

Monday, 27 April 2026

1
2 (10.00 am)
3 **THE CHAIR:** Yes, Mr Blake.
4 **MR BLAKE:** Good morning, Chair. Can I please call Geoffrey
5 Culpin.
6 **THE CHAIR:** Yes.
7 **GEOFFREY CULPIN (sworn)**
8 **Questioned by MR BLAKE**
9 **THE CHAIR:** Thank you. Yes.
10 **MR BLAKE:** Thank you.
11 Mr Culpin, you have produced two witness statements
12 for the Inquiry: the first is dated 10 November 2025 and
13 has a URN of WITN0189001; and the second is dated
14 8 January 2026 and has a URN of WITN0189002.
15 Are both of those statements true to the best of
16 your knowledge and belief?
17 **A.** They are.
18 **Q.** Thank you. You started work for Nottingham City Council
19 as a social worker in 2005; is that right?
20 **A.** It is.
21 **Q.** You have been an AMHP since 2009.
22 **A.** Yes.
23 **Q.** You've set out in your witness statement you estimate
24 that you carry out about or over 30 Mental Health Act
25 Assessments each year; is that right?

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1 **A.** So a referral is made to us, to the -- for a Mental
2 Health Act Assessment, a senior colleague, an admin,
3 will initially look at that because they'll pick up the
4 email and then they'll forward that into a box on a data
5 entry system and they'll alert the senior cover AMHP to
6 look at that and then they'll look at that against other
7 assessments that are there to determine whether or not
8 and in what circumstances that assessment needs to take
9 place.
10 **Q.** When you say that they'll look at that, what exactly are
11 they looking at?
12 **A.** They're looking at the background details to that, I
13 suppose, predominantly to the extent on one level
14 does it need to be a Mental Health Act Assessment. If
15 it does, what that needs to take place and the degree of
16 emergency, and how that needs to, I suppose, fit with
17 the other Mental Health Act assessments that are being
18 asked to be undertaken at that point in time.
19 **Q.** The person that carries out that assessment is a senior
20 AMHP?
21 **A.** Yes.
22 **Q.** Is it only an AMHP who can decide whether or not to
23 ultimately carry out a Mental Health Act Assessment?
24 **A.** Not necessarily, but it is the case that an AMHP makes
25 that decision, and on two levels, but both in terms of

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1 **A.** Yes.
2 **Q.** You've said that you manage various teams. We're here
3 today to talk principally about the 14 July incident,
4 14 July 2020. As at that point, what was your formal
5 position?
6 **A.** Team Manager, Mental Health South Team and Forensic
7 Team.
8 **Q.** Who did you manage?
9 **A.** A group --
10 **Q.** Which teams did you manage at that point?
11 **A.** Both of those two teams.
12 **Q.** Thank you. You've set out in your second statement the
13 role of an AMHP, and we've heard about that before and
14 I'm not going to deal in any great detail with that. The
15 only aspect of that that I'd like to deal with this
16 morning is the triage process. You've set out at
17 paragraph 16 how, when referrals are received, there is
18 a triaging process that's carried out by a senior AMHP.
19 You've said that was established in 2020. Are you aware
20 if that was before or after this particular incident?
21 **A.** It would have been round about, I don't know if it was
22 particularly before or after, but I would have thought
23 it would have been after. I can't say for certain.
24 **Q.** Can you briefly assist us with what that triage process
25 involves?

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1 whether or not to proceed, so that the AMHP which then
2 receives that piece of work will also look at that in
3 greater detail, maybe, to determine whether or not the
4 Mental Health Act needs to take place, if and when.
5 **Q.** How long typically does that triage process take?
6 **A.** I mean, it can take place within a few minutes, if it's
7 clear that that's what needs to happen. If there's
8 more -- if it's more complicated, then it could take
9 a few hours, really, to get additional information to
10 see whether or not the assessment needs to take place.
11 So you might need to contact other professionals, look
12 at other information to clarify the detail, really and
13 the background to see what -- how that needs to kind of
14 take place, really, how to proceed.
15 **Q.** We've heard about AMHPs identifying specific doctors who
16 perhaps have had a previous interaction with the
17 patient.
18 **A.** Yes.
19 **Q.** What about allocation of AMHPs; is there any process
20 which matches a particular AMHP to a particular patient?
21 **A.** Not to a particular patient, no, but some AMHPs, I
22 suppose, kind of maybe have more experience in some
23 areas, but sometimes a degree of travel involved. So
24 there's some practicalities sometimes that will
25 determine which AMHP picks up the assessment, but it's

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- 1 not a matter of linking an AMHP to a particular case.
- 2 **Q.** What about the availability of a bed? How does that
3 interfere or otherwise with that process? To what
4 extent can the decision as to whether to conduct
5 a Mental Health Act Assessment be influenced by the
6 availability of a bed?
- 7 **A.** It's not. We would always proceed to undertake an
8 assessment. It's not determined by the availability of
9 a bed.
- 10 **Q.** Thank you. I'm going to move on, then, to your
11 involvement on 14 July. If we could please bring up on
12 to screen NOCC0000046, and this is the Report Referral
13 and Assessment form that you completed. We've already
14 seen the forms from 23 and 24 May 2020, and this now,
15 we're in July, 14 July.
- 16 You undertook this assessment with Dr Manzar, who
17 we're going to be hearing from this afternoon, and
18 Dr Seedat. Dr Manzar met with VC I think before you saw
19 VC on this day.
- 20 Is that usual, unusual?
- 21 **A.** It happens on a fairly reasonable -- very frequently, so
22 they're not -- the majority of assessments are
23 undertaken with both doctors and the AMHP at the same
24 time, but --
- 25 **Q.** And is it helpful or unhelpful or does it not matter?

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- 1 information from, for example, hospital records or
2 elsewhere?
- 3 **A.** There was sufficient information for me to make that --
4 the decision that I did, yes. Dr Seedat, you'll be
5 aware did know VC well and we undertook that assessment
6 together so he was able to tell me about the details of
7 his interaction with him whilst he was on the ward.
- 8 **Q.** This was the third assessment, so we know that the first
9 assessment in May didn't recommend admission. The
10 second assessment was admission under Section 2, and
11 this was the third and was straight to admission under
12 Section 3 of the Mental Health Act.
- 13 In your view, is Section 2 of the Mental Health Act
14 considered to be less restrictive than Section 3?
- 15 **A.** In my opinion, yes, and I think widely it is seen as
16 less restrictive, yes.
- 17 **Q.** And in light of that, is it your experience that there
18 is a reluctance or perhaps over-caution to go straight
19 to Section 3 because of that least restrictive approach?
- 20 **A.** If the evidence leads to placing somebody on the
21 Section 3, then that's what happens, yes. So no,
22 I don't think so.
- 23 **Q.** When you saw VC, I think he told you that he was
24 stressed about his academic life; is that right?
- 25 **A.** I mean it's hard to remember all this time ago, but

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- 1 **A.** I mean on this occasion it didn't matter. And on many
2 occasions it's not an issue. So, so Dr Manzar would
3 have seen VC kind of shortly before I did, and Dr Seedat
4 did on this occasion. I spoke with Dr Manzar before
5 I saw him, so I was aware of the nature of his
6 assessment so we had an opportunity to talk through in
7 details.
- 8 On some occasions doctors will see a patient before
9 we do, and will leave their medical recommendations such
10 that we don't actually have an opportunity to talk
11 through with them, but on those occasions we do take the
12 opportunity to speak to the doctor so we know the
13 background, to see if we're happy to proceed.
- 14 So as an AMHP, if we felt that was -- if there was
15 a difficulty there, we would deal with that and deal
16 with that issue.
- 17 **Q.** But in this particular case you --
- 18 **A.** No.
- 19 **Q.** -- didn't see an issue?
- 20 **A.** Not at all. No.
- 21 **Q.** You said in your statement this was a very clear case,
22 that VC needed to be in hospital under Section 3; is
23 that right?
- 24 **A.** It is, yes.
- 25 **Q.** And is that the reason why you didn't seek more

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- 1 that's what I recorded, so yes.
- 2 **Q.** Is there anything further in relation to that that you
3 recall?
- 4 **A.** No, no.
- 5 **Q.** Sticking with this form, then, if we please go over the
6 page to the bottom of page 2, you record at the bottom
7 of this page that contact was made with VC's mother, the
8 nearest relative:
- 9 "... who had become concerned over the weekend that
10 [VC's] mental health ..."
- 11 If we scroll over, please --
- 12 "... appeared to be deteriorating. Did not object
13 to [VC] being admitted to hospital and if this could be
14 under section of the [Mental Health Act] ... including
15 S[ection]3".
- 16 Just pausing there, what happens if a nearest
17 relative doesn't consent?
- 18 **A.** So there's a process that we kind of work through. That
19 can be impacted by time, really, in terms of the -- if
20 somebody is -- if somebody would already be on
21 a Section 2, that's a different situation so maybe it's
22 best to talk about the situation here.
- 23 We would -- we have a process where, ultimately,
24 a nearest relative can be displaced and so that wouldn't
25 impact on, ultimately, on somebody being admitted to

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1 hospital.

2 **Q.** Thank you. I think your conversation with VC's mother
3 actually took place after the assessment; is that right?

4 **A.** Yes, I think so. I can't remember exactly, but that's
5 what I recorded.

6 I mean, quite often what we seek to do, if we have
7 time to do so, will be to alert the nearest relative
8 ahead of the assessment so we know that if we need to
9 communicate further, that that doesn't become a kind of
10 problem further down the line.

11 **Q.** Thank you. Then it continues:

12 "When placed [on Section] 136 ... had been
13 experiencing auditory hallucinations relating to
14 upstairs neighbours which he then confronted - who
15 called the police.

16 "Did not fully accept the impact that this had on
17 them — or of actions leading to previous assessment.

18 "[VC] said that he had been non compliant with his
19 medication primarily as he did not believe he needed to
20 or that he was unwell - he reported that he was finding
21 it more difficult to concentrate on his revision and
22 wondered if [that] was linked to the medication he was
23 taking."

24 So there's there the reference to VC revising and
25 his academic studies, and the impact, perhaps, of the

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1 verbal handover at this stage or do you just complete
2 these forms -- with Highbury Hospital?

3 **A.** So we don't provide a handover unless there's
4 a particular thing we'd need to raise, so colleagues in
5 the trust, I think you'll be aware now, use RiO system
6 as the method to record sort of basically what's
7 happening with somebody.

8 So colleagues on 136 Suite will have made an entry
9 on RiO so the ward staff would be able to kind of read
10 that. I'm not sure if Dr Seedat did on this occasion,
11 but it's usually the case that the doctor that's
12 involved in the assessment will record onto RiO too so
13 that all personal information is available to the ward
14 who will also see the medical recommendations, which
15 summarise the kind of reasons for somebody to be
16 detained.

17 **Q.** So Highbury Hospital will receive this form, which also
18 has a report from the two doctors, and then they're also
19 reliant on the accuracy of the RiO records.

20 **A.** Yes.

21 **Q.** Thank you. I'm going to move on, then, to a separate
22 topic and that is issues with the University and
23 correspondence with the University. The impression that
24 is given by your witness statement is that you come
25 across university students quite a lot; is that right?

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1 medication on that?

2 **A.** Yes, I mean, there's a part of the conversation we would
3 have had with him to seek to establish the degree of
4 insight that he maybe had into his own circumstances,
5 but, I suppose, to have a conversation with him, so we
6 could sort of elucidate, really, what his understanding
7 of the circumstances, so he had an opportunity to tell
8 us what had been happening to him, and we would then
9 take that information into consideration in terms of our
10 assessment.

11 **Q.** Thank you. Just for the purposes of the timeline, we
12 then go on to NOCC0000034, this is the LiquidLogic
13 report. If we turn to page 11, please, we see there,
14 almost towards the bottom of the page, the entry from
15 the 14 July at 3.08, contact has been made by Busayo
16 Ajewole, our next witness:

17 "... to arrange. Patient at Cassidy Suite at
18 Highbury Hospital, [she requested] a mental health [Act]
19 assessment ..."

20 Then the entry above that is from yourself:

21 "following assessment under the [Mental Health Act],
22 detained, S[ection] 3."

23 If we could then, please, turn to NHFT0000037 and
24 page 7, you then completed the application for VC to be
25 admitted to hospital under Section 3. Was there any

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1 **A.** Yes, yes.

2 **Q.** What kind of proportion of those Mental Health Act
3 Assessments that you carried out involve university
4 students, so far as you're able to assist?

5 **A.** I couldn't really be able to say, really, but, I suppose
6 it's significant enough to be aware of issues, really,
7 when we see students, because we, you know, we see quite
8 a few, really, one way and another.

9 **Q.** Do you have a designated contact at the University?

