Monday, 27 April 2026

(10.00 am)

THE CHAIR: Yes, Mr Blake.

MR BLAKE: Good morning, Chair. Can I please call Geoffrey Culpin.

THE CHAIR: Yes.

GEOFFREY CULPIN (sworn)

Questioned by MR BLAKE

THE CHAIR: Thank you. Yes.

MR BLAKE: Thank you.

Mr Culpin, you have produced two witness statements for the Inquiry: the first is dated 10 November 2025 and has a URN of WITN0189001; and the second is dated 8 January 2026 and has a URN of WITN0189002.

Are both of those statements true to the best of your knowledge and belief?

A. They are.

Q. Thank you. You started work for Nottingham City Council as a social worker in 2005; is that right?

A. It is.

Q. You have been an AMHP since 2009.

A. Yes.

Q. You've set out in your witness statement you estimate that you carry out about or over 30 Mental Health Act Assessments each year; is that right?

A. Yes.

Q. You've said that you manage various teams. We're here today to talk principally about the 14 July incident, 14 July 2020. As at that point, what was your formal position?

A. Team Manager, Mental Health South Team and Forensic Team.

Q. Who did you manage?

A. A group --

Q. Which teams did you manage at that point?

A. Both of those two teams.

Q. Thank you. You've set out in your second statement the role of an AMHP, and we've heard about that before and I'm not going to deal in any great deal with that. The only aspect of that that I'd like to deal with this morning is the triage process. You've set out at paragraph 16 how, when referrals are received, there is a triaging process that's carried out by a senior AMHP. You've said that was established in 2020. Are you aware if that was before or after this particular incident?

A. It would have been round about, I don't know if it was particularly before or after, but I would have thought it would have been after. I can't say for certain.

Q. Can you briefly assist us with what that triage process involves?

A. So a referral is made to us, to the -- for a Mental Health Act Assessment, a senior colleague, an admin, will initially look at that because they'll pick up the email and then they'll forward that into a box on a data entry system and they'll alert the senior cover AMHP to look at that and then they'll look at that against other assessments that are there to determine whether or not and in what circumstances that assessment needs to take place.

Q. When you say that they'll look at that, what exactly are they looking at?

A. They're looking at the background details to that, I suppose, predominantly to the extent on one level does it need to be a Mental Health Act Assessment. If it does, what that needs to take place and the degree of emergency, and how that needs to, I suppose, fit with the other Mental Health Act assessments that are being asked to be undertaken at that point in time.

Q. The person that carries out that assessment is a senior AMHP?

A. Yes.

Q. Is it only an AMHP who can decide whether or not to ultimately carry out a Mental Health Act Assessment?

A. Not necessarily, but it is the case that an AMHP makes that decision, and on two levels, but both in terms of

whether or not to proceed, so that the AMHP which then receives that piece of work will also look at that in greater detail, maybe, to determine whether or not the Mental Health Act needs to take place, if and when.

Q. How long typically does that triage process take?

A. I mean, it can take place within a few minutes, if it's clear that that's what needs to happen. If there's more -- if it's more complicated, then it could take a few hours, really, to get additional information to see whether or not the assessment needs to take place. So you might need to contact other professionals, look at other information to clarify the detail, really and the background to see what -- how that needs to kind of take place, really, how to proceed.

Q. We've heard about AMHPs identifying specific doctors who perhaps have had a previous interaction with the patient.

A. Yes.

Q. What about allocation of AMHPs; is there any process which matches a particular AMHP to a particular patient?

A. Not to a particular patient, no, but some AMHPs, I suppose, kind of maybe have more experience in some areas, but sometimes a degree of travel involved. So there's some practicalities sometimes that will determine which AMHP picks up the assessment, but it's

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

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

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

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

hospital.
Q. Thank you. I think your conversation with VC's mother actually took place after the assessment; is that right?
A. Yes, I think so. I can't remember exactly, but that's what I recorded.
I mean, quite often what we seek to do, if we have time to do so, will be to alert the nearest relative ahead of the assessment so we know that if we need to communicate further, that that doesn't become a kind of problem further down the line.
Q. Thank you. Then it continues:
"When placed [on Section] 136 ... had been experiencing auditory hallucinations relating to upstairs neighbours which he then confronted - who called the police.
"Did not fully accept the impact that this had on them — or of actions leading to previous assessment.
"[VC] said that he had been non compliant with his medication primarily as he did not believe he needed to or that he was unwell - he reported that he was finding it more difficult to concentrate on his revision and wondered if [that] was linked to the medication he was taking."
So there's there the reference to VC revising and his academic studies, and the impact, perhaps, of the

