

Tuesday, 28 April 2026

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 2 (9.59 am)
 3 **THE CHAIR:** Yes, Ms Langdale.
 4 **MS LANGDALE:** May I call Dr Lomas, please?
 5 **THE CHAIR:** Yes.
 6 **DR BENJAMIN ANDREW MATTHEW LOMAS (sworn)**
 7 **Questioned by MS LANGDALE**
 8 **MS LANGDALE:** Dr Lomas, you've prepared a statement for the
 9 Inquiry dated 2 December 2025. Can you confirm the
 10 contents are true and accurate as far as you're
 11 concerned?
 12 **A.** To the best of my belief.
 13 **Q.** You tell us you were a consultant or appointed as
 14 Consultant Psychiatrist in General Adult Psychiatry at
 15 Nottingham City Council in 2015; is that right?
 16 **A.** Nottingham City Council and County South Crisis Teams in
 17 2015, yes.
 18 **Q.** Before then you tell us you worked, when you were an
 19 ST4, under Dr Tuhina Lloyd in Newark across three teams
 20 working with patients with psychosis, Early Intervention
 21 in Psychosis, Assertive Outreach and recovery teams.
 22 I don't know if you've been following the evidence
 23 to the Inquiry.
 24 **A.** I've followed some of the evidence of the Inquiry where
 25 I can.

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1 relapse out of admission from hospital?
 2 **A.** Yes.
 3 **Q.** Which is exactly what we have with VC, isn't it?
 4 **A.** It is, yes. I would say that the Early Intervention in
 5 Psychosis Team, you know, would also commonly work with
 6 people who might require repeated admission under the
 7 Act. I suspect -- the EIP teams were similarly well
 8 resourced to work with patients with first episode
 9 psychosis, and I suspect the transfer between an EIP
 10 service and an AO service might have occurred towards
 11 the end of the three years of an EI team, unless the
 12 patient's engagement was particularly intractable or
 13 impossible to achieve otherwise.
 14 **Q.** But the EIP approach and the Assertive Outreach approach
 15 are very different, aren't they?
 16 **A.** I wouldn't say very different; I would say essentially
 17 they should be the same. They are both working with
 18 patients who are experiencing illnesses which they do
 19 not recognise they suffer from, and so their ability to
 20 make what seemed to others like wise decisions around
 21 engaging with care and treatment for those conditions is
 22 impaired.
 23 The difference between the two is around the level
 24 of resource available to them and perhaps the efforts
 25 that might be made to continue engaging someone who

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1 **Q.** The evidence of Dr Dissayanaka in relation to Assertive
 2 Outreach. Did you --
 3 **A.** I didn't see that, no.
 4 **Q.** What did you mean by Assertive Outreach, or what was
 5 being deployed then when you were working at that time?
 6 **A.** An Assertive Outreach Team was a specialist team set up
 7 to work particularly with patients with psychosis, who
 8 went through so-called revolving door admissions to
 9 inpatient psychiatric care under the Mental Health Act.
 10 I can't recall the details of the structure of the
 11 team, but generally, its purpose was to be better
 12 resourced with smaller caseloads to work with patients
 13 who represented a particular challenge in terms of
 14 engagement when they suffered a psychotic illness.
 15 **Q.** How were those people identified to get onto that
 16 programme, as it were?
 17 **A.** So I can't recall exactly the referral criteria. I know
 18 that there was an aspect of repeated admission under the
 19 Act, and rapid disengagement and subsequent relapse. I
 20 think, when I started training, there might have been
 21 a particular number of times that had to recur to
 22 trigger a referral. I don't know if that was the case
 23 throughout the life of the Assertive Outreach Team when
 24 it was in place.
 25 **Q.** But that was the effective test, when there was rapid

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1 explicitly did not wish to see the service.
 2 **Q.** And why are the efforts, as you describe it, different
 3 in the context of an AO approach?
 4 **A.** So typically it would be about the perception of the
 5 nature of the person's illness, perhaps the risks
 6 associated with that illness.
 7 **Q.** Do you think that somebody, such as VC, and others that
 8 you have described in that context, who do not believe
 9 they are mentally unwell, have no need for hospital
 10 admission or mental health assistance, are capable of
 11 assessing the benefits of treatment?
 12 **A.** Sorry, I don't quite follow.
 13 **Q.** Somebody who doesn't believe they're unwell.
 14 **A.** Yeah.
 15 **Q.** Believed that there are conspiracies out there and
 16 mental health services are part of them, are they ever
 17 able to weigh up the benefit of taking medication for
 18 an illness they do not believe that they have?
 19 **A.** I think that's an incredibly difficult kind of
 20 assessment to make. I don't think you can blanket rule
 21 that simply by having a psychosis you can never make
 22 a decision for yourself with regards to treatment.
 23 I think --
 24 **Q.** I didn't say psychosis, but I said by not believing that
 25 you are well. I know you say that's part of the

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1 psychosis, but the effect, if it's absolutely clear you
 2 don't believe you are unwell?
 3 **A.** So if you absolutely adamantly don't believe you are
 4 unwell you can still be persuaded to accept treatment by
 5 the views of others perhaps mental health services,
 6 perhaps clinicians like myself, trying to persuade you
 7 of the value of taking a treatment without making it
 8 about treatment for an illness. It might be "Look,
 9 every time you don't take this tablet or every time you
 10 don't accept this injection, you find, from your
 11 experience, that you wind up being brought back to
 12 hospital against your will, you wind up with, for
 13 example, a crisis team visiting you regularly when you
 14 find that intrusive and frustrating. And although you
 15 might not want to take this medication, you can prevent
 16 those things happening in your life by taking it.
 17 That's what we would like."
 18 And you kind of at best agree to disagree on the
 19 reason for the tablet, and you might talk about "Look,
 20 so long as this medication doesn't do you harm, are you
 21 happy to take it?" And on that basis they might accept
 22 treatment.
 23 **Q.** You'd need pretty clear evidence that they would view it
 24 as secondary gain in that way?
 25 **A.** You would need evidence that they would, and you would