10 **A.** No, we don't, but we do know about the counselling
11 services at both universities, such that we can make
12 contact if we need to do so.

13 **Q.** Is there some sort of formal process, so far as you're
14 aware, that if you become aware of somebody being
15 a university student that you are able to contact them?

16 **A.** There isn't, but in terms of my own practice as an AMHP,
17 that's something I'm always kind of aware of and
18 I suppose part of my overall concern for somebody's
19 wellbeing that I would, and quite often do, make steps
20 to make sure that somebody's best interests in terms of
21 their academic studies are known to the University,
22 because obviously if somebody is in hospital -- I mean
23 I know the ward does too, but it can be a massive
24 interruption to -- in people's studies and in their
25 lives which we try our best to mitigate.

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1 Q. How about the opposite side of that, which is seeking
2 information from the University? Do you find that
3 straightforward?

4 A. Yes. I've never found any barriers to doing so, but
5 it's more the other way round: that we're telling the
6 University that we're working with somebody rather than
7 we're seeking information directly from them.

8 I suppose in terms of the University, it would be
9 more "Are you aware -- can we confirm that this person
10 is at the University and what course they're studying?
11 What stage they're at, in terms of their studies?"
12 Because, for example, somebody might be coming up to
13 exams and we wouldn't want those to be disrupted or them
14 to have a negative mark for having not -- literally not
15 shown up.

16 Q. Do you ever come across issues, data protection being
17 raised or anything along those lines?

18 A. No, no.

19 Q. Can we please turn to UNIN0001084, please. This is an
20 email that the Inquiry has already seen of 30 July.
21 If we could start, please, at the bottom of page 2.
22 It's an email from Eleanor Turner, Head of Mental Health
23 Advisory Service at the University, to yourself. If we
24 scroll down, please, we can see that she says that she
25 "has been informed that you were the assessing AMHP for

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1 I would share her concerns, yes.

2 Q. Were you the right person in this circumstance to have
3 been contacted?

4 A. Possibly, yes, yeah. I mean I don't know if there's
5 anybody that would have been more or would have been
6 better placed to do so, you know, I clearly was the AMHP
7 that undertook this particular assessment. And I know
8 about kind of the way in which the mental health
9 services are structured such that, and I was able to
10 kind of communicate directly with Dr Seedat if needed
11 and got, you know -- and that's what I did.

12 Q. If we scroll up, please, you say there:
13 "I have forwarded it to the ward for their
14 consideration."

15 A. Yes.

16 Q. And we'll come to that particular email. If we go,
17 please, on to page 1. We see the response there,
18 between Eleanor Turner and Claire Thompson. Ms Turner
19 says:
20 "See response from the AMHP below. I'm thinking of
21 renaming secondary care liaison project ... the zero
22 care teflon initiative."
23 And Ms Thompson responds:
24 "He's always been rubbish. Excellent renaming."
25 Did you see their evidence on this particular topic?

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1 VC", and she wanted to flag up concerns about his
2 discharge from Rowan 1 and she was seeking your opinion.
3 If we skip past the next paragraph and go to that
4 final substantive paragraph. She says as follows, she
5 says:
6 "... I was surprised to learn that [VC] is being
7 discharged tomorrow to the same address. I remain
8 concerned for the residents but I am also increasingly
9 concerned for [VC] in terms of the other residents and
10 their fears around his mental health. If this was
11 University managed accommodation, we would be carrying
12 out a detailed risk assessment and it is likely that we
13 would be supporting [his] ... return to Wales. [VC] is
14 citing his academic work as a rationale for staying in
15 Nottingham but all his work is now online and there is
16 no need for him to be located near to the University.
17 I am going to continue to try to engage him with our
18 team."

19 Did you share those concerns? Sorry, when I say
20 "share", I mean did you have the same concern?

21 A. Those weren't things that were foremost in my mind when
22 undertaking a Mental Health Act Assessment. But I can
23 understand her concerns, and I think it's part of our
24 kind of email communication -- I can't remember now if
25 we actually spoke on the phone as well, but -- so yes,

14

1 A. Yes, yes.

2 Q. Looking back on this now, what's your view of that
3 correspondence?

4 A. I suppose people are welcome to their opinion.
5 I suppose what I'm picking up is that they were
6 frustrated that sometimes it feels difficult to kind of
7 access some kind of systems when you come slightly
8 outside of them. I kind of think, really, is their
9 frustration. But I think different agencies have
10 different kind of roles and responsibilities, and
11 I think each of those sort of fulfilled those.

12 Q. If I could please take you to NHFT0018308. You did in
13 fact forward, if we look at page 3, their correspondence
14 to Dr Seedat. And we see at the bottom of page 2 and
15 into page 3 Dr Seedat's response. He says as follows,
16 he says:
17 "I cannot dictate where people go and live, he has
18 a paid up tenancy, the landlords will not give him his
19 money back and he has no income.
20 "Maybe that the is the work E[e]leanor needs to do
21 with landlords and see ... they support their students
22 in such situations.
23 "On both occasions the incidence happened in ... his
24 other flat and not in the one he is returning to.
25 "He is well, he is taking his meds, he will have

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1 close follow up and not sure what else she wants. You
2 can just [I think that's 'you can't just'] tell people
3 where they should go, he is an adult."

4 One of the risks you had identified in the form we
5 saw at the beginning was I think a risk to neighbours.
6 At this point were you concerned about his return in
7 close proximity to others, perhaps without a support
8 network?

9 **A.** I suppose my role within this process at this point was
10 to undertake the assessment, which we placed him under
11 Section 3. As AMHPs we rarely have a kind of
12 a follow-up role whilst somebody is admitted, and unless
13 somebody is re-referred into the service we don't have
14 a role when somebody is discharged either.

15 So whereas if we'd have been asked to do so, we
16 potentially could have attended a ward round and -- or
17 put our kind of views and feelings into that process,
18 but the vast majority of the time it's a kind of one-off
19 event, really. And in a way --

20 **Q.** But you --

21 **A.** Sorry.

22 **Q.** You had identified aggression towards neighbours as
23 a particular risk --

24 **A.** Yes.

25 **Q.** -- when you first assessed VC. You had also been told

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1 as they can be, that's a large mitigation. If somebody
2 is on a depot medication, that's a -- in terms of
3 I suppose clarifying with the ward if that was their
4 sort of treatment option for him, because, again, if
5 somebody is on a depot medication you can be clear that
6 they are medicated, and that as long as they're engaging
7 with their nurse to receive that medication, they will
8 be well for a period of time. So both of those things
9 are kind of mitigations, really.

10 **Q.** So something like depot, would you have seen that as
11 something to address the kinds of concerns that you had
12 identified when you first assessed VC?

13 **A.** I mean, those are clinical decisions, and it's for the
14 treating doctors to make those decisions. But in terms
15 of me being aware, for example if VC came back into
16 services I would then be aware of kind of what actions
17 had been taken. So in a way, that's for my own kind of
18 knowledge, really, to see what was happening.

19 **Q.** We see above there the response, Dr Seedat says:

20 "He is on meds, oral meds, he has demonstrated good
21 insight.

22 "He is going to be followed up by crisis team and
23 also his LMHT, city south, he also has CCO Claudia
24 Birtles."

25 I don't think the University were updated following

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1 that he had stopped his medication because it interfered
2 with his studies.

3 **A.** Mm-hm.

4 **Q.** At this point in time when you're being contacted by the
5 University and they're saying, "We're worried about his
6 return to the University", did you have a concern?
7 Irrespective of whether it was your role or not to have
8 that concern, did you have a concern?

9 **A.** When people kind of share risks with me of that nature,
10 yes, I would be concerned, yes.

11 **Q.** If we scroll up we can see a response from yourself, and
12 you say:

13 "Thanks.

14 "It's the well bit that[']s important is he on
15 depot?oral meds?

16 "Will he have a team following him up - or crisis?"

17 Why did you consider, for example, a depot to be
18 relevant or important?

19 **A.** So for me to -- so in my dialogue with Dr Seedat there,
20 that's what I was kind of checking out, really,
21 I suppose in a way taking forward the concerns raised by
22 the University and these would have been mitigations on
23 all of those points because sometimes people are not
24 discharged when they can be as well as they possibly
25 could do. If somebody is, one way or another, as well

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1 this exchange; is that right?

2 **A.** I don't know if they were or not. As far as I was
3 concerned, at that point that would have been for
4 (*unclear*) -- what I was trying to do was to facilitate
5 the University talking directly to the ward, which they
6 then did, and Dr Seedat was in communication, so there's
7 a channel of communication there. I didn't see it as my
8 role to sort of in a way to kind of follow that dialogue
9 further than that at that point.

10 **Q.** Thank you. Finally I just want to ask you briefly about
11 recommendations but I'll take them briefly for no longer
12 than five minutes.

13 The first is that you address, at paragraph 95 of
14 your witness statement, that forensic psychiatric mental
15 health services use the HCR-20 risk assessment and
16 I think you've suggested that some of that could be
17 embedded in the work that AMHPs do. How would that
18 work?

19 **A.** So, you know, assessing risk is a key aspect to the work
20 that we all do. It's an area to which there is some
21 established methodology. The HCR-20, as far as I'm
22 aware, is one of those tools which has been used over
23 a period of time, and is widely respected.

24 As a consequence of that, I'd like to see the
25 learning from the use of that to be used more widely and

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1 I think it would be of benefit to us as a service, as
 2 well.
 3 **Q.** In your view, is there enough emphasis on the risk to
 4 the public as opposed to the risk to the individual?
 5 **A.** I believe there is, yes. We do take that very
 6 seriously.
 7 **Q.** You've also mentioned in your witness statement at
 8 paragraph 93 that in your view a Community Treatment
 9 Order should have been considered for VC on his release.
 10 Can you expand briefly on that, please?
 11 **A.** So Community Treatment Orders have been in place now for
 12 some time, and I think are used extensively for people
 13 who have been in and out of hospital on a number of
 14 occasions, and who have struggled to maintain adherence
 15 to their compliance with their medication.
 16 So there's again protective factors there for all
 17 parties, and I think for somebody who is, such as VC,
 18 who hadn't really engaged with his care team whilst he
 19 was in the community, that would have been really
 20 a useful way of which we could have ensured his
 21 medication had been received.
 22 **Q.** And speaking more generally, is that a significant
 23 advantage of a Section 3 admission as opposed to
 24 a Section 2 admission?
 25 **A.** We wouldn't place somebody on a Section 3 because it

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1 out an investigation but haven't necessarily been
 2 convicted?
 3 **A.** The Forensic Team can offer advice and do offer advice
 4 in those circumstances, but whether they would actually
 5 take them on and work with that person at that point
 6 I kind of doubt, but they would certainly offer advice
 7 to local teams about how their care is best managed.
 8 **Q.** And very finally, the Community Psychiatric Nurse, at
 9 paragraph 95 (*sic*) you've said that:
 10 "If VC had [been] ... allocated a [Community
 11 Psychiatric Nurse] who was seeing him on a regular basis
 12 ... services may have been able to work with him more
 13 [effectively] ... "
 14 He did have a CCO, a care coordinator. Very
 15 briefly, what's the difference between the two and what
 16 is the benefit of a Community Psychiatric Nurse?
 17 **A.** Both of those things could be the same thing, but
 18 I suppose the point I was trying to make is that if
 19 somebody knows somebody well, and works with somebody
 20 over time, there's significant benefits in terms of
 21 engagement, in terms of sort of spotting early warnings
 22 signs, so -- and helping them kind of engage wider with
 23 other services.
 24 So back to my earlier interchange with the -- it
 25 would be -- to be discharged, somebody would need to

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1 would lead to a CTO, but -- so the decision around a CTO
 2 would come later, not at the point of somebody being
 3 admitted.
 4 **Q.** But is it a significant advantage of the Section 3
 5 admission vis à vis the Section 2 admission?
 6 **A.** Well, you do need to be on a Section 3 in order to be on
 7 a CTO.
 8 **Q.** The Community Forensic Team, I think you managed that
 9 team.
 10 **A.** Yes, social workers in that team, yes.
 11 **Q.** And that monitors those who have mental health issues
 12 and who have committed crimes.
 13 **A.** Yes.
 14 **Q.** We know in respect of VC there were reports to the
 15 police but he hadn't actually been convicted yet of any
 16 offences. Does that team incorporate those kinds of
 17 individuals?
 18 **A.** Thinking about the sort of circumstances behind this,
 19 and knowing the work that the Forensic Team does,
 20 I think he'd be somebody to which, in all likelihood,
 21 who would have been referred to the Forensic Team at
 22 some stage in the future, given his profile. But
 23 whether or not he'd been accepted, I'm not entirely
 24 sure.
 25 **Q.** So does it extend to those who the police are carrying

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1 have a community nurse or care coordinator at that point
 2 in order for that discharge to be as safe as it could
 3 be.
 4 **MR BLAKE:** Thank you.
 5 Thank you, those are all the issues that I am
 6 addressing with you today. There are some brief
 7 questions from Core Participants.
 8 **THE CHAIR:** Yes. Thank you.
 9 **Questioned by MS CARTWRIGHT**
 10 **MS CARTWRIGHT:** Good morning, Mr Culpin, I ask questions on
 11 behalf of the survivors.
 12 Could I briefly have displayed, please, your
 13 paragraph 93 which is page 32 of -- thank you -- of the
 14 statement.
 15 Now you've just looked with Mr Blake at the chain of
 16 correspondence with Dr Seedat, that was just before VC
 17 was discharged, and you say this about the CTO you've
 18 just asked about:
 19 "... I was not consulted about whether a CTO would
 20 be used for VC on release. I do believe a CTO should
 21 have been considered in VC's case and that is
 22 appropriate for people who has struggled to be
 23 concordant with medication or to maintain contact with
 24 their care team."
 25 Is that correct?