medication on that?
A. Yes, I mean, there's a part of the conversation we would have had with him to seek to establish the degree of insight that he maybe had into his own circumstances, but, I suppose, to have a conversation with him, so we could sort of elucidate, really, what his understanding of the circumstances, so he had an opportunity to tell us what had been happening to him, and we would then take that information into consideration in terms of our assessment.
Q. Thank you. Just for the purposes of the timeline, we then go on to NOCC0000034, this is the LiquidLogic report. If we turn to page 11, please, we see there, almost towards the bottom of the page, the entry from the 14 July at 3.08, contact has been made by Busayo Ajewole, our next witness:
"... to arrange. Patient at Cassidy Suite at Highbury Hospital, [she requested] a mental health [Act] assessment ..."
Then the entry above that is from yourself:
"following assessment under the [Mental Health Act], detained, S[ection] 3."
If we could then, please, turn to NHFT0000037 and page 7, you then completed the application for VC to be admitted to hospital under Section 3. Was there any

verbal handover at this stage or do you just complete these forms -- with Highbury Hospital?
A. So we don't provide a handover unless there's a particular thing we'd need to raise, so colleagues in the trust, I think you'll be aware now, use RiO system as the method to record sort of basically what's happening with somebody.
So colleagues on 136 Suite will have made an entry on RiO so the ward staff would be able to kind of read that. I'm not sure if Dr Seedat did on this occasion, but it's usually the case that the doctor that's involved in the assessment will record onto RiO too so that all personal information is available to the ward who will also see the medical recommendations, which summarise the kind of reasons for somebody to be detained.
Q. So Highbury Hospital will receive this form, which also has a report from the two doctors, and then they're also reliant on the accuracy of the RiO records.
A. Yes.
Q. Thank you. I'm going to move on, then, to a separate topic and that is issues with the University and correspondence with the University. The impression that is given by your witness statement is that you come across university students quite a lot; is that right?

A. Yes, yes.
Q. What kind of proportion of those Mental Health Act Assessments that you carried out involve university students, so far as you're able to assist?
A. I couldn't really be able to say, really, but, I suppose it's significant enough to be aware of issues, really, when we see students, because we, you know, we see quite a few, really, one way and another.
Q. Do you have a designated contact at the University?
A. No, we don't, but we do know about the counselling services at both universities, such that we can make contact if we need to do so.
Q. Is there some sort of formal process, so far as you're aware, that if you become aware of somebody being a university student that you are able to contact them?
A. There isn't, but in terms of my own practice as an AMHP, that's something I'm always kind of aware of and I suppose part of my overall concern for somebody's wellbeing that I would, and quite often do, make steps to make sure that somebody's best interests in terms of their academic studies are known to the University, because obviously if somebody is in hospital -- I mean I know the ward does too, but it can be a massive interruption to -- in people's studies and in their lives which we try our best to mitigate.

Q. How about the opposite side of that, which is seeking information from the University? Do you find that straightforward?
A. Yes. I've never found any barriers to doing so, but it's more the other way round: that we're telling the University that we're working with somebody rather than we're seeking information directly from them.
I suppose in terms of the University, it would be more "Are you aware -- can we confirm that this person is at the University and what course they're studying? What stage they're at, in terms of their studies?" Because, for example, somebody might be coming up to exams and we wouldn't want those to be disrupted or them to have a negative mark for having not -- literally not shown up.
Q. Do you ever come across issues, data protection being raised or anything along those lines?
A. No, no.
Q. Can we please turn to UNIN0001084, please. This is an email that the Inquiry has already seen of 30 July.
If we could start, please, at the bottom of page 2. It's an email from Eleanor Turner, Head of Mental Health Advisory Service at the University, to yourself. If we scroll down, please, we can see that she says that she "has been informed that you were the assessing AMHP for

VC", and she wanted to flag up concerns about his discharge from Rowan 1 and she was seeking your opinion.
If we skip past the next paragraph and go to that final substantive paragraph. She says as follows, she says:
"... I was surprised to learn that [VC] is being discharged tomorrow to the same address. I remain concerned for the residents but I am also increasingly concerned for [VC] in terms of the other residents and their fears around his mental health. If this was University managed accommodation, we would be carrying out a detailed risk assessment and it is likely that we would be supporting [his] ... return to Wales. [VC] is citing his academic work as a rationale for staying in Nottingham but all his work is now online and there is no need for him to be located near to the University. I am going to continue to try to engage him with our team."
Did you share those concerns? Sorry, when I say "share", I mean did you have the same concern?
A. Those weren't things that were foremost in my mind when undertaking a Mental Health Act Assessment. But I can understand her concerns, and I think it's part of our kind of email communication -- I can't remember now if we actually spoke on the phone as well, but -- so yes,

I would share her concerns, yes.
Q. Were you the right person in this circumstance to have been contacted?
A. Possibly, yes, yeah. I mean I don't know if there's anybody that would have been more or would have been better placed to do so, you know, I clearly was the AMHP that undertook this particular assessment. And I know about kind of the way in which the mental health services are structured such that, and I was able to kind of communicate directly with Dr Seedat if needed and got, you know -- and that's what I did.
Q. If we scroll up, please, you say there:
"I have forwarded it to the ward for their consideration."
A. Yes.
Q. And we'll come to that particular email. If we go, please, on to page 1. We see the response there, between Eleanor Turner and Claire Thompson. Ms Turner says:
"See response from the AMHP below. I'm thinking of renaming secondary care liaison project ... the zero care teflon initiative."
And Ms Thompson responds:
"He's always been rubbish. Excellent renaming."
Did you see their evidence on this particular topic?

