

Monday, 27 April 2026

1
2 (1.30 pm)
3 **THE CHAIR:** Yes, Ms Langdale.
4 **MS LANGDALE:** May I call, please, Dr Manzar.
5 **DR OMAR MANZAR (sworn)**
6 **Questioned by MS LANGDALE**
7 **THE CHAIR:** Yes.
8 **MS LANGDALE:** Dr Manzar, you have provided a statement to
9 the Inquiry dated 17 December 2025. Can you confirm
10 that the contents are true and accurate as far as you're
11 concerned?
12 **A.** Yes, it is correct.
13 **Q.** Can you tell us about your background in psychiatry and
14 your professional relationship with the Trust?
15 **A.** I am a qualified medical practitioner. I finished by
16 medical degree in 1985. Following completion of my
17 initial housework or house job, and associated training,
18 I worked as a physician approved. Came -- when I came
19 to UK, I have completed my PLAB exam, back in 2003, and
20 joined the old SHO training scheme between 2004 and
21 2006.
22 Following those completion of those training, I have
23 worked for a year as a staff grade. I have then
24 returned back to training for a short period. Then in
25 2014, I have completed my membership exam. I have then

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1 establish whether there is a need for detention for that
2 person in hospital setting and also consider the risk
3 associated with those presentation.
4 **Q.** What do you do when you're conducting a Section 12
5 assessment in terms of learning something about the
6 person first?
7 **A.** The general sort of rule is that before embarking on
8 such assessment, as a practitioner I should look around
9 and gather information from available sources. In
10 day-to-day practice, this happens as such that AMHP, the
11 Approved Mental Health Practitioner, contacts me and
12 provides me the bulk of information and cases, and then
13 whenever I'm near the Trust computer I do look at the
14 information available in front of me.
15 **Q.** The RiO notes?
16 **A.** The RiO notes, yeah. On the occasion when those
17 information are not straight away available to me,
18 I tend to sort of gather the information from the
19 practitioner who is attending the mental health
20 assessment with me. Rather, if I am in, for example, in
21 case of safety such as Cassidy Suite or Acorn Suite,
22 I do tend to get information from the staff.
23 **Q.** When you say practitioner, do you mean the other doctor?
24 **A.** Absolutely.
25 **Q.** What does that doctor usually have that you don't have,

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1 entered a higher training courses and I have completed
2 my CCT, both in general adult and older psychiatry
3 around 2018.
4 I joined the Trust in 2018, and since then have been
5 working as a part-time consultant in old age psychiatry.
6 **Q.** In old age psychiatry?
7 **A.** That's correct, yes, but also I dual trained both in
8 general and old age.
9 In terms of professional background and
10 qualification, I have obtained a diploma from Royal
11 College of Physicians of Ireland back in 2008. I have
12 also obtained a Diploma in General Psychiatry from
13 University of Cardiff in 2020. I have associated
14 certificates in medical education obtained from Edge
15 Hill University and also medical and leadership
16 certificate from University of Manchester.
17 **Q.** So you have continued to work part-time for the Trust in
18 your consultant role and you also conduct independent
19 work as a Section 12 Approved Doctor. Can you tell us
20 what the role of a Section 12 Approved Doctor is?
21 **A.** The role of Section 12 Approved Doctor is to making sure
22 when a medical practitioner in that role is attending a
23 Mental Health Act assessment ensuring that if there is
24 evidence of mental disorder, the doctor should be able
25 to formulate those illness, establish the illness and

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1 coming along to do a Section 12 when you don't know the
2 patient?
3 **A.** The normal practice is they are -- approved mental
4 health practitioner usually contacting the first doctor
5 who is familiar with the patients, has got previous
6 acquaintance with the patients. They usually also
7 contact someone who probably know patient very well from
8 the service, such as the local mental health team, it
9 might well be that someone from the Crisis Team, usually
10 they are senior doctors at the level of consultants.
11 **Q.** You tell us at paragraph 23 of your statement:
12 "On average, I usually undertake at least two
13 assessments per week."
14 By the time you assessed VC in July 2020, how many
15 assessments roughly do you think you would have
16 conducted?
17 **A.** This is the minimum number. Obviously it varies, it can
18 go up to eight, ten. I would say probably in hundreds.
19 But, generally speaking, I probably have done in
20 thousands. So yeah, so roughly --
21 **Q.** A lot?
22 **A.** Yeah, probably a rough, yeah, rough figures.
23 **Q.** Paragraph 27, you tell us about CPD activities you've
24 participated in:
25 "... includ[ing] completing relevant [Mental Health

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1 Act] legislation courses, [and] keeping updated with
2 local and national guidelines, and referring to the
3 [Mental Health Act] Code of Practice for queries and
4 guidance."

5 Arising from that training and activities, how do
6 you understand the least restrictive option and
7 maximising independence operates when you're conducting
8 an assessment?

9 **A.** As per Code of Practice, the Mental Health Act
10 legislations clearly states before you decide that
11 someone is deemed detainable to hospital setting, you
12 should explore the least restrictive principles, and the
13 least restrictive principle is if you could deliver that
14 service to the persons in the community near to the
15 person's home, near to the person's family when they
16 have support, but also should you consider that the
17 risks associated with that, whether that is feasible.
18 So you need to take those into consideration.

19 **Q.** And you tell us at paragraph 40:

20 "This can be challenging as it carries tension
21 between patient autonomy and public protection."

22 How do you say that tension can be resolved?

23 **A.** I mean it is more to do with the risk assessment. So
24 you have to have that risk assessment in front of you.
25 You have to balance those in the lights of if the least

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1 informations between the Mental Health Act
2 practitioners, the AMHP, and the police. There tend to
3 be sort of a discussions and I guess in most of those
4 cases information tend to be exchanged in the right
5 manners.

6 **Q.** It tends to be, did you say?

7 **A.** Usually, usually.

8 **Q.** But it's verbal information that passes between the
9 mental health professional and the police who are
10 present.

11 **A.** That's true. That's true.

12 **Q.** The police who are present aren't necessarily those who
13 would know about the previous incidents in relation to
14 the patient, are they? They're not necessarily the same
15 officers.

16 **A.** Well, there are time when police are actually aware of
17 the persons from the previous time when they have seen
18 the persons in the community. So I guess they are aware
19 of the person's presentations, risk associated with that
20 persons. So yes, if the person is known to the police
21 before, yes, there are generally -- it should be known
22 information.

23 **Q.** Do you rely in your risk assessment to some extent on
24 what the police say has happened and how serious it is?

25 **A.** Yes. If this information has been shared with us, yes,

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1 restrictive option is considered, if the patient is gone
2 to the community with the care and treatment, if this
3 risk subsequently could be contained by a team?

4 Normally when you say -- when we say that a person
5 is considered to be treated in the community, in those
6 kind of Mental Health Act assessments usually we have
7 a team, like a Crisis Team or LMHT, and usually we do
8 tend to think about their inputs and their involvement
9 and their capability to (a) to be able to support the
10 person.

11 **Q.** And to manage risk?

12 **A.** To manage risk, yeah.

13 **Q.** To understand how a risk can be managed, you need to
14 have a clear understanding of that risk, don't you?

15 **A.** Yes.

16 **Q.** A clear factual background.

17 **A.** Yes.

18 **Q.** In, as we're going to come, cases such as this, where
19 you need information from the police, as well, to
20 understand that factual background, do you think the
21 system works well or badly?

22 **A.** I mean generally, in instance when I do attend a Mental
23 Health Act Assessment in the community, for example,
24 a 135 warrant, there is usually police available, and
25 most of the time there are a general exchange of

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1 and vice versa as well. We do also tend to exchange
2 those information and what we know, most of the time
3 AMHP is the lead person in those kind of scenarios
4 because AMHPs tend to get the bulk of informations
5 before they call doctors, like myself, in a position of
6 Section 12 Approved Doctor.

7 **Q.** If the police do not charge a suspect, the suspect being
8 your patient, if they don't charge them with a relevant
9 criminal matter, does that influence you about how
10 significant that event is in the context of the criminal
11 justice system?

12 **A.** I guess the caveat to that is that if a person is not
13 charged by the police, that assumption would be
14 superficially without looking in details that the crime
15 has not been so serious or the offence that is not been
16 so serious. On the other hand, if the police tell us
17 that the person has been seen and the person has been on
18 bail, then at least we have some fair idea about what
19 has led to do those offences in the first place, and
20 what *remit* is there with us, as a mental health service
21 what we can do.

22 But this is for me, as an Approved Section 12
23 Doctor, I have to balance those when I'm conducting my
24 Mental Health Act Assessment.

25 **Q.** And you would think it was more serious, the offence or

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1 the action of a patient, if they were on bail and they'd
 2 been charged with something?
 3 **A.** I mean generally yes, that would be, yeah, something
 4 that you need to be considered carefully, yes.
 5 **Q.** When do you refer to forensic services?
 6 **A.** I mean as Section 12 Approved Doctors, to be honest with
 7 you, all those years of -- I have done Mental Health Act
 8 Assessment, not myself as Section 12 Approved Doctors,
 9 I've referred someone straight away to the forensic
 10 service. However, saying so, in most of this assessment
 11 I have been supported by someone from the mental service
 12 work for the Trust, in most instances there's been
 13 either local mental health team who know the patient
 14 very well, the patient has been attached to their
 15 service, they have got CPN care coordinators,
 16 consultants and the rest of the team with the Crisis
 17 Team, similar the same thing. And if the patient is
 18 compelled to hospital, for detention and that will be
 19 within the remit of the inpatient service to -- to make
 20 those referrals appropriate to the service.
 21 **Q.** You say at paragraph 43 of your statement:
 22 "As a clinician and in line with the [Mental
 23 Capacity Act], I presume that adults have capacity
 24 unless proved otherwise."
 25 Can I ask you this: if a patient believes they are

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1 still can detain the persons. Yeah, that have to be
 2 fulfilled within the criteria, statutory criteria set
 3 out clearly in the Mental Health Code of Practice, for
 4 Section 2 and Section 3.
 5 **Q.** You assessed VC in your capacity as a Section 12 Doctor
 6 in July, didn't you, the 14 July 2020? If we can have,
 7 please, NHFT0000037, page 11 and 12 on the screen, while
 8 we're getting that, Dr Manzar, you tell us in your
 9 statement this was the first time you'd be involved in
 10 an assessment with VC and you spoke with the AMHP
 11 preceding the assessment and you also had access to his
 12 RiO notes; is that right?
 13 **A.** That's correct.
 14 **Q.** How much time do you have to do that, to look at the
 15 AMHP material and the RiO notes?
 16 **A.** With regards to those specific Mental Health Act
 17 assessment I have conducted, this is quite long period
 18 of time. So normally the general practice would be that
 19 I just go scroll by the notes, I do usually tend to
 20 start from clinical -- from medical entries. That RiO
 21 has got that options when you put -- tick the medical
 22 sort of entries. Usually bringing all the doctors who
 23 have been documented, their informations when they have
 24 seen VC before.
 25 So that's the normal sort of -- I mean, I give

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1 not mentally ill, and there's absolutely no need for
 2 them to take treatment or antipsychotic treatment, in
 3 your view, are they likely to be able to have capacity
 4 to make a decision about treatment?
 5 **A.** When the issue of capacity comes with someone who's
 6 psychotic, a persons who doesn't believe he or she is
 7 suffering from a mental disorder, doesn't believe that
 8 they need medication, doesn't believe that they need
 9 hospitalisation, care and treatment, I think the
 10 presumption would be that the persons would not have the
 11 capacity, but you have to go through the capacity
 12 elements with the person to understand that the persons
 13 understand the informations, the person retained the
 14 information, the person is able to weigh, use and weigh
 15 the information, and whether the person can communicate
 16 it back to you.
 17 **Q.** Would the fact that they really did not consider they
 18 were unwell and that mental health professionals were
 19 causing them to be unwell, be a significant factor for
 20 you, assessing that issue?
 21 **A.** Yes, because the capacity is a core issue when
 22 conducting that Mental Health Act assessment, but it
 23 does not exclude or make you to think that the person
 24 doesn't need to be detained -- doesn't need to be
 25 detained. I mean a person is lacking capacity, you

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1 a general answer, but that would be the normal practice
 2 for me, to look at those information. Then if there is
 3 sufficient time and there's no press of time in terms of
 4 time wise, I would try to gather as much information as
 5 I could do from the RiO.
 6 **Q.** About ten lines up from the bottom of that box on the
 7 right, you record:
 8 "... his presentation appeared to be in line with
 9 a relapse of his psychotic disorder, possibly a
 10 schizophrenia in nature."
 11 Were you aware that, in July 2020, Dr Seedat had
 12 recorded in the RiO notes "likely schizophrenia"?
 13 **A.** Yes, I was aware. But for me also, as a Section 12
 14 Approved Doctor, when I see a person as well, I have to
 15 make sure that I am satisfied with the conditions the
 16 person has presented at that time, though psychotic
 17 disorder is, as a general broad terms, which is in --
 18 can include schizophrenia, but is also, depending on how
 19 I see Valdo at that point and I'm not in disagreement
 20 that he didn't have schizophrenia but at that point
 21 that's what I recorded: that he was suffering from
 22 psychotic disorder.
 23 **Q.** You say:
 24 "He seems to be lacking capacity to make an informed
 25 decision about his care."