24

1 A. Yes.

2 Q. And so can we then just go back up, please, to
3 paragraph 90. Thank you. So we can see the email
4 exchange you've just looked at when the concerns were
5 being read by -- raised by the University. And
6 obviously, we can see your reply, which was:
7 "It's the well bit that's important is he on depot?
8 Oral meds?
9 "Will he have a team following him up -- or crisis?"
10 Obviously we've seen the response from Dr Seedat.
11 But can I ask you, bearing in mind it was your view
12 that a CTO should have been considered, and bearing in
13 mind the role that an AMHP has for a CTO, it's right,
14 isn't it, that an AMHP is a key part of suggesting
15 a CTO, and in terms of the assessments and reports that
16 have to be considered for a Community Treatment Order?

17 A. Yeah.

18 Q. Why you didn't pursue this further if it wasn't --

19 A. It's not necessarily suggesting. What happens is we are
20 requested to participate in the decision. So somebody's
21 care team or their doctor will decide whether or not
22 they want to proceed within the Community Treatment
23 Order, and we checked to decide whether or not we
24 believe the conditions have been met to place somebody
25 on a CTO. So we don't instigate them; we are part of

25

1 I mean again, we kind of raise that as a general point,
2 but it needs to come from the clinician in the first
3 place.

4 Q. Then can I ask you, just from a different perspective of
5 statutory obligations that now came into play now VC had
6 been detained on a Section 3. Again, from the
7 perspective of the University effectively raising
8 concerns about accommodation and the discharge plan, and
9 whether it was a safe discharge plan. We know that the
10 AMHPs sit, from your statement, within the Adult Social
11 Services Directorate; is that correct?

12 A. It is, yes.

13 Q. So can you assist as to why you weren't more proactive
14 in liaising back with the University or just checking
15 that VC knew all aspects about the Section 117 aftercare
16 obligations that now applied?

17 A. So in place of Section 3 for Section 117 aftercare, the
18 processes that we kind of worked to is that the hospital
19 will refer somebody to us on discharge if they believe
20 that there's a need for Section 117 to -- for somebody
21 to be assessed for their aftercare needs. They didn't
22 do that on this occasion.

23 Q. So the hospital didn't refer for an assessment under
24 Section 117, but that's why I'm wondering, from the
25 aspect of your knowledge and experience, here you have

27

1 the process.

2 Q. No, I appreciate that but the AMHP's role in the
3 scenario of a CTO would be to look at the social
4 circumstances, wouldn't it?

5 A. To a point. It's more to look at the conditions
6 attached to community treatment order to see if they're
7 appropriate.

8 Q. That's why I wonder, because really what you have here
9 is the University raising real concerns about the
10 discharge package for VC and about where he was
11 returning back to. So can I ask why, if your thought
12 was a CTO should have been considered, why you didn't
13 challenge the Responsible Clinician more, bearing in
14 mind that VC had been on a Section 3?

15 A. So my -- I mean I made a number of points there to kind
16 of check if each of those things were being considered.
17 If somebody has been in a hospital on a Section 3 that
18 I think is always the case that a CTO will be
19 considered; whether or not that's pursued or not is
20 a slightly different matter.

21 So kind of again it's for the clinician to decide
22 whether or not they're going to request an AMHP to
23 participate in the process, placing somebody in
24 a Community Treatment Order. It's not for the AMHP to
25 kind of suggest that somebody should be at that point.

26

1 the University raising concerns about his accommodation
2 and that's the sort of thing that can be looked at as
3 part of a review of the aftercare plan and whether
4 there's appropriate compensation.

5 A. Yes.

6 Q. So again, if the hospital haven't referred VC to the
7 local authority for an assessment, essentially it
8 provides free aftercare for a patient, and so I'm just
9 wondering why you didn't refer VC or suggest to the
10 University to refer VC in for a Section 117 assessment
11 to make sure he had a fully comprehensive aftercare plan
12 and package in place?

13 A. So it would be -- I mean, I've never known the
14 University to do that, and that's not particularly their
15 role to do so, in terms of referring for 117.

16 Section 117 discharge is, as again, they're
17 instigated by the ward. It's for the ward to kind of
18 inform us that they believe someone has Section 117
19 needs and we would undertake an assessment at that point
20 if we believed -- if we were notified of the need to do
21 so.

22 So we don't follow everybody up that's for 117 that
23 we place on Section 3. That gives somebody aftercare --
24 so they can receive Section 117 aftercare, but we would
25 need to be alerted to the fact they were reaching that

28

1 point in order for an assessment to take place.
 2 **Q.** Can I ask, then, why you didn't respond back to
 3 Dr Seedat also raising the section 117.
 4 **A.** Dr Seedat, as I'm sure the ward would do, is fully aware
 5 of Section 117 duties and discharges under Section 117.
 6 **Q.** So you say it wasn't for you to raise these things?
 7 **A.** Not on this occasion, no.
 8 **MS CARTWRIGHT:** Thank you.
 9 **THE CHAIR:** Thank you.
 10 Mr Beggs. Mr MacNamara. Thank you.
 11 **Questioned by MR MCNAMARA**
 12 **MR McNAMARA:** A few questions, please. Can we deal with the
 13 most recent questions first.
 14 So as far as your exchanges with the University and
 15 then with Dr Seedat were concerned, what could you have
 16 done other than raise it with the clinician?
 17 **A.** I suppose it depends on what hypothetically, if I hadn't
 18 had that response from Dr Seedat, as I did, I was
 19 satisfied that he was alerted to the concerns of the
 20 university, and I said earlier, I think both parties
 21 were able to continue that discussion if they needed to
 22 do so. If they required me to kind of participate
 23 further in that discussion, I'd have been happy to join
 24 in at whatever level would have been helpful to both
 25 parties.

29

1 parties were able to get that information from one
 2 another, so didn't require myself to participate in that
 3 role.
 4 **Q.** You passed on the University's concerns to the ward in
 5 any event, didn't you?
 6 **A.** Yes.
 7 **Q.** Would you please have a look at your report, so document
 8 number NOCC0000046, please. So you should have the
 9 first page of your AMHP report, Mr Culpin. If you could
 10 please have a look at page 3. Would you look in the
 11 bottom box, please, so where it begins "VC has recently
 12 been discharged", and then, third line down, can you
 13 assist us, please, with where you identified the
 14 principal risk in this case? As in: did you put the
 15 safety of the public first or did you put the safety of
 16 VC first?
 17 **A.** I think, given what we're aware of and what had taken
 18 place, risks to the public were very high on our -- in
 19 our consideration. Yes.
 20 **Q.** Forgive me, I didn't catch that. Somebody was coughing
 21 behind me.
 22 **A.** Yes, we were very attentive to the risks that were
 23 presented to the wider public.
 24 **Q.** Thank you. You were asked some questions also about the
 25 relationship between sections 2 and 3. Is a decision

31

1 **Q.** As a matter of fact, did you know when VC was to be
 2 discharged from Section 3?
 3 **A.** I wasn't aware, no.
 4 **Q.** Then winding back a little to some of the questions you
 5 were asked earlier, and thinking again about the
 6 University, Mr Blake asked you some questions about the
 7 exchanges with the university. Would that be
 8 a relationship which would benefit from a formal
 9 information-sharing agreement?
 10 **A.** Maybe so, but the absence of that has not hindered our
 11 work with the University in any way. I've always found
 12 the University to be very open to having dialogue with
 13 us and we equally are very happy to receive
 14 communication from them.
 15 **Q.** Thank you. You were asked some questions about some
 16 rather personal observations which were made in emails.
 17 Did you in fact ignore what was sent to you by the
 18 University?
 19 **A.** I mean, people write emails, don't they, and sometimes
 20 they're venting. I didn't take that as a criticism in
 21 any way.
 22 **Q.** Forgive me, I think you may have misunderstood the
 23 question. Did you ignore what was asked of you in terms
 24 of finding out additional information?
 25 **A.** No, I think I'd go back to the point that as both

30

1 for somebody to be detained pursuant to Section 2
 2 a once-and-for-all decision?
 3 **A.** Say again, please?
 4 **Q.** Is -- when someone is detained pursuant to Section 2, is
 5 that a once-and-for-all decision, which would entitle
 6 you thereafter always to detain someone pursuant to
 7 Section 3?
 8 **A.** No, each assessment stands on its own merits.
 9 **Q.** Clearly because of the two hats you wear, both in terms
 10 of general social work and AMHP work and forensic social
 11 work is concerned, when does the Forensic Team take on
 12 a patient?
 13 **A.** I mean, so with the criteria -- so the Community
 14 Forensic Team is part of the Notts Healthcare Trust.
 15 Our social workers within the Forensic Team are employed
 16 by Nottingham City Council and work alongside colleagues
 17 in the Trust, so they will work with people who are part
 18 of their caseload. So people who come to the Community
 19 Team are people who have committed offences in the
 20 context of their mental health, maybe not just once or
 21 twice, but have a long-term history of doing so.
 22 **Q.** How, if at all, does the forensic teams' input differ
 23 from, say, the input of the general social work team?
 24 **A.** So, these -- so people that are on forensic sections, so
 25 section 37, 41, people have been on hospital orders, so

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1 they're undertaking social supervision so that's a role
2 which is within the Forensic Team. We have one or two
3 other people that are being socially supervised in other
4 parts of the service, but predominantly they're all
5 within the Forensic Team. So it's a specialised role, I
6 suppose, within adult mental health.
7 **MR BEGGS:** Thank you very much. Those are all my questions.
8 Thank you, Chair.

9 **Questioned by THE CHAIR**

10 **THE CHAIR:** Yes, Mr Culpin I just have two questions for
11 you. The first is in relation to the structure. You've
12 said in your statement that you managed the integrated
13 Assertive Outreach Team until 2015, when there was
14 a restructuring, and then after that you carried two
15 roles: you ran the Mental Health Social Care and also
16 the Community Forensic Team; is that correct?

17 **A.** So the -- so the Community Forensic Team is part of
18 Notts Healthcare trust.

19 **THE CHAIR:** Yes.

20 **A.** We have social workers who are forensic social workers
21 who are in a different team. I managed the social
22 workers in both teams.

23 **THE CHAIR:** Did you find that the Assertive Outreach Team
24 was a better or less good vehicle for ensuring care than
25 what happened afterwards, after 2015?

33

1 **MR BLAKE:** Thank you very much.
2 You should have in front of you a witness statement
3 dated 8 December 2025 and that as a URN of WITN0145001;
4 is that statement true to the best of your knowledge and
5 belief?

6 **A.** Yes, it's true.

7 **Q.** Thank you. You are a Clinical Team Leader employed by
8 Nottinghamshire NHS Foundation Trust; is that right?

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

10 **Q.** You qualified with a diploma in mental health nursing in
11 2012 and have worked for various trusts since then --
12 sorry, you've worked for this Trust since then.

13 **A.** Yes.

14 **Q.** But you've worked on various wards throughout that time;
15 is that right?

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

17 **Q.** Most significant for today's purpose is that you were
18 the team leader in the Section 136 Cassidy Suite at
19 Highbury Hospital; is that correct?

20 **A.** That's correct.

21 **Q.** The Cassidy Suite is a place of safety rather than an
22 inpatient unit, and it's where Mental Health Act
23 Assessments take place; is that right?

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

25 **Q.** I think you've also said in your witness statement that

35

1 **A.** So I managed the Assertive Outreach Team for several
2 years. When that work finished, I suppose I -- and in
3 a new role, I would not be as familiar with the care
4 that the people were kind of getting subsequently. What
5 I do know is that having a defined caseload of people
6 within Assertive Outreach meant that those people were
7 getting a very high standard of care.