A. Yes, yes.
Q. Looking back on this now, what's your view of that correspondence?
A. I suppose people are welcome to their opinion. I suppose what I'm picking up is that they were frustrated that sometimes it feels difficult to kind of access some kind of systems when you come slightly outside of them. I kind of think, really, is their frustration. But I think different agencies have different kind of roles and responsibilities, and I think each of those sort of fulfilled those.
Q. If I could please take you to NHFT0018308. You did in fact forward, if we look at page 3, their correspondence to Dr Seedat. And we see at the bottom of page 2 and into page 3 Dr Seedat's response. He says as follows, he says:
"I cannot dictate where people go and live, he has a paid up tenancy, the landlords will not give him his money back and he has no income.
"Maybe that the is the work El[e]anor needs to do with landlords and see ... they support their students in such situations.
"On both occasions the incidence happened in ... his other flat and not in the one he is returning to.
"He is well, he is taking his meds, he will have

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

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

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

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

Q. But you --

A. Sorry.

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

A. Yes.

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

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

A. Mm-hm.

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

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

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

"Thanks.

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

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

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

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

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

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

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

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

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

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

I don't think the University were updated following

this exchange; is that right?

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

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

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

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

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

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

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

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

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

A. Yes.
Q. And so can we then just go back up, please, to paragraph 90. Thank you. So we can see the email exchange you've just looked at when the concerns were being read by -- raised by the University. And obviously, we can see your reply, which was:
"It's the well bit that's important is he on depot? Oral meds?
"Will he have a team following him up -- or crisis?"
Obviously we've seen the response from Dr Seedat.
But can I ask you, bearing in mind it was your view that a CTO should have been considered, and bearing in mind the role that an AMHP has for a CTO, it's right, isn't it, that an AMHP is a key part of suggesting a CTO, and in terms of the assessments and reports that have to be considered for a Community Treatment Order?
A. Yeah.
Q. Why you didn't pursue this further if it wasn't --
A. It's not necessarily suggesting. What happens is we are requested to participate in the decision. So somebody's care team or their doctor will decide whether or not they want to proceed within the Community Treatment Order, and we checked to decide whether or not we believe the conditions have been met to place somebody on a CTO. So we don't instigate them; we are part of

the process.
Q. No, I appreciate that but the AMHP's role in the scenario of a CTO would be to look at the social circumstances, wouldn't it?
A. To a point. It's more to look at the conditions attached to community treatment order to see if they're appropriate.
Q. That's why I wonder, because really what you have here is the University raising real concerns about the discharge package for VC and about where he was returning back to. So can I ask why, if your thought was a CTO should have been considered, why you didn't challenge the Responsible Clinician more, bearing in mind that VC had been on a Section 3?
A. So my -- I mean I made a number of points there to kind of check if each of those things were being considered. If somebody has been in a hospital on a Section 3 that I think is always the case that a CTO will be considered; whether or not that's pursued or not is a slightly different matter.
So kind of again it's for the clinician to decide whether or not they're going to request an AMHP to participate in the process, placing somebody in a Community Treatment Order. It's not for the AMHP to kind of suggest that somebody should be at that point.

I mean again, we kind of raise that as a general point, but it needs to come from the clinician in the first place.
Q. Then can I ask you, just from a different perspective of statutory obligations that now came into play now VC had been detained on a Section 3. Again, from the perspective of the University effectively raising concerns about accommodation and the discharge plan, and whether it was a safe discharge plan. We know that the AMHPs sit, from your statement, within the Adult Social Services Directorate; is that correct?
A. It is, yes.
Q. So can you assist as to why you weren't more proactive in liaising back with the University or just checking that VC knew all aspects about the Section 117 aftercare obligations that now applied?
A. So in place of Section 3 for Section 117 aftercare, the processes that we kind of worked to is that the hospital will refer somebody to us on discharge if they believe that there's a need for Section 117 to -- for somebody to be assessed for their aftercare needs. They didn't do that on this occasion.
Q. So the hospital didn't refer for an assessment under Section 117, but that's why I'm wondering, from the aspect of your knowledge and experience, here you have

the University raising concerns about his accommodation and that's the sort of thing that can be looked at as part of a review of the aftercare plan and whether there's appropriate compensation.
A. Yes.
Q. So again, if the hospital haven't referred VC to the local authority for an assessment, essentially it provides free aftercare for a patient, and so I'm just wondering why you didn't refer VC or suggest to the University to refer VC in for a Section 117 assessment to make sure he had a fully comprehensive aftercare plan and package in place?
A. So it would be -- I mean, I've never known the University to do that, and that's not particularly their role to do so, in terms of referring for 117.
Section 117 discharge is, as again, they're instigated by the ward. It's for the ward to kind of inform us that they believe someone has Section 117 needs and we would undertake an assessment at that point if we believed -- if we were notified of the need to do so.
So we don't follow everybody up that's for 117 that we place on Section 3. That gives somebody aftercare -- so they can receive Section 117 aftercare, but we would need to be alerted to the fact they were reaching that

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

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

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

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

they're undertaking social supervision so that's a role which is within the Forensic Team. We have one or two other people that are being socially supervised in other parts of the service, but predominantly they're all within the Forensic Team. So it's a specialised role, I suppose, within adult mental health.