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1 Why did you arrive at that view? What had you asked
2 about?

3 **A.** I think generally when I spoke with him at that point,
4 he did not, from what I remember, he did not acknowledge
5 that he was suffering from a mental disorder. And
6 I didn't think -- so, clearly acknowledged that he would
7 need care and treatment.

8 So based on those informations and the level he
9 engaged with me, I can't remember the in and out of
10 those sort of full discussion I had with him, I formed
11 my mind that he was lacking capacity to make decision
12 about his care and what I mean by his care is
13 specifically admission to hospital, agreeing to take
14 medications and agreeing to be -- thank you.

15 **Q.** Do take a drink when you need one.

16 **A.** Thank you. And agree to accept care and treatment.

17 **Q.** You say here:

18 "He appeared not to be using any illegal substances
19 ..."

20 That was just before the bit where it says:

21 "... and his presentation appeared to be in line
22 with a relapse."

23 Why do you say he appeared not to be using any
24 illegal substances?

25 **A.** From what I remember, I think I did ask him. I may be

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1 Practice and also quite clear from sort of our daily
2 practice, that if someone is under influence, you should
3 not assess that person under the Mental Health Act.

4 It's difficult for me to comment why other doctors
5 in any specific time with relation to VC has not done
6 any blood tests, they have not offered any UDS urine
7 drug screening. So I'm unable, I'm afraid, to comment
8 on those.

9 **Q.** You say he was refusing an informal admission. You say
10 that at the end of the box on the right. Was that
11 because he didn't think he was unwell?

12 **A.** Sorry, could you repeat that?

13 **Q.** He was not -- he was refusing an informal admission.

14 You record there he was refusing an informal admission?

15 **A.** That's true.

16 **Q.** Why was that?

17 **A.** I think there was quite clear from the conversation
18 I had with him that he didn't believe that he was
19 mentally unwell and I guess, if he felt that he was
20 mentally unwell, why you should accept an informal
21 admission.

22 **Q.** You tell us in your statement that the nature of his
23 hallucinations, they were distressing and intrusive.
24 Did you know what they were?

25 **A.** From this particular assessment, I didn't see it was

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1 wrong, but I didn't believe that he was at that point
2 under influence of any drugs because his conversation
3 didn't come across as someone who may have taken drugs
4 or alcohol, because that's more of a clinical judgement
5 when you see someone.

6 This is an objective sort of examination, obviously,
7 you still have to have tests done, someone's urine has
8 been tested for presence of drugs or for alcohol been
9 breathalysed.

10 I didn't have that feeling at that point when I saw
11 him that he would have been taking drugs or using drugs.

12 **Q.** There is no time when VC's bloods are taken that they
13 are tested for illegal drugs, not on 23 May, when he
14 presented at A&E, and ambulance staff were querying
15 whether he'd taken drugs. So there's no blood tests at
16 all. Are there any circumstances, as a doctor, that you
17 would request tests for illegal substances in
18 a psychotic patient?

19 **A.** I mean, I have to talk in this occasion with my position
20 as a Section 12 Approved Doctor. If I thought in that
21 situation when I saw him on 14 July 2020 that he was
22 under influence of drugs, he was displaying the manner
23 or a behaviour consistent with someone being under the
24 influence, I would actually not embark on that
25 assessment because it is quite clear from Code of

14

1 clearly stated in a manner that applied that he was
2 distressed because of A, B, C. I think generally he
3 gave me a general sense that he was hearing voices and
4 he was distressed. I can't remember the full details
5 from my memory what it was apart from what has been
6 written in the medical recommendation.

7 **Q.** Did you know that he had assaulted a flatmate on 5 July,
8 somebody he was living with and that flatmate had called
9 the police? Did you know about that when you were doing
10 this?

11 **A.** On 5 July?

12 **Q.** Yes. I'm not asking you about the January assessment;
13 I'm asking you about the July one. Did you know that
14 had happened in July?

15 **A.** In 5th July, from memory I wasn't aware, but I was aware
16 of the assault previously to this, in May, in 2020,
17 which led up to initial arrest and subsequent detention
18 under the Mental Health Act.

19 **Q.** What did you think that happened in the assault in May?

20 **A.** The assault in May was in relations to -- the first one
21 was in relation to him being breaking into a flat and
22 the first episodes. And the second one was in relation
23 to him entering a property, in response to hearing
24 voices that his family member was in danger.

25 **Q.** Can we have, please, NHFT0000168, page 58. You had done

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1 your recommendation in advance, hadn't you, for this
 2 assessment?
 3 **A.** That's true.
 4 **Q.** Is that unusual?
 5 **A.** That's not unusual, no.
 6 **Q.** Why does that sometimes happen, then?
 7 **A.** Well, most of the time with this Mental Health Act
 8 Assessment, when the AMHP do ring the practitioner,
 9 sometimes it's very difficult to marry those times
 10 between the practitioner. There are time they -- one
 11 practitioner do tend to see the patients themselves, and
 12 then the AMHP organise another Approved Mental Health
 13 Practitioner to see the patients.

14 On that particular occasion Dr Seedat was not
 15 immediately available to be conducting that assessment
 16 with me, so I have seen VC on my own.

17 **Q.** If we look at this note of the assessment, Dr Seedat and
 18 Geoff Culpin, we see at paragraph 4:

19 "It was clear from today[s] assessment ... he had
 20 decided to stop taking his medication 2 weeks after his
 21 discharge from hospital. He believed he was well, he
 22 did not have mental health problems and he would be
 23 fine. For 2 weeks he had started to hear voices, the
 24 voices were in the 3rd person and for the most part were
 25 derogatory in nature. He was convinced this was the

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1 page 11, you recommend Section 3 admission, detention,
 2 and you certify your opinion at the front on page 11:

3 "... suffering from mental disorder [and] ...
 4 "... it is necessary for the patient's own health.
 5 "... for the patient's own safety.

6 And you also tick:

7 "... for the protection of other persons".

8 You haven't included more information regarding the
 9 circumstances leading to the detention or the risk he
 10 was to other persons. Is there a reason why you haven't
 11 done that?

12 **A.** I guess when you are saying for protection of others,
 13 this was quite clear from the presentation he presented
 14 at that time. I guess sometime is very difficult to
 15 include all the informations in a Mental Health Act
 16 paper, but clearly I think from my knowledge and
 17 understanding that I completed those paper, that he was
 18 posing risk to public.

19 **Q.** And similarly, you haven't elaborated on his degree of
 20 compliance with medication, have you, or the problems
 21 there?

22 **A.** If I go back, sorry, to the page --

23 **Q.** Yes, of course. Page 12.

24 **A.** And your question was that about medication?

25 **Q.** Yes, about medication compliance and the need for

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1 doing of his nextdoor neighbour and went to confront
 2 him. He was unclear how this person was able to do
 3 this."

4 So were you aware of the event immediately preceding
 5 this assessment on 14 July, that he'd gone round to
 6 confront a neighbour in these circumstances?

7 **A.** I'm sorry, could you repeat that?

8 **Q.** Did you know -- if you look at this paragraph 4 -- did
 9 you know about this event: that he'd gone round before
 10 this assessment to confront a neighbour?

11 **A.** I was aware from -- what I was aware that he -- the
 12 night before, when the police had detained him, he had
 13 broke into, or forced his way to a flat, and that's what
 14 I was aware. I wasn't fully aware of the incidents
 15 around the 5th July.

16 **Q.** And further down in this page, it says:

17 "He said the right things that he ... made a stake
 18 [that must mean 'mistake'] not taking his meds, he would
 19 now take them but he still was not convinced he was
 20 unwell nor did he feel he needed to be in hospital."

21 That's similar to the information that you'd
 22 gathered: that he didn't want an informal admission,
 23 didn't need to be there.

24 **A.** That's true.

25 **Q.** If we go back to your recommendation please NHFT0000037,

18

1 treatment around medication.

2 **A.** I said: "He is not compliant with his medication." I
 3 have to mention:

4 "His mood, affect & presentation fluctuate & he is
 5 not compliant with his medication."

6 **Q.** You tell us in paragraph 117 of your statement to the
 7 Inquiry:

8 "My recommendation for detention under s[ection] 3
 9 was made because, at the time of my assessment,
 10 I believed he required a further period of inpatient
 11 treatment in a hospital setting for stabilisation of his
 12 mental health and review of his medication. His
 13 symptoms were of a nature and degree that necessitated
 14 continued treatment under the [Mental Health Act] in
 15 a hospital setting."

16 Why was it necessary in a hospital setting?

17 **A.** I guess because the level of risk at that point, (a),
 18 and (b), I think from what I remember, he was seen by
 19 the Community Mental Health Team prior to this
 20 assessment. I think he was not compliant with his
 21 medications, and I guess the only way for him that he
 22 could take medication were to be in hospital, and the
 23 hospital setting provide those kind of facilities for
 24 him to take medication.

25 **Q.** Can we have on the screen, please -- that can go down --

20

1 NHFT0000168, page 21. When you looked at the RiO notes
2 before seeing him, did you see this entry by Dr Seedat
3 on 3 June?

4 NHFT0000168, page 21. That top box can perhaps be
5 enlarged. There's a summary of text message
6 conversations between VC and his brother from late March
7 to May. Did you read this and the texts that Dr Seedat
8 records? We can see at the fourth paragraph, it's being
9 reported in the text, in this -- these notes, rather,
10 that:

11 "[VC] said people would not mock him in person and
12 made some remark to wanting to hurt these people he was
13 hearing.

14 "He said he believed there were people here who were
15 monitoring him and has been ... for weeks.

16 "He asked his brother if there was technology/AI
17 that could map his thoughts ...

18 "... he was hearing voices ... believed ... he was
19 being watched ... in [another] ... room."

20 Did you read this document?

21 A. I can't recall whether I did read this documents, just
22 because of the passage of time gone by, so it's
23 difficult for me to comment, just because of the time
24 how long it's been since then.

25 Q. Would you be interested in assessing risk to understand
21

1 privately to his brother and saying how he feels, and he
2 says:

3 "Because I think ... they're watching I know ...
4 I can break their heads with my hands."

5 If we go to page 17:

6 "That previous night I felt immense anguish,
7 paranoia, anger, hatred.

8 "Couldn't sleep, had the darkest thoughts of could
9 imagine.

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

11 If we go over the page, page 18:

12 "I was thinking about red rum not 120 minutes ago."

13 Do you know what "red rum" means?

14 A. Sorry, could you repeat that?

15 Q. Red rum. If you read that message, look at the one
16 that's highlighted --

17 A. Yes.

18 Q. "I was thinking about red rum not 120 minutes ago."

19 Would that make you think of anything, that sentence?

20 A. Yes, absolutely. Yeah, absolutely.

21 Q. What does that mean? What would that suggest to you, if
22 you saw that?

23 A. Well, that would suggest a significant violent intent,
24 or behaviour associated with that.

25 Q. So in terms of understanding risk, do you think this
23

1 what the patient had written along these lines about if
2 they wanted to hurt permanently, or anything else like
3 that?

4 A. Well, it's of course it's relevant. This is quite
5 significant, yes.

6 Q. He had written text messages referring to: "Wanting to
7 break their heads with my hands", "having the darkest
8 thoughts could of imagined" and feeling "immense anger
9 and hatred".

10 There was a whole series of text messages that
11 Dr Seedat was able to review. Would you have liked to
12 have seen those text messages in looking at risk and
13 trying to understand the patient more?

14 A. As I said, I can't remember the full details of this,
15 because of the passage of time has gone by, and that's
16 my honest answer, because sometimes you can't remember
17 things you have seen. And again, I'm not in a position
18 to say "Yes, exactly I have seen this", but equally
19 I don't deny that whether I don't see this one or I have
20 seen it.

21 Q. Just to be clear, Dr Manzar, you didn't see the document
22 I'm referring to -- perhaps we can have it on the
23 screen, NGPF0002527 -- because it was never in the
24 notes. So, for example, if we go to that document at
25 page 14, these are messages where VC is speaking
22

1 should have been shared with other doctors who were
2 either assessing or considering risk in respect of VC?