8 **THE CHAIR:** Thank you.

9 Yes, that's the only question that I have to ask.

10 Thank you.

11 **MR BLAKE:** Thank you, Chair.

12 As our next witness is attending via video, could
13 I ask for a 15-minute break?

14 **THE CHAIR:** Yes, we're going to take a break now. We'll
15 take the mid-morning break, in fact. So if we could
16 come back at 11 o'clock. Thank you.

17 **(10.46 am)**

(A short break)

19 **(10.59 am)**

20 **THE CHAIR:** Yes.

21 **MR BLAKE:** Thank you, Chair. Can I please call Busayo
22 Ajewole.

23 **BUSAYO AJEWOLE (affirmed)**

Questioned by MR BLAKE

24 **THE CHAIR:** Yes, Mr Blake.

34

1 it can be an overflow if there are no beds available?

2 **A.** Yes.

3 **Q.** If a patient is awaiting a psychiatric intensive care
4 unit, a PICU, waiting for a secure bed, am I right in
5 saying that they can also await that at the Cassidy
6 Suite?

7 **A.** Yes, we can also use the Cassidy Suite for that purpose
8 to keep patients on until a bed becomes available for
9 them.

10 **Q.** Therefore, the Cassidy Suite can involve individuals who
11 present a real risk of violence; is that right?

12 **A.** That's right, yes.

13 **Q.** I'm going to go chronologically through VC's various
14 admissions. If we start on VC's second admission,
15 that's 13 and 14 July 2020, that's the third incident at
16 Brook Court, so we know that there was a first incident
17 of criminal damage to a door in May 2020. There was the
18 second incident which was damage to somebody who we know
19 as Feven's door, and resulting in her jumping out of the
20 window and severely injuring her spine. And this is the
21 third incident: that is trying to force his way into
22 another flat at Brook Court. Do you understand that?

23 **A.** Yes.

24 **Q.** If we could please bring on to screen NHFT0000261, this
25 is something called a Communications and Monitoring

36

1 Information Form. Can you tell us what the purpose of
2 this form, is, so far as you're aware?
3 **A.** So these forms are called a "form 1", so usually where
4 we get handovers from the police, when patients are
5 detained under Section 136, so they'll give us verbal
6 handovers to the reason why they've been detained. We
7 also get a handover from the street triage who has been
8 involved with their detention at the time. So they'll
9 give us as much information as possible, as to the
10 reason why they've been detained.

11 On this occasion, with VC, he was detained under
12 Section 136 and when they then come to the Cassidy
13 Suite, so it's our role as the nurse in charge to
14 complete a form 1. So this is a separate form within
15 the RiO, it would have spaces where you can put the
16 patient's date of birth and all this information in, and
17 also the reason for the detention. So this form has to
18 be completed for every patient that has been detained
19 under Section 136.

20 And then going forward from that, we then go on to
21 do RiO entry to again do our documentation on that.

22 **Q.** If we turn, please, to page 3, we can see there your
23 name, on 13 July, the entry for 11.49 pm. We also see
24 below that a police officer's name, Jamie Severn?

25 Can you assist us? Who normally completes the form,
37

1 to mask.

2 "The neighbours were very anxious and it was felt
3 that he was a significant risk to himself or others and
4 with a mental disorder."

5 So you received this information and you were aware
6 at this point that VC had tried to force his way into
7 a property.

8 **A.** Yes, that's correct.

9 **Q.** If we look over the page, please, we see there a box
10 for:

11 "Risk factors the place of safety or assessment
12 staff should be aware of?"

13 And that box is empty. Is that usual, in your
14 experience?

15 **A.** We can input any risk that we felt like should be in
16 that box. We can put them in that box. Yeah.

17 **Q.** Who is the person that should be completing this
18 particular box?

19 **A.** So it could be any healthcare professional. So for
20 example, it was myself and my colleague on the day that
21 we worked. So whoever is completing the Form 1 should
22 be completing that box.

23 **Q.** So this isn't for the police officer to complete, or it
24 is? This box?

25 **A.** So it will be -- it will be the police officers would
39

1 is it a police officer or yourself or both?

2 **A.** The police officers will complete it and then send it to
3 us. They either complete it electronically or via the
4 paper form that we have on the suite to give to them to
5 complete.

6 So on this occasion they -- of the staff who
7 completed it would be Jamie Severn, and I'm the nurse on
8 the suite at the time and my colleague, which was
9 Andrew, has updated it as well.

10 **Q.** Thank you. Then if we could please go on to page 1, we
11 can see the notes of the incident, if we scroll down
12 slightly thank you very much, so it says:

13 "From ... Street Triage - male [has] gone to a
14 different floor in his block of apartments, knocked on
15 the door of a stranger and attempted to force his way
16 in. There were similar incidents in May when he had
17 done similar and had been detained under the [Mental
18 Health Act] due to a first episode of psychosis.

19 "The street triage were asked to attend. The male
20 had been cuffed and was in the rear of a Police vehicle.
21 He was calm and talked to the nurse. He acknowledged
22 that due to a feeling that someone was in danger he had
23 attempted to force his way into an apartment. He did
24 answer questions but he was subdued and the nurse felt
25 that there may be underlying issues that he was trying
38

1 write their concern on there, or whatever they feel like
2 should -- that is relevant. They will add it on to
3 there, and then we then transfer it on to the form on
4 RiO.

5 **Q.** In terms of this particular box, are there various
6 options or is this just an empty box that you can write
7 in whatever you consider is appropriate?

8 **A.** It's whatever you feel like is appropriate.

9 **Q.** I'm going to move on to the RiO notes. That's at
10 NHFT0000168. I'm going to take you through quite a few
11 of these notes over the course of this morning, but
12 let's start, please, with the earlier incidents, so
13 that's the May incidents, and that can be found on
14 page 4. We'll start on 25 May. It's an entry about
15 halfway down the page, if we scroll down, thank you, it
16 says -- in the second or third sentence it says:

17 "Recent incidents whereby he has firstly attempted
18 gain entry into his neighbour's flat and then another
19 incident with the same neighbour whereby he has managed
20 to damage the door. On the latest incident the
21 neighbour was fearful for her life that she escaped the
22 property through her window, causing damage to herself
23 requiring hospital treatment."

24 Just pausing there, were you aware of this when you
25 first picked up this case?
40

1 A. I can't recall of much if I'm fully aware, but it would
2 have usually we have handover, so usual practice would
3 be to give the handover as to what's happened. I --
4 what's happening or previous history. I may have been
5 informed but I can't fully recall.

6 Q. Is it likely that relatively early on in your time with
7 VC you would have been aware of at least these two
8 previous incidents in May 2020?

9 A. Yes.

10 Q. Then if we move on, then, to page 56 we then get to
11 July. If we start on that second significant box,
12 14 July, 12.13 am, we have the entry from the Street
13 Triage Team, Nigel Wade, and he says as follows, he
14 says:

15 "The Police were contacted by residents of a flat
16 near to [VC's]. [VC] had been banging on the door and
17 when someone opened it, he immediately forced his way
18 in, attempting to push past the resident. He was
19 restrained on the floor by a number of residents until
20 [the] Police arrived. One of the Officer's had dealt
21 with the previous incident where [VC] forced his way
22 into someone's property in May, and therefore asked
23 [the] Street Triage [team] to attend."

24 So it says there forced his way in, pushed past, and
25 reference to being restrained on the floor.

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1 care. They also, the form helps professionals,
2 healthcare professionals, aware of the current situation
3 that is happening with the patient in terms of how their
4 risk has been managed and also how they can get involved
5 with the continuity of care with all the risks and that
6 they do pose to themselves or others. So that's the
7 purpose of the form.

8 Q. So just to understand the intended audience of this, it
9 will be those professionals who are treating VC or any
10 patient on a ward. Will it also be for other healthcare
11 professionals because it's available on RiO?

12 A. Yeah, it's available on RiO. So every healthcare
13 professional should be able to have access to it.

14 Q. If a future nurse is carrying out a Risk and Safety
15 Assessment, might they also refer to it and perhaps copy
16 some of it for their own forms?

17 A. So they could, depending on the reason why they are
18 assessing the form. Sometimes the nurses will do a new
19 one, or they can go back and have access to the previous
20 ones that has been done, and see if it's still relevant
21 to their care at the time.

22 Q. So is it often the practice of nurses to look at the
23 previous one at least to inform their later risk
24 assessment?

25 A. Generally you will -- the nurses will say, because when

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1 Were you aware when you first took charge of this
2 matter, that this was a case where physical force had
3 been used by VC?

4 A. Yes.

5 Q. If we look down there at the next entry at 1.48, I think
6 this is your entry, and we look over the page, please.
7 You say there:

8 "[VC] arrived at the suite at [11.50 pm] ...
9 accompanied by two police officers, handcuffs were used
10 during transfer. He was orientated to the suite and was
11 shown his room. He appeared preoccupied when staff
12 spoke with him, staring and giving vacant looks. He
13 also appears to be having delayed response when asked
14 questions."

15 Do you recall that at all?

16 A. Yes.

17 Q. Then if we go, please, to NHFT0000196. This is the
18 first Risk and Safety Assessment that I'm going to take
19 you to. Can you assist us with what the purpose of this
20 particular form is?

21 A. So the purpose of the Risk and Safety Assessment is to
22 identify potential risks that patients pose to
23 themselves or others or the environment. It's to
24 identify the risk and how it can be safely managed by
25 the team, and by anyone else who is involved in their

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1 you do go to this page, and even if you were to create
2 new, so there will be previous -- information from
3 previous nurses or healthcare professionals that has
4 done the risk assessment. So it will still be there, so
5 they will be aware of the previous information.

6 Q. So in light of the intended audience for this particular
7 form, do you consider it's important that it is
8 accurate?

9 A. Yes, it is.

10 Q. Now, I just want to look at particular entries. If we
11 start on page 4. The front page said the date was
12 26 May 2020 and then at the bottom of page 4 we see
13 different dates. Can you assist us with how this was
14 created? Was it first created in May, after those May
15 incidents, and is updated now on 14 July?

16 A. That appears to be, yeah, how -- what's the situation,
17 yeah.

18 Q. Are you able to assist us with who created it on 26 May?
19 Was that -- would that have been yourself or would that
20 have been somebody else?

21 A. I'm not sure. I think it may say on the top who the
22 clinician was and who has updated it at the bottom.

23 Q. So if we go to page 1 it has the clinician's name there.
24 But then if we go to page 4 at the bottom of that page,
25 it only has your name. Are you able to assist from that

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1 information as to who is likely to have created this in
 2 May?
 3 **A.** It would have been the clinician's name at the top, have
 4 updated it in July.
 5 **Q.** Thank you. If we turn, please, to page 2, we see risk
 6 "To Others" is ticked "Yes", and then there's a July
 7 entry, 14 July:
 8 "Arrested for attempting to gain entry into random
 9 neighbours flat as he felt that someone is in trouble.
 10 [VC] did not gain entry or harm anyone but he was
 11 kicking the door."
 12 Now we saw in that earlier RiO entry that VC was
 13 attempting to push past a resident. Do you think that
 14 that is relevant information that should have been
 15 included in that box?
 16 **A.** Yes, it should have been included.
 17 **Q.** And then there's a box below that says, "Risk", and it
 18 says, "No data to display." Again, are these dropdown
 19 options under "Risk"?
 20 **A.** Can you repeat that question?
 21 **Q.** It says, "Risk (please select)", so it seems as though
 22 there are a number of different dropdown options that
 23 you could select under "Risk"; is that right?
 24 **A.** Yes, I think, yeah, there are -- yeah, there are options
 25 that you could select.