MR BEGGS: Thank you very much. Those are all my questions. Thank you, Chair.

Questioned by THE CHAIR

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

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

THE CHAIR: Yes.

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

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

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

THE CHAIR: Thank you.

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

MR BLAKE: Thank you, Chair.

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

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

(10.46 am)

(A short break)

(10.59 am)

THE CHAIR: Yes.

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

BUSAYO AJEWOLE (affirmed)

Questioned by MR BLAKE

THE CHAIR: Yes, Mr Blake.

MR BLAKE: Thank you very much.

You should have in front of you a witness statement dated 8 December 2025 and that as a URN of WITN0145001; is that statement true to the best of your knowledge and belief?

A. Yes, it's true.

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

A. Yes, that's right.

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

A. Yes.

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

A. Yes, that's right.

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

A. That's correct.

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

A. Yes, that's right.

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

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

A. Yes.

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

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

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

A. That's right, yes.

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

A. Yes.

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

Information Form. Can you tell us what the purpose of this form, is, so far as you're aware?

A. So these forms are called a "form 1", so usually where we get handovers from the police, when patients are detained under Section 136, so they'll give us verbal handovers to the reason why they've been detained. We also get a handover from the street triage who has been involved with their detention at the time. So they'll give us as much information as possible, as to the reason why they've been detained.

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

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

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

Can you assist us? Who normally completes the form,

is it a police officer or yourself or both?

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

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

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

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

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

to mask.

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

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

A. Yes, that's correct.

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

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

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

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

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

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

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

A. So it will be -- it will be the police officers would

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

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

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

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

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

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

A. I can't recall of much if I'm fully aware, but it would have usually we have handover, so usual practice would be to give the handover as to what's happened. I -- what's happening or previous history. I may have been informed but I can't fully recall.
Q. Is it likely that relatively early on in your time with VC you would have been aware of at least these two previous incidents in May 2020?
A. Yes.
Q. Then if we move on, then, to page 56 we then get to July. If we start on that second significant box, 14 July, 12.13 am, we have the entry from the Street Triage Team, Nigel Wade, and he says as follows, he says:
"The Police were contacted by residents of a flat near to [VC's]. [VC] had been banging on the door and when someone opened it, he immediately forced his way in, attempting to push past the resident. He was restrained on the floor by a number of residents until [the] Police arrived. One of the Officer's had dealt with the previous incident where [VC] forced his way into someone's property in May, and therefore asked [the] Street Triage [team] to attend."
So it says there forced his way in, pushed past, and reference to being restrained on the floor.

Were you aware when you first took charge of this matter, that this was a case where physical force had been used by VC?
A. Yes.
Q. If we look down there at the next entry at 1.48, I think this is your entry, and we look over the page, please. You say there:
"[VC] arrived at the suite at [11.50 pm] ... accompanied by two police officers, handcuffs were used during transfer. He was orientated to the suite and was shown his room. He appeared preoccupied when staff spoke with him, staring and giving vacant looks. He also appears to be having delayed response when asked questions."
Do you recall that at all?
A. Yes.
Q. Then if we go, please, to NHFT0000196. This is the first Risk and Safety Assessment that I'm going to take you to. Can you assist us with what the purpose of this particular form is?
A. So the purpose of the Risk and Safety Assessment is to identify potential risks that patients pose to themselves or others or the environment. It's to identify the risk and how it can be safely managed by the team, and by anyone else who is involved in their

care. They also, the form helps professionals, healthcare professionals, aware of the current situation that is happening with the patient in terms of how their risk has been managed and also how they can get involved with the continuity of care with all the risks and that they do pose to themselves or others. So that's the purpose of the form.
Q. So just to understand the intended audience of this, it will be those professionals who are treating VC or any patient on a ward. Will it also be for other healthcare professionals because it's available on RiO?
A. Yeah, it's available on RiO. So every healthcare professional should be able to have access to it.
Q. If a future nurse is carrying out a Risk and Safety Assessment, might they also refer to it and perhaps copy some of it for their own forms?
A. So they could, depending on the reason why they are assessing the form. Sometimes the nurses will do a new one, or they can go back and have access to the previous ones that has been done, and see if it's still relevant to their care at the time.
Q. So is it often the practice of nurses to look at the previous one at least to inform their later risk assessment?
A. Generally you will -- the nurses will say, because when