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1 them as being relevant as to why you were recommending
 2 detention or medication?
 3 **A.** Yes. You would also hope that where a person lacks
 4 insight what you are wanting is a weight of information
 5 to persuade them to your point of view, and consequences
 6 of actions, you know, problems with housing, problems
 7 with relationships breaking down, problems with, for
 8 example, being prosecuted through the criminal justice
 9 system are very concrete examples you can give to people
 10 of "Look, we believe this is happening to you, this is
 11 what it's doing to your life", and that might weigh in
 12 their consideration about engagement.
 13 **Q.** You tell us in your statement at paragraph 7 that you --
 14 your academic work included teaching responsibilities
 15 for undergraduate students, research into medical
 16 objection and work on the Aetiology and Ethnicity in
 17 Schizophrenia and Other Psychoses. Tell us about that
 18 work or research about aetiology.
 19 **A.** So preparing for today, I had read my dissertation but
 20 I would get across that it was many years ago that
 21 I worked on kind of aetiology, the AESOP study. That --
 22 do you want me to just talk about that research or its
 23 relevance to --
 24 **Q.** Yeah, the key messages. What did you -- (*overspeaking*)
 25 --

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1 need to be able to monitor their response to the
 2 treatment and to be vigilant for evidence of relapse.
 3 I think in psychiatry, I think if you don't work in
 4 psychiatric then it can seem very easy that where a
 5 person is unwell then they can't make a decision for
 6 themselves, it's obviously in their best interests to be
 7 coerced or forced into treatment. But actually we have
 8 to work so much in agreement and collaboration with our
 9 patients, even where they're perhaps subject to the
 10 Mental Health Act or to perhaps issues like a Community
 11 Treatment Order that, you know, you're trying to
 12 persuade and engage someone. You're trying to
 13 psychoeducate them as to the nature of their condition
 14 and hope you can improve their insight.
 15 **Q.** Would you ever view it, in the best interests of a
 16 patient, that they were prevented from committing
 17 criminal offences; that that's part of the consideration
 18 of their best interests?
 19 **A.** Oh absolutely, yes.
 20 **Q.** Because obviously detention is not in their best
 21 interests, is it, long term?
 22 **A.** (*No audible answer*). (*The witness shook their head*).
 23 **Q.** So if you saw a risk that they were going to commit
 24 offences and be embroiled in the criminal justice
 25 system, would that be a factor that you would explain to

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1 **A.** So I mean the key messages that I took away was that
 2 diagnosis, categorical diagnosis in psychosis, although
 3 consistent in terms of bipolar affective disorder and
 4 schizophrenia, patients did move between those
 5 categories, their psychopathology evolved over time and
 6 the foundation for psychiatric diagnosis remains kind of
 7 expert consensus. You know, we lack biological testing
 8 for individual patients to identify particular
 9 conditions, so we still rely on operationalised criteria
 10 and the observation of phenomenological psychopathology
 11 in identifying particular diagnoses in a patient group.
 12 I think working on that study around the time that
 13 EIP teams were kind of becoming firmly established,
 14 I also kind of accepted using the broad term of
 15 "psychosis" to talk about patients experiencing first
 16 episode psychosis as a diagnostic label, as opposed to
 17 applying particular labels like a delusional disorder,
 18 an acute transient psychotic disorder, a schizophrenic
 19 disorder, because all of those conditions come with the
 20 same attendant risks in terms of the lack of insight,
 21 potential for risks to self and to others. And they
 22 need to be as considered as you can in terms of making
 23 sure you don't allow someone to make unwise decisions
 24 who is unwell, essentially.
 25 **Q.** There's a difference, isn't there, between a functional

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1 illness, paranoid schizophrenia, and a first episode
 2 psychosis though. Even though psychosis refers to both,
 3 from a patient perspective the first gives prospect of
 4 recovery, first episode, early diagnosis, better for
 5 outcomes. It may be a first episode. That must be
 6 a more positive diagnosis for someone than facing
 7 paranoid schizophrenia?
 8 **A.** So I think what you have to tell people is that they
 9 remain vulnerable to episodes of psychosis going
 10 forward. I think most people achieve -- I think the
 11 figure quoted is 80%, but an expert witness from
 12 research background would be better placed than me to
 13 give that exact figure.
 14 I think around 80% of patients achieve a good
 15 remission from their first episode of psychosis, but
 16 they remain vulnerable whatever the particular label
 17 might be applied at that point to episodes in the
 18 future. Place any of us in this room to under the right
 19 circumstances and any of us here could develop psychotic
 20 symptoms. You know, enough sleep deprivation, enough
 21 exposure to the wrong kind of stress, the unfortunate
 22 combination of the right physical health problems, you
 23 know, medical treatments. All sorts of things could
 24 pre-dispose you to a relapse of psychotic symptoms.
 25 **Q.** We know that Dr Seedat stated in the records, you'll

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1 that were referenced in that talk about schizophrenia
 2 and schizophrenia spectrum disorders and, for example
 3 the OvMIX(?) (*sic*) tool that's used to assess risk,
 4 which I have actually started to use after
 5 Professor Whiting presented it to the Trust a few months
 6 ago, is for patients with bipolar affective disorder and
 7 schizophrenia and spectrum diagnoses so patients with
 8 psychosis.
 9 **Q.** Is it a useful tool?
 10 **A.** I mean, it's very useful in that it's the first time
 11 I've had a tool that gives an actuarial figure at the
 12 end of it. I mean, I have run VC through it, and it
 13 came back as, you know, not frighteningly high --
 14 **Q.** It depends what information you put in there, so I'm not
 15 going to accept that until we've gone through your
 16 evidence, if that's all right?
 17 **A.** Sure, yeah. But it's useful. It gives you a figure
 18 that you can kind of lean on. Although I think you also
 19 have -- I mean, obviously it's used in conjunction with
 20 clinical judgement and with VC's --
 21 **Q.** Exactly.
 22 **A.** -- case you would be thinking about the risk of relapse
 23 given he'd had at least four distinct episodes.
 24 **Q.** Exactly. You'd need to have an accurate history before
 25 you put facts in it?

