Tuesday, 28 April 2026

(9.59 am)

THE CHAIR: Yes, Ms Langdale.

MS LANGDALE: May I call Dr Lomas, please?

THE CHAIR: Yes.

DR BENJAMIN ANDREW MATTHEW LOMAS (sworn)

Questioned by MS LANGDALE

MS LANGDALE: Dr Lomas, you've prepared a statement for the Inquiry dated 2 December 2025. Can you confirm the contents are true and accurate as far as you're concerned?

A. To the best of my belief.

Q. You tell us you were a consultant or appointed as Consultant Psychiatrist in General Adult Psychiatry at Nottingham City Council in 2015; is that right?

A. Nottingham City Council and County South Crisis Teams in 2015, yes.

Q. Before then you tell us you worked, when you were an ST4, under Dr Tuhina Lloyd in Newark across three teams working with patients with psychosis, Early Intervention in Psychosis, Assertive Outreach and recovery teams.

I don't know if you've been following the evidence to the Inquiry.

A. I've followed some of the evidence of the Inquiry where I can.

Q. The evidence of Dr Dissayanaka in relation to Assertive Outreach. Did you --

A. I didn't see that, no.

Q. What did you mean by Assertive Outreach, or what was being deployed then when you were working at that time?

A. An Assertive Outreach Team was a specialist team set up to work particularly with patients with psychosis, who went through so-called revolving door admissions to inpatient psychiatric care under the Mental Health Act.

I can't recall the details of the structure of the team, but generally, its purpose was to be better resourced with smaller caseloads to work with patients who represented a particular challenge in terms of engagement when they suffered a psychotic illness.

Q. How were those people identified to get onto that programme, as it were?

A. So I can't recall exactly the referral criteria. I know that there was an aspect of repeated admission under the Act, and rapid disengagement and subsequent relapse. I think, when I started training, there might have been a particular number of times that had to recur to trigger a referral. I don't know if that was the case throughout the life of the Assertive Outreach Team when it was in place.

Q. But that was the effective test, when there was rapid

relapse out of admission from hospital?

A. Yes.

Q. Which is exactly what we have with VC, isn't it?

A. It is, yes. I would say that the Early Intervention in Psychosis Team, you know, would also commonly work with people who might require repeated admission under the Act. I suspect -- the EIP teams were similarly well resourced to work with patients with first episode psychosis, and I suspect the transfer between an EIP service and an AO service might have occurred towards the end of the three years of an EI team, unless the patient's engagement was particularly intractable or impossible to achieve otherwise.

Q. But the EIP approach and the Assertive Outreach approach are very different, aren't they?

A. I wouldn't say very different; I would say essentially they should be the same. They are both working with patients who are experiencing illnesses which they do not recognise they suffer from, and so their ability to make what seemed to others like wise decisions around engaging with care and treatment for those conditions is impaired.

The difference between the two is around the level of resource available to them and perhaps the efforts that might be made to continue engaging someone who

explicitly did not wish to see the service.

Q. And why are the efforts, as you describe it, different in the context of an AO approach?

A. So typically it would be about the perception of the nature of the person's illness, perhaps the risks associated with that illness.

Q. Do you think that somebody, such as VC, and others that you have described in that context, who do not believe they are mentally unwell, have no need for hospital admission or mental health assistance, are capable of assessing the benefits of treatment?

A. Sorry, I don't quite follow.

Q. Somebody who doesn't believe they're unwell.

A. Yeah.

Q. Believed that there are conspiracies out there and mental health services are part of them, are they ever able to weigh up the benefit of taking medication for an illness they do not believe that they have?

A. I think that's an incredibly difficult kind of assessment to make. I don't think you can blanket rule that simply by having a psychosis you can never make a decision for yourself with regards to treatment. I think --

Q. I didn't say psychosis, but I said by not believing that you are well. I know you say that's part of the

psychosis, but the effect, if it's absolutely clear you don't believe you are unwell?

A. So if you absolutely adamantly don't believe you are unwell you can still be persuaded to accept treatment by the views of others perhaps mental health services, perhaps clinicians like myself, trying to persuade you of the value of taking a treatment without making it about treatment for an illness. It might be "Look, every time you don't take this tablet or every time you don't accept this injection, you find, from your experience, that you wind up being brought back to hospital against your will, you wind up with, for example, a crisis team visiting you regularly when you find that intrusive and frustrating. And although you might not want to take this medication, you can prevent those things happening in your life by taking it. That's what we would like."

And you kind of at best agree to disagree on the reason for the tablet, and you might talk about "Look, so long as this medication doesn't do you harm, are you happy to take it?" And on that basis they might accept treatment.

Q. You'd need pretty clear evidence that they would view it as secondary gain in that way?

A. You would need evidence that they would, and you would

need to be able to monitor their response to the treatment and to be vigilant for evidence of relapse.

I think in psychiatry, I think if you don't work in psychiatric then it can seem very easy that where a person is unwell then they can't make a decision for themselves, it's obviously in their best interests to be coerced or forced into treatment. But actually we have to work so much in agreement and collaboration with our patients, even where they're perhaps subject to the Mental Health Act or to perhaps issues like a Community Treatment Order that, you know, you're trying to persuade and engage someone. You're trying to psychoeducate them as to the nature of their condition and hope you can improve their insight.

Q. Would you ever view it, in the best interests of a patient, that they were prevented from committing criminal offences; that that's part of the consideration of their best interests?

A. Oh absolutely, yes.

Q. Because obviously detention is not in their best interests, is it, long term?

A. *(No audible answer). (The witness shook their head).*

Q. So if you saw a risk that they were going to commit offences and be embroiled in the criminal justice system, would that be a factor that you would explain to

them as being relevant as to why you were recommending detention or medication?

A. Yes. You would also hope that where a person lacks insight what you are wanting is a weight of information to persuade them to your point of view, and consequences of actions, you know, problems with housing, problems with relationships breaking down, problems with, for example, being prosecuted through the criminal justice system are very concrete examples you can give to people of "Look, we believe this is happening to you, this is what it's doing to your life", and that might weigh in their consideration about engagement.

Q. You tell us in your statement at paragraph 7 that you -- your academic work included teaching responsibilities for undergraduate students, research into medical objection and work on the Aetiology and Ethnicity in Schizophrenia and Other Psychoses. Tell us about that work or research about aetiology.

A. So preparing for today, I had read my dissertation but I would get across that it was many years ago that I worked on kind of aetiology, the AESOP study. That -- do you want me to just talk about that research or its relevance to --

Q. Yeah, the key messages. What did you -- *(overspeaking)* --

A. So I mean the key messages that I took away was that diagnosis, categorical diagnosis in psychosis, although consistent in terms of bipolar affective disorder and schizophrenia, patients did move between those categories, their psychopathology evolved over time and the foundation for psychiatric diagnosis remains kind of expert consensus. You know, we lack biological testing for individual patients to identify particular conditions, so we still rely on operationalised criteria and the observation of phenomenological psychopathology in identifying particular diagnoses in a patient group.

I think working on that study around the time that EIP teams were kind of becoming firmly established, I also kind of accepted using the broad term of "psychosis" to talk about patients experiencing first episode psychosis as a diagnostic label, as opposed to applying particular labels like a delusional disorder, an acute transient psychotic disorder, a schizophrenic disorder, because all of those conditions come with the same attendant risks in terms of the lack of insight, potential for risks to self and to others. And they need to be as considered as you can in terms of making sure you don't allow someone to make unwise decisions who is unwell, essentially.

Q. There's a difference, isn't there, between a functional

illness, paranoid schizophrenia, and a first episode psychosis though. Even though psychosis refers to both, from a patient perspective the first gives prospect of recovery, first episode, early diagnosis, better for outcomes. It may be a first episode. That must be a more positive diagnosis for someone than facing paranoid schizophrenia?

A. So I think what you have to tell people is that they remain vulnerable to episodes of psychosis going forward. I think most people achieve -- I think the figure quoted is 80%, but an expert witness from research background would be better placed than me to give that exact figure.

I think around 80% of patients achieve a good remission from their first episode of psychosis, but they remain vulnerable whatever the particular label might be applied at that point to episodes in the future. Place any of us in this room to under the right circumstances and any of us here could develop psychotic symptoms. You know, enough sleep deprivation, enough exposure to the wrong kind of stress, the unfortunate combination of the right physical health problems, you know, medical treatments. All sorts of things could pre-dispose you to a relapse of psychotic symptoms.

Q. We know that Dr Seedat stated in the records, you'll

have seen it, by July 2020, "likely paranoid schizophrenia".

A. Mm.

Q. Yet we see repeated references to first episode psychosis, referring to treatment. Why is that? There appears to be a reluctance to refer to paranoid schizophrenia.

A. So I think there was a -- during my sort of training years, there was a general appetite to de-stigmatise mental ill health so that people were more willing to come forward with symptoms of mental disorder, so that people were more willing to report family members with symptoms of mental disorder and so on. And psychosis doesn't carry the cultural burden that the label paranoid schizophrenic does.

Q. What do you mean cultural burden?

A. The association with violence, the idea of otherness, the idea of difference of social exclusion, of inevitable decline of, you know, the burdens of the worst manifestations of that disorder.

Q. There is, Professor Fazel has told us, an associated link, isn't there, particularly for men and younger men, between violence and schizophrenia?

A. Well, I mean, so I did read Professor Fazel's evidence, and most -- or some of the studies at least that I read

that were referenced in that talk about schizophrenia and schizophrenia spectrum disorders and, for example the OvMIX(?) *(sic)* tool that's used to assess risk, which I have actually started to use after Professor Whiting presented it to the Trust a few months ago, is for patients with bipolar affective disorder and schizophrenia and spectrum diagnoses so patients with psychosis.

Q. Is it a useful tool?

A. I mean, it's very useful in that it's the first time I've had a tool that gives an actuarial figure at the end of it. I mean, I have run VC through it, and it came back as, you know, not frighteningly high --

Q. It depends what information you put in there, so I'm not going to accept that until we've gone through your evidence, if that's all right?

A. Sure, yeah. But it's useful. It gives you a figure that you can kind of lean on. Although I think you also have -- I mean, obviously it's used in conjunction with clinical judgement and with VC's --

Q. Exactly.

A. -- case you would be thinking about the risk of relapse given he'd had at least four distinct episodes.

Q. Exactly. You'd need to have an accurate history before you put facts in it?

A. *(The witness nodded)*.

Q. So these tools, whatever they are, are only as useful as the accuracy of the information put in, aren't they?

A. They are, yeah.

Q. You say at paragraph 9:

"In 2015 [you were] appointed as a substantive consultant psychiatrist ..."

And you say you:

"... since April 2015, part of a team of 3 consultants ..."

So who are the other two with you now and at the time of VC's appointment?

A. At the time of VC it was myself, Dr Ben Di-Mambro and Dr Mike Skeleton. Now we're not quite fully staffed and haven't been for some time, but we have myself, Dr De-Mambro and Professor Gillian Doody who is less than full time, but helps us fill the work that she can.

Q. How often do you speak together as consultants about cases or generally. I don't know where you work physically, if there's time for -- *(overspeaking)* --

A. So when Dr Skelton and Dr Di-Mambro and myself were the team, Dr Di-Mambro and I shared an office and Dr Skelton was next door. We would be frequently in the same building and we set aside times to discuss cases that caused us particular kind of anxiety or alarm or

that were particularly clinically challenging. That would be done kind of *ad hoc* between the three of us.

Q. Paragraph 10, you tell us one of your additional roles is as primary care mental health practitioner supervisor; what does that entail?

A. So some years ago, there was an initiative set up where some primary care mental health practitioners were embedded in GP practices. So these were band 7 experienced psychiatric nurses who were meant to provide a sort of link between patients whose needs weren't quite meetable in primary care, but who were being rejected by secondary care, and there was an identified need for them to be able to access kind of supervision from psychiatric consultants.

And myself and Dr Di-Mambro agreed to step in to provide that in the initial period of the rollout of that particular service. It has kind of continued and in practical terms the way it works is they reach out to us electronically, either via email or a Microsoft Teams chat, to ask us about advice particularly about medication or formulation or plan about patients for they're uncertain about what to do for the best.

Q. What information should a GP get on the discharge of a patient?

A. So I would say that a GP should be aware of the kind of

diagnosis, the historical risks, the signs of a patient's kind of relapse signature, and kind of a really clear advice about any medications that we were prescribing in the long term about what the appropriate duration of treatment is. If the patient requests for changes or reductions, what the response should be. So there should be some gentle steer as to future care although it's impossible to envisage every potential eventuality.

Q. How does it fit with the EIP team and the work of the Crisis Team? Who's responsible, ultimately, for prescriptions and making sure the patient is getting the prescriptions for medication?

A. So when a patient is under the care of the Crisis Team, it might be that they're collecting medication from the GP, it might be they're receiving it from their longer-term mental health team, the EIP, or the local mental health team, or it might be that we take over prescribing and delivery and dispense medication.

Q. How is that agreed between you all?

A. So, I mean, it's generally agreed between the patient and the clinician seeing them about where the medication supply will come from, and it can be as simple as whatever is kind of easiest or practicable, for example, if the patient has existing supplies of medicine

already.

The -- there might be occasions where if somebody presents as very acutely unwell we would just decide to take over prescription, remove all old supplies of medicine from their house, advise other prescribers that we're taking over prescription for a short period of time and sort out that medication for that period of time.

Q. You tell us Multi-Disciplinary Team meetings are a place where you can consider the risks of a particular patient, and whether they're sufficiently contained in the community or require hospitalisation. Who initiates the MDTs for patients?

A. So, I mean, being under the team and being allocated a RAG rating of red or amber in crisis, so red RAG being cases that we feel need kind of daily oversight, amber cases being cases that we feel need weekly discussion in MDT, and at least two to three visits per week. That would be the trigger. We do our utmost to ensure that we discuss every red case every day and every amber case at least once per week.

Green cases we used to discuss, but those are patients being seen less frequently, identified as less pressing in terms of the risk, so we rely on the senior nurses to check their records just to make sure there's

a clear and cogent plan appropriate to the risks in place. If there are concerns that they identify, then they bring it back to the MDT, so that would be the main way.

THE CHAIR: Sorry, can you just slow down a little bit because a note is being taken of what you're saying.