you do go to this page, and even if you were to create new, so there will be previous -- information from previous nurses or healthcare professionals that has done the risk assessment. So it will still be there, so they will be aware of the previous information.
Q. So in light of the intended audience for this particular form, do you consider it's important that it is accurate?
A. Yes, it is.
Q. Now, I just want to look at particular entries. If we start on page 4. The front page said the date was 26 May 2020 and then at the bottom of page 4 we see different dates. Can you assist us with how this was created? Was it first created in May, after those May incidents, and is updated now on 14 July?
A. That appears to be, yeah, how -- what's the situation, yeah.
Q. Are you able to assist us with who created it on 26 May? Was that -- would that have been yourself or would that have been somebody else?
A. I'm not sure. I think it may say on the top who the clinician was and who has updated it at the bottom.
Q. So if we go to page 1 it has the clinician's name there. But then if we go to page 4 at the bottom of that page, it only has your name. Are you able to assist from that

information as to who is likely to have created this in May?

A. It would have been the clinician's name at the top, have updated it in July.

Q. Thank you. If we turn, please, to page 2, we see risk "To Others" is ticked "Yes", and then there's a July entry, 14 July:

"Arrested for attempting to gain entry into random neighbours flat as he felt that someone is in trouble. [VC] did not gain entry or harm anyone but he was kicking the door."

Now we saw in that earlier RiO entry that VC was attempting to push past a resident. Do you think that that is relevant information that should have been included in that box?

A. Yes, it should have been included.

Q. And then there's a box below that says, "Risk", and it says, "No data to display." Again, are these dropdown options under "Risk"?

A. Can you repeat that question?

Q. It says, "Risk (please select)", so it seems as though there are a number of different dropdown options that you could select under "Risk"; is that right?

A. Yes, I think, yeah, there are -- yeah, there are options that you could select.

Q. And would it have been helpful, in this case, to have added a particular risk in that box?

A. Yes.

Q. Thank you. If we go over the page, please, at the bottom of the next page it has "Risks Under Investigation", and it says:

"Criminal damage to a flat door."

Are we to understand that that is the current incident, so that's the July incident? Because we know that, for example, the police were still at this time investigating one of the May incidents. Can you assist us with which incident that relates to?

A. I think it may have been probably the May or July incident but I really cannot recall the exact incident that it was in relation to.

Q. It says, "Risks Under Investigation". Whose investigation is that? Is that healthcare professionals, the police, or something else?

A. It's generally, could be from the police or healthcare professionals, yeah.

Q. So it's just a general risk that's being looked into by somebody.

A. Yes.

Q. If we go, then, over the page, please, we see an entry in May and we see an entry in July. If we start with

the May entry, it has 23 May 2020. Now, we know that the second incident involving VC was actually the 24 May, and that he wasn't at Rowan 1 until I think 25 May. Do you know how this date has been identified?

A. So I think the reason why the date is there is because, like I said, the risk formulation was created by the clinician's name at the top, and so that was their entry at the time, and my entry was the one for the 14th July --

Q. Okay.

A. *(unclear)*.

Q. So it's likely that first entry is not yours; that's the previous clinician.

A. *(The witness nodded)*.

Q. The date there, you're not able to say why that date is not correct.

A. No.

Q. I'll read to you your entry, and that's 14 July, you say:

"[VC] is a 28 year old man experiencing early psychosis. He was previously admitted on Rowan 1 ward and was discharged in June to his flat. He has had input from his CPN and community doctors post-discharge. He was detained on Section 136 following making attempts to get into neighbours apartments, he appears to be

responding to Auditory hallucination. [VC] seemed to be responding to unseen stimuli. Acted suspicious of all activities. [VC] is a student at Nottingham University studying Mechanical Engineering. He lives on his own in block of flats. He is currently single. His parents live in Wales. He has no past history of mental health difficulties. He has no past history of illicit substance use or forensic history.

"[VC] was arrested by the police for criminal damage (kicked a door in of another flat). The police were called for burglary but they found [VC] who resides in group of flat.

"... no history of violence or aggression.

"[He] has been hearing voices and believes his mother was in the flat that he was trying to get in to, had a lack of sleep during the past week and has been feeling the pressure from his studies. Not eating and drinking well from his own admission."

Now, we spoke earlier, you were aware by this point of those two incidents in May.

A. Yes.

Q. Reference there to:

"... no past history of mental health difficulties".

And no history of violence and aggression. VC did have both of those, didn't he?

A. He did.
Q. Forensic history, when you refer to:
"He has no past history of illicit substance use or forensic history".
Can you assist us with what you mean there?
A. So forensic history, where there has been previously admitted to a forensic environment in the past. That was what I meant.
Q. We've also seen, in relation to this very incident on RiO, reference to VC forcing his way in and having to be restrained. Not just kicking in a door.
Looking at this now, the reference to he has no past history of mental health difficulties, looking at no history of violence or aggression, that's not only lacking in detail, but that's also wrong, isn't it?
A. Yes, I understand that was an error for me. It should have reflected that he had history of violence and aggression in the risk assessment.
Q. Thank you. If we go back to the RiO notes, please, that's NHFT0000168, and we're going to go to page 59, we're just returning now to the chronology. Halfway down the page, 14 July, 11.57, there's an entry from yourself:
"[VC] was transferred to Rowan 1 at [11.20 pm]... He was escorted by three staff members without issues.