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1 the May entry, it has 23 May 2020. Now, we know that
 2 the second incident involving VC was actually the
 3 24 May, and that he wasn't at Rowan 1 until I think
 4 25 May. Do you know how this date has been identified?
 5 **A.** So I think the reason why the date is there is because,
 6 like I said, the risk formulation was created by the
 7 clinician's name at the top, and so that was their entry
 8 at the time, and my entry was the one for the 14th
 9 July --
 10 **Q.** Okay.
 11 **A.** *(unclear)*.
 12 **Q.** So it's likely that first entry is not yours; that's the
 13 previous clinician.
 14 **A.** *(The witness nodded)*.
 15 **Q.** The date there, you're not able to say why that date is
 16 not correct.
 17 **A.** No.
 18 **Q.** I'll read to you your entry, and that's 14 July, you
 19 say:
 20 "[VC] is a 28 year old man experiencing early
 21 psychosis. He was previously admitted on Rowan 1 ward
 22 and was discharged in June to his flat. He has had
 23 input from his CPN and community doctors post-discharge.
 24 He was detained on Section 136 following making attempts
 25 to get into neighbours apartments, he appears to be

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1 **Q.** And would it have been helpful, in this case, to have
 2 added a particular risk in that box?
 3 **A.** Yes.
 4 **Q.** Thank you. If we go over the page, please, at the
 5 bottom of the next page it has "Risks Under
 6 Investigation", and it says:
 7 "Criminal damage to a flat door."
 8 Are we to understand that that is the current
 9 incident, so that's the July incident? Because we know
 10 that, for example, the police were still at this time
 11 investigating one of the May incidents. Can you assist
 12 us with which incident that relates to?
 13 **A.** I think it may have been probably the May or July
 14 incident but I really cannot recall the exact incident
 15 that it was in relation to.
 16 **Q.** It says, "Risks Under Investigation". Whose
 17 investigation is that? Is that healthcare
 18 professionals, the police, or something else?
 19 **A.** It's generally, could be from the police or healthcare
 20 professionals, yeah.
 21 **Q.** So it's just a general risk that's being looked into by
 22 somebody.
 23 **A.** Yes.
 24 **Q.** If we go, then, over the page, please, we see an entry
 25 in May and we see an entry in July. If we start with

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1 responding to Auditory hallucination. [VC] seemed to be
 2 responding to unseen stimuli. Acted suspicious of all
 3 activities. [VC] is a student at Nottingham University
 4 studying Mechanical Engineering. He lives on his own in
 5 block of flats. He is currently single. His parents
 6 live in Wales. He has no past history of mental health
 7 difficulties. He has no past history of illicit
 8 substance use or forensic history.
 9 "[VC] was arrested by the police for criminal damage
 10 (kicked a door in of another flat). The police were
 11 called for burglary but they found [VC] who resides in
 12 group of flat.
 13 "... no history of violence or aggression.
 14 "[He] has been hearing voices and believes his
 15 mother was in the flat that he was trying to get in to,
 16 had a lack of sleep during the past week and has been
 17 feeling the pressure from his studies. Not eating and
 18 drinking well from his own admission."
 19 Now, we spoke earlier, you were aware by this point
 20 of those two incidents in May.
 21 **A.** Yes.
 22 **Q.** Reference there to:
 23 "... no past history of mental health difficulties".
 24 And no history of violence and aggression. VC did
 25 have both of those, didn't he?

48

1 A. He did.

2 Q. Forensic history, when you refer to:

3 "He has no past history of illicit substance use or

4 forensic history".

5 Can you assist us with what you mean there?

6 A. So forensic history, where there has been previously

7 admitted to a forensic environment in the past. That

8 was what I meant.

9 Q. We've also seen, in relation to this very incident on

10 RiO, reference to VC forcing his way in and having to be

11 restrained. Not just kicking in a door.

12 Looking at this now, the reference to he has no past

13 history of mental health difficulties, looking at no

14 history of violence or aggression, that's not only

15 lacking in detail, but that's also wrong, isn't it?

16 A. Yes, I understand that was an error for me. It should

17 have reflected that he had history of violence and

18 aggression in the risk assessment.

19 Q. Thank you. If we go back to the RiO notes, please,

20 that's NHFT0000168, and we're going to go to page 59,

21 we're just returning now to the chronology. Halfway

22 down the page, 14 July, 11.57, there's an entry from

23 yourself:

24 "[VC] was transferred to Rowan 1 at [11.20 pm]...

25 He was escorted by three staff members without issues.

49

1 [pepper] ... spray. [VC] was then taken to the

2 [emergency department] for medical assessment and will

3 be transferred to Cassidy when he is deemed to be

4 medically fit."

5 Then if we go to the top of the next page, 8.05.

6 This is the entry from the Street Triage Team and it

7 provides more detail on what occurred in relation to the

8 police officer. It says:

9 "We were in the vicinity of [VC's] home ... when an

10 emergency shout for support went out from Officers on

11 scene executing the S[ection]135 warrant, dictating that

12 they were being assaulted and needed extra support.

13 "When we arrived Officers had deployed the Taser

14 twice and also Pava Gas to subdue [VC] due to him

15 punching an Officer with significant force 3 times in

16 the face ... attempting to assault other Officers on

17 numerous occasions. [VC] was not complying with any

18 instruction or de-escalation techniques. Officers had

19 to use leg restraints to remove [VC] from the address

20 due to further attempted assaults."

21 Skipping that paragraph, we'll go to the next

22 paragraph. It says:

23 "Officers wanted to know if [VC] could be charged

24 due to the serious nature of the assault with the

25 Officer likely needing Hospital treatment."

51

1 His section documents and flat keys [were] ... handed

2 over to the nurse in charge."

3 So that's the end of this particular matter for

4 yourself, is it?

5 A. Yes.

6 Q. We'll move on, then, in the chronology. We're going to

7 VC's third admission and that was 3 September 2021, so

8 over a year later. This followed the assault on

9 PC Pritchard and we've heard a lot about that. If we

10 could please turn to page 164, I'll take you again

11 chronologically through the RiO notes.

12 It's the bottom of the page, please. 3

13 September 2021, 7.22 pm, Cassidy Suite Section 135. So

14 I think this is written by a colleague of yours; is that

15 right?

16 A. Yes.

17 Q. "[Telephone]/C[all] from Dr Manzar who has gone to

18 execute Section 135 at [VC's] house. [VC] has been

19 reported to be settled at first and was responding well

20 to the assessing team however he refused them entry to

21 his house and they had to call the police officers.

22 Four officers attended and [VC] was aggressive towards

23 them, they had to call for more support and several

24 officers attended however he continued to be aggressive.

25 He was tasered twice but to no avail. Police had to use

50

1 When you first became aware of this matter, were you

2 aware, looking at these notes or otherwise, that there

3 was a pretty serious assault on a police officer that

4 had occurred?

5 A. Yes, I was given handover.

6 Q. And then if we look at the entry below 8.07, Cassidy

7 Suite, 8.30 pm:

8 "[VC had] arrived ... with 5 police officers."

9 Is it usual for somebody to arrive with five

10 officers or is that a significant number for you?

11 A. That's quite a significant number.

12 Q. And is that itself an indication of somebody presenting

13 a serious risk to others?

14 A. Yes.

15 Q. If we scroll down to 9.34, please, there's an entry that

16 says:

17 "Previously informed by consultant in charge of

18 patient's care that this patient's [Mental Health

19 Act]... assessment was done with full restraint team

20 present due to the physical assault on the police

21 officers during arrest.

22 "His advice was not to see/examine without restraint

23 team if I do not feel safe. Restrain team no longer

24 present."

25 Were you aware of a specialist team being present

52

1 when doctors see VC because of the risk that he posed?
 2 **A.** I cannot fully recall if I am -- I was aware of the full
 3 team being present at the time.
 4 **Q.** Is it likely that you would have read these notes on
 5 RiO?
 6 **A.** Yes. Prior to during handover, I would have been
 7 informed, as well as reading back on his notes.
 8 **Q.** Thank you. If we go over the page, then, to 10.35, we
 9 see Dr Ben Lomas and he sets out the account from the
 10 mental health assessment, over the page, please. I'll
 11 just read to you a selection of information from his
 12 account. He says --
 13 **THE CHAIR:** Just a moment, Mr Blake. If we could just go
 14 back to the page we were just looking at. Where it says
 15 in relation to that note "The nurse on Cassidy reports
 16 no concerns", just to check whether that was you or not?
 17 Do you have that there? Sorry, I think we're going
 18 back -- can we just go --
 19 **MR BLAKE:** It may be page 165.
 20 **THE CHAIR:** 165, yes, at the bottom.
 21 **MR BLAKE:** Yes, absolutely.
 22 **THE CHAIR:** I just wanted to check that, if I could. Thank
 23 you.
 24 **MR BLAKE:** You can see there there's a note there from
 25 Dr Bhatti, and after the section that I took you to,

53

1 what -- in specific, if it was referring to myself or my
 2 colleague.
 3 **Q.** Thank you. If we could then move on to page 167, and
 4 that's the Mental Health Act Assessment. It says:
 5 "[VC] is known to services with a diagnosis of
 6 psychosis and has been treated ..."
 7 And it gives the medication. If we look at about
 8 halfway down the page there's a paragraph that begins
 9 "The officers", it's under "Seen", yes, currently the
 10 bottom paragraph. It says:
 11 "The officers went to restrain him and he seriously
 12 and repeatedly assaulted the male police officer
 13 particularly. He punched and headbutted him several
 14 times, and was able to wrestle the handcuffs off a
 15 female officer to use as a weapon. He was eventually
 16 subdued [by] ... police used CS gas and a Tazer ..."
 17 So this is a summary of what happened with the
 18 assault on the police officer. Then there's a section
 19 under the heading "Discussion". It says:
 20 "[VC] appears to be experiencing a relapse of his
 21 psychosis, though we could not establish the full nature
 22 of his psychopathology due to his refusal to discuss
 23 this with us. The history from his CCO was strongly
 24 suggesting of a schizophreniform pattern of psychosis,
 25 and his assault on the officers and current mental state

55

1 that addressed the team, it says there:
 2 "The nurse on Cassidy reports no concerns. States
 3 he is sat in ... chair having not moved since the
 4 assessment."
 5 Is that yourself or is that another nurse, so far as
 6 you're aware?
 7 **A.** I'm not -- it may have been the previous nurse that
 8 worked before my shift, because that entry from that
 9 doctor, 9.34 pm, that was made, so it would have been
 10 the day doctor that was on shift. Yes. So I'm not sure
 11 if this refers to me or my colleague.
 12 **Q.** When you say your colleague, if we scroll up slightly,
 13 we can see entries from Ms Sophia Mutoonono. Is that who
 14 you're referring to?
 15 **A.** Yeah.
 16 **THE CHAIR:** Thank you.
 17 **MR BLAKE:** Is it likely to have been certainly one of the
 18 two of you and, if so, is it more likely to have been
 19 her because of the time of day, or not?
 20 **A.** Yes, it will be one of us. And the other thing that
 21 I was I'm thinking is, when, with that entry it says,
 22 "The nurse has no concern", it may be that there's no
 23 current concern with the way he is presenting at that
 24 current time, because he didn't say that there was no
 25 concern with this previous incident. So I cannot recall

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1 made it very clear he posed a significant risk of
 2 violence to healthcare staff attempting to treat him."
 3 If we go over the page, please, it identifies the
 4 risk to others. And it says there, it's the second
 5 paragraph on the screen. It says:
 6 "... marked agitation and clearly focused aggression
 7 at police and healthcare staff attempting to coordinate
 8 his assessment in the community. He has required CS gas
 9 and repeated tasers to subdue him, and handcuffs and
 10 ankle restraints to transport him. His mental state is
 11 unchanged from prior to his transportation to hospital,
 12 and the risk of serious assault to hospital staff is
 13 high and immediate."
 14 If we look at the entry below, there's an entry at
 15 10.40. He is seen by a senior nurse, Highbury Hospital.
 16 And it says there, about halfway down that entry:
 17 "Informed that a PICU referral had been completed to
 18 manage current presenting risk.
 19 "Informed of violence and assaults on police
 20 officers during the day. Ongoing verbal threats of
 21 violence and aggression on healthcare staff."
 22 And the entries continue in a very similar way
 23 below. You have an entry of 10.45 and there's reference
 24 about halfway down that entry to VC presenting "as
 25 highly agitated and hostile".

56

1 And over the page another entry that says he is
2 "very angry and agitated -- requested that staff leave
3 him alone."

4 Then just after midnight, so 12.08 am, we have that
5 bottom entry and that goes over the page. The referral
6 to the PICU unit is accepted. There's a section, if we
7 go down slightly below "Current situation", thank you.
8 So the "Current situation", the last sentence there
9 says:

10 "[VC] was taken to [the emergency department] ...
11 for medical assessment and was transferred later to
12 Cassidy suite today."

13 So that's looking back. Then it has
14 a recommendation. It says:

15 "Due to the extreme levels of violent and aggression
16 eg, physically assaulting a police officers by punching
17 him on the face and attempting to assault other
18 officers, [VC] will require a PICU bed to manage his
19 risk towards others. Due to him experiencing
20 persecutory ideations and command delusions he will
21 require a PICU bed to effectively manage his mental
22 state and ensure the safety of others."

23 Then over the page we see further recommendation is
24 exactly the same form of words I've just read.

25 I'd like to take you now to NHFT0014976. And these

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1 expected that July incident to have been identified
2 here?

3 **A.** Yes, yeah, could potentially be recorded on there.

4 **Q.** Following the attack on PC Pritchard, the police, by
5 this stage, had also added a marker on their own records
6 for extreme violence. We have here Louise Symcox adding
7 something on the RiO system. Would you have seen that
8 entry on the RiO system?