A. Okay, sure. So we also have the option for practitioners within the team to identify particular cases that they've been involved with or had contact with that they feel need raising to the MDT as well outside of those structures.

MS LANGDALE: In terms of being one of three consultants, do you ultimately take responsibility for decisions that are made within the Crisis Team surrounding when somebody should be taken off it and hospitalised, or not?

A. Well, I mean, we -- I think an MDT is meant to be a shared kind of decision-making process, but as a kind of senior clinician and a section 12 approved doctor in that context, any of the three of us might decide: actually, I'm not sure that home treatment is feasible or effective here and we need to think about admission for this person.

Q. You say, in preparation for MDTs, you read the RiO notes. So you would read the entries made by nurses --

we're going to hear from a couple more, we've heard from one -- where they record exchanges with VC, you can bring to bear your experience and understanding of mental health reviewing what's written in any exchange.

A. Yeah. I would say, so for example in a red RAG MDT in a morning we have -- well, ideally about an hour-and-a-half to complete those MDTs, and there might be 20 to 30 cases to discuss. So we have minutes for each case, and I generally try and restrict myself to a review of their risk history, a review of recent events that led to the current referral to the Crisis Team, and then a handover from the nursing team, who have either taken a referral or assessed the patient about the current pressing kind of issues around presentation and risks.

And I'd also generally try and filter, by profession. So read medical entries, medical reviews of patients to glean kind of formulations of previous doctors who have been involved in a patient's care and so on. I wouldn't be able to read the entirety of the RiO record for every patient. I just could not do that in the time available.

Q. Can we have, please, NHFT0000530, page 12. This, Dr Lomas, is the Theemis Report from January 2025, "Key findings in relation to VC's care and treatment." And

when we have it on the screen we'll see in the second box the criticism:

"The way in which risk was being documented and from lady was not indicative of a dynamic approach to risk assessment and management. That is to say, risk was not considered to be changeable based on the presence of known hazards and in the context of different settings. For example, VC's risk in hospital would have been different from when in the community where hazards such as non-concordance and disengagement from services may have led to new or increased risks. The risk assessment's formulation section reads as a list of previous violent behaviour rather than a true formulation and therefore does not demonstrate active risk control or understanding of the impact in change of effectiveness of protective factors. In the community, the section of the risk assessment form does not detail the actions taken or needed to attempt to minimise or mitigate known risks. Hence, reviews may not focus on how effective the intended controls were at that time or in the context of the setting."

Over the page, the "Finding":

"The prioritisation of a positive risk management approach may have impacted the ability to achieve medication concordance, engagement with services and an

increased level of insight. Instead a dynamic approach to risk [assessment] ...would provide the opportunity to consider clear points at which to move from positive risk management to taking a more [risk] restrictive approach. This would ultimately support the management of hazards ... [and] VC with the long-term management of his mental health condition."

Do you accept those criticisms?

A. Sorry?

Q. Do you accept those criticisms of how risk was assessed and formulated and managed in VC's care, including when he was in the community and being managed by Crisis?

A. So, like I would accept that the documentation in the core risk assessment document kind of became a list of historical factors.

I think, in terms of the detail that you go into when you make a documentation in a service that sees as many patients a year as we do is never going to be as entirely detailed or nuanced as you might want it to be when subjected to kind of, you know, the detailed level of scrutiny going through the Inquiry.

I would say that actually the awareness of the potential risks kind of led to our being particularly vigilant and kind of having a low threshold for calling a Mental Health Act Assessment in VC's case for the week

that he was under our care, prior to the last assessment that I undertook.

I think that there is a problem around documentation of risk and the difference between completing a form to satisfy a kind of -- an organisational process as opposed to a clinician taking time to properly formulate and understand the person's risks, yes.

Q. Can we look at page 15, please, "Key findings in relation to VC's capacity":

"VC's ability to fully understand the implications of his mental health condition were limited by his lack of insight. This may have meant he lacked full capacity to make decisions in relation to his care and treatment and engagement, particularly in the community. There does not appear to be a systemised approach to assessing patient capacity based on presentations across care settings and relied upon in the context of voluntary treatment within the community. Therefore, the question of capacity does not appear to inform all assessments of risk across the different care settings."

Do you agree with that?

A. I mean, I think the question of capacity is at the forefront of kind of every decision you make about a person when you're assessing them under the Mental Health Act, but the framework of the Mental Health Act

supersedes the Capacity Act in terms of determining a person's treatment, and a person's kind of need for admission for assessment or kind of input. And I think although we don't document explicitly what a person's capacity is in every interaction we might have, I think the tendency to not go into the details of making a capacity assessment might be around the fact that you're making an assessment of a person's ability to make decisions about acceptance of care and treatment for a mental disorder, and that's when you come into thinking about the use of the Mental Health Act.

Q. Paragraph 21 of your statement, you say:

"A conservative estimate, [you'd assume you did] ... 2-3 assessments per week for 46 weeks per year ..."

So by the time you assessed VC, how many Mental Capacity Act Assessments do you think you'd done?

A. So I think I'd probably done 750-ish as a consultant in the Crisis Team alone, and obviously before that I'd undertaken three-years' of assessments as an on-call ST doctor, Section 12 Approved. So I don't know. It's a large number.

Q. Can we that have on the screen, please, a paragraph of your witness statement, 29. So WITN0316001, page 11. At paragraph 29, Dr Lomas, you say what information you would take into account when assessing a patient's risk.

And you say:

"... [you] take into account all information regarding their history that I am able to obtain from any source ..."

A. Mm.

Q. Can you tell us what sources you potentially go to, and then tell us what sources you went to in the case of VC?

A. So I could go to kind of family, housemates, police, records, and that includes paper records, not just kind of digital records, and records from Out of Area if the patient had been involved Out of Area. I could go to the person's regular care team, to their care coordinator, to their consultant, to consultants who have been previously involved in their inpatient care.

Q. Generally do you find people resist sharing information with you, or because it's you in your role, they're happy to?

A. No, I mean people are happy to tell me kind of whatever generally. I think in VC's case I can't recall what I'd looked at, but as a bare minimum, in terms of the time available to me, I would at least try and read a person's records in a more full way than I would, for example, for an MDT discussion. I would also ideally speak with their regular care team, but I think on both the occasions I assessed VC it took place out of hours.

I think they were both Fridays, I can't recall exactly. I'm fairly -- I know the second one was. And so those kind of avenues of kind of information aren't available to you.

I suppose particularly pertinent to the second assessment I undertook might have been speaking to the police to gain details about the assault that had taken place a week before.

And if I undertake an assessment in the custody suite it's really easy to get information from police logs and records. You simply speak to the desk sergeant, we both have a chat about what our views are on what the particular outcomes of an assessment is likely to be, or what the outcome of an investigation is likely to be in terms of is the person is going to be bailed or remand and so on.

That's very straightforward. I think when you get into the realms of having to ring 101, go through to the control room, then identify a police officer who is available to speak to you, that can be more time consuming and you're just limited by the time available to you.

So for the second assessment, I think I'd -- I think -- I can't remember, I put the details in my witness statement about the work I'd done that day

and --

Q. We'll go through it later.

A. Okay.

Q. In terms of the police and patients being arrested or bailed by the police, do you have a view about the appropriateness or otherwise of mental health patients being prosecuted through the criminal justice system?

A. Yeah, where it's serious, it should definitely be prosecuted through the criminal justice system, because the seriousness of an event can be lost over time, and I don't think I reference this in terms of VC because I think both his initial arrest and his subsequent assault on the police officer at the first assessment I was involved in, kind of loomed large in my mind at least.

But in other cases I've been involved with, where a person is inappropriately diverted from the criminal justice process, that's resulted in care in the general adult psychiatric system rather than the forensic psychiatric system, which is resourced to another level, has the time to use kind of structured assessments of risks like the HCR-20 and so on, and generally is slower paced and there is less emphasis on getting people through periods of admissions and through periods of crisis quickly and efficiently because of the demand on

services and so on.

I think that psychiatrists also have a role in that, though as well. So I remember that, and it stayed with me very strongly, when I did my first Section 12 induction course, Dr Tony Zigmond was one of the presenters, and he talked about one of the case examples was a man who was obviously -- this is the training course that you go through to be a Section 12 Approved Doctor -- the case example used was a man who is floridly manic, who was arrested on suspicion of a serious sexual offence and the police were very convinced of his guilt and so on and, you know, the question was: should you detain this person to hospital? And the answer really was no, because you don't have appropriate treatment available to you.

The level of security available in a general adult psychiatric hospital is not sufficient to contain that kind of level of risk, and actually what requires is remand and referral to the prison inreach mental health service to ensure that treatment is initiated and that process is triggered. But diverting certain cases away from the criminal justice system can lead to those cases not being subject to the rigour of the forensic -- kind of forensic psychiatric system.

I think it most commonly happens with really

borderline cases around -- fire setting is the commonest one that I -- I think I've been to two assessments in the custody suite in the past where I've said I'm not doing an assessment on this person. One of them, I have to say, turned out completely inappropriately because the offence was nowhere near as serious as it immediately appeared, and that person spent several weeks on remand in prison needlessly, which is a source of reflection for me, but the other one certainly did go down the criminal justice route and I can't remember the outcome but that was appropriate.

Q. Here, when you assessed risks, you tell us at paragraph 29, that you look at a combination of factors, static and dynamic and you say:

"... Static factors include matters such as gender, employment status, housing status, history of abuse, history of the patient engaging ... acts which result in the risks in question."

What information do you obtain in order to assess those static factors?

A. So, I mean, it's -- I mean, in the case of direct observation in terms of patient's gender or just simply asking them if there's any question about that, and you gain it from taking a good history from a patient and from relevant kind of previous histories, assessments

undertaken by previous practitioners.

Q. If we look at paragraph 31, page 12, in terms of risk of violence or aggression, what do you ask about?

A. Ask the patient in particular?

Q. Yeah, or other people.

A. So I would ask about when you've -- so one of the questions might be: "When you've been unwell in the past, what's the most dangerous thing that's happened? Have you ever got into fights? Have you ever got into conflict with another person? Has that escalated to physical violence? Have you felt the need to carry weapons to protect yourself?"

I would go through the clinical record looking for examples of similar kind of incidents, and then I would focus on the patient's present mental state at the moment in time, trying to get detail about what their current thoughts, feelings and experiences are and how those impact their kind of intended action at that moment in time, whether or not they might feel the need to defend themselves, whether or not they might want to hurt an individual who they identify as being a cause of their experience, and so on.

Q. You say at paragraph 32:

"It's impossible to predict which individuals will go on to commit such acts."

Acts like homicide.

A. Mm.

Q. Effective risk assessment and management can prevent that, can't it?

A. So I think what -- I think identifying particular individuals that go on to commit particularly serious offences is very -- well, is impossible, as far as I understand it. But what you can do is identify groups of people who are at greater risk of carrying out some form of violence and that has to form part of your kind of ongoing management plan.

Q. You can assess and risk assess those who are capable of serious violence, however you categorise that?

A. I think that gets a little harder because "serious" is such a subjective description of violence, you know, I don't know ... so, you know, somebody who -- if I can use an example from my own clinical practice, you know, a patient has physically laid hands on me and thrown me out of their home. The patient was subsequently detained to hospital, and the nursing team, when trying to identify a bed for the patient will add "doesn't the patient need a PICU?" And actually my interpretation of the event, even being a victim of the assault, was that, you know, he laid hands on me, he grabbed me, he shoved me, it didn't strike me as serious violence and it was

done more in the spirit of kind of outraged indignance than any desire to do me serious harm, if that makes sense. But other people might look at that and say, "That's really serious, Dr Lomas, you're downplaying or under-recognising the seriousness of that incident" and I don't think that there's an easy answer to that gradation of what "seriousness" can mean.

Q. How regularly does that kind of situation or event occur?

A. In my 17 years as a psychiatrist, I've been assaulted three times.

Q. So not very often. So that event would be unusual or rare --

A. *(The witness nodded)*.

Q. -- and it's necessary to look at other events and triggers in the patient's circumstances presumably to assess risk.

A. Yeah.

Q. So I'm not saying an individual event of itself, but the trigger, if it came from nowhere, zero to 100, unexpected, unpredictable, unprovoked, they're relevant factors, aren't they; relevant factors in assessing risk?

A. Yes, I think you're assessing the assault on the police officer that myself and Amie Staples witnessed. I think

the use of the word "unprovoked" is interesting, given, you know, I don't -- if I was in VC's world at the moment in time, you know, and it was an exercise of fantasy to try and understand what that world was because he wouldn't speak with us, but if I perhaps believed that I was the victim of state surveillance and then agents of the state turned up in large numbers to forcibly people remove me from my home for a purpose I didn't believe in, I might understand that as being kind of provoking.

Q. To the people around him, when we say unprovoked attack, we're talking about it from the victim perspective and the victim doesn't anticipate what's going to happen next, and I dare say -- well, it's clearly the case, we've all seen the video -- the officers did not expect what was going to happen next.

A. No, and --

Q. So unprovoked from their perspective.

A. Unprovoked from their right perspective, unexpected from mine, perhaps.

Q. If we go then, let's go to September, but just to take us in there, please, if we can have NHFT0000168, page 49. This is so people can orientate themselves in time, Dr Lomas, including yourself. He's discharged on 17 June from his second admission. We see that at

NHFT0000168, page 49.

And: "He must continue his medication [we see in the bottom box] for at least 6 to 9 months minimum and seek medical advice if wishes to stop.

"He will have follow-up with [the] city Crisis team - there was planned 3 day follow up for 18 [June] ... and will be done by Izzy Fairbrother and Lesley Mahachi between 12 and 3 PM."

The discharge summary, if we can see that please, NHFT0000223, page 3, risk factors in the discharge summary at page 3:

"... no risk to self identified."

You see the middle box:

"Others - he believed others were trying to spy on him/torment his mind and tried to enter a neighbour flat to confront them. ... kicked the door, damaged it, scared the person ... who had to jump out of the window from her first-floor flat and injured her back and needed treatment."

And it's recorded here:

"There were no further incidences whilst on the ward, ... clear remorse for his actions."

Can we go, please, to NHFT0000168, page 50, and we see here, 18 June, the Crisis Team, NHFT000168, page 50, at the top, the Crisis Team make a telephone call to VC:

"... reports feeling well in himself. Things have gone well since returning home ... Feels that he is managing ... well.

