unclear was what the risk factors were."
Do you agree with that: that as group, you didn't grapple with the risk factors and what might happen again, the formulation?
**A.** All I can say is that I was part of the assessment, and when the risks were discussed and considered, I would have been part of the discussion, but I don't recall, you know, all those discussions we had.
**Q.** If we go to page 4, please. We see "no history of [mental health] ... issues in the past" in the bottom box.
"[VC] agreed ... he needs help ..."
"Risk deemed low enough for Home Treatment to be explored."
What was the risk?
**A.** I can't recall what were the risks identified during the first assessment.
**Q.** You can't recall. So you don't remember --
**A.** I can't --
**Q.** -- being consideration --
**A.** I can tell you about the second assessment but I can't



tell you about the first one.
**Q.** So you can't remember any discussion about the trigger, how any risk was going to be managed --
**A.** I think it was clear that he was unwell. He obviously was presenting with psychotic symptoms, and he was hearing these distressing voices, you know, and he was acting in response to those beliefs, you know. There's no question about that. But what I'm saying is that I don't remember what was discussed, you know. Yeah.
**Q.** It looks as though Benjamin Williams, if we go to page 5, has recorded the risks as follows, and you'll no doubt set those out, but:
"Risk to Self: Further [mental health] ... deterioration. Likelihood: high ...
"Risk to Others: Aggression to neighbours -- broke into neighbour's flat. Likelihood: med[ium] -- severity; high".
And in his statement he says he thinks it should have been high because he'd already done this; it says "medium" here.
It must have been appreciated as a group that he had already done this: been aggressive and broken into a neighbour's flat even though no one was in that flat, fortunately.
**A.** I think if we go -- if we look at the medical records,



the RIO, if we look at Dr Gandhi's entry.
**Q.** The first entry that we went to?
**A.** Yeah.
**Q.** Would you like to have a look at that?
**A.** Dr Gandhi clearly documented that he denied any thoughts of harming to self or harming others. This report, it's not done by AMHP in presence of us. So this is AMHP, they do it in their own time and we don't receive a copy of this assessment.
**Q.** No, but you'd agree that that's obviously what Benjamin Williams, having been present at the same assessment, concluded, and so there may have been discussion about these matters.
**A.** I would have been part of the discussion but what I'm trying to say to you is that this is not my normal practice, to categorise risk. So Benjamin might be the best person to reply to that, because if you look at Dr Gandhi's entry there is no mention of, you know, anything like that. For --
**Q.** So you don't remember -- and I will ask Dr Gandhi -- discussing risk or risk formulation at all.
**A.** I don't recall the conversation, no.
**Q.** If we go to page 7 of this document, please:
"[VC] could not understand information given to him regards possible care a[nd] treatment. He lacked

insight into his mental health issues, believing them to be real.

"However, it is in [VC's] best interest to pursue home treatment at this time."

You'd agree he did need further assessment, didn't he?

**A.** Definitely, yeah.

**Q.** The best place for that would have been an assessment in hospital, wouldn't it?

**A.** I think at the time, based on the available information and assessment, it was felt that community is inappropriate.

**Q.** We know, of course, and you now know, that he was released from custody at 19:18 hours, and a 999 call was made at 20:29 hours, so, allowing for him to get back from Bridewell Custody Suite to Brook Court, about an hour later?

**A.** That's right.

**Q.** He tried again and did gain entry into someone's flat, leading to somebody jumping out of a first-floor window. You did the second assessment, didn't you? How serious did you think that was from the victim's perspective?

**A.** It was a serious incident.

**Q.** Did you know the extent of injury to the victim?

**A.** No.



**Q.** That can come down, please. And if we can have NHFT0000168, page 3. Again, we assume, if it was your practice, did you read the RIO notes?

**A.** I would have.

**Q.** Yeah. If we look at the fourth box down:

"Caller reporting ... there was a male trying to smash the door ... saying that the person inside is in danger.

"... female neighbour whose door VC has damaged was in the shower ... reported to be [in fear] for her life ... jumped from a first-floor window, currently in the back of the ambulance complaining of lower back pain, plan[ned] to transport to QMC".

"Complaining of lower back pain" is how that's described. Did you see anything else other than that to describe that event?

**A.** No.

**Q.** Did you ask any questions about that event?

**A.** Questions from whom?

**Q.** VC, when you saw him in the next assessment.

**A.** We tried to ask VC about the incident, he couldn't tell us much.

**Q.** What about the police, did you ask the police about the incident?

**A.** I can't remember. We would have discussed as normally,



like we do normally, when you go to the station, but I can't remember.

**Q.** When something like that has happened, in other words he was released and then this serious incident happens straight away -- or event -- is there a requirement within the Trust to report that in some way, either as a serious incident or through a Datix, or in some way so that that can be assessed within the Trust?

**A.** The Trust has got an incident reporting system. Yeah.

**Q.** Did you report this: that effectively somebody who had been discharged for home treatment went on to commit a similar offence?

**A.** So I assessed him the following day. This incident happened approximately 20 hours before, and we had no firsthand information -- *(overspeaking)* --

**Q.** Oh, you didn't know it had happened within an hour of you releasing him earlier?

**A.** No.

**Q.** When did you find that out?

**A.** Well, I think what I'm trying to say is that we didn't have the firsthand information. There were a lot of people involved before us, you know ... so street triage, you know, Crisis Team, Liaison and Diversion, you know. Before we assessed him on the next day in the afternoon around quarter to four.



**Q.** If we go to page 4 of these notes: "Telephone call from Elena Cullen AMHP about attending", we see there was no gatekeeper role at that next assessment, was there, because it was understood he would not be going home --

**A.** That's right.

**Q.** -- or using home treatment services. If we go to page 5, Dr Sadraei does the notes of this assessment, doesn't she?

**A.** She was on call that day.

**Q.** Yeah. So with the assistance of that, can you tell us about that mental health examination, state examination, and what decision was made?

**A.** There was a very minimal engagement from VC, you know. He came across as very unwell, you know. He was taking very long time, you know, to reply back. There were long, very long pauses, you know. It's -- to some of the questions he shouldn't answer. So I think to me he -- degenerated significantly as comparing to the day before, it was like, you know.

**Q.** Well, he still hadn't had any medication, had he?

**A.** Yeah, yeah, so if I'm comparing obviously have seen him the day before and he engaged reasonably well, then, you know, we were there at least more than an hour, you know, in the first assessment, but this assessment, you know, it's a very limited assessment and he came across

as very unwell, having no insight at all, and he couldn't tell us exactly what happened about the incident.

**Q.** He needed medication on the first occasion when you saw him, didn't he?

**A.** Yeah, he needed to be treated yeah.

**Q.** He needed to be treated. So should he have had --

**A.** Yeah, he needed to be assessed as well and treated.

**Q.** Yeah, assessed and treated. So should he have had medication before he went anywhere?

**A.** There is no such provision for medication to be given in the police custody. They don't give anti-psychotics there or anything like that, and this is -- we don't carry any FP10s or prescription pads, you know. So that's not how we normally -- normal practice is, you know.

**Q.** Could he have been accompanied to his home if that was your decision, and observed to take medication before he was left alone? Was that another option?

**A.** I don't know. That ... normally when somebody is with Crisis Team, then it's their decision. How often -- once a referral gets accepted by them, then it's their decision how often they want to see somebody, and what they want, if they want to observe medication or is there any things they need to put in place, you know.



It's their decision. But if we have identifiable request, you know.

**Q.** You've said more than once that it's their decision, Annette Palmer will give her own evidence, but in her statement to the Inquiry she has said:

"While I can voice my opinion as to whether somebody should receive treatment at home, it is not my job to persuade them [doctors] of my view. The decision as to whether to admit someone to the hospital is the decision of the AMHP and the medical doctors." *(As read)*

That's right, isn't it?

**A.** Yeah, I think what I was referring to was if somebody is under a Crisis Team, if he needs any ongoing, yeah, so in the assessment when we do the assessment, to detain and audit on somebody, it's the decision of the two doctors and the AMHP.

**Q.** That can come down, please. Can we have, please, RLIT0000031, page 1. Not to do with VC's case, Dr Malik, because it's clear you didn't make enquiries of beds or anything like that in relation to the first assessment, but this is Royal College of Psychiatrists membership survey on local capacity, February to March 2025. And we see from page 2:

"... survey ... sent to [Royal College of Psychiatrists] membership to gather their experience



of local inpatient capacity pressures over the last year and whether such issues affected their decisions about the admission, treatment and discharge of patients."

So this was a survey opened between 3 February to 2 March 2025: "Response rate was 6.3% (1,012 members ..."

Not as much as --

**A.** A small number.

**Q.** A really small number. Why is that, do you think? That's a surprisingly low number, one might say.

**A.** I'm not sure, you know.

**Q.** Did you fill it in, out of interest?

**A.** No.

**Q.** If we look at page 4:

"A substantial proportion of respondents describe pressure coming from insufficient and unsuitable local inpatient provision. Many respondents reported concern and pressure from bed management teams - [and]

"A substantial proportion of members reported a lack of cohesion with external partners ..."

Have you ever felt pressure to not admit a patient or to discharge a patient early because of service constraints?

**A.** I personally never have made any decision like that. So we normally go with the -- if we assess somebody, just



the clinical decision, if they need to come in, we will do a recommendation, and then people go on the bed list. So sometimes we have got 15, 18, 20 people waiting on the bed and that might take sometimes days, weeks.

**Q.** Days, weeks?

**A.** It can be -- it can take days up to a week, you know. So depending on, you know, sometimes there is nationally no bed, you know. So it has been times where we have to send people to Scotland and to other parts of the country.

**Q.** So you find them a bed elsewhere, but it's not about keeping them in the community when they're not safe to be there? Or is it that, please tell us?