9 **A.** It's something that we, because it's an alert, so it
10 just would show in the tab that there are some alerts
11 there we should be aware of.

12 **Q.** So it should be clear from essentially the homepage on
13 RiO that there are these alerts, and that on 3
14 September, an alert had been entered in relation to
15 a serious assault on a police officer?

16 **A.** Yes.

17 **Q.** Can we please then turn to NHFT0000193, and this is the
18 risk and safety assessment. If we can look at it, it's
19 produced by yourself on 4 September, so the day after,
20 11.31 in the morning. So that's the morning after.

21 If we could please turn to page 2, VC is marked as
22 a risk to others. But it's the entries below that I'd
23 like to ask you about.

24 First of all, they seem quite out of sync, I mean,
25 in terms of timing I think we start from the middle one,

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1 are RiO screenshots that have been produced for the
2 Inquiry. If we go over the page, please, we can see an
3 "Alert" tab. Are you aware of an alert tab function on
4 RiO?

5 **A.** Yes.

6 **Q.** Have you yourself ever entered anything on an alert tab
7 on RiO?

8 **A.** Previously, yes.

9 **Q.** We see there the bottom two entries, so there's one from
10 May 2020. So the May 2020 incidents, it's at the bottom
11 entry, and it says:

12 "Arrested for damage to a neighbouring flat door
13 after he believed that he heard his mother screaming
14 from inside the flat."

15 Then there's now, by this stage, 3 September 2021,
16 a second alert, and that says:

17 "[VC] has assaulted a Police Officer by punching him
18 in the face with significant force 3 times when
19 executing a S135 warrant. He has also attempted to
20 assault numerous other Officers and was Tasered twice
21 and Pava Gas deployed. The Officer is likely to require
22 hospital treatment for injuries."

23 We don't here see anything in relation to the
24 further incident in July, so it only has the May
25 incident and the September incident. Would you have

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1 the 14 July, we then go to the bottom one, 31 August,
2 then we go to the top one, 3 September. Are you able to
3 assist us with why that might be?

4 **A.** I'm not sure why they've not been in order. However,
5 with my experience, I think -- so it would have started
6 with the clinician that's created the assessment, and
7 then updated afterwards by the next clinician that was
8 to -- that would like to update it, but I'm not entirely
9 sure why it's not in order.

10 **Q.** So we have your name at the front, 4 September 2021.
11 Are you able to assist us with which of these you
12 entered? Did you enter them all? Did you copy and
13 paste from somewhere else; or how did this information
14 come to be entered?

15 **A.** So the way the risk assessment, when we do one to create
16 bundle one or update one, so the previous assessment has
17 been done by the previous clinician will reflect. So
18 it's our job to be able to take out or remove any risks
19 that are not relevant at the time. So I think, on these
20 occasions, I think what I would have inputted would be
21 the 3 September, the top part.

22 **Q.** So let's start with the first in time, and that's

23 14 July. That second paragraph, it says:

24 "Arrested for attempting to gain entry into random
25 neighbour's flat as he felt that someone is in trouble.

60

1 [VC] did not gain entry or harm anyone but he was
 2 kicking the door."
 3 We had seen from the July entry that in fact VC
 4 tried to gain entry and tried to push past the resident;
 5 do you recall that?
 6 **A.** Yes.
 7 **Q.** So looking at this, that particular entry is wrong
 8 there, isn't it?
 9 **A.** Yeah, there's an error in there.
 10 **Q.** Then it says:
 11 "Prior to previous admission [VC] was involved in
 12 a similar incident whereby he entered into another
 13 resident's flat whilst experiencing distressing auditory
 14 hallucinations. The woman that resided in the flat
 15 jumped out of the window due to being frightened, she
 16 injured herself severely and needed surgery on her back.
 17 "No further incidents of violence or aggression
 18 towards others, [VC] is usually a very polite and gentle
 19 personable young man."
 20 Do you know where that form of words came from?
 21 **A.** No.
 22 **Q.** We've seen similar words used by Claudia Birtles
 23 following a home visit. Do you have any understanding
 24 of that at all?
 25 **A.** What did you say? Say that again, please?

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1 what he was doing, and other neighbours came to the
 2 rescue and called police.
 3 "[VC] is known to services with a diagnosis of
 4 psychosis. Historically when unwell he has force[d]
 5 entry into his neighbours houses under the influence of
 6 his psychotic experiences, though no violence has
 7 resulted. He has had two admissions last year.
 8 "He continued to experience auditory hallucinations
 9 and fixated on persecutory ideas relating to the
 10 government."
 11 That isn't the September incident, is it?
 12 **A.** No, um ...
 13 **Q.** I mean, that might be some information about the July
 14 incident. We've just heard about what the September
 15 incident involved, the assault on the police officer.
 16 That can't be found anywhere in these details, can it?
 17 **A.** I can't recall why that was not reflected in this
 18 assessment, which should have been.
 19 **Q.** That 3 September entry in fact says, "though no violence
 20 has resulted", I mean, that's quite the opposite of the
 21 situation, isn't it --
 22 **A.** Yes.
 23 **Q.** -- now we're in September. Severe violence had been
 24 used on a police officer, hadn't it?
 25 **A.** Yes.

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1 **Q.** Claudia Birtles and Gary Carter visited VC's home and
 2 I think has used similar words to that on a RiO entry.
 3 Are you able to assist us at all with who is likely to
 4 have written that paragraph, that says that:
 5 "[VC] is ... very polite and gentle personable
 6 young man"?
 7 **A.** I'm not sure who has written that paragraph.
 8 **Q.** Then if we go to the entry below, so the next in time,
 9 31 August, it says:
 10 "[VC] appears to be relapsing. Appears quite
 11 suspicious/paranoid, little bit confrontational although
 12 no evidence of any aggression. [VC] has stopped
 13 treatment ... abruptly, unsure when he stopped although
 14 suspect that it was a lot longer than 3 days ago (which
 15 is [what he had] ...said)."
 16 Then I'll take you now to the top entry and I think
 17 you've said you're confident you entered that top entry.
 18 **A.** I think so, yes.
 19 **Q.** It says:
 20 "[VC] had gone into a neighbour's flat who was
 21 staying above him, knocked at his door to confront him
 22 as to why he was discussing him as he had heard voices
 23 to that effect and he was certain that it was this
 24 person living above his flat responsible. He barged
 25 into the persons flat and wanted the person to admit

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1 **Q.** Can you assist us with why there are repeated references
 2 to "no violence having resulted", "no further incidents
 3 of violence or aggression"? Why the level of violence
 4 and level of aggression of VC doesn't seem to be
 5 reflected here?
 6 **A.** I've previously said, should have been reflected. It
 7 may have been documented on the RiO entry rather than
 8 just in the risk and safety assessment. However, it
 9 should have been clearly documented on the assessment as
 10 well.
 11 **Q.** Yes, I mean, it should have been because, as you said
 12 earlier, this Risk and Safety Assessment is quite an
 13 important document --
 14 **A.** (*The witness nodded*).
 15 **Q.** -- upon which VC's risk to others is assessed; is that
 16 right?
 17 **A.** Yes.
 18 **Q.** It's not only lacking in detail but once again, it's
 19 wrong, isn't it?
 20 **A.** Yes.
 21 **Q.** Then if we go over, please, to page 4, there's another
 22 section "Risk formulation", and I'll just read to you
 23 again some significant paragraphs there:
 24 "[VC] is a 30-year-old gentleman known to services
 25 with a diagnosis of psychosis. Historically when unwell

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1 he has forced entry into his neighbours' houses under
2 the influence of his psychotic experiences, though no
3 violence has resulted. He ... had two admissions last
4 year.

5 "He continued to experience auditory hallucinations
6 and fixated on persecutory ideas relating to the
7 government. He was previously admitted on Rowan 1 ward
8 and was discharged back to his flat. He has had input
9 from his CPN and community doctors post discharge, He
10 was detained on section 136 following making attempts to
11 get into neighbours' apartments, he appears to be
12 responding to Auditory hallucination. [VC] seemed to be
13 responding to unseen stimuli. Acted suspicious of all
14 activities. [VC] is a student at Nottingham University
15 studying Mechanical Engineering. He lives on his own
16 ... block of flats. He is currently single. His
17 parents live in Wales. He has no past history of mental
18 health difficulties. He has no past history of illicit
19 substance use or forensic history."

20 Just pausing there, is this a paragraph that you
21 wrote?

22 **A.** I'm not entirely sure which of those that I've inputted
23 or not.

24 **Q.** I mean I think in your witness statement, you will
25 correct me if I'm wrong, but I think you've said that

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1 diagnosis, knows we know exactly what is going on, feels
2 care team are being dishonest.

3 "[VC] has no support network in Nottingham, unclear
4 whether there is another resident in the flat, [VC] has
5 been reluctant to discuss anything in detail, won't
6 disclose whether he is hearing any voices. Appears to
7 be attending to ADL's evidence of cooking and washing up
8 on flat, he denies any current concerns, says he is
9 'absolutely fine'. Appeared well-kempt.

10 "Risk of further deterioration of mental state."

11 Looking at this, do you think these have just been
12 copied from somewhere?

13 **A.** Perhaps. I don't -- I'm not sure if I was involved with
14 VC in August or not, as well. Because that looks like
15 he was updated in August.

16 **Q.** But August is of course before September. This form has
17 your name on it having been completed on the
18 4 September 2021, so you essentially sign this document
19 off in September.

20 Can you assist us with why, as at September 2021,
21 the risk formulation doesn't contain anything about that
22 assault on the police officer, the use of CS gas, the
23 headbutting, and what it does include is the sentence
24 that says: "He has no past history of mental health
25 difficulties, no violence has resulted", and similar

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1 that final paragraph, in capitals, was not yourself.
2 But certainly I had understood that you believed that
3 those two paragraphs, first two paragraphs, were written
4 by you?

5 Looking at it now, do you think, looking at the
6 language used, do you think it was you or was not you
7 who inserted that information?

8 **A.** There are some ways the words has been used there. My
9 usual practice, I usually -- I usually not use those
10 words or term those words in that way, so I'm not
11 entirely sure which of those. Part of it may have been
12 my entry but I'm not entirely sure which is mine and
13 which isn't.

14 **Q.** Let's move on to the second paragraph. It says:

15 "Update August 2021 -- [VC] appears to be relapsing,
16 currently presenting with complex delusional beliefs,
17 believes CCO and care team are conspiring against him
18 with the police/judicial system and MH hospital and have
19 created technology to cause voice experiences and
20 monitor him. Very paranoid and suspicious, not willing
21 to engage ... has stopped taking [his drugs] ... not
22 willing to work with the care team, not willing to
23 resume treatment. Nil insight, does not believe he has
24 ever been unwell/wasn't psychotic episode as we have
25 indicated over the last year, doesn't agree with this

66

1 words.

2 **A.** The -- it was an error, however what are those words
3 there in there could have been used as an historical
4 record and highlighted as an history, rather than
5 current situation.

6 **Q.** If -- I mean, if perhaps we go to page 1 and we'll just
7 go through and scroll from page 1. We'll scroll down
8 slowly, down page 1, over to page 2. The section there
9 is the one that I've read to you earlier. If we keep on
10 scrolling. Keep on scrolling, please.

11 You are completing this form for the purpose of
12 a current risk assessment. No mention of, for example,
13 the female jumping out the window, requiring
14 an operation. Sorry, there is that information, sorry,
15 on the second page. If we scroll up, please, to page 2.
16 But what there isn't any mention of -- so that's the
17 historic information, there is information, although
18 it's the wrong date, it's down there as July when in
19 fact it occurred in May 2020. But what we don't see
20 there at all is any information about the current risk
21 that he posed and the very serious violence that he had
22 committed by that stage. Do you agree with that?

23 **A.** Yes.

24 **Q.** Yes, I mean he had two violence and aggression markers
25 on the RiO system. If you were completing a risk and

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1 safety assessment, on reflection do you think those were
 2 all pretty important things to have noted down on this
 3 document?
 4 **A.** Yes, it's important.
 5 **Q.** And again, would you say that that is a significant
 6 error?
 7 **A.** Yes.
 8 **Q.** Thank you. If we please go to CYGN0000106. This is
 9 a letter to essentially VC's GP, University of
 10 Nottingham Health Services. We can see your name there
 11 as a clinician. Can you assist us with why your name is
 12 there?
 13 **A.** I believe that I was asked to send the letter to his GP.
 14 **Q.** Thank you. When you say you were asked to send it, did
 15 you also write it or create it?
 16 **A.** So it would have been created from using RiO. It would
 17 input relevant information in there.
 18 **Q.** When you say it could import, is it automatically copied
 19 from somewhere, or do you have to personally enter at
 20 least some information or copy some information into
 21 there?
 22 **A.** So when you, on RiO, so the way what you would go to --
 23 and the purpose of the letter, and then you can
 24 formulate the letter, and you can take the inserts or
 25 edit it as well.