"... calm, stable ... not experiencing any hallucinations/abnormal thoughts."

If we go to WITN0163046, page 2. We see Dr Seedat letting you know that he recently discharged VC from the ward:

"... not sure why face to face visits are not happening, the message given was ... it [was] ... due to ... COVID ... When I spoke to ... crisis staff ... [that] I was assured .. he would be visited at home.

"I feel follow up needs to be face to Face ... as he does not let things out and will give the impression that [he's] ... well.

"Please can you guys look into [it]..."

And we see NHFT0000168, page 51, your note on 22 June:

"email received ... requesting .. [VC] be seen face to face as he is likely to down play any symptoms/[and] problems."

We know, we'll be hearing evidence from a nurse who does a visit on 23 June and their observations, also on the 11 July we know that VC's mother telephones. If we can have that on the screen, please, NHFT0000168,

page 55.

Box at the bottom:

"[VC's mother] ... said she thinks [VC's] mental state may be deteriorating ... she's been speaking to [him] recently ... conversation wasn't making sense ... asked if [he] was getting any support from services, ... thinks [he] may not be taking ... medication as prescribed ..."

And indeed, 168, page 56, there's an event, 14 July, again, where he -- if we look at the top box:

"... Police ... contacted by residents of a flat near to [VC's]. [He's] been banging on the door ... immediately forced his way in, [and] attempting to push past ..."

And in fact it took a number of residents to restrain him on the floor until the police arrived.

We see -- and you'll have seen these notes presumably at some point, Dr Lomas, yes?

A. I think I'll have read them prior to my Rule 9 submission, but not recently.

Q. We know he's then admitted to hospital in June. There's a mental health assessment you're not involved in. He's discharged 17 June, as I said earlier, admitted again on 14 July and discharged on 31 July. Relatively short admissions, both of them; do you agree?

A. Not necessarily in the context of General Adult Psychiatry.

Q. And he is not at any point, is he, established on a therapeutic dose to manage his symptoms? That's the bottom line when we look between the admissions when he stops taking his medication, when he comes back again.

A. So I can't see what dose of medication he was prescribed, sorry.

Q. Let's go, please, whatever he was prescribed, to NHFT0000168, 121. Because the records demonstrate that by 3 August:

"[VC] had decided to stop taking his medication 2 weeks after his discharge from his last admission ... believed he was well and he did not have mental health problems ... believed the medication was slowing him down when he was studying for [a] ... university exam ...

"... showed no signs of remorse or insight into how his actions have affected others.

"In the light of the above, I would recommend for CRHT to stay involved for the next 2-3 weeks at least and then review as [VC] is working towards his exams ..."

Did you see that at the time, that he had stopped taking his medication?

A. I can't recall discussing that particular incident.

Q. If we go over the page at 122, and again the author of this document will be giving evidence, but:

"MDT today for a plan. What is the next step should he continue to refuse meds concordance?"

So knowledge that he's not taking his meds and what steps next. And then we see you, NHFT0000168, 123, please. Bottom of the page, this now 5 August. You see from the bottom, 5 August, and we have 124 instead on the screen. Multi-Disciplinary Team meeting with Dr Lomas, "presentation with history of psychosis" at the top.

"... related increase risk to others and himself."

Why do you record there, risk to himself?

A. It would have been around the chance of accidental harm and not necessarily direct harm to the self, but harm to one's social circumstances through one's behaviour, so I might have been thinking about his contact with the criminal justice system.

Q. "... though seemingly appears symptom free from last visit."

So you accepted what the nurse had recorded, did you, about "symptom free"?

A. Well, no, I say "seemingly".

Q. So you doubted that then, that it was likely he was just

saying that to get them out of his hair?

A. I thought it was possible he could be symptom free and it was possible he might not be.

Q. And very serious if he was not. You thought he might not be; very serious, in the context of him not taking medication.

A. Yeah, it would be an indication that we would need to act more promptly to reinstate treatment.

Q. Or to find out if he was actually symptom free more quickly by someone who may be better able to assess that.

A. Yeah, although I don't think there's any particular profession or professional that's -- you know, talking about qualified professionals -- that is able to elicit kind of symptoms of severe mental ill health. A psychiatric nurse with a good relationship with a patient will do better than a doctor who has not met a patient before, for example. But certainly we needed to keep going and to keep an eye on the situation, which is why we carry on with daily visits and try and persuade him of the value of taking medicine.

Q. When you say "remain red RAG for concordance", what does that mean?

A. So that is -- red RAG is daily contact and concordance is to supervise his taking medication, and to persuade

him of that if he's refusing, or attempt to persuade him of that if he's refusing.

Q. So that meant the Crisis Team should keep going every day.

Part of the role of the MDT is to identify, isn't it, a formulation and level of risk. You said earlier that's where people would come together and discuss that.

A. So an MDT can perform multiple roles, and an MDT, for example, to discuss a case after an initial assessment, where formulation was felt to be unclear, might focus on that. I think the MDTs on a red RAG basis are about, because they take place every day, they're about "Has anything changed overnight? Do we need to do anything different today? Is what we're doing adequate?"

Q. It records here "presentation with history of psychosis", we spoke earlier about the fact there was a likely diagnosis of paranoid schizophrenia, wasn't there? So this was a schizophrenic patient, and do you accept the link, potentially, with violence?

A. I mean, there's a link with violence with psychosis.

Q. So you think it's the same, irrespective of describing psychosis or paranoid schizophrenia?

A. My understanding is that most of the research talks about schizophrenia and spectrum disorders in terms of

analysing the risk between major mental illness and offending, violent offending.

Q. We know that he's then assessed on 15 August by someone else who is going to be giving evidence, and the risk is noted to be, "appear[s] low in all areas. He's not a risk to himself and [he's] not a risk to people."

So that's the assessment on 15 August 2020.

Subsequent to that, he's not engaging, is he, with the Community Team?

A. I can't -- I don't have anything on my screen, so I ...

Q. Okay. But he doesn't work with the Community Team, which is why, on 2 September, there's the decision made to go and see him, isn't there?

A. If that's in the record, yes.

Q. Can we have a look, please, at NHFT0000168, page 164.

So this is when yourself, Jen Shaw and Dr Manzar are going to see him because of that non-compliance with you, not working with the team. Tell us about that. Are you helped by going to your statement or can you remember seeing him on the 2nd and deducing that he didn't want to have the Mental Health Act Assessment?

A. So I think I talk about it in my statement that we visit the property but it's empty. I remember climbing on the back wall of the flat, which I think was based in an old pub, and peering through the back windows trying to see

if there was signs of anybody in there deliberately avoiding us, because that would support the AMHP in making an application for a Section 135 if that was the case. But I just remember seeing an empty flat.

Q. And do you remember him later driving past you and Dr Manzar?

A. I don't recall that, no.

Q. So you go and conduct the assessment on the 3rd. Can we have, please, NOCC0000050, page 3, and this is Amie Staples's note of the assessment. Perhaps we can have 2 and 3 on the screen, if it assists you.

We see at page 2 is:

"[When] ... we were waiting for the police to arrive [at the bottom], a man pulled up in a car ... got out and approached us. He asked if we were from the hospital. He confirmed ... he was [VC]. I explained that we had come to see him and asked if we could speak to him in his flat. He initially agreed and let us in; however as Dr Lomas entered he then changed his mind and asked us to leave."

Can you remember now what he said and what you said and how that arose?

A. No, I remember I think I got into the flat. I don't think I even got as far as sitting down. And he -- well, just changed his mind and asked us to leave.

I think all I would have spoken about was the reason we were there to see him, and the kind of legal process that he was subject to, the kind of basic facts of it.

Q. Then if we look at page 3, do you agree with her assessment there at the top of the page:

"The police ... explained the need to accompany him to hospital. He then stated that the male officer should step forward ..."

Could you see into the room at this point or not?

A. I can't recall --

Q. You can't recall?

A. -- no, in all honesty, like if I could see at that exact moment. I remember being stood in the doorway to his bedroom, I think it was.

Q. Do you remember seeing him take his glasses off as a preparatory act?

A. I don't remember him wearing glasses.

Q. So you didn't see that?

A. No.

Q. You didn't see him take his glasses off.

A. *(Witness shook head).*

Q. You did think that he'd targeted the male officer in particular?

A. I did. So my recollection of it was -- I think there were two female officers with us and we kind of had this

circular discussion of "Look, you have to come with us" and VC simply saying no, and that no assessment was going to happen.

And eventually -- like you will spend as long as you have available to you trying to avoid the police having to lay hands on anybody, and the overwhelming majority of patients -- well, not the overwhelming majority, the majority of patients -- kind of being assessed in this way will give in, especially if it's happened to them before, they sort of know the routine and --

Q. Indeed, the next time he goes with you, doesn't he?

A. Yeah, he does. They accept it and go with you. But sometimes people just simply passively resist as a sort of kind of demonstration of how unhappy they are with the assessment. So there was a number of times when people have sort of clamped themselves into a chair or held on to their bed, for example, to try and prevent them being carried out by the police and the ambulance crew. And I at first thought that that was what VC was doing, a sort of kind of protest at -- just being outraged at the process taking place, and my recollection is that I think the female officers attempted to restrain him and the male officer stepped forward, but that's when he assaulted the male officer.

Q. Well, he had made clear, hadn't he, that he would walk

out with the male officer and he made reference to the fact that he doesn't harm female officers who were there. That's what he said at the time; did you hear any of that?

A. I might well have done, I can't recall it.

Q. So the male officer was required, if that process was going to move forward, to move forward, wasn't he, and he did that?

A. Mm.

Q. So there's no question in your mind, is there, that any of that could have been done differently, in terms of how you talked to VC about --

A. We'd given it our best shot, in terms of trying to persuade him to engage with the assessment process, yeah.

Q. You have extensive experience in doing that?

A. I mean, I probably have as much experience as anybody does in kind of taking forward those kind of assessments, yeah, although I -- I am more used to undertaking Mental Health Act Assessments without a Section 135 being required, and that might require a lot of persuading of people to let us into their home and so on.

Q. In a subsequent detention, VC described the attack on the police officer as "poor judgement" of his and also

said, "If they'd explained it better" -- differently, effectively. How do you feel about that?

A. Well, I do not know what else I could have said about the process.

Q. So manipulative, to state that, in terms of talking to people who didn't know you, didn't know what had been said?

A. Sorry?

Q. Explaining why he did it, because it hadn't been explained to him in a particular way, if they'd done it differently, it might have been better. In other words, blaming the people around him?

A. I mean, I don't think I could draw dramatic conclusions about a person's character from that one exchange. Like, if that, you know, if the idea was that we could have -- perhaps there was a way I could have explained it better, but I certainly can't think of it.

Q. Police, if you look back at the document in front of you, at the top box:

"Police used CS gas to attempt to subdue him with no effect. ... tasered three or four times; at which point the police were able to restrain him in handcuffs and leg restraints."

This was a violent attack and it took a lot, didn't it, for the police to bring it under control?

A. Yes.

Q. You paused there.

A. I'm just -- I'm framing it in light of other assaults that I've witnessed, both in inpatient care and in the community.

Q. Tasering three or four times? Restraining him in handcuffs and then someone trying to use a handcuff as a weapon?

A. So I think I've seen that or, rather, been involved in a case where that happened in at least one other occasion, and in terms of violent assaults I've seen on inpatient patient units that nursing staff have been subject to, there are some that are perhaps up there with that. You know, getting someone in a headlock and ramming their head into a wall, for example.

Q. When he's asked about medication, the last paragraph, asked whether he'd take medication for his mental health, he said "Of course not". Same old, isn't it: he's been telling the Crisis Team, people visiting him, this the same thing: "I don't need to take it, of course not"?

A. Mm.

Q. You, if we can have on the screen, please, WITN0316005, page 5. I think these may be your draft notes in preparation for interview about this case, or maybe they

were ones that you submitted in writing, but if you have a look, please, at page 5 of the document. You set out, in the last three paragraphs:

"When he resisted transportation to hospital, the impression I had observing the incident was that [VC] was terrified and appeared to be fighting for his life. Even in this context however, he would only aim physical violence at the male police officer present, not the two female officers. He was clearly highly aroused however CS gas and repeated taser charges were required to eventually subdue him.

"I formed the view based on the description of his psychopathology in his records (that he was being monitored and having his thoughts interfered with by agents of the state ...) that he believed he was about to be killed or tortured rather than taken to psychiatric hospital."

He's never said that at all to anyone. Didn't say that to you, did he, that he thought he was about to be killed or tortured?

A. No, as I referenced earlier, there's a degree of fantasy in trying to understand what might explain it.

Q. A degree of fantasy?

A. Yeah, as in, you know, an attempt to imagine another's mental state, I think PH fantasy and psychotherapy gets

used in that way sometimes.

Q. Speculation?

A. Speculation.

Q. Not evidence based?

A. Not evidence based --

Q. Is that a worry as a psychiatrist?

A. Well, I'd say it's not completely plucked out of the air, it's a best guess.

Q. Is that significant that for psychiatry, is that significantly understood it's a best guess -- you used the word fantasy -- for guessing a patient's state of mind and imposing more rational thought on that, potentially?

A. So what you'd rely on is, as I talked about earlier, the kind of phenomenological psychopathology a patient describes to you, that in order for you to get a grip of that and to understand a person's mental state at any given point in time, you need to have, hopefully, kind, of a fruitful conversation between the two of you during which you can recognise, check off, the psychopathology that you have been trained to recognise. But sometimes when people don't say anything to you, you're left inferring as best you can.

I mean, I don't know, shut me up if this is irrelevant, but there's a picture that always stayed

with me from Sims' Symptoms in the Mind, one of the books that psychiatrists read to learn psychopathology where it contrasts a mental state examination with a physical examination. A physical examination you have lots of objective measures, blood pressure, pulse, heart rate, temperature, you can physically lay hands on a patient; and then the image of a mental state examination is someone who is blind fold and their hands restrained trying to understand another person next to them. But it's based on observation of behaviour and the clinical interview that you undertake and the exchange of information and the context of that interview.

Q. It's based on informants?

A. It's based on collateral history as well, yeah.

Q. If you don't have informants and the people around the patient, then it really will just be fantasy, won't it?

A. Not necessarily. Like, I think you can still infer things from a person's mental state and you can infer things from -- sorry, infer things from a person's behaviour and observations of the behaviour, and you can also infer things in light of your kind of historical knowledge available to you and the record.