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1 have seen it, by July 2020, "likely paranoid
 2 schizophrenia".
 3 **A.** Mm.
 4 **Q.** Yet we see repeated references to first episode
 5 psychosis, referring to treatment. Why is that? There
 6 appears to be a reluctance to refer to paranoid
 7 schizophrenia.
 8 **A.** So I think there was a -- during my sort of training
 9 years, there was a general appetite to de-stigmatise
 10 mental ill health so that people were more willing to
 11 come forward with symptoms of mental disorder, so that
 12 people were more willing to report family members with
 13 symptoms of mental disorder and so on. And psychosis
 14 doesn't carry the cultural burden that the label
 15 paranoid schizophrenic does.
 16 **Q.** What do you mean cultural burden?
 17 **A.** The association with violence, the idea of otherness,
 18 the idea of difference of social exclusion, of
 19 inevitable decline of, you know, the burdens of the
 20 worst manifestations of that disorder.
 21 **Q.** There is, Professor Fazel has told us, an associated
 22 link, isn't there, particularly for men and younger men,
 23 between violence and schizophrenia?
 24 **A.** Well, I mean, so I did read Professor Fazel's evidence,
 25 and most -- or some of the studies at least that I read

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1 **A.** (*The witness nodded*).
 2 **Q.** So these tools, whatever they are, are only as useful as
 3 the accuracy of the information put in, aren't they?
 4 **A.** They are, yeah.
 5 **Q.** You say at paragraph 9:
 6 "In 2015 [you were] appointed as a substantive
 7 consultant psychiatrist ..."
 8 And you say you:
 9 "... since April 2015, part of a team of 3
 10 consultants ..."
 11 So who are the other two with you now and at the
 12 time of VC's appointment?
 13 **A.** At the time of VC it was myself, Dr Ben Di-Mambro and
 14 Dr Mike Skeleton. Now we're not quite fully staffed and
 15 haven't been for some time, but we have myself,
 16 Dr De-Mambro and Professor Gillian Doody who is less
 17 than full time, but helps us fill the work that she can.
 18 **Q.** How often do you speak together as consultants about
 19 cases or generally. I don't know where you work
 20 physically, if there's time for -- (*overspeaking*) --
 21 **A.** So when Dr Skelton and Dr Di-Mambro and myself were
 22 the team, Dr Di-Mambro and I shared an office and Dr
 23 Skelton was next door. We would be frequently in the
 24 same building and we set aside times to discuss cases
 25 that caused us particular kind of anxiety or alarm or

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1 that were particularly clinically challenging. That
 2 would be done kind of *ad hoc* between the three of us.
 3 **Q.** Paragraph 10, you tell us one of your additional roles
 4 is as primary care mental health practitioner
 5 supervisor; what does that entail?
 6 **A.** So some years ago, there was an initiative set up where
 7 some primary care mental health practitioners were
 8 embedded in GP practices. So these were band 7
 9 experienced psychiatric nurses who were meant to provide
 10 a sort of link between patients whose needs weren't
 11 quite meetable in primary care, but who were being
 12 rejected by secondary care, and there was an identified
 13 need for them to be able to access kind of supervision
 14 from psychiatric consultants.

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

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

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

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1 already.

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

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

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

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

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

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

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

20 **Q.** How is that agreed between you all?

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

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

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

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

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

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

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

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

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

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

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

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

8 Do you accept those criticisms?

9 **A.** Sorry?

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

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

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

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

19

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

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

22 Over the page, the "Finding":

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

18

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

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

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

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

21 Do you agree with that?

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

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

12 **Q.** Paragraph 21 of your statement, you say:

13 "A conservative estimate, [you'd assume you did] ...
14 2-3 assessments per week for 46 weeks per year ..."

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

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

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

21

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

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

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

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

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

23

1 And you say:

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

5 **A.** Mm.

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

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

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

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

22

1 and --

2 **Q.** We'll go through it later.

3 **A.** Okay.

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

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

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

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1 services and so on.

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

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

25 I think it most commonly happens with really
25

1 undertaken by previous practitioners.

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

4 **A.** Ask the patient in particular?

5 **Q.** Yeah, or other people.

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

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

23 **Q.** You say at paragraph 32:

24 "It's impossible to predict which individuals will
25 go on to commit such acts."
27

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

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

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

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

21 **A.** So, I mean, it's -- I mean, in the case of direct
22 observation in terms of patient's gender or just simply
23 asking them if there's any question about that, and you
24 gain it from taking a good history from a patient and
25 from relevant kind of previous histories, assessments
26

1 Acts like homicide.

2 **A.** Mm.

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

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

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

14 **A.** I think that gets a little harder because "serious" is
15 such a subjective description of violence, you know,
16 I don't know ... so, you know, somebody who -- if I can
17 use an example from my own clinical practice, you know,
18 a patient has physically laid hands on me and thrown me
19 out of their home. The patient was subsequently
20 detained to hospital, and the nursing team, when trying
21 to identify a bed for the patient will add "doesn't the
22 patient need a PICU?" And actually my interpretation of
23 the event, even being a victim of the assault, was that,
24 you know, he laid hands on me, he grabbed me, he shoved
25 me, it didn't strike me as serious violence and it was
28

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

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

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

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

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

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

18 **A.** Yeah.

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

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

29

1 NHFT0000168, page 49.

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

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

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

12 "... no risk to self identified."