**A.** People go on the bed list and if there's no bed, then they remain, if they are in acute hospital, they will remain there, which is not ideal. And if they're in a care home or even if they're in the community in their homes, they remain there, and Crisis Team will remain involved and they will provide, you know, intensive home treatment during that time.

**Q.** Have you had the experience of not being able to admit a patient or delays in admitting a patient when they have been sectioned because there were no beds available?

**A.** It does happen quite a lot. We have -- so sorry, can

you --
**Q.** Yeah, when you've sectioned somebody.
**A.** Yeah, there are times when we have done the section and there is no bed and people go on the bed list. So I might --
**Q.** But you would follow the correct principles of making the section --
**A.** Yeah, yeah.
**Q.** -- saying he needed to be sectioned.
**A.** Yeah.
**Q.** So it's not as though you'd alter your decision; you'd make the decision but then it would be a question of finding the beds.
**A.** Yeah. So it will be a decision, you know, on the pure clinical -- you know, somebody's presentation risks, you know, if somebody needs -- can't be managed safely in the community we'll do a recommendation.
**MS LANGDALE:** Thank you. Those are my questions, Chair.
**THE CHAIR:** Yes, Mr Moloney. Thank you.

**Questioned by MR MOLONEY**

**MR MOLONEY:** Dr Malik, can I clarify, is it right that your account of your dealings with VC in May 2020 is based on the records and you have no independent recollection of these events?
**A.** That's right.



**Q.** Thank you. So can I just ask you couple of general questions, hoping not to have to test your memory.
Firstly, in relation to your Section 12 approval, did you become Section 12 approved in 2013?
**A.** That's right.
**Q.** As a doctor, do you have to refresh your Section 12 approval on a period --
**A.** Every five years.
**Q.** Every five years, and you --
**A.** So I would have done, in 2018 and then again in my next is due in January next year, so it's every -- if I don't do that I can't continue with my job. So I have to do that.
**Q.** It's a legal requirement to --
**A.** To --
**Q.** Or a professional and regulatory requirement.
**A.** For me to work as a consultant, as an RC, I need to have the AC status. So yeah, we do that every five years.
**Q.** Thank you, Dr Malik. May I ask you, please, to look at a document which is EMAS0000002. This was mentioned to you, I don't think you've looked at it. I just want to ask you to clarify if I could, Dr Malik, a couple of details in relation to this.
Now you, of course, saw VC in the early part of 24 May of 2020.



**A.** That's right.
**Q.** Have you seen this document before, which is a record --
**A.** No.
**Q.** No. So this is a -- as you can see, it's an East Midlands Ambulance Service document, and it refers to an admission of VC about 24 hours before the incident that you were dealing with, just after midnight in the morning of the 23 May 2020. And we, if we look at the "History of Presenting Complaint", it says:
"Chief Complaint ... Chest Pain ... Developed L[eft] sided chest pain at rest."
Then we see underneath:
"IMPRESSIONS
"... acute behavioural disturbance ... mental health [et cetera] chest pain and hearing mumbling."
And then if we go over the page, please, we can see under "PAST MEDICAL HISTORY":
"P[atien]t admits to having mental health problems in past but would not say what. Not currently medicated for anything on questioning."
So this is a day before the incident and he's obviously released from the hospital, having gone to A&E in the ambulance, that ambulance having been called to deal with the problems that he was suffering with.
Now, I just want to ask you, as it were,



a hypothetical question --
**A.** That's fine.
**Q.** -- because you haven't seen this document. If you had known that he had spoken of mental health problems in the past, but was not prepared to speak about them, would you have wanted to know more about that?
**A.** That's right, yeah.
**Q.** If the problems had been of a longstanding nature, because of course that comment is not in any way clear in terms of parameters --
**A.** *(The witness nodded)*.
**Q.** -- nor indeed nature or seriousness, but if the problem had been of a longstanding nature, let's say, just even back into 2019, as one definition of longstanding, would that have been relevant to whether he would be admitted to hospital?
**A.** I don't think that would have made any difference to admission, so it's relevant information, so it's important to know, but I think the decision would have been based on the clinical presentation and the assessment at the time, you know.
**Q.** Okay. So in any event, even if you had seen that, then the assessment would have been made, as it were, in that moment in time.
Can I ask you about prescription of olanzapine. Is

it -- is the prescription of medication as part of a Mental Health Act assessment something that doesn't happen very often?

**A.** It doesn't happen very often, and if I'm going as a second doctor, I wouldn't normally do any prescribing, but we need to remember that there are occasions and there are times when, although Dr Gandhi is doing a Mental Health Act assessment, but he is on-call registrar as well, so he is asking Home Treatment to see the patient. So this is a bank holiday weekend, you know, so it's 25th May was bank holiday. So if he wouldn't have started the medication, you know, that would have further delayed, you know.

So as an on-call, you can prescribe somebody, there is no restriction on you that -- if I give you an example. If I'm a community RC and I've got a patient under my care and I go and do an assessment for that person, and if I feel that this person can be safely effectively managed in the community by changing his medication, then I will do that.

**Q.** Yes. And in fact, I mean doctors can prescribe in the police station, can't they?

**A.** When you say prescribe, what do you mean by that?

**Q.** So prescribe medication whilst in the police station. Is there a bar on doctors prescribing medication in the



police station and then actually providing medication, if necessary, in the police station, anticipating release?

**A.** Okay. We, first of all we don't carry any prescription pads with us. The second thing is that, as far as my understanding, is that antipsychotic medication is not something which is topped up in police custody.

**Q.** Right.

**A.** I never came across in my 20 years, you know, somebody being given medication, antipsychotic medication, in police custody.

**Q.** So it's a question of practicality rather than any bar on doctors prescribing?

**A.** Yeah.

**Q.** Yeah. Now VC was prescribed olanzapine --

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

**Q.** -- and a relatively low dose, 2.5 milligrams. Does olanzapine take time to control acute symptoms of psychosis?

**A.** Olanzapine is an effective medication. It's -- regarding the dose, you know, it's -- because it would -- he was an antipsychotic naive. By that I mean is that he's never been on antipsychotic medication, you know. So sometimes people -- it varies from the practitioner to practitioner, you know, some people will



like to start slow and go slow, you know. There is no right or wrong, you know.

**Q.** So the -- I think perhaps to try and rephrase that question --

**A.** Sorry.

**Q.** -- olanzapine, if somebody -- because VC was displaying psychotic symptoms --

**A.** Yeah.

**Q.** -- when you examined him, wasn't he?

**A.** That's right.

**Q.** Olanzapine doesn't provide an instant cure to psychotic symptoms all the time, does it?

**A.** If we treat it, it will. If he takes it consistently. So obviously you started on a small dose --

**Q.** I'm sorry, it's me not being clear, Dr Malik.

**A.** Okay.

**Q.** Yes, if somebody takes olanzapine consistently, then of course it can be an effective treatment of psychotic symptoms.

**A.** Yeah, yeah.

**Q.** But in terms of somebody displaying psychotic symptoms in the way you've witnessed --

**A.** Yeah.

**Q.** -- then olanzapine does not guarantee, as it were, an instant cure of taking those psychotic symptoms away



within a couple of hours, for example.

**A.** Yeah, it's not a couple of hours but we need to understand that at that time we were not clear about the nature of his, his, his -- you know, mental disorder, and he was feeling stressed, there was lack of sleep. These things can, can affect, you know, people can present with psychotic symptoms and if you try to focus on that sometimes we give people some medication to address sleep and some people recover very quickly, you know, from that. So it varies from person to person.

**Q.** So, as you say, you were not clear about the nature of his mental disorder at that time, and so some people recover very quickly from that, it varies from person to person.

**A.** Yeah.

**Q.** But of course for some people, then dosages have to be changed of olanzapine --

**A.** Yeah.

**Q.** -- to ensure that it becomes effective, and alternative medication tried.

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

**Q.** But you felt it was appropriate for Dr Gandhi to prescribe antipsychotic medication following this assessment.

**A.** He was presenting with psychotic symptoms, that needs to

be treated, and -- yeah.
**Q.** Just as one point of clarification, you proceeded on the basis that VC's bloods had been taken at the hospital, didn't you?
**A.** That's right.
**Q.** Yeah, and you've said that in response. Were you sure about that, and are you sure about that, Dr Malik?
**A.** I think we looked at the records, and we -- he was seen by a mental health practitioner, Liaison and Diversion, and we had no reason to doubt, you know. So he documented so we -- yeah.
**Q.** Can I just ask you to look at one of the records that you may have seen, because of course, when you came to the police station, you look at the custody record, wouldn't you, to see what had been going on?
Can we look at the custody records, please? It's NGPF0000077. If we could go to page 7 of this, please. And if we there look at "Medical", and this is 24 May 2020 at 04:01. We can see there:
"Detainee has now returned from hospital, PACE clock to restart, PER form is returned and reviewed by the Custody Officer. Any medication information that has been provided by the hospital on release will be shared with the HCP and the Custody Officer will consult with the HCP reference fitness to detain/interview. Any



medication provided by the hospital will also be reviewed by Custody Officer/HCP.
"DP has not had blood taken but seen by the senior consultant stated that his actions maybe more mental health."
Did you see that?
**A.** We don't have any access to custody records --
**Q.** You don't?
**A.** -- so these are not shared with us.
**Q.** Okay. But in any event, VC was not given any olanzapine at the police station and it was going to be given to him by the Crisis Team --
**A.** Indeed.
**Q.** -- later on, is your understanding.
**A.** That's my understanding, yeah.
**Q.** But he was arrested again for doing pretty much exactly the same thing before the Crisis Team could get to him. Yes?
**A.** Yes, that's right.
**Q.** Just in terms of the admission, he was presenting with psychotic symptoms at the police station, he'd not been well for a week. There was no indication that he was going to get better in the next few hours, was there? And he wasn't receiving any medication at the police station, and he was going back to exactly the same