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1 information in the risk and safety assessment, but that
 2 has now been passed to VC's GP?
 3 **A.** Yes, and because, like I said, the way the letter works,
 4 the RiO will go into what's been previously done and
 5 generate a letter as we requested, and we can then send
 6 it to them.
 7 **Q.** I mean, perhaps -- if we keep this on the screen and if
 8 we can bring up onto screen NHFT0000193, page 2, this
 9 was the Risk and Safety Assessment that you created and
 10 we see there on that top box, it's an exact copy and
 11 paste from that box; do you see that?
 12 **A.** Yes, so this will -- yeah, it will have generated,
 13 a letter would have been generated, using the words and
 14 the tools that's been recorded in the assessment.
 15 **Q.** So the same mistakes that were contained within that
 16 Risk and Safety Assessment and the lack of information
 17 about his serious assault on a police officer are
 18 replicated here?
 19 **A.** Yes.
 20 **Q.** Can you see how that's a significant problem?
 21 **A.** Yes, I can.
 22 **Q.** If we could please bring on to screen NHFT0000200, we're
 23 going back in time now, back to 4 September. This is
 24 called a "Summary & Care Plan". Can you assist us?
 25 We've looked at other documents, the risk assessment

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1 **Q.** So you have the freedom to add information as well as to
 2 remove information?
 3 **A.** Yes.
 4 **Q.** I think you've said in your witness statement that it's
 5 not usual to send this kind of letter.
 6 **A.** Yes.
 7 **Q.** Why is that?
 8 **A.** So we don't usually automatically send letters to
 9 patient's GP, only if we are asked to do it.
 10 **Q.** Was this, then, specifically created to inform VC's GP
 11 about the risks that he posed?
 12 **A.** I believe at the time I think the doctor has asked me to
 13 send the letter to the GP to make them aware that -- of
 14 the current situation and also that he's with us at the
 15 time.
 16 **Q.** Because it's important that the GP knows about the
 17 current risks that he poses?
 18 **A.** Yes.
 19 **Q.** If we please scroll down under "Risk to others", and
 20 over the page, can you see, that's exactly the same
 21 information as the risk form that I've just taken you
 22 to, the Risk and Safety Assessment? So those dates, the
 23 same information?
 24 **A.** Yes.
 25 **Q.** Yes? So by 9 September, not only is there incorrect

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1 form, the risk and safety assessment. What is a summary
 2 and care plan?
 3 **A.** So a care plan and summary is to basically put a plan in
 4 place as to the best way to care for the patient that we
 5 have at the time, and considering their needs at the
 6 time and how it will be best to look after them whilst
 7 in hospital.
 8 **Q.** We see there this particular form was completed by
 9 yourself on 4 September at 2.26 pm; is that right?
 10 **A.** Yes.
 11 **Q.** If we could bring back on to screen, please, that Risk
 12 and Safety Assessment, so NHFT0000193 -- at the same
 13 time, please -- and this time we're going to look at
 14 page 4.
 15 We see there the risk formulation section that I
 16 took you to a moment ago, that is now copied and pasted
 17 effectively into the summary and care plan, or the same
 18 words are used in exactly the same two places?
 19 **A.** Yes.
 20 **Q.** So again, the areas that I took you to in relation to
 21 the risk form is now replicated in a summary and care
 22 plan; is that right?
 23 **A.** Yes.
 24 **Q.** Could we please bring onto screen your witness statement
 25 at page 19. It's paragraph 78. You say:

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1 "Upon review, the information contained under
2 'Summary/Formulation' is accurate, but not complete.
3 I am aware that VC had in fact seriously assaulted
4 a police officer during [the] execution of the
5 S[ection] 135 warrant, and that this information is not
6 captured within the Summary and Care Plan."

7 It's more than just accurate and not complete, isn't
8 it? I mean, it's quite fundamentally wrong, the
9 information that I've just shown you.

10 **A.** Yes.

11 **Q.** If we go back, then, to the summary and care plan,
12 that's NHFT0000200, and the bottom of that page, I just
13 want to ask you about a particular entry at the very
14 bottom of the page. This has a diagnosis there of
15 first-episode psychosis.

16 Now, we've seen a discharge summary from 2020 where
17 the primary diagnosis is listed as paranoid
18 schizophrenia. Whether there's a difference between the
19 two and whether it affects anything will be a matter for
20 other witnesses, but in terms of your own evidence,
21 where do you think that information came from, and do
22 you have any discussions with those treating VC as to
23 what his actual diagnosis is?

24 **A.** I am aware of his actual diagnosis and the first episode
25 of psychosis would have been from the previous risk

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1 sufficiently flagged on the RiO system, or are there any
2 improvements there that could be made?

3 **A.** It's not flagged like the way the -- like the way the
4 alerts are flagged. It's just something that will --
5 you have to look through the RiO notes and check what
6 the doctors have written, and then follow it.

7 **Q.** Thank you. Before we leave this particular admission,
8 I just want to ask you about contact with VC's mother.
9 If we could go back to the RiO notes, that's
10 NHFT0000168. And we're going to go back to the
11 4 September. Could we please have a look at page 173.
12 The very bottom entry, we can see, has been entered by
13 yourself. And then we go over the page, please. It
14 says:

15 "[VC] remains in his bedspace appearing asleep. He
16 was observed to be moving and breathing, he was offered
17 a hot meal for tea at [5.30] however refused, He
18 requested for his phone to make phone calls to a
19 relative, when staff ask whom he was planning to call,
20 he stared at staff, and ignored staff. Staff wished him
21 a happy birthday, again continued to have a fixed stare
22 in his face. He returned to bed and was observed to
23 have given to the toilet on two occasions.

24 "[VC's] mum contacted and requested to speak to him
25 on the phone and wish him a happy birthday, his mum was

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1 assessment that was generated, because most time that
2 gets left from when you create new or updating the risk
3 assessment.

4 So yeah, so the reason why it's left there is
5 because he's just still when you generate a new risk
6 assessment, the previous entry that's been made still
7 remains there. However, it can be taken out if -- if
8 it's not relevant at the time.

9 **Q.** So does this actually appear on the -- when you create
10 the form, is that automatically populated?

11 **A.** So when you create the form, it brings everything that
12 has been created from the previous clinician, everything
13 will reflect there. So it's -- so you can then take
14 out, remove things or add onto it at the time.

15 **Q.** Not focusing on this particular case, but just in
16 general, do you have discussions as to what a formal
17 diagnosis may be with those who are treating the
18 patients, or is that just something that is taken from
19 the RiO notes?

20 **A.** So it depends. We do have discussion, depends if we
21 were present during the assessment or it would have been
22 clearly documented on RiO by the consultant, but it's
23 generally been passed on during handover as well.

24 **Q.** Looking at it more broadly, is it easy for you to
25 understand what a patient's diagnosis is? Is it

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1 advised that phones are not allowed in seclusion,
2 discussed with on call doctor about giving access to
3 [VC] to call his mum, the team felt it was unsafe at
4 present due to non-engagement with the team therefore
5 staff are unsure of what to expect from him. [VC's] mum
6 was informed however she wasn't happy with the decision.
7 She has requested to speak to [the] on call doctor".

8 What is the policy on your particular ward in
9 relation to access to mobile phones?

10 **A.** Usually, patients have access to their mobile phone. If
11 they haven't got their mobile phone, they can use the
12 ward phone. However, because in seclusion it's a bit
13 different, where -- and there's more restriction in
14 place as to what they can have and what they can't have,
15 on this occasion, VC was not allowed to have his mobile
16 phone, so that was why he couldn't have his mobile phone
17 on him because he was in seclusion.

18 **Q.** We see the entry below. It says:

19 "Explained that ..."

20 This a conversation with VC's mother:

21 "Explained that [he's] ... the seclusion room.

22 Staff on the ward is not feeling safe to go into
23 seclusion room as patient is unpredictable. She seems
24 to understand this".

25 Did you have a conversation with VC's mother at this

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1 stage?

2 **A.** Yeah, I spoke to -- I think I spoke to his mother and
3 explained that the reason why he couldn't have his phone
4 to make a call at the time.

5 **Q.** The entry above says that "the team felt it was unsafe
6 at present" to allow him to use his telephone.
7 Was that something you would have communicated to
8 VC's mother?

9 **A.** Yes.

10 **Q.** I'm going to move on now, then, to the fourth admission.
11 That's 28 January 2022. We know that this relates to --
12 there was first an incident where the flatmate
13 Christopher was put in a headlock. He wasn't allowed to
14 leave. That was 15 January. And then VC was detained
15 couple of weeks later, 28 January. If we could have
16 a look at those notes, which are at page 214.
17 We see this is an entry from Dr Lomas. If we scroll
18 over the page, please. It sets out there in the
19 "Background" section it says that:
20 "[VC had] held his flatmates hostage, though details
21 ... [weren't] clear."
22 It says that:
23 "At each visit the engagement has been superficial,
24 and on at least one occasion he was believed to be
25 witnessed spitting medication from his mouth and putting

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1 accommodation, he denied that he went and stated that he
2 is unsure of why someone would give false information
3 about his whereabouts. He was informed that his leave
4 is currently suspended until there are clearer
5 information as to where he went on the day".
6 What do you recall of your conversation with VC at
7 this time?

8 **A.** So my conversation was what I documented regarding his
9 whereabouts on the day.

10 **Q.** Were any checks carried out about whether he was telling
11 the truth or not?

12 **A.** I'm not entirely sure, because on this -- during this
13 admission, I think that was the only contact that I had
14 with him at the time, because I usually don't work on
15 the ward where he was admitted. I think this was on
16 Redwood 1 Ward, and the reason why I've gone there on
17 that particular day was because we were sent from the
18 Cassidy Suite over to cover on the ward because there
19 was no patient on the suite. So I'm not entirely sure
20 if this was followed up afterwards, because I don't
21 think I saw him again after, after -- I mean on this
22 admission.

23 **Q.** There's an entry there "Spent time on his phone".
24 That's presumably now, because he was on that other
25 ward --

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1 it in the bin ... Hence a further mental health act
2 assessment was called."
3 And at the bottom we see the plan is to detain him
4 on Section 2.
5 If we could please move to page 228. There came
6 a time where VC had been permitted unescorted leave and
7 we can see this on the second entry on page 228. It
8 says:
9 "Note concern raised from university that [VC] was
10 spotted at his old address yesterday, by his former
11 flatmates who were concerned to see him there given ...
12 history."
13 The next entry from Dr Gibson. He's spoken to
14 Eleanor Turner from the University, and it appears
15 there's an allegation that VC attended the property.
16 "She requested that if he needs ... access ... [to]
17 belongings for the ward, the university will be notified
18 and someone can be present to supervise that."
19 If we scroll down there's then an entry from
20 yourself. And it's this entry I'd like to ask you
21 about. It's over the page, please.
22 You say there:
23 "Staff requested to speak with [VC] regarding the
24 telephone call that was received yesterday from his
25 accommodation. [VC] was asked if he had been to the

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1 **A.** Yes.
2 **Q.** -- he had free access to his phone. Are you aware of
3 anyone looking at what he was doing on the phone in
4 light of that allegation from the university?

5 **A.** No, I'm not aware.

6 **Q.** Then very finally, I just want to ask you about your
7 reflections. We've seen quite a few forms now that were
8 not accurately completed. What do you understand the
9 duty to be on you in respect of the keeping of accurate
10 records?

11 **A.** So my duty is to ensure that all the information that
12 I do document are as accurate as possible. In my normal
13 practice now, I make sure that I cross-check things that
14 I've written and documented, and also I've realised that
15 the (*unclear*) completion as to updating the risk
16 assessment, and creating one.
17 So my usual practice now is to create one rather
18 than updating it, so to avoid confusion as to which
19 clinician has done what and which clinician has not done
20 what. So that's my learning through the process.

21 **Q.** Do you think you had been provided with sufficient
22 training at the time?

23 **A.** Yes.

24 **Q.** You had been provided with sufficient training?

25 **A.** Yeah, I was provided, yes.