Q. That's really important: accurate historical knowledge for those who have experience of the patient in

different contexts?

A. Yes, you would ideally -- ideally, in every assessment, you'd want someone who's got kind of substantial prior acquaintance and familiarity with the case, ideally.

Q. If we go to CYGN0000085, page 1 and 2. You complete this, Dr Lomas. It's the PICU Gatekeeping Referral Form. "Reason for admission to Hospital" is set out:

"Current mental state and presentation:

"... presenting with relapse of psychosis, ... persecutory beliefs about being monitored by the government ... does not recognise he is unwell."

At page 2, states:

"... his relationship with mental health services has ended ... he will have no more to do with us. ... refusing medication ... extremely antagonistic ...

"... risk of serious physical assault to healthcare staff."

It wasn't just to healthcare staff, was it; it was to others?

A. So it was to others more broadly. At that particular moment in time, I was kind of focused on managing the acute behavioural disturbance.

Q. Getting him into a PICU. I think it was 14 units that didn't take him and one eventually did; is that right?

A. I understand that's the case, yeah, from the record.

Q. Was that to do with bed availability or the details of the patient?
A. You'd have to ask the PICUs.
Q. That can come down. Can we have, please, NHFT0000168, page 167.
This is Patient Record Summary. You, Dr Manzar, Amie Staples, in relation to this September assessment.
Who wrote the content of this, Dr Lomas?
A. Me.
Q. So if we go above "Discussion", you say:
"We could not draw him in to a discussion about his beliefs or experiences, or why he chose to fight so vehemently with the officers given he is normally a gentle law abiding young man."
Why did you say "gentle law abiding young man" at this point?
A. I think I based that on Claudia Birtles' description of him earlier in the notes. I think I referenced the quote in my statement, I can't remember exactly when or where it was from, or what it was word for word.
Q. But you knew from the discharge summary we've been to, and other records about the event when he forced his way into a flat and a woman jumped out of the window seriously injuring herself, yes?
A. Yes.

Q. You knew about other events at Brook Court, the one precipitating the July admission when --
A. Yes.
Q. -- it takes a number of people to restrain him, and you'd watched him being restrained yourself by police officers in the context of the September events.
So why did you regurgitate that, whatever Claudia Birtles had found on any day or whatever she thought, when you were doing this?
A. I think it was about trying to understand, you know, a man without an extensive history, so with an extensive history of offending towards his, you know, multiple contacts with police over many months, many years and so on, and when he had been in contact with the criminal justice system and assaulted others, you know, it was sporadic and seemed to be between periods where he would work, he would attend his studies, his education and, at least from Claudia's description of his character, she found him as she described him.
Q. You refer to his eye contact in that paragraph. But before I ask you about how he appeared then, in your statement at paragraph 59 -- we don't need it up -- you say:
"When I first encountered VC, he approached us on a street corner where he was polite and coherent, but

his eye contact and affect suggested subtle indications of psychosis. His eye contact was staring, though not threatening, and his affect -- that is, the range of emotional expression communicated through facial expression -- was blunted."
A. Mm.
Q. So that was before you had seen him look like that on the 2nd -- sorry, on the 3rd, when he drove past you.
A. I don't remember seeing him on the 2nd at all. That was when he approached us on the street outside his house.
Q. On the 3rd --
A. Prior. On the 3rd, prior to us going in to the address.
Q. So you observed "eye contact and affect [suggesting] ... subtle indications of psychosis".
A. Yes.
Q. I think we see Claudia Birtles' refer to a "fixed stare" or "psychotic stare", or something like that.
A. Yes.
Q. Is that something that's familiar with you?
A. Yes.
Q. Here in this, when we go back to the assessment, you say:
"His eye contact was staring and clearly meant as a challenge."
Challenge to what?

A. So a kind of physical attempt at intimidation. I think the best way I can think of describing it is, you know, a lay term of staring someone out, as you would before you have a fight with them.
Q. Indeed you say in your statement at paragraph 62:
"... squaring up to me, moving into my personal space and anger on his part at being detained."
A. Yes.
Q. Did he appear to have, to you, in your conversation, self-control, able to be polite?
A. So I mean he was in control of his behaviour to a degree. He resisted the transportation to hospital vigorously, but on arrival -- I'm going by recall here rather than anything that I've written down so, you know, this is impacted by, you know, the vagaries of human memory but like he was, on arrival, kind of calmer and not indiscriminately attacking everybody who came near him as other patients have in the past when they've arrived on the Cassidy Suite.
So to a degree, yes.
Q. You say finally on this document, the top paragraph:
"Historically when unwell he has force[d] entry into ... neighbours houses under the influence of his psychotic experiences, though no violence has resulted."
Why did you say "no violence has resulted", given

the history of events at Brook Court?
A. I should have said he'd not directly assaulted someone or no direct violence had resulted. Because I remember the person had injured themselves fleeing from him and I remember thinking that, you know, they sustained a fracture in this incident, and should that have led to a criminal justice charge? I found myself wondering if I'd been asked to assess him in the suite what would I have said to that? And I was genuinely unsure about how the law would view the injuries sustained by the individual.

What I meant by that is he'd not directly hurt somebody by physically hitting them, I guess.
Q. If we go, please, to NHFT0000168, page 21. This is a document in the RiO notes of Dr Seedat -- prepared by Dr Seedat. Did you ever read this, Dr Seedat's summary account of text message conversations between VC and his brother?
A. I can't remember if I did or didn't. I suspect I would have done if it was -- was it entered by Dr Seedat?
Q. Yes.
A. Then I suspect I would have seen it because I usually filter RiO notes by profession, including medic to pick out --
Q. When you say "entered", do you mean has it got his name

on it somewhere? Because I can't tell you that. It's information that only Dr Seedat had, and therefore he's the author of it, but how it appeared on RiO ...?
A. So if he made the entry into RiO, then I would have seen that as, through filtering that information. If I hadn't, if it wasn't entered by Dr Seedat, if it was entered by his secretary, I might have seen it but I can't comment for certain.
Q. Would you have wanted to know what VC was saying to his brother about his delusional beliefs?
A. From a text message conversation --
Q. Yes --
A. -- from 2020? In all honesty, I don't know.
Q. Would you have wanted to know -- I mean it's been recorded in the record here -- "he is doing this", he's "telling", "He said ... people would not mock him in person and made some remark to wanting to hurt these people he was hearing."

That's how it's been summarised by Dr Seedat.

"... said he was hearing voices, you won't believe me. He believed he was being watched by people in the next room and ... other people. He did not know any of these people."

Would that tell you much about risk or not?
A. Which particular --

Q. The quotes, particularly "He said the people would not mock him in person and made some remark to wanting to hurt these people he was hearing."

"... wanting to hurt these people he was hearing."
A. I would have wanted to know -- I would have wanted to know that, and I would also make asking questions about that kind of experience -- I mean that's a routine kind of area to explore. So wherever anybody is experiencing persecutory beliefs, the belief they're at the centre of some malicious conspiracy against them, you always ask "And do you know who these people are? Have you had thoughts about confronting these people? Have you got into conflict with any of these people you've identified?" And, you know, escalate the questions through to asking about thoughts of violence, as I described earlier.
Q. Because knowing if they have thoughts of violence is significant to what?
A. To thinking about risk.
Q. And whether they might do it?
A. And whether they might harm someone, yes.
Q. If you go, please, to NGPF0002527, page 14. No suggestion you or anyone other than Dr Seedat saw these at the time. My question is: should you have done? So if you look at page 14, there's many text exchanges and

here at the top, reference to VC saying:

"Because I think that they are watching I know that I can break their heads with my hands".

Is that the type of comment you'd like to know or source if he'd been having that?
A. I mean, in all honesty, it's difficult to know how significant a thought of violence that's, let's say a year or two years old, would have been to an assessment some years down the line. And in all honesty, I think the question that might come to about whether or not this should have been uploaded into the record and whether or not I would have seen it, I'm not sure, in all honesty, I would have read every document in VC's record and I'm not sure I would have read a transcript of a phone conversation from a few years ago. I would have taken note of anything entered in the risk -- core risk assessment document about that.
Q. So if somebody had summarised this, and if we go to page 17, other messages, one from 12 April:

"That previous night I felt immense anguish, aranoia, anger, hatred.

"couldn't sleep, had the darkest thoughts of could imagine.

"Wanted to hurt ... permanently ..."

Over the page, page 18:

"I was thinking about red rum not 120 minutes ago."
Would you understand a reference to red rum?
A. Well, it's murder backwards or I think it was a racehorse, I think.
Q. Both.
A. Yeah.
Q. So would you have understood that that could be a reference to murder? "I was thinking about murder not 120 minutes ago".
A. If I'd read that, that would come to mind, yes.
Q. Would that worry you? Would that be a factor on the formulation or as part of the formulation?
A. I would definitely want to talk to the patient in detail about it, but I would put this in the context of how very many patients we see that have thoughts of violence, in the context of psychosis and other disorders.
Q. In terms of -- that can go down, thank you -- we have analysed what VC was viewing. He was viewing various terrorist attacks. He was viewing a live stream of capital punishment that he refers to, to his brother. Would you be concerned or interested to know what a patient is viewing on the Internet, when assessing risk?
A. I mean, thinking about what is available on the Internet

and the kind of controversies around, you know, consumption of media and the potential risk of violence, you know, thinking back to the nineties and video games, for example, or the consumption of violent films, I'd -- I suppose I would factor it in but I'd be uncertain of its kind of significance unless there was research pointing me in the direction of particular types of footage were horrendous. You know, I mean, horror films are often consumed by a big proportion of the population for pleasure. I don't find that pleasurable myself, but in the context of this, I think it's hard to know.
What I'd be more interested in is: how did what he was consuming relate to his mental disorder and experience of his symptoms?
Q. Do you ever ask patients what they're looking at on their phone? Does it disturb them in any way? Just as part of an exploratory assessment.
A. Yes, so I'll -- so often what happens is, a patient has come to our attention because family members, friends, others raise concerns about them, but the person doesn't want the patient told that they've raised concerns, or sometimes they might be more acceptable of that. And it's often about content of, you know, repeated messaging, strange messaging, that's been sent. I'll go and see the patient and they'll appear to be symptom

free, but I will then ask "Can I, you know, talk about what you've been doing on your phone recently? Can we have a look? Is it okay if I see your phone?"
The practicalities of getting access to someone's phone is not something that's available to me. But some patients are more than happy to let me flick through messages, browsing histories, whatever it might be. But, you know, phones contain, for all of us, vast amounts of information we'd be reluctant to share with anybody no matter what their trusted position, I'm sure.
Q. Can we have a look, please, at NHFT0014459, page 6, alongside the same INQ number, page 8. And Dr Lomas, these are your recommendations, yours on the left and Dr Manzar's on the right, in relation to the assessment on the 3 September, and we see Dr Manzar at the end of his on the right says:
"The patient has poor insight, is lacking capacity to make decisions about his care." *(As read)*
And he also identifies four lines up:
"[VC] is currently paranoid about his neighbours."
He hasn't seen the text messaging either, but just the symptomology of describing what his neighbours are doing, et cetera, and how he feels about that and the confrontation, he says, "He's a risk to neighbours".
Your -- you express:

"... presents as experiencing a relapse of psychosis secondary to collateral history ... not engaged with the assessors and has violently resisted efforts to execute [the warrant] ... Does not accept he is unwell ..."
You don't say anything about either risk here, treatment or anything else. Why is that? It's an admission for assessment that you're recommending.
A. So in terms of completing a medical recommendation, your focus is very much kind of ensuring that you meet the legal criteria for detaining someone and that you document the relevant clinical information that justifies that person's detention.
So the information we had from Claudia Birtles kind of described -- he described to her ongoing symptoms, but in terms of our attempt at a personal examination of a patient, which a doctor assessing a patient under the Mental Health Act must undertake, we hadn't gleaned any useful clinical information other than me inferring from past history and possible explanations of his behaviour during the assault on the officer, what was going on in his mental state, that I wasn't certain of that, I wasn't definitively clear, you know, other than saying, "No assessment is going to happen, I'm not unwell, I don't need to go with you", no useful exchange of information took place between VC and I.

And I don't recall any reference to neighbours at that point either, if I'm honest. What I recall from Claudia Birtles's entry was about the state being involved in surveilling him. I don't remember reference to his neighbours at the time, so he would have only had upstairs neighbours.

And my recommendation is short and to the point, that it meets the requirements of a recommendation for somebody to be detained for assessment.

Q. Do you not think detention for treatment would have been better under Section 3? You knew he wasn't taking the treatment, you knew and later on went to discuss depot.

A. So I undertook two assessments of VC and both of them ended up in a Section 2 admission. And I think I can understand when somebody has been to hospital a couple of times before, why people might, especially without having been involved in assessing patients under the Mental Health Act, and without being involved in delivering care to patients with psychotic illnesses over very many years might think: but you know they're unwell, why don't you just make them take a treatment?

I think, in the first of the two, reflecting on kind of decision-making process made, that was the more likely one where we could have landed on the side of recommending detention for treatment. But, again this

comes from my Section 12 induction course, you know, I was taught that the personal examination by the doctor informs significantly the justification of detaining a patient against their will when you're dealing with somebody's liberty.

And although you definitely do use collateral information and you certainly don't ignore collateral information, for example examining a patient remotely I think has been decided as not legally meeting the requirements, and in the training, and explicitly in the Act, explicitly I think it talks about examining someone through a door or window is insufficient in terms of recommending a detention. And I suppose my view at that moment in time was: should he have -- should he be diverted to the criminal justice system for the assault on a police officer? Was that the appropriate course of action? Should he be treated with, you know, kind of depot antipsychotic medication from the outset, without kind of at least being able to treat him initially, improve his insight to where he might be able to have a more reasoned discussion around that later in his assessment?

And it was for those reasons that I thought admission for assessment was appropriate, because I think on that occasion he did end up on a Section 3,

didn't he. It doesn't preclude you using a Section 3 should you need one later.

Q. But had you -- you could have done both of those things at the time, a Section 3 with a recommendation for depot, given what had happened and the history?