13 You see the middle box:

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

20 And it's recorded here:

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

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

31

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

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

17 **A.** No, and --

18 **Q.** So unprovoked from their perspective.

19 **A.** Unprovoked from their right perspective, unexpected from
20 mine, perhaps.

21 **Q.** If we go then, let's go to September, but just to take
22 us in there, please, if we can have NHFT0000168,
23 page 49. This is so people can orientate themselves in
24 time, Dr Lomas, including yourself. He's discharged on
25 17 June from his second admission. We see that at

30

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

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

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

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

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

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

17 And we see NHFT0000168, page 51, your note on
18 22 June:

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

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

32

1 page 55.

2 Box at the bottom:

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

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

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

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

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

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

21 Q. We know he's then admitted to hospital in June. There's
22 a mental health assessment you're not involved in. He's
23 discharged 17 June, as I said earlier, admitted again on
24 14 July and discharged on 31 July. Relatively short
25 admissions, both of them; do you agree?

33

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

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

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

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

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

14 Why do you record there, risk to himself?

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

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

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

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

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

35

1 A. Not necessarily in the context of General Adult

2 Psychiatry.

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

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

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

12 "[VC] had decided to stop taking his medication 2
13 weeks after his discharge from his last admission ...
14 believed he was well and he did not have mental health
15 problems ... believed the medication was slowing him
16 down when he was studying for [a] ... university exam
17 ...

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

20 "In the light of the above, I would recommend for
21 CRHT to stay involved for the next 2-3 weeks at least
22 and then review as [VC] is working towards his exams
23 ..."

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

34

1 saying that to get them out of his hair?

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

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

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

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

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

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

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

36

1 him of that if he's refusing, or attempt to persuade him
 2 of that if he's refusing.
 3 **Q.** So that meant the Crisis Team should keep going every
 4 day.
 5 Part of the role of the MDT is to identify, isn't
 6 it, a formulation and level of risk. You said earlier
 7 that's where people would come together and discuss
 8 that.
 9 **A.** So an MDT can perform multiple roles, and an MDT, for
 10 example, to discuss a case after an initial assessment,
 11 where formulation was felt to be unclear, might focus on
 12 that. I think the MDTs on a red RAG basis are about,
 13 because they take place every day, they're about "Has
 14 anything changed overnight? Do we need to do anything
 15 different today? Is what we're doing adequate?"
 16 **Q.** It records here "presentation with history of
 17 psychosis", we spoke earlier about the fact there was
 18 a likely diagnosis of paranoid schizophrenia, wasn't
 19 there? So this was a schizophrenic patient, and do you
 20 accept the link, potentially, with violence?
 21 **A.** I mean, there's a link with violence with psychosis.
 22 **Q.** So you think it's the same, irrespective of describing
 23 psychosis or paranoid schizophrenia?
 24 **A.** My understanding is that most of the research talks
 25 about schizophrenia and spectrum disorders in terms of

37

1 if there was signs of anybody in there deliberately
 2 avoiding us, because that would support the AMHP in
 3 making an application for a Section 135 if that was the
 4 case. But I just remember seeing an empty flat.
 5 **Q.** And do you remember him later driving past you and
 6 Dr Manzar?
 7 **A.** I don't recall that, no.
 8 **Q.** So you go and conduct the assessment on the 3rd. Can we
 9 have, please, NOCC0000050, page 3, and this is Amie
 10 Staples's note of the assessment. Perhaps we can have 2
 11 and 3 on the screen, if it assists you.
 12 We see at page 2 is:
 13 "[When] ... we were waiting for the police to arrive
 14 [at the bottom], a man pulled up in a car ... got out
 15 and approached us. He asked if we were from the
 16 hospital. He confirmed ... he was [VC]. I explained
 17 that we had come to see him and asked if we could speak
 18 to him in his flat. He initially agreed and let us in;
 19 however as Dr Lomas entered he then changed his mind and
 20 asked us to leave."
 21 Can you remember now what he said and what you said
 22 and how that arose?
 23 **A.** No, I remember I think I got into the flat. I don't
 24 think I even got as far as sitting down. And he --
 25 well, just changed his mind and asked us to leave.

39

1 analysing the risk between major mental illness and
 2 offending, violent offending.
 3 **Q.** We know that he's then assessed on 15 August by someone
 4 else who is going to be giving evidence, and the risk is
 5 noted to be, "appear[s] low in all areas. He's not
 6 a risk to himself and [he's] not a risk to people."
 7 So that's the assessment on 15 August 2020.
 8 Subsequent to that, he's not engaging, is he, with
 9 the Community Team?
 10 **A.** I can't -- I don't have anything on my screen, so I ...
 11 **Q.** Okay. But he doesn't work with the Community Team,
 12 which is why, on 2 September, there's the decision made
 13 to go and see him, isn't there?
 14 **A.** If that's in the record, yes.
 15 **Q.** Can we have a look, please, at NHFT0000168, page 164.
 16 So this is when yourself, Jen Shaw and Dr Manzar are
 17 going to see him because of that non-compliance with
 18 you, not working with the team. Tell us about that.
 19 Are you helped by going to your statement or can you
 20 remember seeing him on the 2nd and deducing that he
 21 didn't want to have the Mental Health Act Assessment?
 22 **A.** So I think I talk about it in my statement that we visit
 23 the property but it's empty. I remember climbing on the
 24 back wall of the flat, which I think was based in an old
 25 pub, and peering through the back windows trying to see

38

1 I think all I would have spoken about was the reason we
 2 were there to see him, and the kind of legal process
 3 that he was subject to, the kind of basic facts of it.
 4 **Q.** Then if we look at page 3, do you agree with her
 5 assessment there at the top of the page:
 6 "The police ... explained the need to accompany him
 7 to hospital. He then stated that the male officer
 8 should step forward ..."
 9 Could you see into the room at this point or not?
 10 **A.** I can't recall --
 11 **Q.** You can't recall?
 12 **A.** -- no, in all honesty, like if I could see at that exact
 13 moment. I remember being stood in the doorway to his
 14 bedroom, I think it was.
 15 **Q.** Do you remember seeing him take his glasses off as
 16 a preparatory act?
 17 **A.** I don't remember him wearing glasses.
 18 **Q.** So you didn't see that?
 19 **A.** No.
 20 **Q.** You didn't see him take his glasses off.
 21 **A.** (Witness shook head).
 22 **Q.** You did think that he'd targeted the male officer in
 23 particular?
 24 **A.** I did. So my recollection of it was -- I think there
 25 were two female officers with us and we kind of had this

40

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

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

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

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

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

41

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

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

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

8 **A.** Sorry?