place. Did you not think that there was every chance he could do exactly the same thing?
**A.** You can't predict somebody's, you know, trajectory of the illness or somebody is going to, you know. It's -- Crisis Team is an intensive Home Treatment Team and they see people like this, you know, day in, day out and successfully treat it as well.
So it was based on the, you know, available information and assessment that that was the right thing to do. So it's -- sometimes if people are under stress like I mentioned, with sleep, they might be better in a few days, you know. So we don't know the nature of his illness at that time, it's only been one-week history.
**MR MOLONEY:** Yes. Thank you very much, Dr Malik.
**THE CHAIR:** Yes, Ms Benyounes.
**Questioned by MS BENYOUNES**
**MS BENYOUNES:** Good morning, Dr Malik. I ask questions on behalf of the survivors. I'm going to cover three topics, and the first relates to information that was known and available at the time of the first Mental Health Act assessment.
You've stated that as part of the assessment process, it was important to get as much information as possible, and you say that you had limited information



about the alleged offending that had brought VC into custody.
**A.** That's right.
**Q.** You've been shown the photograph of the damage to the door of flat 12 and you said you hadn't seen that at the time of your assessment, and you said that if you'd had more information you would have explored that directly with VC.
**A.** Well, we would have considered and taken into account and explored, yeah.
**Q.** Yes. You've also said that you weren't aware that at the time of the police arrival, VC was trying to push his way into a flat, resulting in the police officer restraining and handcuffing him. In fact, this was a different flat to the one that he forcefully attempted to enter and cause damage on the photograph. This was entering flat 11, so another neighbouring property, and that was occupied. You weren't aware of that at the time of your assessment.
**A.** *(The witness shook his head).*
**Q.** When the police arrived, the occupant from flat 11 was preventing VC from entering. Again, you weren't aware of that.
**A.** We were not aware of that.
**Q.** Were you aware that the occupant of flat 11 raised

concerns with the police that VC may try and gain entry or cause further issues for them if he was to be released?
**A.** We were not aware of this.
**Q.** Do you agree that this information was highly relevant to the assessment of risk, of VC's risk to others?
**A.** It is important information, it's relevant.
**Q.** But it's also relevant, isn't it, to the detention and the criteria under Section 2, specifically the protection of other persons; do you agree?
**A.** I agree, yeah.
**Q.** And you said that this was one incident, but in fact VC had attempted to access two neighbouring properties during that incident; he was actively trying to access one such property at the time of the police attendance, requiring restraint, and there were the concerns of the occupants of that flat.
Do you agree you should have had that information in order to properly assess VC's risk to others?
**A.** It should have been very helpful.
**Q.** Now VC in fact was not detained following this assessment and we know he was discharged from police custody, and he was taken back to Brook Court. And you were aware that shortly afterwards he forcefully broke into a third property, and that caused the occupant,



Feven, to jump from the window and she sustained serious fractures to her spine.
Now can I be clear, you became aware of that because you were involved in the second Mental Health Act assessment.
**A.** I became aware of the -- I wasn't aware of the injuries, so -- I wasn't aware of the injuries.
**Q.** No.
**A.** No.
**Q.** But you were aware of the circumstances and the fact that this was another neighbouring property.
**A.** That's right, yeah.
**Q.** Do you agree that the knowledge of VC's actions in respect of the two flats and the concerns of the occupants of the one flat, that would have been at the forefront of the assessing team in the first Mental Health Act assessment?
**A.** We would have considered and explored that.
**Q.** In respect of the risk and the safety of the discharge, from custody back to Brook Court, you say that, after the assessment, it was then that you learnt that VC's mother was indicating she was going to travel from Wales; is that correct?
**A.** I don't exactly recall. So I never had any direct conversations with VC's mother. So I understand that



these conversations were done by social workers so he might be the best person to clarify.
**Q.** But can I be clear, you said it wasn't available information at the time that you assessed VC?
**A.** Which information, sorry, are we talking about?
**Q.** The information that VC's mother had indicated that she was going to travel; that wasn't available at the time of your assessment?
**A.** I think --
**Q.** Or can you simply not recall?
**A.** I can't recall.
**Q.** Do you agree that had the team been aware of that information, and that she was going to travel, albeit maybe taking some hours, there then would have been consideration about discharge potentially to an alternative address?
**A.** We will have considered. We would have looked into that.
**Q.** You would have looked into that?
**A.** If somebody is raising concerns and she would like for us to wait here -- and I'll give you an example, we're assessing somebody on a 136 or we have done the decision and that, for whatever reason, you know, they can't go and if they need to stay a bit, we can make those sort of arrangements. But I don't know how feasible is that,



you know, in the custody when somebody has been, you know, being interviewed and fit to release. I don't know how it works.
**Q.** Because it's not just a question of her wanting to be involved, it's a question of considering the safety of a return to the property?
**A.** It's relevant, yeah.
**Q.** She'd indicated her intention to travel some hours, but you simply weren't aware --
**A.** I wasn't aware of that, no.
**Q.** -- whether that was brought to the assessing team's attention?
**A.** I don't think assessing team were aware of.
**Q.** Moving on to the second area, this is the communication and particularly communication with the Custody Sergeant. You didn't make any notes yourself. You've referred to -- and you've been referred to Dr Gandhi's entry on RIO, and also taken to the AMHP report completed by Ben Williams.
Is it right that you simply don't have the recollection now, so you can't challenge what's stated and recorded in these documents?
**A.** I'm purely relying on the medical records.
**Q.** You've talked about your usual practice and you said that when attending Bridewell, the custody suite, you

would go together, the team, the other attendees of the assessment, and speak to the Custody Sergeant, effectively introducing yourself, checking where it's safe to undertake the assessment?

**A.** That's the -- we can't start the assessment without that. So they take our names down, they check our ID, and obviously when people are arrested and we need to make sure that first of all they want to know about the incident, why somebody has been arrested, how they have been since they have been here, and where is it safe for us to see?

So we would like to interview people in an appropriate manner, so I really try to take them in a medical room, but we need the information from the custody, where is it safe to assess the person? So this can -- sorry -- so this conversation could have happened. Without that, we wouldn't have taken him to an interview room.

**Q.** But that's an opportunity to gain information from the police?

**A.** Yeah.

**Q.** What led to somebody coming into custody, but also how they presented during custody?

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

**Q.** Now, within the records that you've been taken to, it's



already been read to you that -- it's recorded that VC found it difficult to understand and retain information?

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

**Q.** He struggled to follow conversations, required repeating of questions and information, and it's recorded that he lacked insight and capacity to consent to treatment. How did all of that impact on VC's fitness to detain and fitness to interview? Is that something that the team considered?

**A.** This is not something we consider. It's police decision. And I would disagree with the -- about the insight.

**Q.** Sorry, you disagree about that?

**A.** Disagree with the lack of insight. So he had some insight. So it's very clearly documented that he had limited insight. So by that, my interpretation is that he's got partial insight or some insight, you know? So he's aware of difficulties.

**Q.** Because it's recorded in the AMHP report that the Custody Sergeant was informed as to the outcome of the assessment, and that VC wasn't going to be detained but he was going to have visits from the Crisis Team.

What was communicated to the Custody Sergeant about the findings, the difficulty in understanding, the struggling to follow conversations, how that would



impact on VC's time in custody? What was communicated?

**A.** I think normally, in normal circumstances, we will tell them what we think and is the outcome, so we wouldn't go into --

**Q.** Do you recall, or do you --

**A.** I don't recall. I don't recall. I'm just saying normally we tell them this is the decision and this is the outcome and this is what is going to happen, you know, unless they ask us any specific question, then we will provide that information.

**Q.** Because we know that VC was interviewed before he was released under investigation, and you've described that the plan for treatment, the medication, that was only to commence later when the Crisis Team visited. Was that something that you would expect to have been communicated to the Custody Sergeant?

**A.** I'm not sure, you know, normally we would tell them what the plan is, you know.

**Q.** Because it's relevant, isn't it --

**A.** Yeah.

**Q.** -- if medication is not going to commence, but a suspect is going to be interviewed?

**A.** Yeah, it --

**THE CHAIR:** Ms Benyounes, you've had ten minutes. You have had more than ten minutes, in fact.



**MS BENYOUNES:** I'm sorry, Chair. Would you permit me to ask just two more questions, please?

**THE CHAIR:** How long are they going to take because we need to take a break.

**MS BENYOUNES:** One is a minute, and then a final question, please.

**THE CHAIR:** Right.

**MS BENYOUNES:** Given that it was recorded during the assessment about the failure to -- the difficulties, struggling to follow conversations, the repeating of questions, how was it concluded that it was suitable for VC, and he was going to be able to engage and follow and comply with the home treatment plan?

**A.** It wasn't like that for the assessment, so there were times when he struggled and there were times when he engaged, you know. So we would have taken that into consideration.

**Q.** Just finally, the third topic, the question of incident reporting. You didn't complete a report. I think it's Ulysses, the system.

**A.** Ulysses, we used that, yeah.

**Q.** Do you agree that there was an obligation on you, it's not just simply from trust policy, but with your own professional obligations, there's guidance that requires you to be open and honest and raise concerns?

**A.** I can't recall, because, like I said, I didn't have the firsthand information. I assessed VC 20 hours afterwards. So following the first assessment, he was already under the Crisis Team, and when the incident happened, there has been a lot of other people involved, and we assumed that, you know, the incident had been filled, you know, by the community --
**Q.** Somebody else had completed the Ulysses form?
**A.** Honestly, I don't recall what happened six years back, but yeah, I -- so I assessed him with the on-call SPR and the social worker after 20 hours after the incident.
**MS BENYOUNES:** Thank you very much. Thank you, Chair.
**THE CHAIR:** I think we're going to have to take a break before any further questions. So if we come back at 12.00.
**(11.44 am)**
(A short break).
**(11.59 am)**
**THE CHAIR:** Yes, Mr Straw.