His section documents and flat keys [were] ... handed over to the nurse in charge."
So that's the end of this particular matter for yourself, is it?
A. Yes.
Q. We'll move on, then, in the chronology. We're going to VC's third admission and that was 3 September 2021, so over a year later. This followed the assault on PC Pritchard and we've heard a lot about that. If we could please turn to page 164, I'll take you again chronologically through the RiO notes.
It's the bottom of the page, please. 3 September 2021, 7.22 pm, Cassidy Suite Section 135. So I think this is written by a colleague of yours; is that right?
A. Yes.
Q. "T[elephone]/C[all] from Dr Manzar who has gone to execute Section 135 at [VC's] house. [VC] has been reported to be settled at first and was responding well to the assessing team however he refused them entry to his house and they had to call the police officers. Four officers attended and [VC] was aggressive towards them, they had to call for more support and several officers attended however he continued to be aggressive. He was tasered twice but to no avail. Police had to use

[pepper] ... spray. [VC] was then taken to the [emergency department] for medical assessment and will be transferred to Cassidy when he is deemed to be medically fit."
Then if we go to the top of the next page, 8.05. This is the entry from the Street Triage Team and it provides more detail on what occurred in relation to the police officer. It says:
"We were in the vicinity of [VC's] home ... when an emergency shout for support went out from Officers on scene executing the S[ection]135 warrant, dictating that they were being assaulted and needed extra support.
"When we arrived Officers had deployed the Taser twice and also Pava Gas to subdue [VC] due to him punching an Officer with significant force 3 times in the face ... attempting to assault other Officers on numerous occasions. [VC] was not complying with any instruction or de-escalation techniques. Officers had to use leg restraints to remove [VC] from the address due to further attempted assaults."
Skipping that paragraph, we'll go to the next paragraph. It says:
"Officers wanted to know if [VC] could be charged due to the serious nature of the assault with the Officer likely needing Hospital treatment."

When you first became aware of this matter, were you aware, looking at these notes or otherwise, that there was a pretty serious assault on a police officer that had occurred?
A. Yes, I was given handover.
Q. And then if we look at the entry below 8.07, Cassidy Suite, 8.30 pm:
"[VC had] arrived ... with 5 police officers."
Is it usual for somebody to arrive with five officers or is that a significant number for you?
A. That's quite a significant number.
Q. And is that itself an indication of somebody presenting a serious risk to others?
A. Yes.
Q. If we scroll down to 9.34, please, there's an entry that says:
"Previously informed by consultant in charge of patient's care that this patient's [Mental Health Act]... assessment was done with full restraint team present due to the physical assault on the police officers during arrest.
"His advice was not to see/examine without restraint team if I do not feel safe. Restrain team no longer present."
Were you aware of a specialist team being present

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. Previously, yes.

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

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

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

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

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

expected that July incident to have been identified here?

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

Q. So let's start with the first in time, and that's 14 July. That second paragraph, it says:

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

[VC] did not gain entry or harm anyone but he was kicking the door."

We had seen from the July entry that in fact VC tried to gain entry and tried to push past the resident; do you recall that?

A. Yes.

Q. So looking at this, that particular entry is wrong there, isn't it?

A. Yeah, there's an error in there.

Q. Then it says:

"Prior to previous admission [VC] was involved in a similar incident whereby he entered into another resident's flat whilst experiencing distressing auditory hallucinations. The woman that resided in the flat jumped out of the window due to being frightened, she injured herself severely and needed surgery on her back.

"No further incidents of violence or aggression towards others, [VC] is usually a very polite and gentle personable young man."

Do you know where that form of words came from?

A. No.

Q. We've seen similar words used by Claudia Birtles following a home visit. Do you have any understanding of that at all?

A. What did you say? Say that again, please?

Q. Claudia Birtles and Gary Carter visited VC's home and I think has used similar words to that on a RiO entry. Are you able to assist us at all with who is likely to have written that paragraph, that says that:

"[VC] is ... very polite and gentle personable young man"?

A. I'm not sure who has written that paragraph.

Q. Then if we go to the entry below, so the next in time, 31 August, it says:

"[VC] appears to be relapsing. Appears quite suspicious/paranoid, little bit confrontational although no evidence of any aggression. [VC] has stopped treatment ... abruptly, unsure when he stopped although suspect that it was a lot longer than 3 days ago (which is [what he had] ...said)."

Then I'll take you now to the top entry and I think you've said you're confident you entered that top entry.

A. I think so, yes.

Q. It says:

"[VC] had gone into a neighbour's flat who was staying above him, knocked at his door to confront him as to why he was discussing him as he had heard voices to that effect and he was certain that it was this person living above his flat responsible. He barged into the persons flat and wanted the person to admit

what he was doing, and other neighbours came to the rescue and called police.