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

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

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

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

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

43

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

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

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

9 **A.** Mm.

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

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

16 **Q.** You have extensive experience in doing that?

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

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

42

1 **A.** Yes.

2 **Q.** You paused there.

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

6 **Q.** Tasered three or four times? Restraining him in
7 handcuffs and then someone trying to use a handcuff as
8 a weapon?

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

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

22 **A.** Mm.

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

44

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

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

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

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

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

23 **Q.** A degree of fantasy?

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

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

14 **Q.** It's based on informants?

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

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

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

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

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1 used in that way sometimes.

2 **Q.** Speculation?

3 **A.** Speculation.

4 **Q.** Not evidence based?

5 **A.** Not evidence based --

6 **Q.** Is that a worry as a psychiatrist?

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

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

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

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

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1 different contexts?

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

5 **Q.** If we go to CYGN0000085, page 1 and 2. You complete
6 this, Dr Lomas. It's the PICU Gatekeeping Referral
7 Form. "Reason for admission to Hospital" is set out:
8 "Current mental state and presentation:
9 "... presenting with relapse of psychosis, ...
10 persecutory beliefs about being monitored by the
11 government ... does not recognise he is unwell."

12 At page 2, states:

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

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

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

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

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

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

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

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

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

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

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

12 What I meant by that is he'd not directly hurt
 13 somebody by physically hitting them, I guess.
 14 **Q.** If we go, please, to NHFT0000168, page 21. This is
 15 a document in the RiO notes of Dr Seedat -- prepared by
 16 Dr Seedat. Did you ever read this, Dr Seedat's summary
 17 account of text message conversations between VC and his
 18 brother?

19 **A.** I can't remember if I did or didn't. I suspect I would
 20 have done if it was -- was it entered by Dr Seedat?

21 **Q.** Yes.

22 **A.** Then I suspect I would have seen it because I usually
 23 filter RiO notes by profession, including medic to pick
 24 out --

25 **Q.** When you say "entered", do you mean has it got his name

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

4 "... wanting to hurt these people he was hearing."

5 **A.** I would have wanted to know -- I would have wanted to
 6 know that, and I would also make asking questions about
 7 that kind of experience -- I mean that's a routine kind
 8 of area to explore. So wherever anybody is experiencing
 9 persecutory beliefs, the belief they're at the centre of
 10 some malicious conspiracy against them, you always ask
 11 "And do you know who these people are? Have you had
 12 thoughts about confronting these people? Have you got
 13 into conflict with any of these people you've
 14 identified?" And, you know, escalate the questions
 15 through to asking about thoughts of violence, as
 16 I described earlier.

17 **Q.** Because knowing if they have thoughts of violence is
 18 significant to what?

19 **A.** To thinking about risk.

20 **Q.** And whether they might do it?

21 **A.** And whether they might harm someone, yes.

22 **Q.** If you go, please, to NGPF0002527, page 14. No
 23 suggestion you or anyone other than Dr Seedat saw these
 24 at the time. My question is: should you have done? So
 25 if you look at page 14, there's many text exchanges and

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1 on it somewhere? Because I can't tell you that. It's
 2 information that only Dr Seedat had, and therefore he's
 3 the author of it, but how it appeared on RiO ...?

4 **A.** So if he made the entry into RiO, then I would have seen
 5 that as, through filtering that information. If
 6 I hadn't, if it wasn't entered by Dr Seedat, if it was
 7 entered by his secretary, I might have seen it but
 8 I can't comment for certain.

9 **Q.** Would you have wanted to know what VC was saying to his
 10 brother about his delusional beliefs?

11 **A.** From a text message conversation --

12 **Q.** Yes --

13 **A.** -- from 2020? In all honesty, I don't know.

14 **Q.** Would you have wanted to know -- I mean it's been
 15 recorded in the record here -- "he is doing this", he's
 16 "telling", "He said ... people would not mock him in
 17 person and made some remark to wanting to hurt these
 18 people he was hearing."

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

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

24 Would that tell you much about risk or not?

25 **A.** Which particular --

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1 here at the top, reference to VC saying:

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

4 Is that the type of comment you'd like to know or
 5 source if he'd been having that?

6 **A.** I mean, in all honesty, it's difficult to know how
 7 significant a thought of violence that's, let's say
 8 a year or two years old, would have been to
 9 an assessment some years down the line. And in all
 10 honesty, I think the question that might come to about
 11 whether or not this should have been uploaded into the
 12 record and whether or not I would have seen it, I'm not
 13 sure, in all honesty, I would have read every
 14 document in VC's record and I'm not sure I would have
 15 read a transcript of a phone conversation from a few
 16 years ago. I would have taken note of anything entered
 17 in the risk -- core risk assessment document about that.