3 A. Yeah, absolutely.

4 Q. Why do you say "absolutely"?

5 A. Just because risk assessment is part and parcel of every
6 assessment. When patient is presenting to that degree
7 of violence and aggressive behaviour, then the other
8 clinicians should be aware, because especially in the
9 context of Mental Health Act Assessments or any other
10 sort of support you want to offer, you should be aware
11 of those risks, with that remit.

12 Q. That can come down, please. Can we have NHFT0000168,
13 page 164. You are then involved again in September,
14 aren't you, 2 September?

15 A. Yeah.

16 Q. We see at page 164 a note made by Jen Shaw, the AMHP.
17 You, and Dr Lomas and Jen Shaw attending VC's property
18 and there was no answer. Why were you going to the
19 property? Why were you going to the property on this --

20 A. Yeah, so this was -- sorry, I couldn't hear you -- it
21 was in response to a 135 warrant has been obtained from
22 the court in order for VC to be brought to hospital to
23 a place of safety for assessment.

24 Q. You formed the opinion:

25 "... it seemed likely that [VC] ... [had] left the
24

1 property in anticipation of being assessed ..."

2 You thought he'd left because he didn't want to be

3 assessed; is that right?

4 **A.** Yeah, this is -- yeah, this is -- yeah, that's right,

5 yeah.

6 **Q.** The plan was to go back on the 3rd, wasn't it?

7 **A.** Yes.

8 **Q.** Can you tell us -- and if it helps you we can have on

9 the screen your statement, which is WITN0350001, page 30

10 and 31. If we have page 30 and 31 on the screen, if it

11 helps, Dr Manzar, because it was some time ago, when you

12 first encountered VC he was standing outside his flat:

13 "A short while after, a car pulled over beside us."

14 What did he say to you? What happened then?

15 **A.** Actually, when we went to execute that warrant on that

16 particular day, when we were successful finally to

17 manage to see VC, we were congregating outside his flat,

18 not immediately to the flat, but a few steps away. To

19 the vicinity of a courtyard. So I was standing there

20 with my colleagues, Dr Lomas and Amie, when a car pulled

21 over.

22 And I forgot the question, but that was the time

23 when I saw VC. If you could repeat.

24 **Q.** Just tell us what happened.

25 **A.** Yeah. So when he came, obviously we have seen a car

25

1 to happen." And he was quite resolute with that

2 conviction, that he didn't want to see anyone.

3 **Q.** So the police were called to assist?

4 **A.** That's correct.

5 **Q.** The police are very important, aren't they, for mental

6 health professionals in a situation like this?

7 **A.** Yes.

8 **Q.** Because what would you do if they weren't there and you

9 had their assistance: you wouldn't persist, presumably?

10 **A.** I mean, the Section 135 warrant is needed for the police

11 to be present and also for the Approved Mental Health

12 Practitioners and AMHP. I guess, yes, it is true, yeah,

13 the police has to be present, yeah, and the risk could

14 not be contained otherwise.

15 **Q.** We have seen the body-worn video footage of what

16 happened and the attack, but you were there, what do you

17 remember about that?

18 **A.** I think it's what happened initially when we went even

19 to doorstep, and from what I remember, he allowed

20 Dr Lomas to enter the little corridor adjacent to his

21 bedroom or the flat. But then he stopped us from

22 entering the property and he was quite clear and stating

23 that he doesn't want to see us.

24 And I think from what I remember, Dr Lomas has

25 explained to him that the reason why we are here,

27

1 pulled over, he lowered the windows and he asked some

2 questions "Why you are here?" I can't remember the

3 exact wording, or "What are you doing here?"

4 I think then Dr Lomas has said -- Dr Lomas has

5 stepped in to say, "We are here" or something along the

6 line, I can't remember the exact wording, but apply that

7 to him, "Are you VC? Are you the person?" If I'm right

8 and I can remember correctly. And then what happened is

9 he just disappeared for a short period. He parked his

10 car and he came on foot.

11 When he came on foot, the first thing he said, he

12 turns to me and says, "Are you Dr Manzar?" And by that

13 point I was a little bit frightened, scared "What do you

14 mean by me, Dr Manzar?" So I suppose he's not going to

15 have a rant at me or, I said, "Yes, I am" and then

16 I think Dr Lomas has taken over the conversation. I

17 can't remember his word by word what has happened.

18 I think we followed him to the flat, and there we

19 explained, I think Amie explained from what I remember,

20 and Dr Lomas as well, the reason why we are there.

21 **Q.** He said that the assessment wasn't going to take place,

22 he didn't want the assessment, did he?

23 **A.** Exactly, yeah. I think the word I remember quite

24 clearly -- I think the wording probably I remember

25 clearly because he said, "This assessment is not going

26

1 because of this concern about his mental health.

2 I think Amie, from probably what I remembered, also

3 explained things on the same line. I can't remember the

4 exact wording, but it's a general sort of thing when the

5 AMHP introduced the reason for why we are here.

6 And I think the next things we say to him that if he

7 doesn't comply to this assessment, obviously police will

8 be called. And he said, "Let that process happens."

9 **Q.** Let that process happen?

10 **A.** Yeah.

11 **Q.** So the police did come, and what happened then?

12 **A.** I can't remember how long later the police came. When

13 the police came, again a similar process has happened.

14 We knock on the flat door. I think Amie, if I can

15 remember correctly, and Dr Lomas and the police followed

16 off the road. I was there sort of joining the team.

17 And, again, the same conversation started again, to say

18 that "The team is here to assess you, and there is

19 concern about your mental health."

20 **Q.** You were outside of the room, weren't you? Could you

21 see what happened?

22 **A.** I think from what I remember, and I couldn't hear

23 clearly, first of all, because there was quite a few

24 people around. I could hear that conversation initially

25 went well. I think all the professional were trying to

28

1 explain the things to him in a very gentle way, and
2 gentle manner that people are concerned about his mental
3 health, and they are worried that "You need to come into
4 hospital for an assessment".

5 But then the things suddenly change, he seemed to
6 become quite violent. There was a significant scuffle
7 between him and the police.

8 **Q.** Scuffle?

9 **A.** Yes, scuffle. A fight. Because from the corner of my
10 eyes I could see he was striking his hand and he was
11 hitting a police officer. I think they tried to cuff
12 him, but he became very aggressive and agitated.

13 **Q.** Did you see VC take his glasses off in preparation for
14 the attack on the officer?

15 **A.** I can't remember, but it may be correct. It's just the
16 passage of time. He may have been.

17 **Q.** Was it an unpredictable event, as far as you were
18 concerned? Did you expect it to happen or it was
19 unpredictable?

20 **A.** I think this was very unpredictable because he wasn't --
21 I mean we do see people in kind of the situation like
22 this, usually there is a warning sign beforehand.
23 I mean a person become wound up, agitated, and it does
24 show some, you know, verbal or non-verbal sign or
25 symptoms of someone becoming violent and aggressive.

29

1 matter ceased after communication with Dr Seedat about
2 VC? You weren't aware of that?

3 **A.** No, I wasn't aware, no.

4 **Q.** Were you ever asked to give a witness statement in
5 relation to this attack on PC Pritchard and the other
6 officers?

7 **A.** No.

8 **Q.** Can we have a look, please, at NOCC0000050, page 3 and
9 this is Amie Staples: the "AMHP report referral and
10 assessment". And this is Ms Staple's description of
11 events in the top of the box:

12 "The police again explained the need to accompany
13 him to hospital. [VC] then stated the male officer
14 should step forward; this officer agreed and offered for
15 [VC] to walk with him to the ambulance ...

16 "... other officers sought to restrain him but
17 couldn't do so and he violently resisted. He managed to
18 obtain the handcuffs and use these to hit the male
19 officer."

20 First of all, do you agree with her description
21 insofar as you can, to those events?

22 **A.** Yes.

23 **Q.** I say "as far as you can" because you were further away,
24 weren't you, behind the --

25 **A.** Yes.

31

1 And I think on this occasion I was quite surprised how
2 he acted in the circumstances then.

3 **Q.** Because he'd been relatively quietly spoken and sounded
4 calm when he was talking to you before?

5 **A.** Yes.

6 **Q.** And did it go from nought to 100, in terms of the
7 ferocity of that?

8 **A.** Yes.

9 **Q.** It was an unprovoked attack, wasn't it, in terms of what
10 the officers were saying, what you'd all been saying?

11 **A.** That's true.

12 **Q.** Were you aware at this time that he was still subject to
13 police investigation in relation to an earlier event
14 when a woman had jumped out of the window to escape him
15 and had caused serious injury to her back?

16 **A.** I can't remember off the top of my head, but I was aware
17 that there was something going around with relation to
18 that past incident, but I wasn't fully aware and I can't
19 remember -- (*overspeaking*) --

20 **Q.** So you can't remember if you knew he'd been offered
21 a caution in 2021 which he'd refused in relation to an
22 earlier event?

23 **A.** Yeah, I wasn't aware, but I was aware of those incidents
24 early on but not.

25 **Q.** And you weren't aware that any development of that

30

1 **Q.** And there were a number of people in the room.

2 **A.** Yes.

3 **Q.** There was a bag of unused medication dating back to
4 February 2021, so that's seven months earlier, dating
5 back. Were you aware that there was that much
6 medication found?

7 **A.** I can't recall that.

8 **Q.** Because that's significant, isn't it: a bag of unused
9 medication dating back months?

10 **A.** Yes, but I wasn't aware of that.

11 **Q.** You had flagged up, in your previous visit, the concern
12 about taking medication and VC needing treatment and
13 medication, and here we have seven months of medication.
14 But you say you didn't know about that at the time.

15 **A.** Sorry, could you repeat that?

16 **Q.** Did you not know that there was that much --
17 (*overspeaking*) --

18 **A.** No, I didn't know. No. I didn't know.

19 **Q.** Can we have look, please, at NHFT0014459, page 7. You
20 subsequently see him, of course, on 3 September. Did
21 you see him with the police, when you did do
22 an assessment?

23 **A.** The actual assessment at the Cassidy Suite? Yes.

24 **Q.** Yes. And if it's not obvious, why was that? Why did
25 you want the police to be there too?

32

1 A. Because of the level of aggression and violence
 2 behaviour he displayed in the previous assessment, so
 3 I was really worried and concerned.
 4 Q. If we go to page 8, please. And you say at the top:
 5 "He' had ... previous detention & admission under
 6 the Mental Health Act. [VC] is open to [local mental
 7 health team & the [Crisis Home Treatment Team] ... at
 8 the moment. He is relapsing ... he is disengaging from
 9 the Mental Health services ... guarded, suspicious,
 10 paranoid ... & expressing auditory hallucination."
 11 And you then say:
 12 "[VC] believes that there are a conspiracy against
 13 him & the voice he hears are a result of technology and
 14 a conspiracy from the Highbury Hospital."
 15 So did you ask him about these voices and what they
 16 were saying?
 17 A. I can't remember the full details of the assessment,
 18 apart from what I've recorded in my medical
 19 recommendation.
 20 Q. And you have record here:
 21 "[VC] is currently paranoid about his neighbours."
 22 Yes?
 23 A. Yes, that's right.
 24 Q. "... poor insight ... lacking capacity to make decisions
 25 about his care."

33

1 regards to those instance, and communicated with them.
 2 Q. You had said "paranoid about his neighbours." That was
 3 your assessment of him, wasn't it?
 4 A. Yeah.
 5 Q. So that would have been very relevant for the University
 6 to know.
 7 A. Yes.
 8 Q. Because of the impact on students, and the risk to them.
 9 A. Yes.
 10 Q. And the risk needed managing, didn't it?
 11 A. That's true.
 12 Q. So whose responsibility was it to formulate the risk at
 13 this time, at the time of the assessment?
 14 A. I mean, in a general sort of, from the Mental Health Act
 15 Assessment point of view, obviously as in a position of
 16 a Section 12 Approved Doctor, when I have attended that
 17 particular assessment, obviously the team accompanied me
 18 was consultant from the Crisis Team, and I believe the
 19 risk formulations as a part of the -- his assessment
 20 would have included in those documentation of his notes,
 21 and the inpatient service I guess should have known as
 22 well that what exactly has happened. Because it's
 23 clearly written in my medical information what has
 24 happened.
 25 Q. It's astonishing that the University didn't know.