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1 Q. But then how did that lead to the filling out of
2 incomplete and inaccurate records?
3 A. It was an error that I'd missed at the time. But like
4 I say, so I make sure now that I check clearly more in
5 detail, and cross-check every entry or any assessments
6 that I do take to make sure that all the documents are
7 accurate.
8 Q. Have you been provided with new training, improved
9 training, at all?
10 A. So now we do -- what we do, used to do, block training
11 where we have all our training in one week. So it
12 involved a different level of training and assessment is
13 part of it as well. So I think that started at perhaps,
14 I'm not sure, probably three years or two years ago,
15 compared to the previous ways of doing trainings. So --
16 and this is face-to-face, as well, where we have to
17 attend for a week.
18 Q. The errors that you made in the completion of the forms
19 that I've taken you to, in your view, are they more
20 widespread? Is this something that we should focus on
21 you for or is it a widespread problem so far as you're
22 aware amongst nurses who work --
23 A. I think it's an individual, could be individual,
24 depending anyone it could happen. On my case, it's like
25 I say, something that happened by error. But I'm not

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1 your completion of the risk and safety assessment forms,
2 in particular the one on 14 July 2020.
3 Now, Ms Ajewole, we've seen that you have completed
4 a series of risk and safety assessment forms, yes?
5 A. Yes.
6 Q. You've said that when you are completing the risk and
7 safety assessment forms, you would refer back to
8 previous risk and safety assessment forms, completed
9 during any previous admission or assessment; is that
10 correct?
11 A. It -- yeah, it would usually automatically come on
12 anyway.
13 Q. Okay, that's what I wanted to ask you about. You've
14 said in another bit of your evidence that the form was
15 pre-populated.
16 A. Yes.
17 Q. Is it this form, the Risk and Safety Assessment form,
18 that was pre-populated with any information from the
19 last admission or assessment?
20 A. Yeah, it will have all the information of the previous
21 clinician in, so yes.
22 Q. Okay. So when you open up the form for your current
23 assessment, it's got the last one on it, and you need to
24 delete things from it?
25 A. Yes.

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1 entirely sure if it's -- if it's an error that reoccurs
2 a lot within every(?) nurses, I'm not entirely sure.
3 Q. Have you gone back to look at previous cases that you've
4 been involved in to see if you've had the same errors in
5 different cases, and it may have caused risk to other
6 patients?
7 A. I've not been looking at every patient that I've been in
8 contact with in terms of going back to check what I've
9 done at the time, but from the last few years I've been
10 going back when I do do my risk assessment,
11 I cross-check and take my time to read through it to
12 ensure that all the information are accurate.
13 Q. Has somebody from the Trust, somebody senior, spoken to
14 you about what went wrong here?
15 A. Yes. Yes.
16 MR BLAKE: Thank you.
17 Chair, I don't have any further questions. There
18 are further questions.
19 THE CHAIR: Yes, Mr Blake. Thank you.
20 Mr Moloney? Ms Cartwright?
21 MR BLAKE: Mr Beer.
22 THE CHAIR: Mr Beer.
23 **Questioned by MR BEER**
24 Q. Good afternoon. You know that I ask questions on behalf
25 of the Trust. I want to ask you some questions about

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1 Q. Okay. So as an opening question, is it right that that
2 has now changed and now it comes up as a blank form?
3 A. It doesn't come up as a blank form. So we -- we come
4 up -- we create new, but it doesn't come up with a blank
5 one. We still have every information in, so it will our
6 role delete everything and then start again from the
7 beginning.
8 Q. Okay. Now, in relation to the risk and the risk
9 formulation sections of the form, we've seen that in
10 your current assessments, you have included within them
11 reference back to previous events and admissions?
12 A. Yes.
13 Q. Is that usual practice?
14 A. Sorry, can you repeat that question?
15 Q. Yes. Is that usual practice?
16 A. Can you repeat the first part, please?
17 Q. Yes, of course. In the risk part of the form, and the
18 risk formulation part of the form, we've seen that
19 you've included reference back to previous events and
20 previous admissions?
21 A. *(The witness nodded)*.
22 Q. Is that usual practice?
23 A. Yes, so we can add historical items in, where to make --
24 we do have an overview of what's been happening in the
25 past. So we can leave the historical part in as well,

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1 but it should be highlighted as historical.

2 **Q.** Is that, in fact, good practice, to refer back to
3 previous events in the current assessment of risk and
4 the current risk formulation?

5 **A.** I think so. It just give a more of continuation and
6 more understanding of the patterns that the patient has
7 been -- the way the patient has had their patterns as to
8 what they've been doing in the past.

9 **Q.** But leaving the past assessment of risk, essentially
10 copying and pasting it, although that has advantages, it
11 also carries disadvantages; do you agree?

12 **A.** Yes.

13 **Q.** It has the advantage of recording accurately what the
14 previous assessment of risk was?

15 **A.** Yes.

16 **Q.** But the disadvantages include that it shouldn't be
17 presented in a way that it suggests that it's the
18 current reflection of the position; do you agree?

19 **A.** I agree.

20 **Q.** It shouldn't be presented in a way which fails to
21 reflect any updated information?

22 **A.** Yes.

23 **Q.** Can we just use your first interaction with VC, that on
24 14 July 2020, as an example. You've explained that you
25 were required to complete a Risk and Safety Assessment

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1 **Q.** Does it follow -- and you'll see that it's word for word
2 the same as it carries on, in relation to the section on
3 the left, down to "who reside in a group of flat", to
4 your entry on the right-hand side: "who resides in
5 a group of flat".

6 **A.** Yes.

7 **Q.** So it includes a typo missing out the "s", yes?

8 **A.** Yes.

9 **Q.** Then on the left-hand side, Annette Palmer has written
10 "no history of violence or aggression", and you've left
11 that in which is obviously incorrect, isn't it?

12 **A.** Yes.

13 **Q.** Then "[he's] ... been hearing voices" down to "own
14 admission", again, word for word the same; do you see
15 that?

16 **A.** Yes.

17 **Q.** So you have effectively left in, or cut and pasted, as
18 part of an entry on 14 July, something that was correct
19 back on 24 May 2020, yes?

20 **A.** Yes.

21 **Q.** You've explained that it's good practice, or usual
22 practice, to refer to the past assessment of risk in the
23 current assessment of risk, but that's not what you've
24 done here, is it?

25 **A.** No.

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1 form as part of your duties, and can we look at that
2 alongside another document. So to start with
3 NHS0000196.

4 Thank you. And if we look at -- we can see this
5 is -- if we go to page 4, please. We can see that
6 there's the entry on 14 July 2020, which is recorded, as
7 you've told us, by you. And that the previous entry,
8 although it's misdated, is a reference back to his
9 previous admission, back in May 2020. Yes?

10 **A.** Yes.

11 **Q.** Can we look at the May 2020 version of this form,
12 please, at the same time, and that's NHFT0000197. If we
13 go to page 4 -- so if we look at page 1 first, sorry, we
14 can see this is 24 May 2020, in fact I think completed
15 by Annette Palmer.

16 If we go to page 4, please, and look at the
17 equivalent entry, the "Risk Formulation". Do you see
18 the words beginning "[VC] is a student at Nottingham
19 University" on the left-hand side?

20 **A.** Yes.

21 **Q.** Then on the right-hand side, do you see, in relation to
22 the highlighted entry, five lines in, "[VC] is a student
23 at Nottingham University studying mechanical
24 engineering", yes?

25 **A.** Yes.

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1 **Q.** You've included it as if it's part of the current
2 assessment of risk.

3 **A.** Yes.

4 **Q.** Can you help us as to why or how this might have
5 happened? Is it pressure of time? Is it need to get to
6 the next patient? Is it your caseload? Is it the need
7 to do other work on Cassidy? What has led to this
8 mistake being made? And I'm using it as an example.

9 **A.** I'm not -- I can't remember as to how the shift was on
10 the day or how, if it was very busy or not busy. But
11 yeah, I'm not -- I can't recall.

12 **Q.** So you can't say exactly what it was that caused you to
13 make this mistake.

14 **A.** I understand that it's an error from myself, but I can't
15 recall whether it's because of how busy the ward was at
16 the time, or what the situation was at the time.

17 **MR BEER:** Thank you very much. That's all I ask.

18 **THE CHAIR:** Thank you.

19 **Questioned by THE CHAIR**

20 **THE CHAIR:** Can I just ask about the RiO system. I think
21 you've said that it populated the letters itself, and
22 produced a letter -- it generated a letter itself, and
23 this was back in 2021. Is that almost like an AI letter
24 or how did that happen?

25 **A.** No, it's not an AI letter. So if -- there's a place

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1 where you go to to have a heading of the purpose of the
 2 letter and then you would then input it with all the
 3 information that is on the -- on RiO from the patient's
 4 record. So you will fill those gaps in.

5 **THE CHAIR:** So do you have to yourself effectively cut and
 6 paste, or does it fill it in for you?

7 **A.** It fill its in.

8 **THE CHAIR:** Right. And is that the same for both of these
 9 risk assessments as well?

10 **A.** So with the risk assessment, like I said, we can edit
 11 it, we can change things or delete the old paragraph and
 12 input a new one in.

13 **THE CHAIR:** And although things have changed now, you said,
 14 you're still in a position where some of the material is
 15 again populated when you -- when it comes up; is that
 16 right?

17 **A.** Yes.

18 **THE CHAIR:** Is the population just the details of the
 19 patient or is it risk assessments, or what's still
 20 included?

21 **A.** So it's everything that's been done previously will be
 22 included.

23 **THE CHAIR:** I see. And in terms of your own experience at
 24 this time, was it always the case that if you were doing
 25 a risk formulation of this kind you would leave in what

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1 I add as much information that I've been provided with,
 2 and include it in every documentation that I'm doing.

3 However, on this occasion, with VC's case, it was an
 4 error that I've not inputted this information.

5 **THE CHAIR:** Right. Thank you.

6 Yes, so we'll --

7 **MR BLAKE:** Thank you, Chair. Before we break for an early
 8 lunch, Ms Haider has some information to read onto the
 9 record.

10 **THE CHAIR:** Yes, thank you. We can now, I think, terminate
 11 the link. Thank you.

12 **MS HAIDER:** Thank you, Chair. With your permission, I will
 13 read into the record URN references identifying a number
 14 of witness statements that the Inquiry has received.

15 The statements I refer to are relevant to VC's first
 16 and second admissions to NHFT's Highbury Hospital in
 17 2020 which the Inquiry has, of course, heard evidence
 18 about last week and this morning.

19 The underlying statements will be uploaded to the
 20 Inquiry website later today. The relevant URNs are
 21 WITN0197001, that's the statement of Dominic Lloyd,
 22 a Liaison and Diversion nurse who was involved in VC's
 23 first presentation to mental health services.

24 The next statement is WITN0413001, that's the
 25 statement of Dr Gareth Foote, who is a psychologist, and

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1 was already there?

2 **A.** So if it's still relevant, you can leave it in.

3 However, if it's not, we can edit it.

4 **THE CHAIR:** Right. Not just editing, but did you put in, in
 5 other cases, the current position?

6 **A.** Sorry, can you repeat that question?

7 **THE CHAIR:** So in this case, as you've accepted, you didn't
 8 put in what had actually happened on this occasion --

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

10 **THE CHAIR:** -- and then factor on the previous occasion as
 11 well. But on the September incident involving police
 12 constable Pritchard, none of that appears in the risk
 13 assessment.

14 So what I was asking is, as well as editing what
 15 comes up in the -- as a result of the RiO populating
 16 itself, in other cases, apart from this one, had you
 17 also not put in the reason for the current admission?
 18 Do you know? Was that --

19 **A.** Are you asking for the reason why I've not put in the
 20 reason for the --

21 **THE CHAIR:** Well, what I'm really saying is: was it limited
 22 to this case or was that the practice at the time, your
 23 practice?

24 **A.** So my general practice would be to add as much
 25 information all the time, that's my general practice, so

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1 he provides evidence on the role of psychological
 2 treatment in VC's care, generally at the Trust, and
 3 during his first and second admissions.

4 There are also a number of mental health nurses who
 5 provided evidence, which is particularly relevant to the
 6 monitoring and reviewing of VC. The first one is
 7 WITN0218001, that is the statement of Sarah Rivers. The
 8 next is WITN0014001, that is the statement of Godwin
 9 Gonde. Finally, in relation to the inpatient mental
 10 health nurses, WITN0203001, that is the statement of
 11 Campbell Mtetwa, who was VC's key worker during his
 12 first second admissions.

13 Additionally, WITN0146001 is a statement of Dominic
 14 Matiru, who is a healthcare assistant, and this
 15 statement briefly explains the role of healthcare
 16 assistants in providing inpatient care to patients
 17 admitted under the Mental Health Act.

18 Finally, WITN0092001 is the statement of Merima
 19 Jordan, who is a community Mental Health Nurse within
 20 the Crisis Resolution Home Treatment Team and provides
 21 evidence in relation to VC's treatment at that time.

22 Those are the statements, Chair, and they will be
 23 uploaded to the website.

24 **THE CHAIR:** Yes, thank you very much.

25 Right. Well, I think we're going to take an early

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1 break today and we'll come back at 1.30. Thank you.
 2 (12.29 pm)
 3 (The short adjournment)
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