A. I could have done if I'd have kind of ignored the principles around promoting patient inclusion in their -- decision-making around their treatment and the need to promote autonomy and independence and the other kind of guiding principles of the Mental Health Act Code of Practice.

Q. So restrictive -- the interpretation of least restrictive option, maximising independence, patient autonomy took you to Section 2 instead of Section 3, when in fact you've identified the depot, the treatment, what was needed. You knew that at this point?

A. I didn't know that at that point.

Q. Really?

A. No, no. I mean so, you know, I recognised the need for kind of immediate control of the risk he posed to others at that point in time, that any further assessment and treatment of him couldn't happen in the community.

I recognised that he needed to be rapidly tranquilised, but in terms of that being a long-term, you know, appropriate treatment plan, I wouldn't have

dreamt or wanted to suggest that he was just repeatedly rapidly tranquilised, for example, on and on against his wishes.

Q. I wasn't suggesting indefinitely, a longitudinal plan, but at that point he --

A. But after he'd been rapidly tranquilised and this initial, kind of, acute behavioural -- period of acute behavioural disturbance had passed, maybe then at that point you can further discuss and assess VC's mental state, maybe you would, or hopefully you would get -- as I do kind of later on in his admission -- get a more clear discussion around the psychopathology, what drove him to disengage from services, and discuss at that point, you know: "Would you accept a depot in the first instance?" And if that was felt to be absolutely necessary, and that the risk couldn't be managed any other way, then you could, in the circumstances, where it -- the reasonable components of a treatment plan are available to you.

Q. Can we have, please, NHFT0000168, 188 on the screen and that's Dr Lomas, when you see him on 10 September. While that's coming up, the issue of disengagement, what more did he need to say other than "I don't believe I'm mentally ill?" He'd repeatedly stated this, and indeed when we see on 10 September he is speaking to you about

the technology called neural remote imaging and neural remote mapping.

And non-engagement was a consequence, wasn't it, of all of this? He just didn't think he was ill.

A. He just didn't think he was ill at that point and the hope was that with the treatment he could recognise that he was unwell, as we would do with any other patient and try and persuade them of the value of taking treatment.

Q. How many times and opportunities are they given to express that genuine belief that they're going to take medication because they accept that it's secondary gain and it's better for them? How long do you persist with those types of -- *(overspeaking)* --

A. So I think it's very difficult to, you know, define a limit, a cut-off, a time when if a person has had this many goes at being allowed to take oral treatment, they should be coerced into accepting long-acting injections.

Because it -- you know, it requires that the long-acting injection is, to start with, effective. It requires that you balance the patient's choices, autonomy, their own rights, against the risks they pose to others and that's a really challenging kind of decision to make and if you do make it you want it to be really clear, consulting with as many people as you can.

And in the context of an assessment where

considerable amounts of pepper spray had been deployed by the police, where a person has not engaged with you in any meaningful way, where you're meeting a person for the first time, I think it's reasonable -- and I felt it was reasonable at the time -- to want to take time to assess that further. You know, the Mental Health Act recognises that an assessment can take 28 days, whereas a Mental Health Act Assessment, the process of interviewing with doctors and AMHP, it would have been unusual for it to take more than an hour.

Q. That can come down, please. Can we have CYGN0000056, page 5 and this is the Mental Health Act Tribunal decision in September 2021. Did you ever see this decision, his appeal against his detention and the decision?

A. Sorry, it wasn't on the screen.

Q. It will be in a minute. Page 5. Did you ever see this at the time or subsequently when you were reviewing his notes?

A. No.

Q. So you've never seen it until you've seen it via the Inquiry?

A. No.

Q. So if we look at page 5 at (iii):

"Whilst [VC] accepts these events occurred, [the

assault against the police officer] his evidence appeared to minimise them somewhat, describing them as 'unfortunate' ... and the consequence of 'poor judgement' which suggests a lack of insight."

At the same time as receiving this decision, VC emailed a police officer asking for reconsideration of a conditional caution. That shows real intelligence, doesn't it, to see that lack of insight is being described, and he then goes back to the police officers and says, "I'd like to accept a conditional caution"?

A. Sorry, he says, "I'd like to" --

Q. "I'd like to." He'd like to. It's too late by then, the events have closed.

A. Right.

Q. But he recognises and says he'd like to accept a conditional caution in relation to an earlier event --

A. Yeah.

Q. -- that he assumed was being proceeded with. That's real calculation, isn't it?

A. I mean, it -- I'd have to understand kind of the details of the consequences of not accepting the caution, of understanding his kind of motive for doing so, before I could draw any conclusions about it.

Q. Well, he's being told here that he minimises past events, so I suppose accepting a caution and going to

the police and saying, "I now accept that earlier event" is demonstrating that he is, to some extent?

A. I suppose you could argue it from the way you've put it to me, yes.

Q. Can we have, please, NGPF0000019, page 1, an email to you. I think you don't recollect receiving this particular email.

This is a request for information surrounding VC, diagnosis, whether he's still detained, et cetera. And there's no statements from the AMHPs, it's in relation to the prosecution for the offence against the officer, but you don't remember receiving that one.

A. I don't recall receiving that, no, or reading it.

Q. You did, at NGPF0004194, page 1, receive emails in December and January requesting a statement, didn't you? Can we have those on the screen?

Dr Lomas, Matthew Johnson, chasing the statements in January, and you do make a police statement, don't you, in relation to the events?

A. I do, yes.

Q. If we go to NGPF0000032 and have page 1 and 2 on the screen, you say in your statement at paragraph 101 to the Inquiry:

"I ... thought it was in the interests of the assaulted officer and VC to have this considered by the

criminal justice system, given VC's history."

So you've given a version of the events of the attack, yes?

A. Mm.

Q. You asked VC, didn't you, to consider granting the police permission to access his medical records? Did you think that was necessary before you handed over any information to the police about his condition or from his medical records?

A. So yes, because I was -- as I understood it, I was giving a witness statement to the police as a witness to a crime, not as a professional witness or an expert witness, making judgements about VC's capacity or fitness to plead or any of the aspects of the legal process.

You know, I don't undertake private court reporting work, I don't physically have the time to do it. I don't have the insurance from my defence union to cover me were I to undertake such work. So I would -- we often get asked for reports by the criminal justice system at various points in a person's kind of investigation/prosecution. I generally just say "no" to them.

But for this case, I thought it was important that the investigation continued, and I was giving evidence

as I understood it as a witness to a crime, rather than in my professional capacity.

When the police officer started to ask about his diagnosis and prognosis and capacity at the time of the event, I declined to give that information because, as I understood it, like I'm aware of the doctor's duty to breach confidentiality information generally and I'm also aware of the Caldicott Principle that, you know, there's a duty to share information when it's necessary, but I'm also aware that you share information when it's necessary, and my own view was giving a statement where I clearly described the assault on a police officer and I say "I think this man should be kind of charged with this offence and this should be considered by the criminal justice system", was sufficient to kind of serve that protection of the public interest, investigation of a crime, prosecution of a crime, and so on, kind of purpose.

When they get into the realms of asking me about capacity and diagnosis and prognosis, like, as I understand it -- I'm not a forensic psychiatrist, but I have experience of working in prison inreach services and was part of a peer supervision group, a forensics psychiatrist for a while who were very good at educating me as to kind of the legal process. Those kind of

questions shouldn't be answered at the investigatory stage and my honest experience, not necessarily of the police, but the CPS often drops charges as soon as a mental disorder or mental illness is present and particularly if the incident takes place in course of mental health care being delivered or takes place in a hospital.

You know, it's just no further action. And that's not the best outcome sometimes. And not just about in terms of patients with psychosis accessing forensic services, it's also about patients who I think should have been charged and who were fully criminally responsible for their actions not being charged and not being pursued.

MS LANGDALE: Thank you. I think that's a good time for the morning break.

THE CHAIR: Yes, thank you.

All right, we'll start again at 11.55.

(11.34 am)

(A short break)

(11.54 am)

MS LANGDALE: Dr Lomas, moving forward now to January 2022, we know that VC was disengaging from the EIP team and your colleagues, Dr Manzar and Dr Skelton, did an assessment, didn't they, on 19 January?

A. Yes.

Q. Did you see that assessment at the time and the decision for a plan of community treatment?

A. Well, I'll have seen it later in the week when I was on duty with the Crisis Team.

Q. Yes, and if we go to NHFT0000168, page 205, there's a Multi-Disciplinary Team meeting. The bottom box:

"note outcome of mental health act assessment yesterday."

That's treatment in the community still, yes?

A. Yes.

Q. "Previous aggression was in the context of being coerced in to hospital though was significant. There is also a history of forcing entry into other's property in response to psychotic symptoms."

Had you seen by then, if we can have -- had you seen the account from the students in January as described as a hostage situation, VC preventing his flatmates from leaving? Had you seen any account at this time about that event in January?

A. I hadn't seen the detail of that, no.

Q. So when did you see RiO notes about that, if at all?

A. So I can't recall reading the student account of it.

Q. At all.

A. I don't think so.

Q. You said before matters had to pique your interest, if I can put it like that, to read in previous notes, given your time in respect of each case; is that right?
A. Yeah, so I would try and read all of the notes, let's say, a month or three months leading up to the current referral to the Crisis Team generally.
Q. Is it possible to do a search, for example, for Dr Seedat's entries, can you just name search and get what a doctor has said, rather than going through every page?
A. Yes, you can, and you can also use the control F find function for risk to get other people's views of risks.
Q. To get the risk assessments. But we know they weren't being recorded in an appropriate way at that time at all, were they? Risk assessments, in terms of being updated, dynamically, we went to those criticisms this morning. They weren't recorded in a readily ascertainable manner, were they?
A. So the risk document, core risk assessment document was being used in a way that was inconsistent and perhaps lacked the detail and formulation you might like, but I think people were recording their impressions around risk in the progress note and adding risk history to the core risk assessment document.
Q. Dr Seedat did enter that summary I referred you to earlier, a summary of text messages. But again, looking

at the document, the way he'd summarised it, that would not have, you said, caused you undue concern. Had it summarised some of the other messages and said "There's a disturbing exchange, red rum, making reference to that, breaking hands" *(sic),* other text messages that I've referred to, would you have been interested, if he had been interested in highlighting them, about what they might have represented in terms of risk?
A. Yes, I would have had asked kind of explicitly about those kind of thoughts, and I would have had a better hook to attach my questioning to, if I'd have known about that text message exchange. But I would have also asked about that kind of thought anyway in terms of, you know, as I would with any patient with persecutory ideation, with persecutory beliefs.
Q. If you'd got that information, as Dr Seedat had in this case, from a family member and there was a need to protect the source of that information for that relationship, would you have nevertheless found a way of introducing that information or would you have considered you couldn't do it for risk of harming the relationship between the family members?
A. I think it would have -- I mean this is a really hypothetical question, I think it would have been hard work to ask explicit questions about a particular

conversation exchanged with one readily identifiable individual. So I'm not sure how I would have gone about it. I might have just asked more pointed generic questions.
Q. Or asked the consent of the individual and said, "Look it's really important for my reasoning" --
A. Yeah, so -- *(overspeaking)* --
Q. -- and see what they said.
A. You know, if I'd had the opportunity to contact and speak to the individual who was raising the particular concerns, I would say to them: "Look I know you don't want this, but actually, ultimately" --
Q. It's necessary.
A. -- "... the person needs to know and the person is going to know, however circuitous we might be in terms of our questioning about this topic".
Q. If we can have NHFT0000168, 205, back on the screen. Sorry if we digress from that document. But if we look at the bottom of your entry there please for the MDT:

"remain red RAG".

You've explained what that means:

"contact in pairs."

What were you saying there?

A. So for staff to visit in pairs. So for two staff to visit as a precaution against violence or aggression.

We might also do it where staff need to visit in pairs in case the patient might make allegations about inappropriate behaviour, based on their mental state as well. But in this case it would have been about the risk.
Q. The risk. So they get some protection from being in pairs. It's not anything anyone around him in the University would know, contact in pairs, would they? The same risk -- we know your colleague identified risk to neighbours? They don't get the memo, do they, around this?
A. Er no, they don't have -- the University wouldn't have access to his medical records, no.
Q. Should the University have been told that you required, for your medical staff to visit in pairs? And that -- although it appears Ellie Turner was concerned already, but if they knew you were also sufficiently concerned enough to say staff had to visit in pairs, it heightens even further, arguably, the level of risk for people around him.
A. Well, I think I'd point out that this is about his reluctance to accept treatment and his reaction to his previous attempts at being conveyed to hospital. I think there should be kind of information sharing with those who have a duty of care to an individual.

I suppose thinking about university is difficult because they have a duty of care towards their students but, you know, would we have contacted his employer or would we have contacted an estate agent or his neighbours directly? It's hard to judge how far you go in disclosing a person's potential risk to others.

I think what you hope is that the daily contact, the medication concordance, visiting in pairs, is sufficient to mitigate the risk to others more broadly. And if you were thinking that, you know, no one could be alone with VC at all under any circumstances regardless of who they are, then community treatment would not be feasible.

Q. You mentioned the Caldicott Guardian earlier. Have you found it useful, speaking with the Caldicott Guardian, about such scenarios, for example, where you are concerned that a fellow employee or, in this circumstance, neighbours might be at risk of harm, whether you could or should share that?

A. So I don't think I've consulted directly with the Caldicott Guardian. I've looked at the Caldicott Principles to guide my decision-making, and also looked at the GMC Guidance around confidentiality to make those decisions. And it can be a real challenge. Like the commonest one is about a patient driving against medical advice when they're in a period of recovery from

psychosis. So let's just take a straightforward case where the patient is entitled, is concordant, is engaging with treatment but isn't following the rules around DVLA restrictions.

You know, when you're in the sort of circumstance where you're interpreting legal language around, you know, concern, risk, protection to the public, then I might speak to a Caldicott Guardian to get kind of further guidance or --

Q. I mean, he was driving on the 3rd, wasn't he, when you saw him -- *(overspeaking)* --

A. Well, I don't remember seeing him driving on the 2nd.

Q. On the 2nd, sorry.

A. I saw him come up to us on the street on the 3rd. I didn't see him driving on the 2nd. I didn't know what he looked like.

Q. But if you knew that about a patient and they weren't taking treatment, you would say that was one of the issues: do you notify the DVLA?