35

1 So again, lacking capacity as far as you were
 2 concerned about his care, yes?
 3 A. That's true.
 4 Q. Were you aware, around this time in September '21, that
 5 VC was planning to resume his studies at the University
 6 of Nottingham? He'd had a period of leave and he was
 7 planning to resume his studies there.
 8 A. Can you repeat that sorry, again?
 9 Q. VC was going to go back to university around this time
 10 of these events; in September, he was planning to go
 11 back to his studies. Did you know that?
 12 A. I can't recall.
 13 Q. The University did not know about this assault, that VC
 14 committed against the police officers, and they didn't
 15 know about the detention of VC. They should have known,
 16 shouldn't they --
 17 A. Yes.
 18 Q. -- about both of those things?
 19 A. Yes.
 20 Q. Whose responsibility was it to tell the University about
 21 both of those things?
 22 A. I guess at that point when he was detained, obviously he
 23 went to hospital, it would have been, I would imagine
 24 that is correct the inpatient service, the MDT, they
 25 should have communicated with the University with

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1 A. I suppose so, yeah.
 2 Q. So you agree?
 3 A. I agree, yeah, yeah.
 4 Q. You can't recall VC's presentation now during the
 5 assessment, but you know you jointly decided that
 6 detention under Section 2 was necessary, yes?
 7 A. That's true.
 8 Q. If we go, please, to your witness statement, it can go
 9 on the screen, WITN0350001, page 35. And if we have
 10 page 35 on the screen, please. You say at
 11 paragraph 153:
 12 "From what I can recall, VC's overall presentation
 13 had returned to a similar state as before the scuffle
 14 with the police."
 15 I'm going to challenge the description of "scuffle".
 16 We see VC uses that term later on, but that wasn't
 17 a scuffle, was it? It was an attack. It was a violent
 18 attack, and you described it as an attack on four
 19 officers, actually. That's how you describe it.
 20 A. Yeah, probably I have not used the word correctly, but
 21 what I applied is the significant amount of violence
 22 that he displayed at that point. Maybe not the correct
 23 word to choose.
 24 Q. And if you -- and to be fair, you do say four officers.
 25 In your statement you say -- in your recommendation, you

36

1 say he attacked four officers. So you knew it was
 2 significant, that event.
 3 **A.** That's true, yeah.
 4 **Q.** Here at 153, you say:
 5 "[VC's] language remained assertive, and he appeared
 6 resolute in his conviction that he neither required
 7 hospitalisation, nor any form of medication ... guarded
 8 and reluctant to engage, offering little in the way of
 9 meaningful dialogue about his symptoms or mental state".
 10 Yes?
 11 **A.** That's true.
 12 **Q.** If we go, please, to NHFT0000168, page 167. And we can
 13 have, please, 168 as well next to it. So it's 168, 168.
 14 You record at 168 at the top:
 15 "... highly likely to deteriorate in the community
 16 without treatment, with subsequent social harm and ...
 17 neglect."
 18 So you're referring to the need for treatment here,
 19 aren't you?
 20 **A.** Yes, this is Dr Lomas writing, yes.
 21 **Q.** And if we go to "Discussion" on page 167:
 22 "[VC] appears to be experiencing a relapse of his
 23 psychosis, though we could not establish the full nature
 24 of his psychopathology due to his refusal to discuss
 25 this with us."

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1 immediately stood out; rather, this appeared to be
 2 a repetition of his established pattern of relapse."
 3 Yes?
 4 **A.** That's true, yeah.
 5 **Q.** So why not a Section 3 detention, then? Just go to
 6 Section 3. You had previously suspected schizophrenia.
 7 Nothing here told you that it was completely different
 8 from that, did it? Or needed further assessment?
 9 **A.** I think I would apply -- what I was trying to apply to
 10 this is that yes, he relapsed. He became unwell. He
 11 has -- he had diagnosis of schizophrenia. But at that
 12 particular time, I think my general sort of view was
 13 that I didn't have that opportunity to explore fully his
 14 symptoms and how he presented then. The risk was
 15 completely out of character, not in --
 16 **Q.** The risk was out of character?
 17 **A.** Yeah, just from what he presented very calm and then
 18 suddenly he -- that's the bit that I apply to. And
 19 I know in the past he presented in an aggressive manner,
 20 but at that particular time, when I've seen him from
 21 135 warrant, to a point when I've seen him at the
 22 Cassidy, I was very shocked and surprised.
 23 **Q.** You'd seen him from nought to 100 when he'd appeared
 24 calm, you'd seen that when he attacked the police
 25 officers. So how calm he appeared --

39

1 Why did you say he needed admission for assessment
 2 at this point?
 3 **A.** I think when at the time he presented on that particular
 4 occasion, it surprised me. Giving the previous
 5 presentation when I've seen him at the Cassidy in, in --
 6 on 14th July 2020, this was a very sudden outburst,
 7 I guess, very sudden aggression. I can't remember the
 8 full details of what went in my mind there. I think one
 9 of the things went to my mind whether he has been using
 10 any drugs. The other thing was whether any medications,
 11 the issue was there as such that he -- the medication
 12 didn't work for him. I can't fully recall why this
 13 would have been but those were the few things.
 14 And again, we have not had appropriate -- not a good
 15 time, really, to interview him, because he was just came
 16 at a lot of police and there was a lot of fear into
 17 atmosphere, how did he presented then.
 18 So I guess there was a lot of not in-depth
 19 assessment we had, apart from what we knew that -- what
 20 the headlines were.
 21 **Q.** If we go, please, to your statement, that can come down,
 22 and if we go to WITN0350001, page 41. So we're going to
 23 go to paragraph 174 of your statement at page 41.
 24 "When comparing this presentation with my early
 25 assessment in July 2020, no specific new features

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1 **A.** Exactly, that surprised me as well that why -- how this
 2 has happened, so I wasn't quite sure. As a clinician,
 3 this surprised me that how polite was he just before the
 4 135 warrant, and how did suddenly he become so violent
 5 and aggressive. He wasn't matching and mirroring his
 6 presentation of -- at a time when I've seen him and he
 7 suddenly become so subdued and become quiet.
 8 **Q.** Can we have, please, page 44 and 45 of your statement on
 9 the screen. And if they go next to each other it's the
 10 assessment under Section 2, and the reason for that and
 11 you say under 185:
 12 "My clear recollection is that the immediate
 13 clinical priority was to secure an urgent hospital
 14 admission under the [Mental Health Act], as the
 15 situation necessitated swift containment and assessment.
 16 From my recollection, the detention was primarily
 17 intended to facilitate assessment and short-term
 18 treatment ... This approach was supported by the
 19 historical pattern of responding well to treatment
 20 within a short period, with previous admissions being
 21 brief and often resulting in relatively rapid
 22 stabilisation and discharge."
 23 That is relevant to an inpatient, being
 24 an inpatient, isn't it, that you say there he appeared
 25 to respond well to treatment in hospital when he had to

40

1 make medication, yes?
 2 **A.** Yes, that's true.
 3 **Q.** When someone is in hospital they have to take it.
 4 **A.** That's true.
 5 **Q.** But in the community, the evidence was the reverse,
 6 wasn't it? He wasn't taking his medication.
 7 **A.** That's true.
 8 **Q.** You knew that back in January and it's certainly here
 9 for a long time hadn't been taking medication.
 10 **A.** That's true.
 11 **Q.** And you say at 186:
 12 "... within the [Mental Health Act] Code of
 13 Practice, there is emphasis on the principle of least
 14 restrictive alternative consistent with the patient's
 15 clinical needs and the protection of others."
 16 So when you chose Section 2, instead of Section 3,
 17 did this principle of least restrictive influence that
 18 decision?
 19 **A.** Well, what I tried to apply, obviously both sections are
 20 restrictive in a way. Section 2 is restrictive as
 21 Section 3. But what I applied to this is that most of
 22 the admission he had, that was within a short window of
 23 a few weeks that he had got better and he was
 24 subsequently discharged. That's what I applied to this.
 25 In the matter at least restrictive principle is that

41

1 compelling the persons -- defining a mental disorder and
 2 compelling a person to hospital setting, you have to be
 3 satisfied those criterias is met.
 4 As I said early on, I didn't think the setting
 5 allowed us and (*unclear*) say I was very sort of
 6 confident that I explored every psychopathology from VC
 7 at that point of time. Do I agreeing that, yes, he had
 8 historical diagnosis? He has been in the community. He
 9 was on medication, and so forth. But the bit which has
 10 stood for me that I didn't have that opportunity,
 11 really, to see him because most of the questions was
 12 "yes" or "no", and it was very difficult for me to
 13 conclude with confidence that I would detain him under
 14 Section 3.
 15 **Q.** You say:
 16 "With the benefit of hindsight [at paragraph 191] -
 17 and in light of how events subsequently evolved I can
 18 now see that a detention under s.3 might have been
 19 a more reasonable course of action."
 20 Yes?
 21 **A.** Yes.
 22 **Q.** But even at the time you knew he'd been assessed as
 23 psychotic with a likely diagnosis of schizophrenia since
 24 July 2020, and you knew he wasn't taking his medication,
 25 because he didn't believe he was ill.

43

1 Section 2 is, time wise, less than Section 3.
 2 **Q.** You thought it was in his interests to think of time?
 3 When you say time wise, it was less --
 4 **A.** I mean, just applying back to Code of Practice when
 5 saying when you try to detain a patient, when you're
 6 detaining a persons, and that detention could be -- when
 7 detention is agreed, you have to apply the least
 8 restrictive ways, least time in hospital as far as
 9 possible, and allows you, of course, considering risk,
 10 considering the treatments, and the rest. That would be
 11 the least restrictive principle.
 12 **Q.** You say at the top of the page of 45:
 13 "[You] did not have a complete or definitive
 14 understanding of VC's psychopathology."
 15 He had been admitted before, there would be more
 16 information there, wouldn't there? Just because you
 17 didn't have a great deal of information in that
 18 assessment, didn't mean he was already assessed and
 19 known by mental health services and they had enough
 20 information.
 21 **A.** I think, as approved mental health practitioners, you
 22 know, when you become an approved Section 12 Doctor, you
 23 have to be satisfied with what you see and what you
 24 agree, because the statutory criteria under the Mental
 25 Health Act is stating that when you're defining and

42

1 **A.** What I mean by with the benefit of hindsight -- and this
 2 is obviously after what the events happen, the tragic
 3 events happen and everyone would say I wish this and
 4 this could have happened in that time -- but the benefit
 5 of hindsight should not conflate with the fact that at
 6 that moment of time, my opinion was that he needed to be
 7 in hospital (a) for an urgent containment of the risk,
 8 (b) for an urgent assessment of his symptoms, and
 9 treatment of his mental disorder.
 10 **Q.** That can come down, please. Can we have NOCC0000038,
 11 page 3, this is a document from Cygnet in Darlington,
 12 where he subsequently went, and he's being asked about
 13 the events when he's attacked the police officer. And
 14 if we look halfway down the page, he said:
 15 "[VC] stated it was 'due to an altercation with
 16 hospital staff who came to my home uninvited after I had
 17 gone to Highbury to ask about my care plan and not been
 18 able to see anyone. I didn't feel like talking as I'd
 19 just finished a 12 hour shift."
 20 He says in the paragraph after that, he was:
 21 "... asked if there was anything that could have
 22 avoided the incident. [VC said] 'if it had been put to
 23 me in another way'.
 24 So he's suggesting that the way the mental health
 25 professionals or the police put to him what they were

44

1 doing, he shouldn't have done it like that. It should
 2 have been put in another way. Do you follow?
 3 **A.** Sorry, if I could read just back a bit.
 4 **Q.** Take the time to read it.
 5 **A.** Yeah, that was from 24.09.21?
 6 **Q.** It's him talking about the September incident when he
 7 attacked the police, and when he's asked: "Could
 8 anything different have happened?" He says: "If they
 9 had put it a different way" if they had said it
 10 differently.
 11 **A.** I'm not quite sure what he meant by this. Different
 12 way -- to put in different way -- mean to explain the
 13 Mental Act procedure different 25 warrant? Yeah, but
 14 from what I recall, I think every professional were very
 15 courteous, were very polite. I think the explanation
 16 has been given to him in full details. And I can't see
 17 anything that, no one has said something that -- to him,
 18 and with regards that he need to come into hospital
 19 immediately without being giving any explanation.
 20 It was quite clear explanation from the AMHPs to
 21 say, "Look, a warrant has been obtained from the Code in
 22 view to that he need to be removed to place of safety,
 23 because of a reason because there is concern about his
 24 mental health".
 25 **Q.** He says:

45

1 **A.** Yes.
 2 **Q.** If we put pages 4 and 5 on the screen, please. We see
 3 on page 4 on the left, Ellie Turner from the University
 4 Mental Health Team:
 5 "[She] ... advised there were risks regarding [VC]
 6 being at his property waiting for an assessment ...
 7 other students were not at the property, however this
 8 was temporary as they need to be back home so they can
 9 study for exams. Ellie wanted an update on the progress
 10 of the day."
 11 What did you understand had happened in his flat?
 12 **A.** My understanding at that point was that there was some
 13 disagreement with VC and his flatmate over some kind of
 14 housework, cleaning, rota, and there was some -- that
 15 disagreement resulted in him being aggressive towards
 16 the flatmate.
 17 **Q.** And if we look on the page 5, second paragraph, we see
 18 VC giving that description:
 19 "Through prompting [VC] described the events with
 20 flatmate as ... an altercation between housemates
 21 regarding the rota for the bathroom cleaning. [VC]
 22 stated this was initially a verbal altercation that did
 23 become physical in a '40 second scuffle'. [VC] states
 24 he normally gets along with this person ... does not
 25 have any ill feelings towards him at the moment ...