18 **Q.** So if somebody had summarised this, and if we go to
 19 page 17, other messages, one from 12 April:

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

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

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

25 Over the page, page 18:

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1 "I was thinking about red rum not 120 minutes ago."
 2 Would you understand a reference to red rum?
 3 **A.** Well, it's murder backwards or I think it was
 4 a racehorse, I think.
 5 **Q.** Both.
 6 **A.** Yeah.
 7 **Q.** So would you have understood that that could be
 8 a reference to murder? "I was thinking about murder not
 9 120 minutes ago".
 10 **A.** If I'd read that, that would come to mind, yes.
 11 **Q.** Would that worry you? Would that be a factor on the
 12 formulation or as part of the formulation?
 13 **A.** I would definitely want to talk to the patient in detail
 14 about it, but I would put this in the context of how
 15 very many patients we see that have thoughts of
 16 violence, in the context of psychosis and other
 17 disorders.
 18 **Q.** In terms of -- that can go down, thank you -- we have
 19 analysed what VC was viewing. He was viewing various
 20 terrorist attacks. He was viewing a live stream of
 21 capital punishment that he refers to, to his brother.
 22 Would you be concerned or interested to know what
 23 a patient is viewing on the Internet, when assessing
 24 risk?
 25 **A.** I mean, thinking about what is available on the Internet

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

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

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

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

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

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

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

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

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

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

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

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

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

18 **Q.** Really?

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

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

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

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

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

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

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

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

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

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1 the technology called neural remote imaging and neural
 2 remote mapping.
 3 And non-engagement was a consequence, wasn't it, of
 4 all of this? He just didn't think he was ill.
 5 **A.** He just didn't think he was ill at that point and the
 6 hope was that with the treatment he could recognise that
 7 he was unwell, as we would do with any other patient and
 8 try and persuade them of the value of taking treatment.
 9 **Q.** How many times and opportunities are they given to
 10 express that genuine belief that they're going to take
 11 medication because they accept that it's secondary gain
 12 and it's better for them? How long do you persist with
 13 those types of -- (*overspeaking*) --
 14 **A.** So I think it's very difficult to, you know, define
 15 a limit, a cut-off, a time when if a person has had this
 16 many goes at being allowed to take oral treatment, they
 17 should be coerced into accepting long-acting injections.
 18 Because it -- you know, it requires that the
 19 long-acting injection is, to start with, effective. It
 20 requires that you balance the patient's choices,
 21 autonomy, their own rights, against the risks they pose
 22 to others and that's a really challenging kind of
 23 decision to make and if you do make it you want it to be
 24 really clear, consulting with as many people as you can.
 25 And in the context of an assessment where

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1 assault against the police officer] his evidence
 2 appeared to minimise them somewhat, describing them as
 3 'unfortunate' ... and the consequence of 'poor
 4 judgement' which suggests a lack of insight."
 5 At the same time as receiving this decision, VC
 6 emailed a police officer asking for reconsideration of
 7 a conditional caution. That shows real intelligence,
 8 doesn't it, to see that lack of insight is being
 9 described, and he then goes back to the police officers
 10 and says, "I'd like to accept a conditional caution?"
 11 **A.** Sorry, he says, "I'd like to" --
 12 **Q.** "I'd like to." He'd like to. It's too late by then,
 13 the events have closed.
 14 **A.** Right.
 15 **Q.** But he recognises and says he'd like to accept
 16 a conditional caution in relation to an earlier event --
 17 **A.** Yeah.
 18 **Q.** -- that he assumed was being proceeded with. That's
 19 real calculation, isn't it?
 20 **A.** I mean, it -- I'd have to understand kind of the details
 21 of the consequences of not accepting the caution, of
 22 understanding his kind of motive for doing so, before
 23 I could draw any conclusions about it.
 24 **Q.** Well, he's being told here that he minimises past
 25 events, so I suppose accepting a caution and going to

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1 considerable amounts of pepper spray had been deployed
 2 by the police, where a person has not engaged with you
 3 in any meaningful way, where you're meeting a person for
 4 the first time, I think it's reasonable -- and I felt it
 5 was reasonable at the time -- to want to take time to
 6 assess that further. You know, the Mental Health Act
 7 recognises that an assessment can take 28 days, whereas
 8 a Mental Health Act Assessment, the process of
 9 interviewing with doctors and AMHP, it would have been
 10 unusual for it to take more than an hour.
 11 **Q.** That can come down, please. Can we have CYGN0000056,
 12 page 5 and this is the Mental Health Act Tribunal
 13 decision in September 2021. Did you ever see this
 14 decision, his appeal against his detention and the
 15 decision?
 16 **A.** Sorry, it wasn't on the screen.
 17 **Q.** It will be in a minute. Page 5. Did you ever see this
 18 at the time or subsequently when you were reviewing his
 19 notes?
 20 **A.** No.
 21 **Q.** So you've never seen it until you've seen it via the
 22 Inquiry?
 23 **A.** No.
 24 **Q.** So if we look at page 5 at (iii):
 25 "Whilst [VC] accepts these events occurred, [the

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1 the police and saying, "I now accept that earlier event"
 2 is demonstrating that he is, to some extent?
 3 **A.** I suppose you could argue it from the way you've put it
 4 to me, yes.
 5 **Q.** Can we have, please, NGPF0000019, page 1, an email to
 6 you. I think you don't recollect receiving this
 7 particular email.
 8 This is a request for information surrounding VC,
 9 diagnosis, whether he's still detained, et cetera. And
 10 there's no statements from the AMHPs, it's in relation
 11 to the prosecution for the offence against the officer,
 12 but you don't remember receiving that one.
 13 **A.** I don't recall receiving that, no, or reading it.
 14 **Q.** You did, at NGPF0004194, page 1, receive emails in
 15 December and January requesting a statement, didn't you?
 16 Can we have those on the screen?
 17 Dr Lomas, Matthew Johnson, chasing the statements in
 18 January, and you do make a police statement, don't you,
 19 in relation to the events?
 20 **A.** I do, yes.
 21 **Q.** If we go to NGPF0000032 and have page 1 and 2 on the
 22 screen, you say in your statement at paragraph 101 to
 23 the Inquiry:
 24 "I ... thought it was in the interests of the
 25 assaulted officer and VC to have this considered by the

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1 criminal justice system, given VC's history."