A. Oh yeah, absolutely. So let's say a person is acutely unwell and driving, you would normally notify the police and you would notify the DVLA if they were not going to follow through with the legal requirements that they had. It's more common that a person might accept that they shouldn't drive and then do it anyway and then you

find that out through third-party information or observations of your own and then you're in stickier water. You still try and revisit the decision with the patient before you breach confidentiality, but yeah.

Q. We went to the discharge records from Cygnet earlier -- and we don't need to put them back on screen -- but in essence, VC did not agree he'd had a relapse. He said he was too stressed and had overreacted when the police had become involved. So he didn't accept that, did he? Did you understand that he didn't accept he was having relapses in psychosis?

A. Well, I mean, I didn't involve my -- well, I wasn't involved in discussions with him about his mental state at the point of discharge, it was always kind of when admission was being broached as a discretion.

And it's not unusual for patients who experience psychosis to try and downplay or explain away the behaviour whilst recognising that they have been acting unusually or experiencing unusual things. But they might want to identify it as a blip or a brief period of insomnia or "Oh, I had a ..." you know, not in VC's case, but in other cases -- "I had a bad reaction to an illicit substance or alcohol that kind of caused a brief reemergence of my symptoms, but I'm okay now".

Q. Can we have two documents, on the screen next to each

other please, NHFT0000070, page 10, and that's your documentation recommendation for 28 January 2022 assessment which you do with Dr Manzar.

Next to that, have NHFT0000168, page 215, which is the typed record of that.

Dr Manzar didn't know VC as a patient, did he, and wouldn't be reading all the records or history about him? Well, he did read some of the RiO notes, he tells us, but he wouldn't necessarily have the MDT meeting conversations in mind.

A. He wouldn't have the face-to-face conversations that I would have with the Crisis Team and so on, but I mean, you know, there's no distinction between either of the doctors in their role in Mental Health Act legislation or the process of the Mental Health Act, and I think it's kind of expected for a medical practitioner to make themselves as aware of all information as far as possible prior to an assessment, so ...

Q. He, once again -- we haven't got his on screen -- but he once again says he'd taken his flatmate hostage, he's lacking capacity to make decisions about his care. He does refer to a lack of capacity about his care given his mindset, doesn't he? You don't mention that in either; why is that?

A. It's not necessary to kind of justify that explicitly in

terms of making recommendations under the Act. I think you'd consider it in terms of a patient making decisions about their care and treatment and what you'd choose to enforce, but the Mental Health Act process is about identifying disorder of a nature and degree and then the need for assessment and/or treatment, or treatment.

Q. But he's flagging up by that, isn't he, legally at least -- you may say otherwise -- that his ability to understand treatment, to weigh its benefits, the care plan, doesn't appear to have that? You are not suggesting that in this.

Let's have a look at what you say:

"Presents as possibly experiencing psychosis."

Why do you say "possibly" experiencing psychosis?

A. Because -- I'd have to read my kind of notes in kind of more full, but from memory --

Q. That is your note to the right, I think, isn't it?

A. Yeah, sorry.

Q. So take your time.

A. Oh yeah, so okay, so I could not elicit kind of the signs of psychopathology that I'd been able to elicit when I'd seen him after his assessment -- after his admission to the Cassidy Suite on the previous occasion in September 2021. Any of those symptoms and in fact he'd denied convincingly experiencing those symptoms at

the moment in time and there were none of the telltale signs of psychosis. The restricted -- the blunted affect, the staring eye contact, no subtle evidence of responding to unseen stimuli, and so on. There was no evidence of thought disorder which is often a really good kind of indicator of a person relapsing even if they're denying experiencing relapse of symptoms.

So I think I talk about him not presenting as overtly psychotic, but I knew his history, I knew the risks in his case, included the risk of assault to others and the forcing entry to the person's flat previously, and I knew his engagement with the team was superficial at best -- that's the Crisis Team I'm talking about, their visits and that he'd missed one visit and possibly been seen spitting medication out on another.

Q. You suggested, three paragraphs lines down from that, that "he have a long acting injection if he was happy to take the medication":

"He flatly refused to accept this saying there was no need as he was taking the medication."

At that point, you knew he wasn't, didn't you, from the history?

A. I didn't know it, I --

Q. Really?

A. No, I didn't know it. There was a reason to suspect he wasn't and his historical pattern was that he would stop taking treatment, but, you know, it's really common in other cases where patients do eventually become concordant with treatment, regain some insight, they learn that services aren't there to persecute them or aren't there as part of their experiences, they learn that by taking these medicines some of their experiences diminish or even ideally stop altogether. And they can become concordant, or they can become concordant because they accept that without it, we keep becoming involved in their care and interfering in their life in a way that they find unnecessary and frustrating and they kind of take it as part of an agreement that we will step back a little bit if they take this treatment.

I would have had to just accept at face -- or just dismissed what VC said about his concordance and his apparent attitude towards treatment at that moment in time in order to be certain that he wasn't. And, you know, as I talked about earlier, the need to collaborate with patients is absolutely kind of core to everything we do, even when we are interfering coercively in someone's care.

Q. Weren't you, with Amie Staples, in the September event where she found unused medication taking back for

months?

A. I was, yeah.

Q. So you knew seven months of undertaken medication was around then?

A. So I remember Amie pointing out the bag of medication to me. I don't remember if it was a full seven months' worth of medication. I knew that packets dating back to seven months prior were there.

Q. So that was the evidence you needed when you said you didn't know he was taking medication. You don't need to turn to it, but it's page 3 of her report, she says:

"There was a bag of unused medication dating back to February 2021". *(As read)*

Whether you looked at precisely how long back, but without a doubt in his flat was the evidence that he just hadn't taken it?

A. Well, if --

Q. 2021.

A. If it was definitely a bag of seven-months' worth of medication then yes. But you go to a patient's house and we've talked about prescribing between teams, supplies from GPs, supplies from EIP, supplies from Crisis Team. You can get overlapping prescriptions. You can get prescriptions that are superseded by changes in prescription, and so on. So it could have been that.

But regardless, he was at that moment seemingly engaging for the most part with the plan agreed at the Mental Health Act Assessment undertaken a week prior.

And it was --

Q. Was he, if he wasn't taking it? Nine days of home treatment, Crisis were late for one visit, and he didn't attend another visit, and each visit his engagement has been superficial.

A. So he -- so he had engaged, in terms of the letter of the agreement, broadly. You know, we'd been late for one visit, which you might not lay at his door in terms of responsibility for meeting that care plan. That would be on us. He'd missed another visit, maybe there was a reasonable explanation for that.

As I say in my Rule 9 statement, you know, his explanation for being seen to spit -- put something from his mouth into the bin was that it -- I can't remember what it was exactly, but I think he said chewing gum or something.

Q. Did you believe him? -- *(overspeaking)* --

THE CHAIR: He said what?

A. I think he said chewing gum, I think, but I can't remember.

You know, I'm not clairvoyant, I don't know if somebody is telling the truth or lying to me. I try and

accept their version of events and I try and understand it in light of our version of events, but then ultimately try and come together in the middle to agree a plan with the person that seems kind of acceptable.

MS LANGDALE: Why do you see it as your role as a psychiatrist to try and accept their version of events?

We've heard reference to the therapeutic relationship or therapeutic alliance, but at what point is it actually destroying that by not being straightforward where you have suspicions, concerns, or flat contradictions to what a patient is saying?

A. Well, as I kind of put to VC, you know, as I say in the statement, I explain that patients we work with secrete or palm medications frequently, or will not take them orally, and accepting a long-acting injection assures clinicians that they're taking the medication as they're required. You know, I am upfront and kind of clear with him but he assures me: "Doctor, I am definitely taking the medication. I've done everything you've asked of me. I don't understand why I've been brought here again, this feels unfair to me."

You know, that kind of exchange is very -- you want to be really clear and very certain in your judgement

that, actually, I'm going to ignore and override kind of your views and wishes in favour of ensuring effective treatment and safe treatment.

Q. So you say, above "Discussion":

"I explained ... I felt concerned enough to suggest hospital admission for further assessment, and to look at starting depot antipsychotic."

We spoke about this in relation to the last admission. You flagged that up, and you say you suggested a 14-day admission.

If we go over the page, you say:

"I would suggest [at the top] continuing aripiprazole 20mg ... for now and explore depot prior to discharge."

So you're referring very much to depot and how it might be dealt with in detention. Surely this was a Section 3 detention for treatment? You'd identified depot, you're talking about it, and someone needed to really go in on that issue with him.

A. So I mean as I kind of describe in my statement, like I was unclear as to the necessary treatment plan. He was agreeing to less restrictive alternatives to hospital and, superficially at least, engaging with the letter of the agreement from a prior Mental Health Act Assessment.

In my examination of him, there was no kind of really clear and obvious evidence that he was experiencing symptoms at that moment in time. There was no repeat of the level of aggression that was seen in his prior admission to assess -- prior admission to the Cassidy Suite, and --

Q. What about 15 January episode with his flatmates? Did you ever see or read about that event? How he'd held a flatmate in a headlock, intimidating, aggressive, stopping them leaving -- *(overspeaking)* --

A. So the information I had was described as a hostage-taking event, which is, you know, incredibly serious.

Q. Right.

A. But then the police had attended and no arrest had resulted in it. Again, I was kind of like how, if somebody has been held hostage, can an arrest not result?

Q. So did that make you doubt the veracity of the events or the account?

A. It didn't make me doubt the veracity of the events of the account; it made me unclear as to the exact nature, the seriousness of it.

Again, I thought that was a cause for kind of further assessment. And essentially, you know, the

Mental Health Act Code of Practice allows patients who are known to services to be detained for the formulation of a new treatment plan, and the current treatment plan, that of community oversight of medication, was not sufficient to mitigate the risks, based on his historical presentation, and given the nature of his disorder, that is that when he is unwell, the risks are elevated, I thought we had to be really clear about what we were doing and why, and that that needed an assessment in a hospital setting to determine whether or not we could readily justify the restrictive practice that would be necessary to administer a depot; or, if it was the case that he was taking aripiprazole and was concordant with treatment, whether or not aripiprazole was an effective choice of depot, whether or not an alternative oral agent would need to be tried before he was commenced on a depot; or if it was in fact that he had been concordant and had been treated with two antipsychotic medications, but first line antipsychotics were no longer indicated and that he might require clozapine treatment, for example, which has no long-acting injection form.

It was with this in mind that I recommended assessment.

Q. That can come down, please. Did you think to ask the

police -- you said you could get information from the police, they were never resistant to that -- about what exactly had happened with his flatmates?

A. No, I just didn't have a chance. I think as I allude to in my kind of statement that day, I'd had a particularly busy day in the Crisis Team, and were the assessment to have taken place in custody, I've no doubt I could have got that assessment -- got that information relatively easily but unless I was, you know, physically there was very little time in my day to make those kind of enquiries.

And --

Q. Have you seen the video since? There's video footage of the beginning of that when he's holding -- *(overspeaking)* --

A. I have been shown it when I was preparing my Rule 9 statement, yes.

Q. Would that have been helpful to have had that at the time?

A. It would have been helpful. I mean, there's also, when a person commits an offence, for a psychiatric response to be appropriate to it, the offence has to be driven by mental illness, and I know VC kind of alludes to this being a disagreement over --

Q. An altercation about house rules and cleaning rotas or

something.

A. Yeah, which isn't -- so that's not him assaulting him because he believes they're part of some, you know, technocratic conspiracy against him and that is just an assault that needs -- *(overspeaking)* --

Q. Yes, angry -- *(overspeaking)* --

A. Yeah.

Q. In terms of risk to others, though, you're doing that Section 2, Section 3, considering what's necessary; does risk to others feature in what you'd go for there at all?

A. In -- so, I mean ... I don't think you can say: oh because risks to others are involved in this case, I'm going to be automatically more draconian and, you know, coercive in my practice. I think patients deserve thorough and considered assessment of their treatment needs in accordance with the kinds of principles of the Mental Health Act, as kind of laid out in the Code of Practice anyway.

And I think that although somebody can be repeatedly psychotic, I think it can be justified to repeatedly assess them in terms of thinking what is absolutely necessary for this person here.

And also, when you're making the recommendation, you're thinking about, like: do I absolutely know what

is for the best in this case? And is this is an appropriate treatment plan? And is the appropriate treatment available?

And at that second assessment, I was undermined, I think, upskittled a little, by VC's difference in presentation from his previous contact with services. And though upskittled by the kind of lack of aggression or kind of threat or violence that was seen in the previous detention, I was still aware of that historically and it was because of that risk and the long-term nature of it I thought we needed to be really clear about do we just coercively intervene and put this man on a depot he doesn't want, against his will, for the foreseeable future or does he need treatment with other agents or does he need treatment with clozapine?

And that was the purpose of the assessment.

Q. How much more coercive do you consider Section 3 is, then, than Section 2? You referred to draconian, coercion; what's the difference?

A. I wouldn't -- I wouldn't say in physical terms they're no different in their kind of physical restrictions of a patient's liberty or their treatment. But in temporal terms, you know, you have rights to appeal much earlier under a Section 2 and the duration of a Section 2 is shorter.

When I'm talking about being draconian, I'm talking about myself, Dr Manzar -- sorry, I've forgotten the AMHP at the last assessment's name -- but I'm talking about the assessment team making a sweeping decision about a person's long-term future --

Q. Fiona Parker?

A. Fiona Parker, thank you -- based on an assessment that might take an hour to complete. Especially where a person is agreeing to evidence based and effective treatment, you know, however much we might have reasons to doubt or suspect kind of non-concordance or non-engagement with that, hence I think, you know, an admission for assessment is a reasonable thing to do: to think, like, do we just actually override all of this and say, "I'm sorry, but no"?

Q. Last document from me, please. NHFT0000168, page 255. This is a document dated 21 February 2022, Dr Lomas.

"... explained to [VC] that following his previous admission where he was restrained by police after assaulting an officer I had been asked to make a witness statement, and that the police had explicitly asked for information about his mental health which I needed his permission to share.

"He said he would like to discuss it with a solicitor before doing so.

"He also took the opportunity to ask for a full copy of his medical records, and if he could have a discussion with Dr Seedat ..."

He seems to have gone back requesting discussions with Dr Seedat. What was your response to that when he said that to you?

A. I'll have told him that there's a routine way of accessing your notes through the medical records department but that I'd also email his current RC and Dr Seedat explaining the request and letting them know that I'd asked if he'd sign this consent form for the police.