47

1 "It was poor judgement on my behalf, I didn't feel
 2 like talking ... I felt frustrated I was being forced
 3 into custody when I had done nothing wrong."
 4 That's why he says that happened, yes?

5 **A.** Yes.6 **MS LANGDALE:** Chair, I wonder if that's a good time for the
7 15-minute break.8 **THE CHAIR:** Yes, we'll take a break now until 3.00. Thank
9 you.10 **(2.42 pm)**11 **(A short break)**12 **(3.00 pm)**13 **MS LANGDALE:** Dr Manzar, you were involved again in January,
14 weren't you, January 19.15 **A.** That's correct.16 **Q.** And we know by way of background that VC is disengaging
17 with the EIP team, and also they have been sent a report
18 from the University of him assaulting a flatmate,
19 another flatmate in January.20 Did you know about the assault of the flatmate in
21 January?22 **A.** I was aware of the assault.23 **Q.** If we go, please, to NOCC0000040, page 5. This is
24 a Report for Referral and Assessment on 19 January 2022,
25 prepared by Roseanna Crane.

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1 [VC] stated he had been taking his medication as
2 prescribed."

3 Did you find out what had happened in fact?

4 **A.** At that point of my assessment, this was all the
5 information I had. I didn't have no further
6 information.7 **Q.** Surely it was essential to have further information
8 about this event when you made this decision?9 **A.** Yes.10 **Q.** So why didn't you obtain it?11 **A.** If I can take you a little back to what exactly has --
12 I have been involved and how did this came to me to see
13 him subsequently after Section 135 warrant has been
14 executed, what information I have exactly, what
15 information has been here produced in this AMHP report.
16 When you arrive to the vicinity of the University, if
17 I am -- if I can recall the events correctly, we were
18 sort of accompanied by three police officers, and
19 I think from that point onward I was uncomfortable, the
20 reason why because I have seen VC before, and I had
21 a great degree of anxiety about how this may have
22 escalates, he might escalate the same manner. I did
23 speak from what I remember with all my honest answer,
24 I spoke with the police officer. I can't remember the,
25 you know, nitty gritty or the full details I had with

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1 the discussion I had with the police. When information
2 was exchanged and spoke with AMPH, she was there and
3 they gives the information. If I'm not losing the
4 questions you're asking me -- so I didn't get anything
5 else apart from what I knew that point and what has been
6 recorded in this AMHPs report.

7 **Q.** What's recorded in the report at the top of page 5 is as
8 you've just said: you felt uncomfortable without police
9 presence. So you wanted the police there,
10 understandably, for your protection, yes? Potentially
11 for your protection doing the assessment?

12 **A.** I think for protection of everyone.

13 **Q.** Everyone, sure.

14 **A.** Yeah, yeah.

15 **Q.** So weren't you interested to know exactly what did
16 happen to his flatmate? You knew he was someone to be
17 a bit worried about, you were worried about being with
18 him.

19 **A.** Exactly, but the information was given to me at that
20 point was what has been said, and those information were
21 that there was disagreement and scuffle between him and
22 his flatmate.

23 **Q.** Have you ever seen now, with the Inquiry, the video
24 footage of what happened to his flatmate and that VC
25 held him in a headlock for some time? Have you seen

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1 **A.** I can't remember the full conversation at that point,
2 but as I said, most of this information was shared prior
3 to executing the section 315 warrant and the subsequent
4 assessment which take place at the Cassidy Suite, but
5 nothing more than that I knew at that point.

6 **Q.** Yes, at this point, if we go to page 7, we see again the
7 repetition of VC's version of events. You see at
8 page 7:

9 "[VC] stated the altercation with the flatmate was
10 a normal interaction with peers over household tasks.
11 [VC] declined an informal admission. [VC] had capacity
12 to consent to a community plan. Although the risks in
13 the community are still there, it was view of the
14 assessing team that the least restrictive solution could
15 be support from the crisis team for medication
16 concordance and further monitoring of his mental
17 health."

18 It looks, if we go back to page 5, if we can, 6 and
19 7 can come off the screen, underneath "Professionals
20 discussion" on page 5:

21 "All professionals agreed [VC] could benefit from
22 a hospital admission. Dr Manzar and Dr Skelton advised
23 that they felt the community plan was most suitable
24 based on the interview, [and] balanced ... with VC being
25 in the middle of his exam period."

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1 that?

2 **A.** This is my -- yes, this is the --

3 **Q.** You've seen it now?

4 **A.** I've seen it now but I wasn't aware at that point.

5 **Q.** Sure, and have you seen how he prevents two of the two
6 flatmates leaving? Stays by the door, VC stays by the
7 door and doesn't let them go out. Have you seen that --

8 **A.** Yeah.

9 **Q.** -- video?

10 **A.** Yes.

11 **Q.** How would you describe that level of intimidation and
12 aggression now, having seen it?

13 **A.** I would say that was significant.

14 **Q.** So there was significant information that you did not
15 have, doing this assessment, wasn't there?

16 **A.** No, I didn't have the information, no.

17 **Q.** But you agree it was significant about the risk he posed
18 to the public?

19 **A.** Yes.

20 **Q.** You should have had it?

21 **A.** No one has shared this information with me at that
22 point.

23 **Q.** Did you ask for more information when you heard what he
24 said about it, what VC said about it? Or did you just
25 accept what he said about it?

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1 So this was January, he had exams. What were you
2 concerned about?

3 **A.** I think it could be helpful if I could explain a little
4 bit more because this is not my report.

5 The issue around offering an informal admission,
6 with all honesty, I can't remember how did it came
7 (unclear), but I guess, from the time when we have seen
8 him and conveyed him to the hospital, the Cassidy Suite,
9 the degree of violence or aggression, I expected that to
10 again happen the same like it happen in September -- in
11 the previous -- sorry, in the --

12 **Q.** In the September?

13 **A.** Yeah, it was September, yeah. I was -- I wasn't -- I
14 wasn't quite sure but what -- as he came, my honest
15 answer was I was thinking: I'm going to detain VC,
16 because there was no doubt in my mind when those
17 informations, you know, produced to me when he said he's
18 not compliant with the medications, there's a risk he
19 has been having an altercation with his flatmate. But
20 when we came to Cassidy Suite and we interviewed him,
21 first of all the interview was led by a Consultant
22 Psychiatrist who was directly overseeing the Crisis
23 Team. The majority of the discussion and conversation
24 has been led by Dr Skelton, and with every questioning,
25 I could not see anything else coming out right now in

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1 terms of how he -- he was giving explanation in term of
2 what exactly has happened.

3 I think if I am right -- and reading from the AMHP
4 report -- I can't put in perspective at what point we
5 offered informal admission to him, and this is my honest
6 answer.

7 **Q.** Leaving aside -- forget informal admission, in terms of
8 managing risk of violence, how did the decision manage
9 that risk?

10 **A.** I mean, the Crisis Team was -- Dr Skelton was quite
11 certain that this just could be mitigated in the
12 community, with giving -- the team would see him on
13 regular basis, offer him medication, care and support,
14 and the contingency plan which was agreed at that point
15 was: should he disengage from the team, not accept
16 medication, risk escalates, he will be called to
17 hospital.

18 **Q.** You had noted previously he was a risk to his
19 neighbours. You remember the last assessment we looked
20 at? You had recorded that: "... he is a risk to his
21 neighbours". His paranoia made him a risk to his
22 neighbours. Do you remember that?

23 **A.** That's true.

24 **Q.** He had, according to VC, had an altercation with his
25 flatmate. If you had investigated that further, you

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1 **A.** Could you repeat again, please?

2 **Q.** When you discussed him being in the community --

3 **A.** Yeah.

4 **Q.** -- VC liked that idea. That's what he wanted, didn't
5 he? So he discussed that with you quite happily.

6 **A.** I guess so. It was his wishes to be treated in the
7 community, but also another point of argument that the
8 Crisis Team was quite resolute that this risk could be
9 mitigated in the community with increased support from
10 the Crisis Team at that point of time. They offered him
11 aripiprazole there on the Cassidy Suite which he took,
12 20 milligrams from what I recall, and they offered him
13 also a plan where to be seen. From what I remember,
14 I think the issue was something around the accommodation
15 itself and he was wished to be seen somewhere apart from
16 the accommodations.

17 I think, based on those evidence at that time, based
18 on that agreement, those opinion has been formed: that
19 he could be managed in the community with the Crisis
20 Team.

21 **Q.** Dr Skelton will be asked the same questions. He was
22 there as well. But you had seen, in September, what
23 happened when something arose that VC did not like. You
24 had seen how he'd attacked the police officer when he
25 did not want to do what was being suggested. You saw

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1 would see that was not an altercation; it was

2 a significant event of intimidation and aggression. You
3 agree with that?

4 **A.** Yes.

5 **Q.** Yet the decision was made at this time, between
6 Dr Skelton and yourself, that that risk of aggression,
7 intimidation, risk to neighbours of violence, could be
8 managed in the community without any plan for
9 managing it?

10 **A.** I mean, my honest answer is that yes, as Section 12
11 Approved Doctor, I attended that, and my role was to
12 provide my independent opinions in term of detention
13 criteria under the Mental Health Act. Of course I have
14 to take those risks into account, but as the discussion
15 progressed from the point we brought VC, and everything
16 that is discussed with him and he agreed that he will
17 do A, B, C, I think based on that, the plan evolve from
18 that discussion that community treatment is still viable
19 option.

20 Dr Skelton was quite confident and reassured -- and
21 assured that this risk could be safely managed in the
22 community.

23 **Q.** When you were discussing management in the community
24 with him, that was what he wanted, and he discussed it
25 with you and was fine, wasn't he, discussing it?

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1 that yourself.

2 **A.** I have seen that, yes. And I, as I said, I was quite
3 surprised what exactly has happened at that point, what
4 has driven that behaviour from being very calm to being
5 very aggressive.

6 **Q.** You were being told in this assessment that there was
7 another occasion where there had been violence or
8 intimidation. Did that not make you think: this is
9 a real risk?

10 **A.** I mean for sure, the risk was there, and for sure, it's
11 made me very curious, and that was exactly as I said
12 from the point even when the police came, I was really
13 worried about his presentation. But during those
14 subsequent assessments, which was I think more than
15 a good 45 minutes and an hour, the reassurance has been
16 given by him and accepted by Dr Skelton and myself
17 because I have also contributed towards the deliberation
18 of those assessments stating: okay, if he's saying that
19 the Crisis Team can support those risks in the community
20 with contingency plan, yes, we'll have to go for that.

21 And I wasn't -- I wasn't thinking about what else
22 could have been happening then; there was some
23 information that the student has been moved, although
24 I didn't think they had been moved permanently; they had
25 been moved because they were being sent home to do their

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1 study from their home. But obviously the subsequent
 2 conversations which took place after that, that was
 3 completely a different matter.

4 **Q.** Well, if we look at 168, page 206 and 211 next to each
 5 other on the screen. So NHFT0000168, page 206 and 211.
 6 We see, after the decision on the 19th, Ellie Turner
 7 contacts from the University asking to move forward,
 8 saying he's:

9 "... due to be kicked-out of students accommodation
 10 residence due to risk to others (hostage taking), other
 11 students have been moved to temporary accommodation but
 12 they need to return."

13 You knew that then, that other students had had to
 14 move out of the flat, did you?

15 **A.** Yes.

16 **Q.** That's not right, is it, that they had to move out, not
 17 him?

18 **A.** Yes, that's true.

19 **Q.** If you look at 211, she's asked by Dr Skelton to attend
 20 a review and she says she doesn't think there'd be
 21 a benefit in that. And she says:

22 "... [VC] has already been asked to leave his
 23 accommodation because if the hostage taking behaviours
 24 are as a result of mental illnesses then he is deemed to
 25 be too unwell to live there with others and if not then

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1 "[VC] did not believe he was mentally unwell ...
 2 continued to question why he was at Highbury when he was
 3 doing what was expected of him. Dr Lomas again
 4 explained that he has been seen by at least seven
 5 different professionals in the past 9 days and 5 of them
 6 could not be certain that he had taken his medication."
 7 So once again, just as you had known in your first
 8 assessment some time back, he was not taking his
 9 medication, was he?