"[VC] is known to services with a diagnosis of psychosis. Historically when unwell he has force[d] entry into his neighbours houses under the influence of his psychotic experiences, though no violence has resulted. He has had two admissions last year.

"He continued to experience auditory hallucinations and fixated on persecutory ideas relating to the government."

That isn't the September incident, is it?

A. No, um ...

Q. I mean, that might be some information about the July incident. We've just heard about what the September incident involved, the assault on the police officer. That can't be found anywhere in these details, can it?

A. I can't recall why that was not reflected in this assessment, which should have been.

Q. That 3 September entry in fact says, "though no violence has resulted", I mean, that's quite the opposite of the situation, isn't it --

A. Yes.

Q. -- now we're in September. Severe violence had been used on a police officer, hadn't it?

A. Yes.

Q. Can you assist us with why there are repeated references to "no violence having resulted", "no further incidents of violence or aggression"? Why the level of violence and level of aggression of VC doesn't seem to be reflected here?

A. I've previously said, should have been reflected. It may have been documented on the RiO entry rather than just in the risk and safety assessment. However, it should have been clearly documented on the assessment as well.

Q. Yes, I mean, it should have been because, as you said earlier, this Risk and Safety Assessment is quite an important document --

A. *(The witness nodded)*.

Q. -- upon which VC's risk to others is assessed; is that right?

A. Yes.

Q. It's not only lacking in detail but once again, it's wrong, isn't it?

A. Yes.

Q. Then if we go over, please, to page 4, there's another section "Risk formulation", and I'll just read to you again some significant paragraphs there:

"[VC] is a 30-year-old gentleman known to services with a diagnosis of psychosis. Historically when unwell

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

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

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

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

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

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

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

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

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

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

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

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

"Risk of further deterioration of mental state."

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

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

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

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

words.

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

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

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

A. Yes.

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. We see the entry below. It says:

"Explained that ..."

This a conversation with VC's mother:

"Explained that [he's] ... the seclusion room. Staff on the ward is not feeling safe to go into seclusion room as patient is unpredictable. She seems to understand this".

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

stage?
A. Yeah, I spoke to -- I think I spoke to his mother and explained that the reason why he couldn't have his phone to make a call at the time.
Q. The entry above says that "the team felt it was unsafe at present" to allow him to use his telephone.
Was that something you would have communicated to VC's mother?
A. Yes.
Q. I'm going to move on now, then, to the fourth admission. That's 28 January 2022. We know that this relates to -- there was first an incident where the flatmate Christopher was put in a headlock. He wasn't allowed to leave. That was 15 January. And then VC was detained couple of weeks later, 28 January. If we could have a look at those notes, which are at page 214.
We see this is an entry from Dr Lomas. If we scroll over the page, please. It sets out there in the "Background" section it says that:
"[VC had] held his flatmates hostage, though details ... [weren't] clear."
It says that:
"At each visit the engagement has been superficial, and on at least one occasion he was believed to be witnessed spitting medication from his mouth and putting

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

accommodation, he denied that he went and stated that he is unsure of why someone would give false information about his whereabouts. He was informed that his leave is currently suspended until there are clearer information as to where he went on the day".
What do you recall of your conversation with VC at this time?
A. So my conversation was what I documented regarding his whereabouts on the day.
Q. Were any checks carried out about whether he was telling the truth or not?
A. I'm not entirely sure, because on this -- during this admission, I think that was the only contact that I had with him at the time, because I usually don't work on the ward where he was admitted. I think this was on Redwood 1 Ward, and the reason why I've gone there on that particular day was because we were sent from the Cassidy Suite over to cover on the ward because there was no patient on the suite. So I'm not entirely sure if this was followed up afterwards, because I don't think I saw him again after, after -- I mean on this admission.
Q. There's an entry there "Spent time on his phone". That's presumably now, because he was on that other ward --

A. Yes.
Q. -- he had free access to his phone. Are you aware of anyone looking at what he was doing on the phone in light of that allegation from the university?
A. No, I'm not aware.
Q. Then very finally, I just want to ask you about your reflections. We've seen quite a few forms now that were not accurately completed. What do you understand the duty to be on you in respect of the keeping of accurate records?
A. So my duty is to ensure that all the information that I do document are as accurate as possible. In my normal practice now, I make sure that I cross-check things that I've written and documented, and also I've realised that the *(unclear)* completion as to updating the risk assessment, and creating one.
So my usual practice now is to create one rather than updating it, so to avoid confusion as to which clinician has done what and which clinician has not done what. So that's my learning through the process.
Q. Do you think you had been provided with sufficient training at the time?
A. Yes.
Q. You had been provided with sufficient training?
A. Yeah, I was provided, yes.