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

4 **A.** Mm.

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

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

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

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

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

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

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

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

18 All right, we'll start again at 11.55.

19 (11.34 am)

(A short break)

21 (11.54 am)

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

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

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

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

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1 **A.** Yes.

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

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

6 **Q.** Yes, and if we go to NHFT0000168, page 205, there's
7 a Multi-Disciplinary Team meeting. The bottom box:
8 "note outcome of mental health act assessment
9 yesterday."

10 That's treatment in the community still, yes?

11 **A.** Yes.

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

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

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

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

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

24 **Q.** At all.

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

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

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1 conversation exchanged with one readily identifiable
 2 individual. So I'm not sure how I would have gone about
 3 it. I might have just asked more pointed generic
 4 questions.
 5 Q. Or asked the consent of the individual and said, "Look
 6 it's really important for my reasoning" --
 7 A. Yeah, so -- (*overspeaking*) --
 8 Q. -- and see what they said.
 9 A. You know, if I'd had the opportunity to contact and
 10 speak to the individual who was raising the particular
 11 concerns, I would say to them: "Look I know you don't
 12 want this, but actually, ultimately" --
 13 Q. It's necessary.
 14 A. -- "... the person needs to know and the person is going
 15 to know, however circuitous we might be in terms of our
 16 questioning about this topic".
 17 Q. If we can have NHFT0000168, 205, back on the screen.
 18 Sorry if we digress from that document. But if we look
 19 at the bottom of your entry there please for the MDT:
 20 "remain red RAG".
 21 You've explained what that means:
 22 "contact in pairs."
 23 What were you saying there?
 24 A. So for staff to visit in pairs. So for two staff to
 25 visit as a precaution against violence or aggression.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 **Q.** On the 2nd, sorry.

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

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

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

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

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

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

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

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

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

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

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

12 Let's have a look at what you say:

13 "Presents as possibly experiencing psychosis."

14 Why do you say "possibly" experiencing psychosis?

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

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

18 **A.** Yeah, sorry.

19 **Q.** So take your time.

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

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

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

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

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

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

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

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

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

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

25 **Q.** Really?

1 months?

2 **A.** I was, yeah.

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

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

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

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

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

17 **A.** Well, if --

18 **Q.** 2021.

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

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

4 And it was --

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

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

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

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

21 **THE CHAIR:** He said what?

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

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

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

4 **Q.** So you say, above "Discussion":

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

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

11 If we go over the page, you say:

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

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

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

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

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

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

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

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

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

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

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

14 **Q.** Right.

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

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

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

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

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

23 It was with this in mind that I recommended
 24 assessment.

25 **Q.** That can come down, please. Did you think to ask the
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1 something.

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

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

7 **A.** Yeah.

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

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

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

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

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

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

12 And --

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

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

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

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

25 **Q.** An altercation about house rules and cleaning rotas or
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1 is for the best in this case? And is this is an
 2 appropriate treatment plan? And is the appropriate
 3 treatment available?

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

16 And that was the purpose of the assessment.

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

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

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

6 **Q.** Fiona Parker?

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

16 **Q.** Last document from me, please. NHFT0000168, page 255.
 17 This is a document dated 21 February 2022, Dr Lomas.
 18 "... explained to [VC] that following his previous
 19 admission where he was restrained by police after
 20 assaulting an officer I had been asked to make a witness
 21 statement, and that the police had explicitly asked for
 22 information about his mental health which I needed his
 23 permission to share.
 24 "He said he would like to discuss it with
 25 a solicitor before doing so.

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

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

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

7 **Questioned by MR MOLONEY**

8 **MR MOLONEY:** Good afternoon, Dr Lomas. I ask questions on
 9 behalf of the bereaved families.
 10 I just want to ask you about three things, if I may:
 11 firstly, depot medication; secondly, the incident of 3
 12 September 2021; and thirdly, your assessment in
 13 January 2022. And only a couple of questions in
 14 relation to each.
 15 Firstly, depot. And it was in January 2022 when you
 16 assessed VC that he flatly refused depot and said it was
 17 unnecessary as he was concordant with oral treatment?

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

19 **Q.** At that stage, you'd had quite a bit of experience of
 20 VC, you'd been involved in his admission in September
 21 2021 --

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

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

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

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

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

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

16 **A.** I mean, I -- it depends on what the patient is expecting
 17 from a consultation. You know, I might speak to a
 18 patient who wants to ask me a question and isn't seeking
 19 care or ongoing treatment from me. I might be asked by
 20 a colleague to see a patient for a second opinion and go
 21 onto their -- and arrange to see them, either in the
 22 community or on an inpatient ward.
 23 And in this case, you know, I was trying to be,
 24 knowing how hard pressed the police are and how
 25 difficult their job is, I was trying to be helpful by

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

2 **Q.** I won't take you to all the entries because you know
 3 there are many there, aren't there, and you, for
 4 example, say he felt it slowed him down when he had an
 5 exam and so he decided not to take it and so on. And
 6 then there was a subsequent history of spitting out
 7 medicine that you raised with him in fact in that
 8 January 2022 assessment, and then the finding of the
 9 medication in September that dated back to February
 10 2021?

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

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

16 **A.** He did, yeah.

17 **Q.** He had autonomy in that sense?

18 **A.** He did, yes.