10 **A.** Yes. If I could explain a little bit more on the
 11 previous time, when we have assessed him, much of the
 12 informations came after I left the assessment. So
 13 I think there was discussion between -- from --
 14 retrospectively if you know -- between Dr Skelton and
 15 Ellie from the Nottingham University. That bit I am not
 16 aware exactly what has happened. So with my all honest
 17 answer, I was only aware of what has happened partially,
 18 that there was some safety net in terms of the students
 19 were not there temporarily --

20 **Q.** So you talk about the 19 January, you thought there was
 21 a safety net then, not now, the 25th, and then on the
 22 19th?

23 **A.** Yes.

24 **Q.** Because they'd moved out?

25 **A.** Yes, that's true. Then, when the community treatment

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1 he is breaching his contract so either way he needs to
 2 leave."

3 So that was the position from the University --

4 **A.** Sorry to interrupt. Could you point me to which page it
 5 was?

6 **Q.** See the box at page 211 just where the arrow is. So --

7 **A.** Sorry, with your permission, sorry to interrupt. Could
 8 I take a couple of minutes to read this?

9 **Q.** Of course. *(Pause)*

10 **A.** Yes. I did read. Thank you, yeah.

11 **Q.** So that can come down. And what we know is that he
 12 doesn't take his medication in the community and there
 13 are concerns raising by Eleanor Turner, and then there
 14 is another Mental Health Act Assessment on 28 January.

15 So can we have NOCC0000043. It could be five zeros
 16 43, and pages 4 and 5. This is the AMHP's note, June
 17 Modern. And again, this is you, isn't it, conducting
 18 this assessment?

19 **A.** Yes.

20 **Q.** We see page 5. This time [VC] agreed to go to Highbury
 21 for a Mental Health Act Assessment with you, yes?

22 You can see page 5 at the top. We can highlight it.
 23 It's the very top paragraph of page 5.

24 **A.** Yes. That's correct.

25 **Q.** We can see at paragraph 3:

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1 plan failed, that bit is, of course, here. If I'm
 2 right, I'm referring to this here now.

3 **Q.** That's right. It had failed and that's why you're doing
 4 this assessment.

5 **A.** Yes, that's correct. Thank you.

6 **Q.** Can we go please to NHFT0000070, page 8. This is your
 7 assessment on 28 January and your recommendation. You
 8 say, lines 3 and 4:

9 "The nature of illness is one of psychotic disorder
 10 it is remitting and relapsing condition." *(As read)*

11 What did you mean by that?

12 **A.** I mean, generally over a period of time, there was
 13 a time he remitted in his symptoms, psychotic symptoms,
 14 and there were time when he relapsed and became unwell.

15 **Q.** Further down you say: "Very suspicious and paranoid."
 16 Yes?

17 **A.** Yeah.

18 **Q.** You say at the bottom:

19 "[VC] is meeting detention criteria under Section 2
 20 ... for a period of inpatient assessment."

21 **A.** Yes.

22 **Q.** If we go over the page to page 10, whose writing is this
 23 at page 10; is that yours?

24 **A.** This is Dr Lomas.

25 **Q.** Dr Lomas's. Dr Lomas records:

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1 "[VC] presents as possibly experiencing psychosis.
 2 He has behaved threateningly to his flatmates ...
 3 guarded or superficial in his interaction with
 4 healthcare [about him] ...
 5 "Attempts at further assessment have been
 6 unsuccessful in the community."
 7 So once again, Section 2 assessment rather than
 8 Section 3 treatment is recommended. Why do you say
 9 Section 2 at this point when it's clear he needs
 10 medication and treatment?
 11 **A.** Just to explain a little bit further from before he came
 12 to the place of safety, he -- when the Section 135
 13 warrant was executed, I wasn't in that warrant present.
 14 My colleague Dr Lomas has attended that warrant. And he
 15 voluntarily came to the place of safety.
 16 From what I remember during that presentation,
 17 during that time, apart from seeing him that he has been
 18 guarded, perhaps, and suspicious, which over the years
 19 of his presentation, that was how knowledge we have that
 20 VC has presented to all these years.
 21 I don't think I have found symptom -- the risk is
 22 yes, but the symptom-wise, I could not find any clear
 23 psychopathology to explain that, to find out, and during
 24 that assessment as clearly documented by Dr Lomas that
 25 after days of admissions when he settled, he become more

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1 Was that how it was explained to him, by the way?
 2 **A.** I can't remember word by word, but I suppose I've got no
 3 doubt that this is not accurate. I think he would have
 4 explained this in the manner that has been written in
 5 this record.
 6 **Q.** That can come down, please, and if we can have
 7 TCLT0000818, page 14. It's the level 2 comprehensive
 8 investigation report by the Trust. Learning point 3:
 9 "... whether Section 2 or 3 ... should have been
 10 used."
 11 That sets out -- I'm not going to take you through
 12 them -- the reasons why the Section 2 detention was an
 13 incorrect decision. Do you agree with that or not?
 14 **A.** I think with the benefit of hindsight, if you were, as
 15 I mention in my statement, if you are not going to
 16 diverted by the lack of clear psychopathology at that
 17 point, I would say yes, Section 3 would have been
 18 a better outcome.
 19 **Q.** Page 15, as well, if we put that alongside it.
 20 "... the detention was required for the health and
 21 safety of VC as well as the protection of others."
 22 It's the protection of others, there was no plan,
 23 was there, no management plan for risks in the community
 24 towards others, towards his neighbours, towards other
 25 students?

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1 open, talking about his symptom presentation.
 2 I think based on that and based how I have seen him
 3 then, I wasn't confident that what kind of treatment
 4 plan I could put, because I wasn't entirely sure about
 5 this symptoms at that point.
 6 **Q.** So were you, when you say "possibly experiencing
 7 psychosis", did you observe any symptoms of psychosis in
 8 this assessment?
 9 **A.** I mean he was guarded and I was suspicious, and from
 10 what I remember I couldn't see floridly that he was
 11 responding to unseen stimulus, he was saying things
 12 underline that suspect me that he was experiencing
 13 significant psychotic symptom at that point.
 14 **Q.** If we can have, please, your statement on the screen,
 15 that can come down, WITN0350001, page 64, during this
 16 Mental Health Act Assessment you did raise depot
 17 medication with him, didn't you?
 18 **A.** Dr Lomas explained that, yes, explained that.
 19 **Q.** So "Dr Lomas" -- we'll have it on the screen --
 20 "... suggested ... he have a long acting injection
 21 if he was happy to take the medication - ... explained
 22 patient [who] ... work with secrete or palm
 23 [medications] frequently, or will not take them orally,
 24 and this assures clinicians ... there are no issues with
 25 concordance."

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1 **A.** I think, given the fact that I so worried about him at
 2 that point that I detained him under Section 2, is that
 3 mean I still compelled him to hospital, to be in
 4 hospital. Yes, as I said early on in my evidence, that
 5 the benefit of hindsight should not conflate with the
 6 fact that what we decided at that point and what we
 7 agreed at that point, but the issue was that -- I mean,
 8 still with Section 2, you still can enforce medication,
 9 you can still give medication, you can still give the
 10 person psychotic medication.
 11 Probably I was myself I was not quite clear in terms
 12 of a clear treatment plan at that point. To detain him
 13 under Section 2, my honest thoughts was at that point,
 14 is that aripiprazole is working; yes, depot and
 15 psychotic medication has been discussed.
 16 As a clinician myself, I mean clinician,
 17 psychiatrist, have got different preferences about
 18 antipsychotic choices. Aripiprazole wouldn't be one of
 19 my best choices when I see someone who may present quite
 20 markedly agitated and aggressive at one point, someone
 21 who may not be sleeping very well. I would rather
 22 choose something completely different than aripiprazole.
 23 That is my personal experiences and my personal
 24 preferences.
 25 Do I have clear evidence that someone has got heart

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1 problems? Someone is diabetic, someone is having weight
2 issues and metabolic symptoms, then I would choose
3 aripiprazole. I am just speaking in a position within
4 shoe of someone in position of Section 12 Approved
5 Doctor.

6 So I wasn't quite clear about the treatment plan,
7 something I wasn't confident.

8 **Q.** What about whether you were confident in your own
9 assessment. You say you want evidence, evidence of
10 physical conditions when you're looking for them. What
11 about evidence about risk here, evidence to know what
12 has happened between students and VC?

13 **A.** I --

14 **Q.** -- (*overspeaking*) -- Why didn't you go looking for that?

15 **A.** Sure. I mean, I absolutely agree. That's why
16 I detained him under Section 2: for protection of
17 others.

18 **Q.** Can we have please WITN0155033, page 32 and 33 alongside
19 each other. This is a report from the CQC on the same
20 point about VC being detained under Section 2.

21 We see at the bottom:

22 "For his fourth admission ... VC was detained under
23 section 2 of the [Mental Health Act]. While section 2
24 is usually used if the person is not known to mental
25 health services, or has not been assessed in hospital

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1 considering whatever they felt was necessary for
2 a further period of treatment in the community, in terms
3 of restrict -- more restrictions for putting him on the
4 CTO.

5 I asked -- stated early on that at that point of
6 time, the general agreement and general consensus was
7 that, you know, because of the psychopathology was not
8 clear because even I think at that point, not myself,
9 I think probably the team was feeling whether he is
10 really unwell at the moment, and I think that's an
11 opportunity for me, as a position of Section 12 Approved
12 Doctor, made me to think Section 2.

13 But obviously I'm not talking about benefit of
14 hindsight. I'm not here to convince that, you know,
15 that I'm not here to prove that why I say it was wrong
16 in my statement as a reflection, but I tried to say at
17 that point of time what was thought to be the framework
18 of registration -- legislation to compel him to hospital
19 for protection of others and further assess him, and the
20 team have to take appropriate steps.

21 **Q.** The least restrictive option; was that relevant too?

22 **A.** I think it was more of my honest answer is not the least
23 restrictive, yes, this is something often comes with
24 Section 2, but I don't think solely that was, I think
25 was also a --

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1 before, it can also be used in cases where they are
2 known to services but have not been assessed for
3 a considerable time.

4 "By this point, VC was known to have a diagnosis of
5 paranoid schizophrenia, as well as being non-compliant
6 with medicine in the community and that he was a risk to
7 others when he was relapsing. Given this information,
8 it could be considered a missed opportunity not to
9 detain him under Section 3. Detaining individuals under
10 Section 3 provides additional powers under the [Mental
11 Health Act] including discharge onto a community
12 treatment order ... This may have provided a practical
13 framework to use depot medicine in the community,
14 although the decision not to use depot at this point was
15 also a missed opportunity."

16 Do you agree with that?

17 **A.** Yes, but I want to also to highlight that when you --
18 when someone is detained under Section 2 -- and first of
19 all you cannot detain someone for under Section 3, by
20 virtue of that person has to be immediately going to
21 CTO. This is wrong. You have to look at the necessity
22 and the reason for CTO consideration. I absolutely
23 agree that CTO was not going to happen after Section 2,
24 but there was opportunity for the inpatient service to
25 look at Section 3 detention following this, and

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1 **Q.** Sorry, I missed that.

2 **A.** It was not solely the least restrictive --

3 **Q.** Not solely, but it was a factor.

4 **A.** Not solely. Yes, yes, a factor, but it was other as
5 well about the treatment which I already stated about
6 the treatment plan was not clear in my head, how that
7 would look like, despite it's been discussed this has
8 been depot or this has been, you know, treatment but, as
9 I said, I wasn't clear in my head what kind of treatment
10 plan would be there.

11 **Q.** Finally, if we could have your witness statement,
12 WITN0350001, page 77, you were asked, as everyone has
13 been, to suggest any recommendations in respect of
14 relevant issues. And we see at paragraph 328a:

15 "Lack of availability of psychiatric beds in the
16 PICU (both locally and nationally) can have
17 a significant implication in term[s] of safety and risk
18 management of very ill patients in the community. In
19 such circumstances very ill patients are left to the
20 care of Crisis Teams or LMHT who have less resources or
21 capacity ..."

22 To be clear, lack of availability of beds did not
23 impact the decisions you made in VC's case looking at
24 them, did it?

25 **A.** No. It was a generally reflections on what I thought

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1 will be important to bring to the attention of the
2 Inquiries about the general lack of availability of
3 beds, in particular PICU beds around nationally; it's
4 not just confined to our Trust. And I could see from
5 the subsequent admission, when VC was admitted, he
6 remained in a place of safety for a number of days.

7 **Q.** Fourteen people -- (*overspeaking*) --

8 **A.** Yes, so he would have been -- this is a national
9 shortage of beds around the country. It's not just
10 confined to Nottinghamshire. And that's why I brought
11 this issue.