**Questioned by MR STRAW**

**MR STRAW:** Dr Malik, I represent VC's family. Do you remember earlier you were taken to the custody record for 24 May 2020?
**A.** *(No audible answer given)*.
**Q.** There was an entry in that timed 4.01 am, on 24 May,



noting that VC had not that his bloods taken. Do you recall being taken to that?
**A.** Could you please repeat that?
**Q.** Yeah. Do you recall being taken by Mr Moloney to a custody record which was timed 4.01 am, and it said that VC's bloods had not been taken at that point?
**A.** We were not shown any custody records. This doesn't normally happen, so they don't --
**Q.** I'm sorry, do you remember just a little earlier this morning, you were shown a custody record by Mr Moloney --
**A.** Yeah.
**Q.** -- that was timed at 4.01 am and it said "bloods not taken"?
**A.** Sorry, I didn't hear your question, what you're trying to ask.
**Q.** Starting off with the fact that you were shown that by Mr Moloney, I'd like to come, please, to the RIO notes, and can we have that up on screen, please. It's NHFT0000168, page 1. And this is the first entry in this again you were referred to earlier, and do you see it's timed at the top there 9.54 am?
**A.** That's right.
**Q.** So that's about six hours after the custody record entry.



**A.** That's right.
**Q.** Correct. Do you see halfway down the page there it says:
"Prior to this referral [VC] was seen by Custody Healthcare and following this was sent to ED ..."
Is that the emergency department?
**A.** That's right.
**Q.** "... in order to rule out organic causes to his presentation, I understand that he had bloods taken there which came back clear of substances."
So was it your understanding that after being in police custody he was taken to the emergency department?
**A.** *(The witness nodded)*.
**Q.** He had his bloods taken there --
**A.** That would have been our understanding, yeah.
**Q.** And that came back clear of illicit substances.
**A.** They don't do normally check for illicit substances in the blood, so we know that.
**Q.** But it came back clear of substances?
**A.** They don't normally do that so I would have been aware of this information, yeah.
**Q.** I see. Thank you very much. Over the next page please, page 2. This is the note you were taken to earlier. Now one of the entries that has already been read to you from that page was -- it says:



"When questioned about what happened last night... [VC] told us that he heard his mother screaming and people were screaming telling him that his mother was being raped and she was in pain."
Was it your impression that he genuinely thought those experiences were real?
**A.** Yes.
**Q.** So he genuinely thought his mother was screaming and being raped in the flat that he then broke into?
**A.** He was concerned about his mum, and when we asked him to give us mum's number and he asked is his mum okay? So yeah.
**Q.** And that's what caused him to break into the flat.
**A.** Yeah.
**Q.** Similarly, you've taken him to the entry where he stated:
"... earlier in the evening his mother had texted him and told him she wanted to visit him but he told her not to travel."
**A.** That's right.
**Q.** Again, was it your impression that he was paranoid about her safety if she travelled?
**A.** I'm not sure. Because obviously we were in the Covid as well, but that could be a possibility as well, you know.
**Q.** Moving on to the second assessment, could you have up on

screen, please, a different document. It's NHFT0000004, and page 7 of that, please.

Yes, so do you see your name here is at the top, Dr Malik?

**A.** That's right.

**Q.** And could you go over the page, please, to the next page. There's a note here dated 25 May. Is that your note?

**A.** That's mine.

**Q.** Towards the bottom of the page, you say this:

"He has been arrested on two occasions in the last 36hrs ... acting in response to hallucinatory experiences. He believes he could hear his mum screaming, in pain and in danger ..." et cetera.

Was it your understanding that his hallucinatory experiences on the second occasion, so the second break-in, were similar to the first, so he could hear his mum screaming and so on?

**A.** That's right.

**Q.** Again, that's what led him to break into the flat.

**A.** He was acting in response to his psychotic beliefs.

**Q.** Finally, you've mentioned earlier that there were some signs or symptoms of paranoia, and it may be obvious, but I'd like to explain why.

So firstly you mention that he was distracted and



there were long pauses. Now, are those signs of psychosis?

**A.** When people are hearing voices, so they would be distracted, you know. So that's quite obvious. So these are the observations we see quite common in people when they're psychotic, yeah.

**Q.** Similarly, you noted he was guarded and suspicious. Is that a sign of psychosis because it indicates paranoia, or --

**A.** That's right.

**MR STRAW:** Okay. All right. Thank you very much.

**THE CHAIR:** Thank you. Yes, Mr Beggs.

**Questioned by MR BEGGS**

**MR BEGGS:** Just one matter, Dr Malik, for me, acting for Nottinghamshire Police. Could you be shown paragraph 74 of your statement which is WITN0355001, page 18. If you look at 74, you say -- this is in the context of the first assessment, but it could apply equally to the second -- you say:

"Following the assessment, a discussion is usually held with all practitioners involved, including the AMHP and the Crisis Team, before a final decision is made."

Just pausing there, what about a discussion with the relevant police officer or officers?

**A.** I think once -- obviously we are there to assess the



patient, the person, under the Act. So we need to make a decision whether this person needs to be admitted or needs to be treated in the community. So that's the decision we as a team need to -- under the Act, needs to determine.

Once we have decided that, normally we go back to the custody of sergeant, and will let them know, we might say that we have detained this person, we've done a medical recommendation, or, from our point of view, we've done the assessment and this person we're going to ask the Crisis Team to home treating. So we'll let them know the outcome, and they normally do a record on their system.

**Q.** So I understand you let them know the outcome, but I was just probing whether it might be useful, whether before, during, or potentially just before the determination of the assessment, to have a more detailed discussion from the officer or officers who might be able to give you more detail of the precipitating event?

**A.** So normally what happens is that we go and do the introduction at the beginning, and the officer on the desk normally -- it is normally very busy when you go to Bridewell, they might be booking somebody in, and they might be, you know, releasing somebody and you're waiting there in the corner, you know, for a while. But



you normally -- we don't proceed before asking those informations, you know. So we enquired them, and in this case, I think after the assessment, Ben -- I think Ben has documented in the AMHP report that we went back to the custody officer in charge and we wanted to know more about the incident and we did ask and we were told that there was no one else involved in the incident.

**Q.** Can I suggest that the benefits of speaking to the police at any stage during the assessment process will be a two-way process. In other words, they can tell you more detail, that's obvious, isn't it?

**A.** Yeah.

**Q.** But also, you might be able to convey to the officers some professional advice about the person you're assessing; is that fair?

**A.** That's fair.

**Q.** If they trouble to write that down on their records, they then have some useful psychiatric input for potentially future events; do you see that?

**A.** Yeah, yeah.

**MR BEGGS:** Thank you very much.

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

**Questioned by MR BEER**

**MR BEER:** Just four topics, if I may. You were asked some questions by Ms Langdale about the information obtained

from VC's mother in the course of the first Mental Health Act assessment.
**A.** That's right.
**Q.** Can we see NOCC0000044, page 1. This is the first page of the AMHP report completed by Benjamin Williams in relation to the first contact --
**A.** That's right.
**Q.** -- that I think you as a team had with VC. Okay?
**A.** That's right.
**Q.** If we can go forwards to page 3, please. Can you see at the bottom it says:
"[Telephone call] ... to Celeste [Calocane] ..."
Yes?
**A.** Yeah.
**Q.** I don't think this record tells us who made the call to Mrs Calocane, correct?
**A.** That's correct.
**Q.** What would be the usual practice? Would it be the on-call doctor, the first Section 12? Would it be the second Section 12 doctor? Would it be the AMHP, or would it be anyone that happened to be attending from the Crisis Team?
**A.** The normal practice is that AMHPs tend to call the family or carers prior to assessment, and they will try to collect the information. That's normally AMHP who



does that. And if -- depending on where the assessment is, if a family member is -- if we're seeing somebody at home then not all of us three will be there, yeah? But it's very rare for the second on-call to ring, so I don't think it's me; it's either Ben or Dr Gandhi. So it's them that would be able to answer that question.
**Q.** I don't suppose on this occasion you can now recall who made the call?
**A.** No, I don't know.
**Q.** But you say the practice, it tends to be the AMHP that --
**A.** Yeah.
**Q.** -- that collects the information?
**A.** Yeah.
**Q.** In any event, is what is set out there by the AMHP, the extent of information passed to you, and upon which you and your colleagues were working to as the information provided by Mrs Calocane?
**A.** Yeah.
**Q.** It is. Okay. It's not recorded there that she was five hours away and wished for him to be detained until she got to Nottingham, correct?
**A.** Yeah, it's not recorded, no.
**Q.** Can we look, please, at NHFT0000168. Page 2, please. And the bottom half of the page, the second box from the



bottom. Thank you very much. We can see about halfway down there "History from Mother", colon. We can see that Dr Gandhi's note is set out in a sort of structured way.
**A.** Yeah.
**Q.** He's dealt with the mental state examination and he's now dealing with history from mother, and you can see what's recorded there. And again, that doesn't help us tell who spoke to Mrs Calocane, correct?
**A.** No. I think it would have been, because I think we might have been able to -- when we started, we didn't have mother's number on the system because it's not known to us. He was in the custody, and after seeing him, we might have gone to the Custody Officer to get the phone number and then, you know, this call was made, you know. I don't know. It's maybe when we -- Ben or Dr Gandhi might be able to, you know, further elaborate, but it's not very clear, you know.
**Q.** Let's not speculate from that. The record doesn't say who made the call.
**A.** No, it doesn't say, no.
**Q.** Okay.
**A.** It doesn't say.
**Q.** But, again, it doesn't record any of the things suggested to you today that Mrs Calocane is said to have