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

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

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

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

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

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

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

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

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- 1 A. "Do you want -- should criminal charges supersede the
2 civil process here? Like, you know, we can assess him
3 in custody later, whatever."
- 4 And again, forensic colleagues might disagree with
5 me about this but just because someone is psychotic
6 doesn't automatically make any act they do that's
7 criminal a result of their psychosis.
- 8 Q. Absolutely.
- 9 A. You know, the reason for his refusal to travel with the
10 police could have been anything, could have been based
11 on reality, could have just been with a disaffection
12 towards, you know, authority figures.
- 13 Q. Yeah.
- 14 A. Whatever it may have been. But I -- and at that point
15 I genuinely didn't know what his mental state was.
- 16 Q. No, of course. And then just finally to build on that
17 with the last question I wanted to ask you, which was
18 about your assessment in January 2022, as you say, you
19 knew him quite well by 2022, and in terms of the
20 previous in incidents of violence, shortly before
21 28 January 2022, if I can describe it in that way, it
22 appeared to you that he wasn't assaulting his flatmate
23 because he thought he was part of some technocratic
24 conspiracy, as you said.
- 25 A. Yeah.

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

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- 1 Q. That essentially the circumstances were unremarkable,
2 weren't they?
- 3 A. Well, I mean it was -- the description, as he gave it to
4 us and as it's recorded elsewhere, is that it's a fight
5 that occurs with people for understandable reasons not
6 relating to mental disorder, would be how I would see
7 it, but, you know, in light of his history --
- 8 Q. You'd have to think -- (*overspeaking*) --
- 9 A. You'd have to consider it, yeah.
- 10 Q. But it didn't have any of the hallmarks, classic
11 hallmarks of psychotically driven violence, did it?
- 12 A. Not that assault, not the --
- 13 Q. No.
- 14 A. -- account that he gave, no.
- 15 Q. Then you'd recorded in the RiO at page 215, I'll just
16 finish with this, that when you saw him, he did not
17 present overtly as psychotic.
- 18 A. I could not identify symptoms of psychosis --
- 19 Q. Absolutely.
- 20 A. -- easily at that assessment, no.
- 21 **MR MOLONEY:** Thank you very much, Dr Lomas.
- 22 **THE CHAIR:** Yes, Ms Cartwright.
- 23 **Questioned by MS CARTWRIGHT**
- 24 **MS CARTWRIGHT:** Good afternoon, Dr Lomas. I ask questions
25 on behalf of the survivors.

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

4 Thank you.

5 Now we can see that this statement is dated
6 27 January 2022. And so we know that you've provided
7 this statement to the police after VC has been involved
8 in the incident attacking his flatmates, and the day
9 before he commences his third period -- sorry, his
10 fourth period of detention on 28 January 2022.

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

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

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

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

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

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

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

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

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

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1 28 January, and so were you receiving some pressure from
2 the police to provide the statement about the earlier
3 criminality in September?

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

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

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

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

3 **A.** Yes.

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

8 **A.** Yes.

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

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

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

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

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

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

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

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

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1 progress.

2 **Q.** So if we can go to page 165, please, which I think
3 captures VC's arrival at the Cassidy Suite. It's under
4 the 8.07, thank you. We can see at 8.30:
5 "[VC] arrived to Cassidy Suite with 5 police
6 officers. He was ... on hand cuffs and was directed to
7 his bed space. He was asked to kneel on the floor and
8 handcuffs were removed. He was not responding much to
9 staffs and he appeared angry. He was offered food and
10 drink but refused saying he'd rather be home. ...
11 avoiding eye contact ..."

12 Then we can see he:

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

16 Then references the assault.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 And in terms of not knowing why the PICUs had
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1 a PICU, many weeks, perhaps longer, before they get
2 a bed in a secure service.

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

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

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

17 *(As read)*

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

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

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

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

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

10 **MS CARTWRIGHT:** Well, there is a question arising because at
11 178, one of the reasons was given for declining was that
12 it needed a male team, but what was being indicated as
13 well -- it's at page 178 -- that you would need --
14 recommended that placement with a predominantly male
15 team or securer services may be more appropriate.

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

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

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

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

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

5 **Q.** So you were the person that noted Dr Seedat's contact on
6 the 22 June and with that being the case, why was
7 medication not looked at, bearing in mind it remained on
8 5 milligrams of aripiprazole during that time he was in
9 the community deteriorating?

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

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

23 **MS CARTWRIGHT:** Thank you.

24 **THE CHAIR:** Thank you.

25 Yes, Mr Straw.

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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

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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

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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

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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

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1 psychotic". You explain, though, that his presentation
 2 was entirely consistent with his previous relapse, 3
 3 September 2021 --
 4 **A.** Mm.
 5 **Q.** -- when he presented similarly calm to prior to the
 6 previous incident of significant violence. And you
 7 didn't take the lack of overt psychotic presentation at
 8 face value, did you?
 9 **A.** I accepted the limitations that any psychiatrist or
 10 mental health practitioner faces in trying to know
 11 what's going through another person's mind.
 12 **Q.** And you were aware that 3 September 2021 incident where
 13 he didn't present as overtly psychotic, but he was, that
 14 demonstrated that he was someone who could appear calm
 15 when he was psychotic.
 16 **A.** Yes, but likewise, patients who appear calm with
 17 a history of psychosis and don't look like they have
 18 psychosis can also not have psychosis at that point.

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

20 **Questioned by THE CHAIR**

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

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

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

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

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

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

23 **A.** Do you mean the --

24 **THE CHAIR:** The Brook Court incident where the --

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

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

2 **A.** Yes.

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

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

7 **A.** Yes.

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

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

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

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

5 **THE CHAIR:** Yes.

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

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

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

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

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

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1 A. I don't know, sorry, I don't know enough about the
 2 recommended changes to identify --
 3 **THE CHAIR:** Well, if you weren't, you weren't.
 4 A. No, sorry.
 5 **THE CHAIR:** It doesn't matter. I think that's an answer to
 6 my question. Thank you.
 7 Right, well, I think we'll finish there. 1 o'clock.
 8 We'll start again at 2.00, thank you.

9 (1.03 pm)

(The short adjournment)

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