12 **Q.** Has that ever influenced your decision on whether
13 someone should be detained or not? Have you felt the
14 pressure of that or have you made the decision you felt
15 was the right one, and then dealt with that afterwards?

16 **A.** No. As a Section 12 Approved Doctor, if I feel if
17 someone is needed to be admitted, I have to look at
18 statutory criteria. The logistic aspects of care is
19 nothing to do with me do, though saying so, as
20 a Section 12 Approved Doctor, you've got
21 a responsibility to look for a bed.

22 But if I feel that someone is need to be detained
23 under the Mental Health Act and that person is
24 fulfilling the statutory criteria, I have to detain that
25 person.

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1 I think there's -- this is a two-way traffic. And
2 that's what I mean in this recommendation that
3 multi-agency has to work together in order to address
4 the issue around very ill patients whom are left in the
5 community sometime without much support. And I think
6 this is the issue nationally, and that has to be looked
7 at carefully, how the information should be shared how
8 the Mental Health Act -- mental health professionals and
9 the police has worked together. There is numerous
10 example of this, and I think will be a little bit for me
11 out of place to bring those here, but as a doctor have
12 conducted so many Mental Health Act Assessments, I felt
13 unsafe during those assessment, and I came to harm
14 during those assessment, as a doctor. And that's
15 something I made those reflection on those.

16 **Q.** You refer to forensic psychiatric service threshold at
17 (d), and you say:

18 "Their service should be flexible in accepting
19 'urgent assessment or review' and accepting such
20 patients to their services before the patient commits
21 a serious index offence."

22 Because that's the concern, isn't it? Someone has
23 to do or commit a really serious offence, even though
24 the risk is concerning and they don't reach forensics
25 until they have?

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1 **Q.** At (c) you say:

2 "There is a need for a broader collaborative working
3 between the police and mental health services in
4 managing very ill service users. Particularly where the
5 service users are very aggressive and violent, it is
6 imperative they are supported in a timely manner."

7 How do you think that should happen? What does the
8 NHS need to do for that part of it?

9 **A.** I think working as a Consultant Psychiatrist for
10 a number of years and also working in a position of
11 Section 12 Approved Doctors, as I say I've done
12 thousands of Mental Health Act Assessments. My general
13 sort of views on this is that -- I mean simple example
14 is when we do conduct 135 warrant, my honest answer is
15 that it's sometimes very difficult to get the police at
16 that time, because they're busy, like us, like all of
17 the NHS doctors, like you want an appointment from a GP,
18 the GP -- you won't get an appointment straight away.
19 You get an appointment for eye operation, you won't get
20 it. I think the same applies to the police as well:
21 when you need that help and support, sometime they are
22 busy with their work.

23 But again, I think during those kind of encounter
24 I think it's important that those information should be
25 shared with the -- with the NHS, and vice versa as well.

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1 **A.** I mean, a lot of this is a reflection from my time when
2 I was -- in olden days when I used to attend a police
3 station, seeing patients although we didn't have a -- at
4 one point long time ago we had forensic doctors in the
5 police stations, and there were a point when they wish
6 to see the persons presented with the mental disorder
7 and the risk was so significant, and they were easily
8 diverted to forensic service.

9 But then following that point, at least we, in the
10 police station, we had so-called forensic medical
11 examiner, which were not forensic psychiatrist, they
12 were medical doctors. And that was still giving us
13 a platform to assess someone and giving us some insight
14 about which route has to be taken from the point whether
15 the Mental Health Act Assessment should be appropriate
16 for this person or should criminal justice system be
17 most appropriate?

18 We have the Liaison and Diversion teams supporting
19 the police, but they are nurses. They do good job, but
20 they are nurses, but they need to be supported by
21 a psychiatrist, by a medical examiner.

22 And again, rightfully, what you said, the threshold
23 for admitting people to forensic bed is quite high. It
24 is a national things and, again, I think it's probably
25 coming to resources, I'm not talking on behalf of the

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1 forensic service, admitting someone to low secure unit,
 2 you have to really work very hard and to prove to them
 3 that this person is really posing significant risk to
 4 people in the community and you need to really take this
 5 person on board.
 6 **MS LANGDALE:** Thank you. Those are my questions, Dr Manzar.
 7 There are a few more.

8 **THE CHAIR:** Yes, Ms Patrick?

9 **Questioned by MS PATRICK**

10 **MS PATRICK:** Good afternoon, Dr Manzar.

11 **A.** Good afternoon.

12 **Q.** My name is Angela Patrick. I represent the families of
 13 those who died on 13 June, and I only have two topics to
 14 cover with you.

15 The first is going to look at 3 September; and the
 16 second is going to look at the assessments on 18 to
 17 28 January. Okay?

18 **A.** Sorry to interrupt. Could you speak a bit loud so I can
 19 hear you?

20 **Q.** Of course I can. I can speak louder. So if we can
 21 start with 3 September, please.

22 **A.** Yes.

23 **Q.** Now, this afternoon you've described seeing VC for the
 24 first time on 3 September. You also deal with it in
 25 your witness statement. So could we look at that

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1 **A.** Yes.

2 **Q.** -- when the fight happened?

3 **A.** Yes.

4 **Q.** Then you said, "He went back to how he was before the
 5 attack." Is that right?

6 **A.** That's right, yeah.

7 **Q.** Was that your recollection: neither agitated nor
 8 disturbed?

9 **A.** Yes, if I could hear you very well at the last sentence,
 10 yes, he was -- he became suddenly very aggressive and
 11 agitated and the word used, he just went from, you know,
 12 zero to 100 in a few seconds and then subsided.

13 **Q.** Went back to how he was before?

14 **A.** Yes.

15 **Q.** Thank you. Now, if we look at, moving forward to
 16 January 2022, and I think you've already agreed there
 17 was significant information at that time you did not
 18 have, and you've described only being aware of what
 19 happened partially; is that right? Not in your witness
 20 statement, Dr Manzar, we're moving on from that.

21 **A.** Oh okay, okay.

22 **Q.** Just in questions that Ms Langdale asked you this
 23 afternoon, moving to January 2022?

24 **A.** January 2022, yeah.

25 **Q.** I think you've already said there was significant

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1 together, please. It's at WITN0350001, maybe 0001,
 2 looking at that, and it's page 30 and the paragraph
 3 I want to look at is 132. It's on the next page, I
 4 apologise. Page 31. Can you see paragraph 132 there,
 5 Dr Manzar, it's right at the top?

6 **A.** That's correct, yeah.

7 **Q.** You can see it reads:

8 "Shortly afterwards, he drove off and appeared to
 9 park his car somewhere nearby before returning on foot.
 10 Upon his return, he mentioned my name and asked whether
 11 I was Dr Manzar. At that point, I did not immediately
 12 recall him from my previous encounter, but he remained
 13 polite and was neither agitated nor disturbed in his
 14 manner."

15 When you saw him then at the flat, was he exhibiting
 16 overt psychotic symptoms?

17 **A.** I don't think so we had any opportunity to explore any
 18 psychotic symptom at that point when we saw him at the
 19 flat because he didn't give us no opportunity.

20 **Q.** But at that time when you saw him outside, as you said
 21 in your witness statement, your recollection was at that
 22 time he was polite and neither agitated nor disturbed?

23 **A.** That's true.

24 **Q.** Okay. Then you described him this afternoon, that going
 25 from zero to 100 --

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1 information about what had happened before the
 2 assessments that you did not have?

3 **A.** Yeah, yeah.

4 **Q.** Now, can we look at one document, please, it's
 5 UNIN0001788, and I'd like to look at page 1 together.
 6 If we could zoom in on the top part above the picture
 7 I'd be grateful. Thank you. Now, if we look four lines
 8 down, can you see there's a line there that starts "His
 9 inappropriate"? Someone has helpfully highlighted it.
 10 Can you see where I'm looking?

11 This is a description of what had been happening in
 12 the flat by the students sent to the University, and
 13 I just want to look at this part to see what you knew
 14 and did not know. You can see there he describes, after
 15 where it is highlighted:

16 "He has previously walked into the bedroom of other
 17 flat members with no prior warning, one of which,
 18 [redacted] had just got out of the shower and could have
 19 been in a state of undress, which fortunately he was
 20 not. This worrying behaviour is further demonstrated
 21 when he walked into [another flatmate's] bedroom,
 22 unannounced whilst he was asleep to ask him 'did you
 23 hear that screaming?' As far as we know, there was no
 24 screaming."

25 Now, just we don't need to look anymore at that, but

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1 the students were reporting VC hearing screaming that
 2 wasn't there, weren't they?
 3 **A.** Yeah.
 4 **Q.** That he was trespassing again? That was what they were
 5 reporting, wasn't it?
 6 **A.** Yes.
 7 **Q.** Did you know that at the time, either on the 18 January
 8 or later on 28 January?
 9 **A.** I was not aware of this in full details, no.
 10 **Q.** Nobody had told you about what the students were saying
 11 about his hearing screaming that wasn't there?
 12 **A.** To my recollections, no.
 13 **Q.** Was that significant information?
 14 **A.** It is. It is.
 15 **Q.** Does it sound a lot like his previous presentations when
 16 he was unwell?
 17 **A.** Sorry, could you repeat that again?
 18 **Q.** Does it sound a lot like his previous presentations when
 19 he was unwell?
 20 **A.** Yes, I think, because it's mirroring in a way, yeah.
 21 **Q.** Now, you've talked today about the least restrictive
 22 principle. Now, just to be absolutely sure, it's the
 23 least restrictive principle in the face of the risks
 24 that are apparent, isn't it? You're looking at what is
 25 the least restrictive possible, given the risks that

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1 I'm not sure if I've got your question right. That
 2 would be my answer in terms of how those risks could be
 3 mitigated, but unless I am missing the question.
 4 **Q.** Just to be absolutely clear. We know there was no
 5 suggestion that he would just walk away without support.
 6 What I am asking, Doctor, is can you assess properly
 7 what the least restrictive option might be in order to
 8 ensure that someone's treatment is safe, if you don't
 9 have all the facts?
 10 **A.** Yes, I agree with you. If these informations are there
 11 available at the time, and fully described in the manner
 12 it is, of course that will be taken into account in
 13 terms of decision-making.
 14 **Q.** Okay. Now I think you have said to Ms Langdale KC, on
 15 the 18th you'd seen VC before, obviously, in September,
 16 and you had real anxiety that the situation might
 17 escalate; is that right?
 18 **A.** Yes, and then I respond as well to that question why
 19 I thought at that point it would have been, yeah.
 20 **Q.** And you wanted the police there, didn't you?
 21 **A.** Yeah.
 22 **Q.** On the 18 or 19 and the 28 January, were the primary
 23 decision-makers really Dr Skelton and Dr Lomas?
 24 **A.** Yes.
 25 **MS PATRICK:** Thank you, Dr Manzar. I don't have any other

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1 somebody is presenting; is that fair?
 2 **A.** Yes, yeah. In a context of Mental Health Act, yes.
 3 **Q.** Now if you don't know, as an assessor, everything that's
 4 happened to prompt the assessment, can you properly
 5 consider what the least restrictive option is?
 6 **A.** I mean, least restrictive option in this context there
 7 is that, when you consider least restrictive options
 8 in -- for a person to be treated in the community, of
 9 course you have to look at the level of those risks, how
 10 they could be contained. But under no circumstances,
 11 I think the least restrictive options has been agreed
 12 that he just walked out without any support, and the
 13 time when, if you're referring specifically to the
 14 assessment around 19 September, this was, as I said
 15 earlier on in my evidence, that when he was released
 16 from the Cassidy Suite and he went to the community, he
 17 was under the team.
 18 I understand where you're coming from but it's
 19 difficult for me to fully elaborate on, as a Section 12
 20 Approved Doctor, how the risk of -- how these risks
 21 could be further mitigated if the Crisis Team saying
 22 that: we want to do A, B, C, and we have got contingency
 23 plan should things escalate, we would have called for
 24 a Mental Health Act Assessment and we will admit him to
 25 hospital.

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1 questions for you.
 2 **THE WITNESS:** Thank you.
 3 **THE CHAIR:** Yes, Ms Cartwright.
 4 **Questioned by MS CARTWRIGHT**
 5 **MS CARTWRIGHT:** Good afternoon, Dr Manzar.
 6 **A.** Good afternoon.
 7 **Q.** I've got some brief questions on behalf of the
 8 survivors, and perhaps just building on general
 9 principles and the matters that you've just been asked
 10 about, it's right, isn't it, that appropriate medical
 11 treatment as the concept for detention under the Act is
 12 treatment that is appropriate for a particular patient,
 13 determined by the patient's medical condition and the
 14 risk a patient presents as a consequence or feature of
 15 that condition; would you agree?
 16 **A.** Yeah.
 17 **Q.** So as a treating or assessing consultant, you need to
 18 have the full knowledge as to risk when making decisions
 19 for detention or discharge.
 20 **A.** That's true.
 21 **Q.** Thank you. And so can I then just finally pick up on
 22 one of the matters that you've addressed in your
 23 evidence, and I think it's the significant evidence as
 24 to risk that you've been sharing with Ms Langdale that
 25 are in the notes that the family had provided to

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1 Dr Seedat, that have not found their way accurately into
2 the medical records. And I think you've had shown to
3 you what is NGPF0002527, and have you had an opportunity
4 before today to look at that document? So I think it's
5 the notes you were taken to that reference "red rum"; do
6 you remember that?