said, correct?
**A.** I wasn't of, no.
**Q.** You, in relation to this first contact with VC on 24 May, you've told us that you have no notes of your own --
**A.** Yeah.
**Q.** -- and you're reliant on those made by the primary Section 12 doctor --
**A.** That's right.
**Q.** -- and by the AMHP? And I think you said that's usual practice.
**A.** That's right.
**Q.** By that, did you mean that's your own usual practice, or is generalised usual practice?
**A.** So it's my experience of working in Nottingham within the neighbouring trusts and speaking to friends and colleagues in some other parts of the country. So that's my understanding.
**Q.** So working practice within Nottingham Trust, to your knowledge, and --
**A.** *(unclear)* Trust --
**Q.** And in other Trusts as well.
**A.** -- *(overspeaking)* -- I had worked with before, yeah.
**Q.** We know that in fact you did make some notes -- you'd just been shown them -- in relation to the second

contact.
**A.** So that's the medical recommendation.
**Q.** Yes, on the form A4, the pink form.
**A.** Yeah.
**Q.** I'm not going to bring it up to show you. Is that because you were recommending admission under Section 2?
**A.** So as the second doctor, we -- if the decision is to detain somebody, then we'll do other individual medical recommendation or a joint medical recommendation. So it's yeah -- so on this, because it was a CT patient and they want individual recommendations, so that's what both of us did.
**Q.** But there is no obligation to fill out an equivalent form when there is no recommendation to detain?
**A.** Sorry, can you just repeat that again.
**Q.** Yes, that's a convoluted question. You don't have to fill out a form to say "I'm not recommending detention."
**A.** No. It's only when you detain somebody that you need to fill in the form.
**Q.** Okay. Second topic, please: the information you were provided with by the police about VC's behaviour and conduct in the first incident.
You said that you, that's all four of you, approached the Custody Sergeant and get information from them as a collective, yes?



**A.** That's our normal practise we'll do, yeah.
**Q.** You don't remember, I think, on this occasion, but is that the universal practice?
**A.** That's the universal practice in that police cell.
**Q.** And so is that you all get -- all three or four of you -- the same information --
**A.** That's right.
**Q.** -- at the same time?
**A.** That's right.
**Q.** You're all working off of the same information that Nottingham Police can give you.
**A.** That's right.
**Q.** And help me, if you can: do you, as group, or one of you, ask an open question about the circumstances of the alleged criminality? Tell us what happened?
**A.** Yeah, we start with open question and then we'll go into, you know, we obviously we want to know if somebody has been aggressive or violent, so how they have been, you know, and is it safe for us to, you know, and where is it safe to see them? So -- and we sometimes might ask "How has he been? Has he been eating and drinking? How is he behaving?" That sort of thing, you know.
**Q.** And do you expect the police to be open and --
**A.** They are normally share with us, so they are helpful. I'm not going to say that they are -- when we ask for



information, they do provide, you know.
**Q.** If you were told that VC had kicked a door in, would you then start cross-examining the Custody Sergeant to say: "Have you got any photographs of the door, please, so that I can see the extent to which the door had been kicked in and whether the lock is still present or absent"?
**A.** I think if we felt that the information is relevant and important then we will ask for further information. We'll explore that.
**Q.** Would you expect to have been told by the Custody Sergeant if there had been a need to restrain the suspect?
**A.** What do you mean by that?
**Q.** Yes, if you said you ask an open question, tell us about the circumstances of what's happened, both --
**A.** It is important and relevant information, so we should -- they should tell us.
**Q.** So you would expect that to be volunteered.
**A.** Yeah, yeah.
**Q.** Third topic, please. It was suggested that as group, the four of you had not grappled with the risk factors that VC presented on the first Mental Health Act assessment.
Can we look, please, at NOCC0000044. We're back to



Mr Williams's AMHP report. This is page 1. Can we look at page 4, please, and the bottom half of the page, please. We looked at this briefly earlier. Under the pre-printed part of the form:
"Reason for the above decision, incorporating current risk assessment, including whether risk to self or others and what type of risk."
This is to include, it said:
"... consideration of alternatives to admission, whether or not the patient is admitted ..."
Although this is Mr Williams's document, should it represent the collective view of the three of you, the AMHP and the two section 12 doctors?
**A.** I don't think so.
**Q.** So this is the AMHP's view rather than the --
**A.** That's AMHP's view, yeah.
**Q.** Do you nonetheless have a discussion as to the risk assessment that this form asks the AMHP to complete? Do the three of you talk about the risk?
**A.** Normally, as part of the assessment, we talk about the risks, and if I'm saying that somebody is high risk, there's no way I'm going to send somebody home. So we would discuss the presentation and the risk, and then the doctor goes and he does his entry, and AMHP does in his own time, you know, and ...

**Q.** Can we look, please, at NHFT0000168, page 3, please. Halfway down the page with the heading "Crisis Team". Thank you. If we just scroll up a little bit, please, and just get the date and time. Thank you. We can see this is Annette Palmer's entry at 9.50 pm. So she was the member of the Crisis Team.
**A.** That's right, yeah.
**Q.** You remember it was part of the plan that the Crisis Team was to follow up?
**A.** That's right.
**Q.** You'll see that she has recorded:
"I went to [VC's] address to deliver medication and observe him taking it."
Was that part of the plan?
**A.** That was part of the plan for the team to visit in the evening and observe him taking medication, and then *(unclear)* same day.
**Q.** We can see, given the timing, that when she goes round to deliver his medication and observe him taking it, she couldn't make contact. We now know he had been arrested in relation to the second incident and therefore wasn't present.
But that was part of the plan, as you understood it: (a) that the Crisis Team would visit; and (b) they would observe VC taking his medication?



**A.** That's right.
**Q.** Lastly, the fourth topic, the RCP survey on the effect of bed capacity on admission decisions. Was your admission decision and that of your colleagues, on the first occasion you came into contact with VC, affected in any way by bed capacity, or was it made on the basis of VC's clinical presentation?
**A.** The decision was based on the clinical presentation and available information at the time.
**Q.** But you never got to the stage of enquiring about bed capacity; is that right?
**A.** That's right.
**MR BEER:** Thank you very much.
**THE CHAIR:** Thank you.
Yes, thank you. I've got no further questions. Thank you.
**MS LANGDALE:** May I call the next witness, please, Dr Gandhi. May Dr Gandhi be sworn?

**DR RAHUL SUSHIL GANDHI (affirmed)**

**Questioned by MS LANGDALE**

**MS LANGDALE:** Dr Gandhi, you have provided a witness statement dated 1 December 2025 to the Inquiry. Can you confirm the contents are true and accurate as far as you're concerned?
**A.** Yes, please.



**Q.** Can you tell us firstly, please, about your background, your training, your qualifications and your experience?
**A.** So I completed my undergraduate medical degree from India, and I worked in A&E in India in Bangalore and then moved to the UK, and then I accompanied -- then I became a member of the Royal College and I also done Diploma in Psychiatric from Nottingham University. Whilst training from 2026 to 2011, I've worked in various different specialties, within the psychiatry.
**Q.** You became approved under Section 12(2) of the Mental Health Act as having specialist experience in diagnosis and treatment of mental disorders, and you have full registration with the GMC and are licensed to practice with the GMC, and since 2016, in addition to your consultant post, you've worked as a locum hire specialist trainee in Nottingham; is that right?
**A.** That's correct.
**Q.** You have undertaken numerous Mental Health Act assessments in various settings such as police stations, 136 suites, places of safety, et cetera, and by the time that you conducted the assessment in respect of VC that we're going to ask you about you estimate you'd have undertaken over 2,400 assessments; is that right?
**A.** That's correct.
**Q.** You -- did you hear the evidence of your colleague



beforehand?
**A.** No, I haven't heard.
**Q.** Okay. But as with him, you tell us you're largely relying on notes in respect of this assessment --
**A.** Yeah.
**Q.** -- because you don't have an independent recollection --
**A.** No, that's true.
**Q.** -- later on.
Can we first, briefly then, have a look at the Mental Health Act Codes and some of the guiding principles and while that's being placed on the screen, please, DHSC0000007, page 23, do you look at the Codes in practice --
**A.** Yeah.
**Q.** Regularly?
**A.** We do --
**Q.** Regularly, occasionally?
**A.** If there are conflicts or if we're not sure, this is the manual we go back to because it's the guiding principle and --
**Q.** Do you find the language straightforward in terms of looking at this rather than looking at the Act, for example?
**A.** -- *(overspeaking)* -- it as much as simple as possible, but obviously there is the AMHP, whose role is also to

kind of make sure that he is able to make us understand if there is any concerns or we are not sure about that, then we can go and talk to them, and do that, so -- but yeah.

**Q.** Can we have a look then, please, with page 23 and 24 on the screen, at the overarching principles referred to, and the first is the "Least restrictive option and maximising independence".

If we can have 24, please, next to it. Which states at 1.2:

"Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained."

Can you tell us what your understanding is of "least restrictive practice", and the significance of this?

**A.** I think my understanding of the least restrictive practice is, is basically goes from, first of all, knowing whether the person or the patient has a mental disorder or impairment of mind, and also looking through that, the risks, what is available at the time or what we know, and what is the best option available in making sure that we go by the guided principle, but also whether it can be safely and lawfully done. And that is the whole idea of least restrictive option when we look at it.



**Q.** So it's a guiding principle, as you say --

**A.** Yeah.

**Q.** -- it's important to do what can safely and lawfully be done.

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

**Q.** So you don't feel wedded to that option or that principle without consideration of other factors; is that right?

**A.** Yes, that's right.

**Q.** You were interviewed by the Deputy Medical Director at the Trust on 13 June 2025, and I think you've told us that you had notes in relation to the case only the day before, didn't you?