Q. Would you see a patient when they're not formally under your remit at a particular time if they wanted to speak to you?

A. I mean, I -- it depends on what the patient is expecting from a consultation. You know, I might speak to a patient who wants to ask me a question and isn't seeking care or ongoing treatment from me. I might be asked by a colleague to see a patient for a second opinion and go onto their -- and arrange to see them, either in the community or on an inpatient ward.

And in this case, you know, I was trying to be, knowing how hard pressed the police are and how difficult their job is, I was trying to be helpful by

giving my geographical location where VC was, saving them a trip and getting him to sign this consent form for them so they can proceed with their investigation.

MS LANGDALE: Thank you. Those are my questions, Dr Lomas. There will be more.

THE CHAIR: Yes, Mr Moloney.

Questioned by MR MOLONEY

MR MOLONEY: Good afternoon, Dr Lomas. I ask questions on behalf of the bereaved families.

I just want to ask you about three things, if I may: firstly, depot medication; secondly, the incident of 3 September 2021; and thirdly, your assessment in January 2022. And only a couple of questions in relation to each.

Firstly, depot. And it was in January 2022 when you assessed VC that he flatly refused depot and said it was unnecessary as he was concordant with oral treatment?

A. *(The witness nodded)*.

Q. At that stage, you'd had quite a bit of experience of VC, you'd been involved in his admission in September 2021 --

A. *(The witness nodded)*.

Q. -- and you would have known, as was documented in the RiO, that there was a long history of non-concordance with oral medication?

A. *(The witness nodded)*.

Q. I won't take you to all the entries because you know there are many there, aren't there, and you, for example, say he felt it slowed him down when he had an exam and so he decided not to take it and so on. And then there was a subsequent history of spitting out medicine that you raised with him in fact in that January 2022 assessment, and then the finding of the medication in September that dated back to February 2021?

A. *(The witness nodded)*.

Q. Now, you mentioned autonomy this morning and I say that with respect, obviously it's an important concept. With oral medication, he had a choice as to when he took it and when he didn't, didn't he?

A. He did, yeah.

Q. He had autonomy in that sense?

A. He did, yes.

Q. Yeah, with depot, you would have had much more limited autonomy around when he was medicated?

A. Well, if he was discharged without being placed on a CTO on depot medication, he would have had just as much autonomy to refuse the depot at any --

Q. Can I just -- if he is subject to depot medication, it has a longer lasting effect, doesn't it, and if it's

taken repeatedly.
A. Oh, I see what you mean. Yes.
Q. Do you see what I mean?
A. Yes.
Q. Depot is something that, you know, he can decide on one day to take medication and then not take it the next.
A. Yeah.
Q. With depot it has that longer lasting --
A. Yes, he would -- let's take a month as an arbitrary unit of time, but he would have had 12 opportunities a year to decide rather than 365.
Q. And then there can be an appropriate response in respect of a refusal.
A. Yes.
Q. Absolutely. So to the extent that I'd mentioned, then the becoming subject to depot medication reduces his autonomy around medication compared to oral medication.
A. Yes.
Q. Yes. Now, when VC flatly refused depot, when speaking to you, and that's the term you used in your statement, "flatly refused", then given the history of non-concordance and indeed deceit around non-concordance in resistance to depot, then in reality this man, by flatly refusing depot was flatly refusing to be medicated except on his terms, wasn't he?

A. Erm -- I don't know. I don't quite follow what you mean by "on his terms".
Q. On his terms. His terms are: "I will choose when I take medication or not and I can ensure that by oral medication. With depot medication, I can't ensure that."
A. Yeah, he's assuring us that he is already concordant with treatment and the need for treatment with a depot is unnecessary because he is taking his medication.
Q. His assurance as to concordance with medication must be taken very lightly given his history of non-concordance and his history of deceit around medication.
A. So I don't know about "very likely", but I think taken with due consideration of their veracity, because you can get patients whose insight improves and they become more concordant with time.
Q. Of course, but with that history and with that essentially reporting concordance, if you'll forgive me for using "very lightly", there'd have to be a healthy scepticism around concordance, wouldn't there?
A. There'd have to be a healthy scepticism, yes, and that was the main basis of detaining for further assessment.
Q. I'll return to it: in flatly refusing depot, he was essentially flatly refusing being medicated except on his own terms.

A. He was refusing depot as he argued it at that point on the basis that it was unnecessary because he was taking treatment.
Q. Exactly. Incident of 3 September 2021, please.
When you first saw VC on 3 September, there was no issue between you, there was no problem between you.
A. No, he -- it was a -- you know, as described in the kind of account, you know, he invited us into his home initially saying he would be happy to undertake -- to let us undertake the assessment at home without the need for a warrant.
Q. Yeah. You can't remember whether or not he went to move his car.
A. I don't remember seeing him --
Q. No. Okay --
A. -- in a car at any point.
Q. As you say, he was perfectly pleasant and he at first consented to the assessment.
A. Yeah.
Q. Yeah, and then he changed his mind when you got to the flat, and you clarified whether or not he had to let you in without the police.
A. Yes.
Q. Yeah. And when you said that he didn't, you said, "Well, we'll wait for the police then," effectively.

A. Sorry, who said?
Q. When he was told that he didn't have to let you in without the police, he said "We'll wait for the police," effectively.
A. Yes, he said, "I think I'd rather let the process go ahead." Something like that.
Q. If you'd simply walked away and said, "Okay, forget it," there'd have been no violence between you that day.
A. No, I think it's unlikely that such an incident would have taken place at that point.
Q. Yeah. If you'd just walked out of the building and thought: oh forget it then, we're not going to wait for the police, we'll leave it, there wasn't any violence between you at that point or prospect of violence.
A. There didn't appear to be at that point, no.
Q. When the police arrived, after knocking on the door, he opened it, didn't he?
A. I can't remember the details exactly but I remember a conversation taking place between officers and Amie, I think, at the door.
Q. Yeah. And that was a cordial conversation to begin with.
A. Reasonably polite, yeah.
Q. And he said he wasn't going to cooperate.
A. He did.

Q. And if the officers had just walked away and let him get on with it, there would have been no violence at that point, would there? They'd have just gone out of the flat then.
A. Yeah, well I don't know what he would have done for the rest of the day, but I don't anticipate or I wouldn't have anticipated at that point him being violent to anybody.
Q. At that point?
A. At that point.
Q. Absolutely, but they walked in -- he walked away from the door and they followed him into the room. They didn't rush him, did they? They were kind to him.
A. No, we were as gentle as gentle can be about the process of conveying, as I've already discussed with --
Q. When you say "we" that includes the police, doesn't it?
A. Oh absolutely.
Q. Absolutely.
A. Yeah.
Q. They never hit him when he was hitting PC Pritchard either, did they? There was no --
A. No, there was -- so again, my recall is influenced by, you know, subsequent reading and things like that.
Q. Sure.
A. But from memory, the police officers were just

struggling to restrain him and get him into mechanical restraints into handcuffs, I think. And my memory is that the response, the OSG or the TSG, whatever it's called, the police response to support the officers, arrived sort of really quickly, but I don't know how long that was. It's just in my mind, they were there very quickly and the situation was got hold of very quickly.
Q. Rapidly brought under control with the assistance of taser and PAVA and so on.
A. Yes.
Q. Yeah. Now, essentially, the violence only happened when he was going to have to do something he didn't want to do, didn't it? If he'd got --
A. So yeah, I mean that's one of the things -- sorry to interrupt --
Q. Not at all. I interrupted you, Doctor.
A. So that was one of the things where, again, I don't know the name of the officer, but I make reference to it in my statement about talking to the police officer who seemed to be in charge about what the correct next course of action should be. And I said "Look, you know, I know we're here executing a Mental Health Act warrant but that looked like a really serious assault to me."
Q. Yeah.

A. "Do you want -- should criminal charges supersede the civil process here? Like, you know, we can assess him in custody later, whatever."

And again, forensic colleagues might disagree with me about this but just because someone is psychotic doesn't automatically make any act they do that's criminal a result of their psychosis.
Q. Absolutely.
A. You know, the reason for his refusal to travel with the police could have been anything, could have been based on reality, could have just been with a disaffection towards, you know, authority figures.
Q. Yeah.
A. Whatever it may have been. But I -- and at that point I genuinely didn't know what his mental state was.
Q. No, of course. And then just finally to build on that with the last question I wanted to ask you, which was about your assessment in January 2022, as you say, you knew him quite well by 2022, and in terms of the previous in incidents of violence, shortly before 28 January 2022, if I can describe it in that way, it appeared to you that he wasn't assaulting his flatmate because he thought he was part of some technocratic conspiracy, as you said.
A. Yeah.

Q. That essentially the circumstances were unremarkable, weren't they?
A. Well, I mean it was -- the description, as he gave it to us and as it's recorded elsewhere, is that it's a fight that occurs with people for understandable reasons not relating to mental disorder, would be how I would see it, but, you know, in light of his history --
Q. You'd have to think -- *(overspeaking)* --
A. You'd have to consider it, yeah.
Q. But it didn't have any of the hallmarks, classic hallmarks of psychotically driven violence, did it?
A. Not that assault, not the --
Q. No.
A. -- account that he gave, no.
Q. Then you'd recorded in the RiO at page 215, I'll just finish with this, that when you saw him, he did not present overtly as psychotic.
A. I could not identify symptoms of psychosis --
Q. Absolutely.
A. -- easily at that assessment, no.
MR MOLONEY: Thank you very much, Dr Lomas.
THE CHAIR: Yes, Ms Cartwright.

Questioned by MS CARTWRIGHT

MS CARTWRIGHT: Good afternoon, Dr Lomas. I ask questions on behalf of the survivors.

Can I take you back, please, to the statement you provided to the police dated 27 January 2022, please, which is NGPF0000032, please.

Thank you.

Now we can see that this statement is dated 27 January 2022. And so we know that you've provided this statement to the police after VC has been involved in the incident attacking his flatmates, and the day before he commences his third period -- sorry, his fourth period of detention on 28 January 2022.

So can you just give us some context as to how it was only in January 2022 you were providing a statement in respect of your involvement with the September 2021 detention of VC, please?

A. Do you mean the length of time between --

Q. -- *(overspeaking)* -- Yes, so --

A. So I think I had been approached by the police in December, perhaps, but was busy clinically and with other work and then away, perhaps on leave over the Christmas period. And it just -- it took that period of time to find time free in my diary to give a witness statement.

Q. And certainly if we look at the period of time when VC had not been detained initially, obviously there's that building storm before he then was detained on

28 January, and so were you receiving some pressure from the police to provide the statement about the earlier criminality in September?

A. I wouldn't describe it as pressure. My, as I've talked about already, my understanding was I was giving a witness statement to support the prosecution of VC for the assault on the police officer.

From reading subsequent evidence, submissions and bundles and things, I gained the impression there was perhaps a time limit that the police had available to them but I wouldn't have known that at the time. The email exchanges that I had with the officer that I recall were, you know, reasonably personable and I made myself available when I could and gave a full witness statement to support that process as best as I could.

Q. All right, and I think you've already referenced some GMC Guidance but we can see if we move through this that we can see it's got the general criminal statement of truth. Thank you, and we can go to page 2, sorry. And it's just this want to explore with you in the period of time when you were the responsible clinician for VC when he was on the Cassidy Suite, you say this by way of information you're providing, then, as part of the prosecution for the police assault, you describe that:

"[VC] was then detained by officers and taken to Highbury Hospital after being checked over at QMC. When arriving at Highbury Hospital, [VC] was calm again, but still refusing to communicate only giving brief answers. Although calm, it appeared highly likely [VC] was unwell."

I just want to explore with you this reference within this statement for the prosecution, the suggestion that VC was calm again when he was at the Cassidy Suite, and I'm going to go through the entries in the RiO. Because I'm going to suggest that reference to VC being calm again for this period of time is misleading and it doesn't give a full picture of what was in the RiO records. And to be fair, you go on to say in the final paragraph:

"I am reluctant to give any comment around his diagnosis and prognosis given patient confidentiality and without [VC's] consent."

But I think the impression this will give to this statement was that once VC was at Highbury Hospital, he was calm again, and I'm going to suggest that that's not what's reflected in the notes. So can we first of all just solidify the position as what happened at the Cassidy Suite. VC was obviously assessed in the way you've been asked about at the Section 135 suite, which

is what the Cassidy Suite is. It's located at Highbury Hospital, isn't it?

A. Yes.

Q. But then essentially following the medical recommendation for detention, VC remained there for nine days before he was transferred to a psychotic Intensive Care Unit; would you agree?

A. Yes.

Q. So I think you described he had to be stepped up to the Cassidy Suite because it shouldn't ordinarily be utilised. I know it can on occasions, but equally, he was then subject to seclusion whilst he was at the Cassidy Suite. So can you just help me with that: is that pretty unique in a scenario where you're using seclusion as well such is the level of violence and aggression that VC was displaying?

A. Yeah, it's not unique, but it is, you know, a significant measure. It comes with its own requirements around monitoring and the review of the appropriateness of the seclusion has to be closely identified and the opportunity to terminate seclusion taken at the first kind of safe opportunity.

I think, reflecting on that statement, I think I make reference in my Rule 9 statement to not using hospital records and medical records to give my witness

statement at that point in time. And I'd agree I'd accept that "calm" is a relative term in this case and he wasn't vigorously resisting conveyancing or making violent attempts to absent himself from the unit or to assault staff, but there was a degree of ongoing agitation and risk, yes.

Q. So you're saying, when you gave the statement, you hadn't reviewed the records and so you're saying that you accept that reference to the use of "calm" is not accurate?

A. I think it's relative to his presentation during transportation, and as I've sort of said already, you know, I was giving this statement to support the prosecution, and I understood that my statement was about describing the events of -- that led up to and then the actual incident of the assault on the police officer, and definitely not trying to pass comment on capacity or subsequent appropriateness of diversion from the criminal justice system, and so on.

Q. But again, would you see, in the context you're giving, anyone ultimately looking at this in due course would make it look like this was a very short-lived incident and then VC was calm again, which is not what the medical records at the Cassidy Suite support at all?

A. I mean, the actual assault on the officer was

a short-lived incident, but the requirement for management of his risk of ongoing aggression lasted until he'd -- I would argue, until he came out of seclusion. I don't know how many days that was.