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

entirely sure if it's -- if it's an error that reoccurs a lot within every(?) nurses, I'm not entirely sure.
Q. Have you gone back to look at previous cases that you've been involved in to see if you've had the same errors in different cases, and it may have caused risk to other patients?
A. I've not been looking at every patient that I've been in contact with in terms of going back to check what I've done at the time, but from the last few years I've been going back when I do do my risk assessment, I cross-check and take my time to read through it to ensure that all the information are accurate.
Q. Has somebody from the Trust, somebody senior, spoken to you about what went wrong here?
A. Yes. Yes.
MR BLAKE: Thank you.
Chair, I don't have any further questions. There are further questions.
THE CHAIR: Yes, Mr Blake. Thank you.
Mr Moloney? Ms Cartwright?
MR BLAKE: Mr Beer.
THE CHAIR: Mr Beer.

Questioned by MR BEER

Q. Good afternoon. You know that I ask questions on behalf of the Trust. I want to ask you some questions about

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

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

but it should be highlighted as historical.
Q. Is that, in fact, good practice, to refer back to previous events in the current assessment of risk and the current risk formulation?
A. I think so. It just give a more of continuation and more understanding of the patterns that the patient has been -- the way the patient has had their patterns as to what they've been doing in the past.
Q. But leaving the past assessment of risk, essentially copying and pasting it, although that has advantages, it also carries disadvantages; do you agree?
A. Yes.
Q. It has the advantage of recording accurately what the previous assessment of risk was?
A. Yes.
Q. But the disadvantages include that it shouldn't be presented in a way that it suggests that it's the current reflection of the position; do you agree?
A. I agree.
Q. It shouldn't be presented in a way which fails to reflect any updated information?
A. Yes.
Q. Can we just use your first interaction with VC, that on 14 July 2020, as an example. You've explained that you were required to complete a Risk and Safety Assessment

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

Thank you. And if we look at -- we can see this is -- if we go to page 4, please. We can see that there's the entry on 14 July 2020, which is recorded, as you've told us, by you. And that the previous entry, although it's misdated, is a reference back to his previous admission, back in May 2020. Yes?
A. Yes.
Q. Can we look at the May 2020 version of this form, please, at the same time, and that's NHFT0000197. If we go to page 4 -- so if we look at page 1 first, sorry, we can see this is 24 May 2020, in fact I think completed by Annette Palmer.

If we go to page 4, please, and look at the equivalent entry, the "Risk Formulation". Do you see the words beginning "[VC] is a student at Nottingham University" on the left-hand side?
A. Yes.
Q. Then on the right-hand side, do you see, in relation to the highlighted entry, five lines in, "[VC] is a student at Nottingham University studying mechanical engineering", yes?
A. Yes.

Q. Does it follow -- and you'll see that it's word for word the same as it carries on, in relation to the section on the left, down to "who reside in a group of flat", to your entry on the right-hand side: "who resides in a group of flat".
A. Yes.
Q. So it includes a typo missing out the "s", yes?
A. Yes.
Q. Then on the left-hand side, Annette Palmer has written "no history of violence or aggression", and you've left that in which is obviously incorrect, isn't it?
A. Yes.
Q. Then "[he's] ... been hearing voices" down to "own admission", again, word for word the same; do you see that?
A. Yes.
Q. So you have effectively left in, or cut and pasted, as part of an entry on 14 July, something that was correct back on 24 May 2020, yes?
A. Yes.
Q. You've explained that it's good practice, or usual practice, to refer to the past assessment of risk in the current assessment of risk, but that's not what you've done here, is it?
A. No.

Q. You've included it as if it's part of the current assessment of risk.
A. Yes.
Q. Can you help us as to why or how this might have happened? Is it pressure of time? Is it need to get to the next patient? Is it your caseload? Is it the need to do other work on Cassidy? What has led to this mistake being made? And I'm using it as an example.
A. I'm not -- I can't remember as to how the shift was on the day or how, if it was very busy or not busy. But yeah, I'm not -- I can't recall.
Q. So you can't say exactly what it was that caused you to make this mistake.
A. I understand that it's an error from myself, but I can't recall whether it's because of how busy the ward was at the time, or what the situation was at the time.
MR BEER: Thank you very much. That's all I ask.
THE CHAIR: Thank you.

Questioned by THE CHAIR

THE CHAIR: Can I just ask about the RiO system. I think you've said that it populated the letters itself, and produced a letter -- it generated a letter itself, and this was back in 2021. Is that almost like an AI letter or how did that happen?
A. No, it's not an AI letter. So if -- there's a place

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

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

A. It fill its in.

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

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

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

A. Yes.

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

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

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

was already there?

A. So if it's still relevant, you can leave it in. However, if it's not, we can edit it.

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

A. Sorry, can you repeat that question?

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

A. *(The witness nodded)*.

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

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

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

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

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

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

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

THE CHAIR: Right. Thank you.

Yes, so we'll --

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

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

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

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

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

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

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

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

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

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

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

THE CHAIR: Yes, thank you very much.

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

break today and we'll come back at 1.30. Thank you.

(12.29 pm)

(The short adjournment)

I N D E X