**A.** Yeah.

**Q.** When interviewed, you were noted to have stated that in the case of VC, in considering the admission, or no admission, that we're going to be looking at shortly, you stated that:

"... the team of professionals considered the research evidence that shows over representation of young black males in detention ..."

And you record that:

"[Annette] Palmer was able to persuade us that CRT could provide a safe and reasonable alternative of supervised medication and 2 visits/day. With the option



to admit if the community treatment plan failed."

First of all, do you remember saying that?

**A.** I don't have the full memory of it, because it was last year when the interview happened.

**Q.** But you don't dispute that you would have said that.

**A.** I don't dispute, but I would like to make kind of come back to that, because if you look at the four kind of -- the five questions I was asked --

**Q.** Do you want -- shall we put this on the screen?

**A.** Yes, please, if you don't mind, because I want to clarify because this document doesn't seem to reflect what has happened on the day and --

**Q.** Okay let's have NHFT0004927, 27, page 2. If we go to page 2, it's in the box, the penultimate box:

"RG states that the team of professionals ..."

Do you see that?

**A.** Yeah. What I was trying to get was to the context -- to the question what was posed on that day, what the interview was actually for. If you look at those questions, if you want me, I can re-read through them, if that's all right.

**Q.** The questions here?

**A.** Not here. So how did this document come to produce? If that's what I'm trying to say. If I --

**Q.** Let's not worry too much about the document. You can go



back to that if we need to, it's really that question: do you remember being asked what was the rationale for not detaining him? That's the question on the left.

**A.** Yeah.

**Q.** Was that a question that was put to you?

**A.** I don't think that was a question put to me. And that's why I said I have the set of five questions which were specifically asked.

So this was an interview. I was told that the Trust response in terms of they have received complaint and concerns, and they were trying to investigate the concerns, and they had a set of five questions, and I had to answer those questions.

**Q.** In the Teams meeting you answered that.

**A.** Yes, in the Teams meeting.

**Q.** So what was the question where you were asked that this topic came up? Can you remember?

**A.** That's why I wanted to come -- to kind of come to there.

**Q.** Tell me the question, then.

**A.** So the first question was confirmation of the knowledge that each medical practitioner had in relation to VC's previous sectioning event. So the --

**Q.** Don't answer it again, but that was the question.

**A.** That was the question.

**Q.** And the second one?

**A.** The second one was a summary of the event that occurred during each sectioning event involving the treatment and medication provided to VC.
**Q.** Understood.
**A.** Confirmation of whether or not capacity assessment was carried out or considered to determine VC's capacity to consent.
**Q.** Yes.
**A.** Was consideration ever given to the potential of drug induced psychosis?
**Q.** Yes.
**A.** What were the Calocane family made aware of in relation to the diagnosis? So these were the questions which were posed to me.
**Q.** Yes, and somewhere, answering one of those, did you say anything of this nature?
**A.** So I might have said, this is not verbatim, this is not -- so she has compiled this document after the interview.
**Q.** Yes, understood.
**A.** Basically, during the interview, after answering those questions, I was sitting there and reflecting, as a good kind of medical practice, in terms of looking at what happened on that day. So I had my notes, which was a skeleton of what happened and what is documented, and



I was just hypothesising, was there any things we thought along these lines at that moment in time? So that was I was trying to convey the message. But the document doesn't come across in that manner.

Clearly, from -- I should hold hand up and say I should have looked at it properly before I signed off, to say in terms of this reflects what happened on that day.

So what I was trying to do was reflect on what was the thinking at that time. So as a doctor, you know, or as a patient when we interact, there are cognitive biases and sometimes some biases come in the way because we are aware of research evidence, we are aware of a lot of things. I work within perinatal services, so I'm very much up to date with MBRRACE report where they talk about health inequalities. So those things are in the background of my head, whether I like it or not like it.

And I was just trying to, that day, I was trying to reflect and kind of come to kind of build up the day which I have no memory about, and I made it quite clear, but this has not been reflected in the notes, as well, that whatever I'm talking here, it's from my notes rather than from my memory of that day, that event, and that's --

**Q.** So you were interviewed in 2025 about this.



**A.** Yes, and that was five years after the incident.
**Q.** So you have no distinct memory at all.
**A.** No.
**Q.** As a reflective practitioner, you were saying, "We do think about that kind of data"?
**A.** Yeah.
**Q.** What about -- has the -- the reference here to Annette Palmer able to persuade us that CRT could provide a safe and reasonable alternative --
**A.** Yeah.
**Q.** -- home crisis visits?
**A.** Yeah. So this is again going from my experience in the past when working with Crisis Team, sometimes they're able to kind of say, "We can provide you a safe treatment plan". Because sometimes I might not agree with them, and again, this is again coming from the context of my experiences of working with the Crisis Team or kind of having situations where Crisis Team have said, "You know what, we can provide you this, why don't you give a try?"

Because what their job is trying to say, you know, why don't -- we are a team, as somebody who can offer an alternative to hospital, they are as good as a hospital sometimes because they're able to go down twice a day and do the treatment and provide the adherence, look at



the engagement, risk assess. So they keep doing.

So this is again from my past experience of whether the Crisis Team could have done that and that is where I'm kind of -- this is what I'm saying, these are all hypotheses, there's nothing to reflect in my notes, my clinical notes, which are from 2020, to say these things have happened.

**Q.** Understood, and you're not, however, this note has recorded, criticising anyone from persuading you about it. You say --
**A.** Not at all. I think that's perhaps a wrong word or strong word to use, "persuade", because she can't persuade me because I'm --
**Q.** You're the doctor, you're deciding about the detention, aren't you? -- *(overspeaking)* --
**A.** -- and the Act tells me is I need to make my independent decision. So how many of people there are, we all have to come to an independent decision. Nobody is forcing you to make any decision. You have to come to the decision based on what you have seen, what you've kind of recorded, and then agree with the whole -- the professionals sitting there.

It's a multidisciplinary working, and you might have disagreement, but obviously you need to come to a kind of conclusion of what is the best for the patient,

because the patient is the heart of this thing, and we need to kind of decide that and that's where the thing is.

So she's a Band 7 nurse, she's got expertise working with the Crisis Team, but she can't tell me what I can do and can't do. I have to make my independent decision. So that's what I'm trying to say is, is it doesn't correlate with me, so sorry for repeating myself.

**Q.** You haven't repeated yourself. That can go down, thank you.

Can we have, please, back on the screen DHSC0000007, page 23. We were just looking at the least restrictive option and maximising independence, and you've explained the relevance of that to your practice. And your evidence is that in the end it's the clinical analysis of each patient that informs your decision, or makes your decision.

**A.** Yes, right.

**Q.** Can we have page 23, please, "Efficiency and equity". Reference here in the Code to guiding principles that:

"... mental health services are of high quality and are given equal priority to physical health and social care services."

In your view, does that happen?



**A.** It does.

**Q.** Why do you -- *(overspeaking)* --

**A.** As far as I'm aware, sorry.

**Q.** As far as you're aware?

**A.** Yeah.

**Q.** Do you struggle with resources or have lack of resources in your work, or experience?

**A.** So I'm a bit away from general psychiatrist. I do work my on-call rota but I work within perinatal services and I am one of the clinical leads within the East Midlands, and I've never had issues with getting beds or resources to kind of get the help and support for what the patient need. That's my understanding -- *(overspeaking)* --

**Q.** In perinatal services?

**A.** Yeah, that's my understanding.

**Q.** Can we go to page 99, please, and the Mental Capacity Act definition of "lack of capacity".

**A.** Yeah.

**Q.** We see, if we can have page 99 and 100 on the screen, 13.20, 13.21 sets out when a person is unable to make a decision for themselves.

How routinely in Mental Health Act assessments did you make assessments of capacity, or do you make assessments of capacity?

**A.** Okay. So I just want to correct you there. From my



practice, or my understanding, in my day-to-day practice, every day I assess capacity, because I work with a group of people who are vulnerable and sometimes we have to kind of make decisions in their best interests and involve the family.

So I do outpatient clinics, I do ward rounds, and whenever I do Mental Health Act assessment, that kind of forms a part of my day-to-day practice. That's what I tend to do.

Because it's very important. Sometimes it guides the process, sometimes, you know, it helps me understand what the patients are able to understand and what can I kind of, you know, talk or how difficult conversations we can have. So ...

**Q.** Do you think detaining someone to prevent them committing aggressive or violent acts against others can be ever in their best interests or not? Where you're concerned someone is going to commit criminal offences.

**A.** I'm sorry, I didn't get --

**Q.** Best interests. You referred to best interests. Would the best interests of the patient not to commit criminal offences be a factor for you or not, a relevant factor?

**A.** Is there a mental disorder there?

**Q.** Yeah, a mental disorder.

**A.** Okay. So if there is a mental disorder, I would rely on



the Mental Health Act to give me that power, because that will give a safeguard to the patient and the staff. If he has got a mental disorder and if there is a risk to other people, then obviously there is the criteria for an assessment met. And I would give that safeguard, because the patient has a safeguard who can appeal against that Section. The staff on the ward, I'm not putting them at risk, because there isn't any safeguard to keep him informal, and if the need to use utilise, if that person if you're saying is dangerous and becomes risk to the staff on the ward, they need a safeguard to make sure that, you know, they're able to utilise de-escalation techniques, either verbal or chemical de-escalation. So that's my understanding.

**Q.** And if we go, please, to page 115 and 116, within the Code there's guidance in respect of "Factors to consider -- protection of others".

We see at page 115 at 14.10. We can have 116 next to it. We see at 14.10, Dr Gandhi:

"In considering whether detention is necessary for the protection of other people, the factors to consider are the nature of the risk to other people arising from the patient's mental disorder, the likelihood that harm will result and the severity of any potential harm, taking into account:

"... it is not always possible to differentiate risk of harm to the patient from the risk of harm to others".