Q. Was there any reason why you didn't reference what we see in your medical recommendation for detention that VC had also been threatening to the healthcare staff, why you didn't include that in the police statement?

A. If I'd been asked about his behaviour towards others, then I would have commented on it, but I was -- in my eyes, I'm being interviewed by the police, to elicit evidence to support investigation and possible prosecution for the assault on the officer.

Q. Well, can we then just briefly look at the medical entries, please, it's the NHFT0000. Whilst that's being displayed, being in mind the GMC Guidance for providing witness statements for legal proceedings makes clear your obligation that it needs to be completely accurate and not misleading, why did you not review the medical records before providing that statement in January 2022?

A. So, as I've described, it was about me giving a description as best I could remember of the events surrounding the assault on the police officer. I kind of believed that my description of the assault on the police officer was sufficient to see the investigation

progress.

Q. So if we can go to page 165, please, which I think captures VC's arrival at the Cassidy Suite. It's under the 8.07, thank you. We can see at 8.30:

"[VC] arrived to Cassidy Suite with 5 police officers. He was ... on hand cuffs and was directed to his bed space. He was asked to kneel on the floor and handcuffs were removed. He was not responding much to staffs and he appeared angry. He was offered food and drink but refused saying he'd rather be home. ... avoiding eye contact ..."

Then we can see he:

"... wouldn't engage with staff. [We] had to call the team around due to unpredictable aggression behaviour".

Then references the assault.

So again, would you agree, that's not a description of VC being calm on arrival at the Cassidy Suite, it's a description of someone who is still angry and unpredictable, and in fact the package that was then put in place was the involvement of the restraint team and then seclusion for whilst he was at the Cassidy Suite; would you agree?

A. I'd accept that, yes. I'd also kind of suggest that the document that's being examined in my witness statement

is about, as I understand it, me being interviewed by police to give an account of an alleged offence, rather than an attempt to convey a complete picture of a person's kind of subsequent mental health care and treatment and management of an episode of violence and aggression, which I'm not sure how I would have been meant to know that going into this level of detail about what occurred after the incident would be relevant to a witness statement of this type.

Q. So why provide any comment about how VC was when he arrived at Highbury Hospital? Because the impression you've given is VC was calm once he got to hospital?

A. Well, calmer, I think, would probably have been a better description. But I'm giving evidence, I'm giving a witness statement to the incident of the assault on the officer.

THE CHAIR: Ms Cartwright, it's gone as far as you can take it, I think, really. He's given his answer about what had happened. I've got the point.

MS CARTWRIGHT: Ma'am you've got all the records, I am not going to take time up.

But then just briefly, one of the questions that you avoided that Ms Langdale KC asked you and that reference to the PICUs and you were the responsible clinician and you suggested you didn't know why the PICUs were

refusing VC, you'd have to ask the PICUs. But would it not be fair to say that, bearing in mind it was nine days before VC was removed, that was something that you would have been well aware of from the medical records and we actually see some of the reasons that were given why PICUs were refusing VC.

A. So, I mean, I was -- so patients stepped up to the Cassidy Suite, as you've already mentioned, shouldn't ideally be stepped up to the Cassidy Suite. They don't have access to the broader MDT that a full acute general adult psychiatric ward has or indeed a Psychiatric Intensive Care Unit, but we do what we can with what we have at times and it's safer that he be there than left in the community waiting for a general adult psychiatric bed or PICU bed to become available to us.

And the Crisis Team consultants have agreed, because of the lack of anybody else able to do it, that on the days when there are patients stepped up there, we well act as their RC because they have to have somebody nominated as their RC, and we will take turns in being the RC. So I would be the RC on the days that I was on duty. I would not necessarily be -- I wouldn't be RC on days when I wasn't on duty with the Crisis Team or out of hours or at weekends.

And in terms of not knowing why the PICUs had

declined him, I don't know what I would have known at the point I was reviewing him, and I don't know what I would have read about the reasons for him being declined. I still don't know because I can't bring it to mind, but if you want to put it on screen I could have a read.

Q. Well, perhaps if we look, then, at page --

THE CHAIR: Ms Cartwright, I think that they're clear on the records, aren't they?

MS CARTWRIGHT: Well, there is a question arising because at 178, one of the reasons was given for declining was that it needed a male team, but what was being indicated as well -- it's at page 178 -- that you would need -- recommended that placement with a predominantly male team or securer services may be more appropriate.

So can I ask you: at any period during this time, bearing in mind the ongoing presentation of VC, and that PICUs were declining, so you needed a male team and had you considered secure services, did you make any referral to the secure services?

A. No, I didn't know that that had been the feedback from the PICUs from as far as I can recall.

I think a referral to secure services would be a referral to the Impact Provider Collaborative in Nottinghamshire and patients just have to wait on

a PICU, many weeks, perhaps longer, before they get a bed in a secure service.

So a PICU would still be the best place available to us in terms of our resources to manage VC that we had available to us.

Q. Again, just finally, Ms Langdale asked you questions about between the first admission and the second admission when VC was seemingly being managed by the Crisis Team and in the context of the email from Dr Seedat of 22 June, and the mother's concerns being raised. You said you didn't know what the medication was:

"VC was discharged on 5 milligrams of aripiprazole and again was still on that medication dose of antipsychotic. It was only increased again when he was readmitted during the second detention on 14 July."

(As read)

Can you assist as to why, then, with the aripiprazole remaining at 5 milligrams there was no consideration of increasing that dosage prior to essentially a patient deteriorating requiring a second period of detention in a short period of time?

A. Like, not without going through the records, from the points I was involved in his care, and in terms of the MDT discussions, I think -- *(overspeaking)* --

Q. You were directly the person responding and noting Dr Seedat's concern about the monitoring and need to face-to-face with VC on 22 June, that is in the records.

A. Sorry, I missed what you said at the start.

Q. So you were the person that noted Dr Seedat's contact on the 22 June and with that being the case, why was medication not looked at, bearing in mind it remained on 5 milligrams of aripiprazole during that time he was in the community deteriorating?

A. So the focus of that email was about the function of mental health teams during the Covid pandemic and the restrictions placed on, you know, wider society. And I took the meaning of that email to be about Dr Seedat's anxiety that had the Crisis Team stopped visiting people face-to-face, which we absolutely should not have done, and so made sure that when the next contact with VC was arranged, that was undertaken.

We would have carried on assessing and attempting to monitor the signs of deterioration. I think later on, in that period of time, although my recollection of it is kind of poor, it was more about whether or not he would take any medication at all.

MS CARTWRIGHT: Thank you.

THE CHAIR: Thank you.

Yes, Mr Straw.

Questioned by MR STRAW

MR STRAW: Dr Lomas, I represent VC's family.

Can we have the RiOs on screen, please, NHFT0000168 and page 188 of that. Dr Lomas, this is a note of your 10 September 2021 assessment.

Do you see in the big paragraph towards the top there under "Seen" you said there:

"I asked about the experience he [VC] had described to Claudia".

Do you see that there?

Can we then go back to page 162. This is now a note of the home visit by Claudia on 31 August 2021. Is this what you were referring to?

A. Yes.

Q. Just reading out a little bit of that, halfway down the top paragraph it said:

"VC presented with a complex delusional system in which he believes we're working in collaboration with the judicial system and the hospital (Highbury) and we've created technology to cause his voice experiences [or] monitor him".

Then in the next paragraph:

"Impression/risk: VC is currently relapsing (third relapse) appears paranoid/suspicious complex delusional belief ... linking various support agencies ... believes

technology has been developed deliberately to cause him harm by producing these voice experiences. No insight. Refuses to engage ... knows we will feed back to the higher powers ..."

Would you agree that the features of his illness include the following: firstly, a delusion that there was a conspiracy against him by the hospital, other agencies, who wanted to cause him harm?

A. Yes.

Q. Secondly, he believed these experiences were real, the voice experiences and so on?

A. Yes.

Q. And thirdly, when he was unwell, those features, especially the first one about conspiracy, led him to disengage, to be guarded and suspicious, to be paranoid?

A. Yes.

Q. By the same token, would you agree that those factors are signs of relapse? So if he's paranoid, guarded, disengaging and so on, those are indications he's relapsing into psychosis?

A. I think paranoid and guarded could be. I think disengaging could be for a number of reasons. Disengaging could just be about the desire to be free from what people perceive as unnecessary interference.

Q. But it could also be an indication that he's getting

more paranoid about the services, he doesn't want to have contact with them?

A. It could be, yes.

Q. Okay. Thank you.

The next question is moving on to the 15 January 2022 incident, please, the hostage incident with a student. You described that in the notes as "highly concerning". Why?

A. The use of the word "hostage taking", because that's a really serious offence, as I understand it, you know, an offence that might see you face serious criminal charges.

Q. Was it also, taking a longitudinal view, back in 2020 there'd been a number of incidents of him breaking into neighbours' apartments. This was apparently unexplained, a pretty odd incident taking a hostage with no explanation of it. Was that another reason why this was highly concerning?

A. Well, it's not that there was no explanation of it. I think as previous questions pointed out, this was put down to a dispute over cleaning duties and shared responsibilities in a student house.

Q. But a dispute over cleaning duties doesn't normally lead to one student taking another one hostage?

A. No, it doesn't normally, and the assault, as it's

described, because -- you know, it's not, to me, to describe what the features are in terms of legal terminology and occurrences what a hostage taking is. But getting somebody in a headlock when you're arguing with them and angry at them about something doesn't necessarily happen only in the context of mental illness.

Q. Sure. But in this context here's someone -- you need to take a longitudinal view, I'm sure you accept that, and this, in the context of the other incidents where he's broken into neighbours' properties, this was a concern about his mental state?

A. I mean, it would be sufficient to raise a concern about his mental state and you'd want to make sure you made a thorough assessment of the person to understand what was going on at the moment in time, but I, if I'm honest, I don't make a direct link between forcing entry to someone's property in response to auditory hallucinations to an assault occurring in what might be described a kind of mundane or prosaic argument about the challenges of living with other people and --

Q. You'd want to explore the background further?

A. You'd want to know more about that incident.

Q. Then you were asked about your comment on the 28 January 2022, "VC does not present [as] overtly as

psychotic". You explain, though, that his presentation was entirely consistent with his previous relapse, 3 September 2021 --

A. Mm.

Q. -- when he presented similarly calm to prior to the previous incident of significant violence. And you didn't take the lack of overt psychotic presentation at face value, did you?

A. I accepted the limitations that any psychiatrist or mental health practitioner faces in trying to know what's going through another person's mind.

Q. And you were aware that 3 September 2021 incident where he didn't present as overtly psychotic, but he was, that demonstrated that he was someone who could appear calm when he was psychotic.

A. Yes, but likewise, patients who appear calm with a history of psychosis and don't look like they have psychosis can also not have psychosis at that point.

MR STRAW: Sure. Okay, thank you very much.

Questioned by THE CHAIR

THE CHAIR: Yes, can I just ask you about -- you've been asked about this reference to what Claudia Birtles said. This is in relation to what's been -- on page 167 of NHFT0000168. And I think you said you took that reference to "normally a gentle, law abiding young man"

from her account that you'd seen; is that right?

A. Yes.

THE CHAIR: Can we just look at that account, because it's on page 162. *(Pause)*

Yes, if we can just look at "Risk to others", and that's the bit you've taken that from, is it?

A. Yes.

THE CHAIR: So further down, she's expressing concern herself about it not being safe to continue there, and concern it was difficult to get out of the flat because it was a long corridor, and also about him breaking down a neighbour's door.

That doesn't appear in your assessment. Why did you simply take out "normally a gentle, law abiding young man" when she was expressing those concerns about her on safety?

A. I mean I was explaining, or I was making reference to his character. So one of the things we're asked to do in risk assessments is take account of a patient's strengths and positive characteristics and protective factors, so that we're not seen as, or the least the documentation isn't seen as wholly, you know, critical or stigmatising or demonising of an individual. And what I was getting at there was the incident of violence that I'd witnessed at that assault was really

significant, and seemed out of character for VC, based on Claudia Birtles's entry.

I didn't make additional reference to her concerns about, you know, her worries about leaving the flat and how hostile he was towards her because it was really clear the risk he posed, particularly at that moment in time, based on the assault that we'd witnessed on the officer.

THE CHAIR: Yes. But you're suggesting there that that's the position at that time, I think, as I understand it, because you've taken it out of her account. But you're saying that you were trying to present a positive version; is that right?

A. I extracted it as a reference to what VC was like when he wasn't unwell, or when at least he did not appear unwell, usually.

THE CHAIR: Yes. Now just one other matter. And that's in relation to, I think, right at the very beginning of your evidence you referred to asking yourself whether, you know, in relation to, I think, the earlier incidents, whether there'd been serious violence; is that right? Do you remember saying that?

A. Do you mean the --

THE CHAIR: The Brook Court incident where the --

A. Yeah, so, like -- we talked about serious violence and

serious risk earlier, and patients assault staff, other patients, other people, frequently in the course episodes of mental health, as you've heard yourself from your expert witness --

THE CHAIR: Yes.

A. -- and the seriousness of that can vary hugely. I gave the example of the man who evicted me from his home as something that I didn't perceive necessarily as done in any desire or intent to do me serious injury.

But where a person sustains a fracture, you know, that suggests significant violence and fear, and anybody suffering a fracture -- and again, I'm not a forensic psychiatrist, I'm not a legal expert, but that, to me, sits in the realm of, you know, the types of offences that lead people into contact with forensic services, you know, woundings, GBHs, that kind of thing.

THE CHAIR: Yes. So you're aware of the changes that have been passed in the new Mental Health Act? The section 2 and Section 3, which haven't yet been enacted, but are you aware of that?

A. I've read about them, yes. I don't know them in great detail -- *(overspeaking)* --

THE CHAIR: Were you considering the question of serious harm in that context or not when you're thinking about it?

A. I don't know, sorry, I don't know enough about the recommended changes to identify --

THE CHAIR: Well, if you weren't, you weren't.

A. No, sorry.

THE CHAIR: It doesn't matter. I think that's an answer to my question. Thank you.

Right, well, I think we'll finish there. 1 o'clock. We'll start again at 2.00, thank you.

(1.03 pm)

(The short adjournment)

I N D E X