And, two bullet points down:

"the willingness and ability of those who live with the patient and those who provide care and support to the patient to cope with and manage the risk".

When considering protection of others, and whether to detain or not detain under the Mental Health Act, how important is it to look at the available support within the community setting for a patient?

**A.** I think it's very important part of the Mental Health Act process because what you're trying to do is work with your patients, and their carers or family, to look at what is -- what is the problem at the moment? What are the risks? And how do we solve those issues, in terms of the diagnosis, if they're suffering from a relapse or if they're having any difficulty with their mental health, what treatment is needed? What can I put in place? And is that safe? And if the carers are on board do they know kind of how they've coped with it before?

So yes, to coin in short *(sic)* I would kind of consider what available option there in the community, and look at what is mitigating those risks and, if they can't, then is the hospital an only option at this



moment in time? Even if it's a hospital, whether informal, could be looked into rather than --

**Q.** So it's important to gather information --

**A.** Yes.

**Q.** -- that's reasonably necessary --

**A.** Yes.

**Q.** -- to inform protective factors --

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

**Q.** -- safety plans, care plans, whatever you want to call them, making it safe for the patient and the people around them.

**A.** Yes.

**Q.** That can come down. Can we have your note, Dr Gandhi, which is NHFT0000168, page 2. This is the assessment the Inquiry has asked you to give evidence about. Can you just tell us the role of the different practitioners who were there: yourself, Dr Malik, the AMHP, and Annette Palmer? We've touched on it before but just tell us what everybody's role in the situation was?

**A.** Yes, so this is out of hours, looking at the date and time. It's out of hours. So obviously for the Trust, they have to provide a Section 12 doctor, normally there are three tiers of people. So the resident doctor who is at the hospital and the local SPR, or called specialist registrar, who is based in the community so



he can respond to emergencies or advise and kind of go to Mental Health Act assessment.

So there is an on-call AMHP or the Approved Mental Health Professional on duty every day, 24 hours a day. So if somebody requests a Mental Health Act assessment, it could be from community, police station, inpatient, medical wards, surgical wards, or 136 suites which are place of safety. So they would contact the AMHP, the Approved Mental Health Professional, to say, "We are requesting for a Mental Health Act". So that is the point where the AMHP will take all the information.

Once the AMHP has got all the information, he will contact the person whoever is on call to say, "I have this situation, I would like you to attend". Agree on a time and a date to kind of -- time to agree to come and do the statement.

It's his job, then, to find another doctor who could be his -- the patient's own GP, or could be a Section 12 approved doctor, or who's got previous acquaintance with the patient, and he'll try to get the doctor to come for the assessment. And obviously, the Crisis Team are there to offer any kind of -- offer to say whether they would be able to support in any shape or form in the community, whether if plans are made for a thing.

Because if -- I'm just going back, because if we



decided at the assessment that Crisis Team can do the job, we have to call them and do a referral and everything to stop that process kind of becoming cumbersome process. So they normally sit in the assessment so that they can --

**Q.** Facilitate that?

**A.** Facilitate that, yeah.

So the role of the on-call doctor is, again, as a Section 12 mental Code of Practice is to be independent assessor and provide that independent assessment, and tell the -- under the Section 12, they have got the experience and expertise to diagnosis mental illness and the treatment of mental illness, and Section 12 doctor who comes as a second doctor, again, he's independent and again, under the Code of Practice is able to make the decision differently and he has got specialist knowledge and experience to diagnose and treat the mental illness.

Obviously, the AMHP is the one from the Act point of view. He's the one who pollinates the whole process, coordinates to make sure he's got all the information, from the referral, from other sources, and making sure that, you know, he's got anything on the social care records, all the information from the police, or whoever has referred him.

**Q.** So they gather the information --
**A.** They gather all the information.
**Q.** -- that underpins it?
**A.** Yeah.
**Q.** You mentioned the police. In this assessment, did you speak to the police directly yourself, either the Custody Sergeant or anyone else from the police?
**A.** So in my normal practice, because -- again, I'm going to be reflecting a lot to my normal practice, because I've been in the police station many a time, so I know exactly -- the normal practice is to talk to the sergeant on duty or on the desk to kind of find out why this person has been brought in.
**Q.** Would you all do that together or --
**A.** Yeah.
**Q.** -- all four of you together?
**A.** Yeah, because I'll give you a bit more complex thing because in the Bridewell, to get into the sergeant's desk, it might take from ten minutes to half an hour because we don't have ID cards to get in. We have to wait outside, ring the bell, we are let in. Normally what we do or my usual practice is wait in the car park for everybody to arrive, because once you go in, there's no place for you to sit or stand. So we normally wait, and then go in, go straight to the sergeant and



basically get all the information. So that's my usual practice, and, hopefully that will have happened because the Covid time, again, you would have all been waiting outside and going in.
**Q.** So you'd all get some information about the events that had just happened --
**A.** *(The witness nodded)*.
**Q.** -- which were described as criminal damage.
**A.** Yeah.
**Q.** Did you get a description or a view of a photo of anything to see --
**A.** No, we never --
**Q.** -- what the extent of that was, how much force may or may not have been required?
**A.** No. As far as my notes looks like, there isn't any mention of photo, there's no mention of any logs or anything. What we got clearly appears like, you know, that there was a criminal damage. That's what I can -- I can look at my notes and tell you.
**Q.** We're going to that in just a moment, but just in terms of gathering information, so the police information, all of you together, from the Custody Sergeant. What about VC's family? We know there's telephone calls to his mother.
**A.** *(The witness nodded)*.



**Q.** Did you make one of those or was it the AMHPs that made those?
**A.** I can't remember if it was me or the AMHP, generally it would be in the same room so I don't want to claim I made it. So it either could have been AMHP or myself, and we normally put the family on the speakerphone so --
**Q.** Everyone can hear.
**A.** -- everybody in the room can hear at the same time rather than the AMHP telling us what exactly heard or whether, you know, he's interpreted whatever they have said. So we normally tend to put on speaker and ask questions, whatever questions we need to hear the conversation.
**Q.** We see, if we look at this note, the "History from Mother", you see three-quarters of the way down.
**A.** Yeah.
**Q.** "She denied any family history of mental illness ... denied [VC] having any mental health issues in the past ... denied any history of risk to self or others. She has noticed for a week [VC's] behaviour has changed and [that] she has been concerned."

There's no reference in your summary to the fact that she had indicated that she could be in Nottingham within five hours, and wanted to be so, and that she had asked whether VC could remain in custody until she got



there. Were you aware of that, that she was coming to Nottingham?
**A.** No, I was not aware of that.
**Q.** What would be the relevance of knowing that she was coming to Nottingham for somebody who was in the mental health state that you assessed him to be in? Would it have been helpful to have her with him?
**A.** Oh yeah, it would be helpful but you need to remember that it's a police station and families are not allowed there. So even if somebody wanted to attend, they couldn't have come in to the police station.

As far as my knowledge and understanding goes, I've done many assessments in the police station, I've never been able to get any family in there or I've never seen any family. I don't think they're allowed in, to come in.
**Q.** Have you ever had an informal admission for a short period of time, just to tide over until someone can go back to their home where there's a family member there? In other words, in this situation he was discharged home, wasn't he, where he didn't live with anyone, there was nobody there, no protective factor, that effectively in an informal admission or voluntary arrangement they can be somewhere else until it's safer to go home?
**A.** If, trying to remember if I've ever done that, where

I've admitted somebody informally just because they haven't got anybody. I can't -- in my understanding I've never done that before.
**Q.** Any problem with that, as far as you're concerned, resource-wise?
**A.** I think the problem with that is you need to define of are you just taking somebody in the hospital because they haven't got anybody in the community?
**Q.** You're managing the risk --
**A.** Yeah.
**Q.** -- the risk that they pose by themselves in the place where they've just caused harm?
**A.** I'd never been -- I've never managed the risk in that form, where it's been straightforward. If you think somebody is at risk and somebody is there, then I wouldn't even send him home.
**Q.** Let's look at the assessment, shall we, and see where you got to on that.
**A.** Yeah.
**Q.** So would you like to tell us, from where it begins, three paragraphs down:
"[VC] was seen in the medical room."
**A.** Yeah.
**Q.** "... dressed casually ... had a face mask."
Can you set out, using the note as an *aide-memoire*,



what you asked him and what your assessment was?
**A.** So the importance of the medical room is: if I'm not feeling safe I wouldn't call anybody to the medical room. So my risk assessment has started from the moment the AMHP contacts me, because that gives me time to go through the notes on the system, collect all the available information, because the AMHP doesn't have access to the medical records. So that's my job, to make sure I look at the records. He might have previous AMHP reports, but given that this is his first presentation, he would not have any AMHP report there.
So we would have start away -- straight away kind of looked at the notes, gathered all the information, and the moment we come in to the police station, then again what I'm trying to say the risk assessment starts from the word go; it's not just a separate entity on its own. We normally go to the sergeant, look at the video and the CCTV. That's my normal practice, again. We look at the CCTV, ask the sergeant how his behaviour has been, has there been any aggression? Verbal, physical? Are we safe to go and see him in the cell or are we -- can we take him to the medical room? Which is much nicer because you can sit down, have a good rapport, rather than seeing somebody in the cell or through a hatch, which I have done before in my previous assessments



where I've felt -- I've talked to people through the hatch because we didn't feel that we were able to get in.
Obviously, we called him in the medical room. I haven't put anything there to suggest that we were in any shape or form scared, worried for our own safety. And the whole idea was I started talking about, you know, what is he doing in the Nottingham -- because that's what he -- the background information I've written, is trying to get to understand how he has come to Nottingham, what he is doing, where did he live? And obviously talked about his background, who is in the family? You know, and then obviously we, once we kind of build that engagement to understand that person, then talk about, you know, their experiences or if there has been an incident then go straight to the incident, saying "Okay, we understand from the police that, you know, you've done this. What is your understanding of that?"
Try and understand whether they are able to give us the clear account of that.
**Q.** And we see that halfway down the page.
**A.** Yeah.
**Q.** You ask about the events and he, on questioning, revealed that he heard his mother screaming.



**A.** Yeah.
**Q.** People were screaming telling him that his mother was being raped and that she was in pain. That's what he told you.
**A.** Yes, that's looks like --
**Q.** What did you say, when he reported that to you?
**A.** I can't remember the whole context, but what I was trying to do is understand his behaviour of what exactly he was trying to kick the door for, and obviously from the notes, it appears that, you know, he was hearing his mother's voice screaming.
So what I was trying to do from -- that appears like I was trying to say, "Okay, you're hearing the voice, so how do you hear your mother's voice? So is it your mother whose voice you're hearing?" Then he's clarified that he's hearing two voices discussing that his mother is in that flat and somebody is harming her, and that's why, you know, he is --
**Q.** So he hears two voices, not his mother's voice?
**A.** Yeah.
**Q.** But they're harming her.
**A.** Yeah.
**Q.** Yes, continue. Thanks.
**A.** Then obviously, which quite clearly indicates it's abnormal experience, and it was kind of not a rational

thing that, you know, he's going and investigating, but he's investigating because what he's hearing in terms of the voice.

Obviously then --

**Q.** Why was he investigating? What was he going to do when he got in there; did you ask that?

**A.** He was just trying to search for his mother. He denied having -- I've not put in the notes here anything, but what he was trying to investigate was whether his mother or not there. That's what he said. Because he was hearing the voice.

**Q.** You asked about thought insertion broadcasting and withdrawal. So are you asking about any paranoia, were you?

**A.** So what I'm applying to is a *passive (unclear)* phenomena we normally try to elicit in patients with psychosis, basically sometimes people think that their thoughts are put, inserted into their head, or their thoughts are withdrawn by some other force or some other agencies. And that's what I was trying to understand from him. But what I have written here, it looks like he didn't understand my style of questioning, most probably.

**Q.** Why do you say that?

**A.** I'm just trying to look at the sentence. Sorry.

**Q.** Because he did start talking about being observed and



bugged, but then declined to discuss any further?

**A.** Yeah, so when I'm talk about the withdrawal, he kept asking what I meant. That's what I'm trying to say. And then obviously I went to talk about any kind of paranoia he had and then obviously he talked about being bugged, and then he did not want to go into that discussion. So I couldn't persuade him to talk.

**Q.** He "had limited insight", you say, "into his current presentation ... described his mood to be fine ..."

Was his mood fine?

**A.** That's what he -- objectively he's saying that he feels his mood is fine, but he appeared distracted, obviously he was ambivalent there --

**Q.** You referred to tearful at another point as well, so he wasn't fine, was he --

**A.** Yeah.

**Q.** -- he was just saying that to you, and he stated he hadn't been eating well, hadn't been sleeping.

You report in the next paragraph, or record:

"... he lacked capacity to consent for treatment."

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

**Q.** Can you explain that, please?

**A.** Yes, I can. There are two parts to the treatment. If you look through my notes, one is about treatment with medication, that is antipsychotic olanzapine and the



sleeping medication, the hypnotic zopiclone, and the second part, the core part, is the Crisis Team, the Home Treatment Team going and seeing him at home.

So I'm deducting from my notes that he told me clearly, from the notes it appears, that there is something wrong with him, he wants help, and he is willing to accept the Crisis Team coming and seeing him.

And I suspect the capacity to consent for olanzapine was clearly, I could not kind of -- and he could not understand that the -- why he wanted the olanzapine because he couldn't understand completely, you know, what was wrong with him.

**Q.** You don't mention olanzapine --

**A.** Yeah, that's why I'm deducting from that. I'm not clearly mentioned --

**Q.** So wouldn't you have said if it was the treatment of olanzapine --

**A.** I should have.

**Q.** -- not consenting to medication? Do you think that was what you were referring to when you say "Lacked capacity to consent for treatment"?

**A.** Yeah.

**Q.** Who tried to obtain the drugs; you or Dr Malik?

**A.** So Dr Malik -- so sometimes what happens in the Mental Health Act assessment in normal processes, we divide the



work up, like contacting family or gaining information, so making sure we come -- because in the normal process or day-to-day practice, we normally meet first, share what we know from each other, kind of make sure that we know that. Then we go and kind of complete the assessment. Then come back and give our views of what we thought so far, in terms of the presentation, in terms of the risks, in terms of what would be the best way forward to manage what we have seen, and do that.

So from the notes, it appears like I think I or Dr Malik would have contacted the junior doctor on the site, because we don't carry prescriptions, and we would normally ask our hospital pharmacy to dispense. So we have a community card, we can call the junior doctor on site and say, "Can you write this medication?" And authorise, put my name, or whoever is called, Dr Malik or myself, put our names on to make sure, you know, that they're doing it on behalf of us, and then the Crisis Team will send that to the pharmacy and they will dispense that medication to the Crisis Team, who can then basically go and dispense those medication.

**Q.** We see, in the impression at the bottom, you say:

"He was consenting to home treatment and prescription of Olanzapine ..."

**A.** Yeah.

**Q.** So recording there to be consenting to it?
**A.** That's what --
**Q.** I'm just trying to unearth the contradiction with "lacked capacity" further up because on the one hand you're saying he lacked capacity and then here you're saying he was consenting to home treatment and the medication?
**A.** Yeah.
**Q.** There's a contradiction there, isn't there?
**A.** It might look that way, but again what I'm just communicated there is the patient is consenting, which means that the four functional test in terms of understanding the way of communicating and in terms of retaining that information. What I've said is just he's communicated there. I've not fully done a formal capacity assessment and the functional test if you could apply and put down exactly the information in terms of what I've given, the way, part of it, the retaining part of it and communicating part of it.
**Q.** In terms of risk factors, they're not listed there, but what would you list as the presence of risk factors at this point?
**A.** I think I've quite, from my notes, it quite clearly appears that I've asked him about thoughts of hurting other people, and he has said no. Thoughts of hurting



himself, he said no.

We have also gained information from the police that was there any violence or was there any injury or anything, but they've only given us the criminal damage.

We contacted the person who might know the best in terms of the person in question, and asked the person about any previous mental illnesses or any previous issues around risk to self or risk to others, and there was kind of matching in terms of her assessment and his assessment of saying he's not been sleeping for seven days, Mum reporting the similar picture of saying he's changed behaviour for a week, and we also kind of talked about not sleeping, and being stressed around exams, the course works, and wasn't eating very well.

And so --

**Q.** So they're the risk factors about him, aren't they?
**A.** Yeah.
**Q.** He's psychotic, he's got delusional beliefs, his mother is being harmed, sleep deprived, university.
**A.** *(The witness nodded)*.
**Q.** What about the scenario of violence, assessing that, or risk? In his own home, believing that's happening in neighbouring flats, was that a factor you took into account, a risk factor in the scenario of potential future violence that it had happened where he was living



and he was going straight back there without any medication when he was released?
**A.** I think what was clear from my documentation and the notes, that there was an emerging psychotic illness. And obviously, the symptoms, in terms of what happened for him to go to the flat was because what was he experiencing. And the plan at that moment was to ameliorate those symptoms, so Crisis Team were going the same evening to take the medication, giving that medication to help with those symptoms, and that is where, in terms of we were thinking the Crisis Team would be able to see him, observe him, take that and that would help him with the sleep, that would help kind of reduce the psychotic symptoms, starting the treatment straight away.
**Q.** Well, it wasn't straight away, was it, though, because he went home effectively by himself when he was transported there, without any treatment, with the same symptoms and, as you said, what he'd experienced earlier without medication and with those symptoms, took him into a neighbouring apartment.

So was there a way, in considering the management of his risk, of making sure he wasn't on his own in that period at all until medication had been introduced and taken effect?



**A.** I'm just --
**Q.** You're in the police station. You've made the point that his mother can't be in the police station. What are the options where you consider the risk or risk to others is such that you need to mitigate it and that person shouldn't be on their own in the community? They don't live with someone, there's someone nearby, but they're not there yet. It can't be a totally unique situation this.
**A.** The police won't keep him there because the PACE clock runs out, so they have their own system going on. We knew exactly where he's going to go, where he'll be, and the Crisis Team had quite clear plan because they liaise with the police officers, making sure that they're informed about when the patient has left so they can prepare and go and see the patient and give that medication.
**Q.** They can't stay with him though, can they? They can't --
**A.** Sorry?
**Q.** -- be there for hours. They can't stay with him for hours. That's not the purpose of home crisis support, is it? They're not going to sit there with him for the next 24 hours when the medication may or may not take effect.

**A.** *(The witness nodded)*.
**Q.** So how is that protective, the fact that they visit and watch it being taken?
**A.** I think what we're trying to say here is if we had thought that that was not a good plan, I wouldn't have gone to that plan at all. From looking at my notes, what was clear, that we considered all the options, and we agreed on the decision that we'll send him home with the medication, and the Crisis Team observing that, taking him the medication, and they're going to visit him twice daily to provide that support in his recovery, and that was the plan at that time.
**MS LANGDALE:** Thank you. Those are my questions, Chair. We might have time, if you'd mind a later lunch, for questions now.
**THE CHAIR:** I think we've had quite a long morning, and I'm sure that we do need a break at this stage, so we're going to ask you to come back after lunch.
If we come back at 2.00, thank you.
**(1.07 pm)**
**(The short adjournment)**



**I N D E X**