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

8 **Q.** I think you were asked about "red rum" and you said that
9 was a serious factor as to risk.

10 **A.** Yes.

11 **Q.** But I don't think you expressly said what you understood
12 that to be. Can I check, did you understand that to be
13 a reference to VC having thoughts of murder?

14 **A.** That's right, that's right.

15 **Q.** So that was well known and understood to you.

16 **A.** That's right, yeah.

17 **Q.** So would you agree, if at any point you had seen in VC's
18 RiO notes and history, that VC was a man who had
19 thoughts of murder, would you agree that that seriously
20 escalates the risk?

21 **A.** If I knew at that time, of course, yes, yes.

22 **Q.** I think you knew at no time that VC had had those
23 thoughts; is that correct?

24 **A.** That's correct, yeah. To my knowledge I was not aware
25 and I can't speak on behalf of someone else who was

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1 murder -- and would you agree that it was that entry in
2 that note, when you were reviewing matters through your
3 interactions with VC, that would have seriously
4 escalated the risk?

5 **A.** Yes.

6 **Q.** And would you agree, again what we don't see in this
7 note, and I don't want to delay you with doing
8 a cross-reference but just the principle if anything
9 I say is inaccurate it can be corrected, but would you
10 agree equally if notes had been provided to a treating
11 consultant that talk about feelings of immense anguish,
12 paranoia and hatred, having the darkest thoughts one
13 could imagine, and wanting to hurt people permanently,
14 that again, that's highly relevant as to risk and should
15 have found its way into the records?

16 **A.** I guess, as a general rule, any risk that has been
17 highlighted, I think it's everyone's responsibility to
18 put that one into the notes so that the clinicians are
19 aware of those risks.

20 **Q.** Not just the clinicians; I think other -- the teams in
21 the community.

22 **A.** Absolutely, absolutely.

23 **Q.** The police.

24 **A.** Yes.

25 **Q.** So anyone that's going to have an interaction, because

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1 aware of those at that point, but myself, at the point
2 when I assessed him, those information, none came to my
3 attention.

4 **Q.** So what I'm going to do is just go through the place
5 where Dr Seedat did record issues as taken from the
6 documents shared with the family. It's in the medical
7 records, NGPF0000168, it's page 21. Thank you. So it
8 should be page 21, please.

9 You've been taken briefly to it, and it's the entry
10 there where Dr Seedat has recorded the third-party
11 information that he records not to be disclosed to the
12 patient, and these are his notes, not yours, and so I'm
13 going to deal with these more as general principles.

14 But would you agree, Dr Manzar, if families share
15 relevant information as to risk that need to be known
16 for the general public, then you can't just omit that
17 information from the notes if requested by family
18 members? If it's relevant to risk and public safety,
19 then that overrides requests to not disclose that to the
20 patient; would you agree?

21 **A.** I agree, I mean this is the general sort of principle,
22 yes.

23 **Q.** And so the notes that had been shared with Dr Seedat,
24 included the note I've already spoken to you about, the
25 reference to VC having thoughts of "red rum" --

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1 it's relevant to risk assessments --

2 **A.** Yes.

3 **Q.** -- the contact.

4 **A.** Sure.

5 **Q.** And again, just to complete the additional information
6 as to risk that we don't find in this note, VC
7 describing how his thoughts about those that were
8 watching him, he wanted to break their heads with his
9 hands. Again, would you agree, highly relevant and
10 should have been in the records?

11 **A.** These risks should be highlighted in the record, yes.

12 **Q.** Also the fact that VC had disclosed that he was
13 essentially roaming the streets at night, shadow boxing;
14 again, relevant to risk to members of the public and
15 should have been in the notes; would you agree?

16 **A.** Yes.

17 **Q.** Thoughts that VC was so angry he couldn't sleep, so he'd
18 go out and walk about. Again, relevant to risk, should
19 be in the notes.

20 **A.** Yes.

21 **Q.** But also that he'd been watching videos about capital
22 punishment and again, relevant to risk, so should be in
23 the notes.

24 **A.** Yes.

25 **Q.** So would you agree also the significant thing it did for

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1 you, when you had your interactions with VC and your
 2 assessment, is it deprived you as a consultant of highly
 3 relevant information as to risk?
 4 **A.** Could you repeat that last bit?
 5 **Q.** So with you -- there not being the information as to
 6 risk in the medical records, first of all, and you not
 7 having those notes --
 8 **A.** I didn't have that, no --
 9 **Q.** -- that were provided by Dr Seedat, it deprived you, as
 10 a consultant in your interactions, of highly relevant
 11 information as to risk?
 12 **A.** That's true.
 13 **Q.** Highly relevant information as to appropriate medical
 14 treatment --
 15 **A.** Yes.
 16 **Q.** -- and decisions you made at various times about
 17 detention; and would you agree?
 18 **A.** If -- I mean, the information I had on that point -- and
 19 just to clarify, if I'm getting the question right, and
 20 answering your question correctly -- if I knew about
 21 this information, of course it will -- I will be
 22 incorporating those risks into my decision-making, yes.
 23 **Q.** Thank you. Then finally, we know that you attended
 24 Salisbury Street in September 2021 as one of your
 25 assessments, when the attack on the police officers took

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1 Then paragraph 122, you address the 3 September 2021
 2 incident, and you explained there: "He [also] stopped
 3 his ... medication ..." at that point. So prior to that
 4 incident.
 5 Then at paragraph 289 of your witness statement, you
 6 refer then to the next one, the 28 January 2022
 7 assessment and you say at that point:
 8 "... out of many CHRT [many crisis resolution team
 9 visits] he had only taken a few tablets of
 10 antipsychotic[s] ... the rest he either [threw] away or
 11 [spat] them [out]."
 12 Now, in light of that history, would you agree that
 13 stopping medication was a clear relapse warning sign?
 14 **A.** Just giving the facts that has been recorded, yes.
 15 **Q.** You explain in respect of two of those incidents, so in
 16 your witness statement, you explain in respect of the
 17 13 July incident and also the 28 January 2022 incident,
 18 so it was 2020 then the 2022 incidents, he told you he
 19 was taking his medication when in fact he wasn't. Would
 20 you agree, you couldn't rely on his assurances that he
 21 was taking his medication?
 22 **A.** I think was difficult with certainty to say he was
 23 taking his medication, but the record has been indicated
 24 that he was not fully compliant with his medication even
 25 if he was partially.

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1 place.
 2 **A.** Yes.
 3 **Q.** Again, just by way of information that had been
 4 available, had you been made aware that VC had had that
 5 accommodation before he moved to Brook Court where there
 6 was the incident in May of 2020 where he attacked other
 7 neighbours and then the neighbour jumped out of
 8 a window?
 9 **A.** That's right, yeah, I was aware.
 10 **Q.** Were you aware that he had been previously at Salisbury
 11 Court --
 12 **A.** Yes, that's right.
 13 **Q.** -- and he had left there and moved to Brook Court
 14 because he thought he was being monitored and listened
 15 to at Salisbury Court; you were aware of that?
 16 **A.** Yes, I was aware of that.
 17 **MS CARTWRIGHT:** Thank you very much, Dr Manzar.
 18 **THE CHAIR:** Yes, Mr Straw.
 19 **Questioned by MR STRAW**
 20 **MR STRAW:** Dr Manzar, I represent VC's family.
 21 First issue, medication. In your witness statement
 22 at paragraph 65, you say the 13 July 2020 incident, you
 23 say of that:
 24 "... relapse was highly likely due to his medication
 25 non-compliance."

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1 **Q.** Thank you. That's medication.
 2 The next issue is the 3 September 2021 incident.
 3 Could we have NHFT0000168 on screen, please. It's the
 4 RiOs, and page 164. Thank you.
 5 So there's an entry there at 8.58 pm on 2 September,
 6 2021 and it refers to the assessment that you and
 7 Dr Lomas carried out and the notes that Jen Shaw, the
 8 AMHP, spoke to VC's mother. Then one paragraph down:
 9 "Mum tried [to speak to] him on his phone and rang
 10 Jen back - he hadn't responded which was felt to be very
 11 unusual and concerned mum, hence a further attempt at
 12 [Mental Health Act Assessment] this evening."
 13 Do you see that?
 14 **A.** Yes, that's right, yeah.
 15 **Q.** Were you aware of that at the time? Was it your
 16 understanding that it was that phone call from Mum that
 17 had led to that assessment?
 18 **A.** I can't fully recall, but I guess this is correct
 19 information, yes.
 20 **Q.** Thank you. Then the next entry which is 3 September at
 21 1.58 pm notes Mum said:
 22 "Celeste ... had spoken to [VC] for an hour last
 23 night. ... [VC] had spent much of the call talking about
 24 the Government monitoring him and it was difficult for
 25 her to challenge these beliefs as [VC] appeared quite

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1 fixated on them."

2 Do you recall hearing about that information?

3 **A.** I can't recall with the full details. From what

4 I recall from the time when I have attended to do the

5 assessment, those information was given in line to me

6 that he was paranoid, he was suspicious, he was talking

7 about conspiracy against him, but I can't, with all

8 honesty, I can't remember word by words what I hear.

9 But yes, this is just because of time lapse.

10 **Q.** The entry in your assessment on that date was read out

11 earlier when you record him talking about the conspiracy

12 by Highbury Hospital, he thinks mental health workers

13 are working with the judicial system against him.

14 **A.** That bit I remember clearly, yes.

15 **Q.** Was that part of his illness, that delusion that the

16 mental health services were conspiring against him?

17 **A.** I guess so.

18 **Q.** Is that one of the things that led him to be guarded and

19 disengage, and so on?

20 **A.** Yes, with subsequent more information, which I can't see

21 right now, I think that view is now completely evolved

22 with change because a lot of informations which we

23 didn't know before confirming how severely he was

24 indulged with those conspiracy theories and theories

25 about how mind -- and his mind was controlled and how he

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1 disengagement, his superficial engagement, was an

2 indication that he was in a state of acute relapse;

3 would you agree with that?

4 **A.** Yes, I mean, whether that note is I think you're

5 referring to what Dr Lomas has noted, stated to record

6 it in his RiO -- it's in the RiO notes. I think prior

7 to that assessment, the information was that out of many

8 Crisis Resolution Home Treatment Team visits, he had

9 been seen either he's taking partially the medications

10 or either not swallowed it but the water was spitten

11 out.

12 As I said, I'm -- I wasn't working with the Crisis

13 Team so I'm not fully aware of what exactly has

14 happened, but information was giving, recorded, it looks

15 like applying (*sic*) that he was not taking his

16 medication.

17 **Q.** Okay and thank you, and the last question, and this is

18 going back to 3 September 2021 incident, in your witness

19 statement, para 166, you say that:

20 "... [VC's] actions were dominated by psychotic

21 processes rather than rational control."

22 Can you explain what you meant by that?

23 **A.** Could I put the -- could you put that one into the --

24 **Q.** Of course. It's Dr Manzar's witness statement, please,

25 if that --

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1 was affected by those delusional beliefs.

2 **Q.** And one thing you say later, paragraph 297 of your

3 statement, about the January 2022 incident, is to

4 indicate that is correct he disengaged at that point,

5 and that was a sign of relapse. Would you agree with

6 that, that disengagement was a sign of relapse?

7 **A.** I mean one can argue sign of, yes, but again, what has

8 led to what? That medication non-compliance has led to

9 relapse, that medication didn't work. Was there any

10 other factors may have caused his relapses? Because

11 what schizophrenia and psychosis, yes, medication is one

12 factor in a person can relapse. Stresses can cause

13 relapse. Drugs can cause relapse. Personal conflicts

14 can cause relapse. So there's many factors.

15 I can see why you stating that the medication

16 non-compliances may have been, or have been, partially

17 or fully, implemented in his relapse, without a doubt,

18 yes.

19 **Q.** The way you put it at 297 -- and again, sorry to jump

20 around, this is about the January 2022 assessment, you

21 say:

22 "Superficial engagement with the crisis team

23 indicated that VC was in an acute phase requiring close

24 community input for stabilisation ..."

25 So there that indicates, doesn't it, his

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1 **A.** Oh it's that one, yeah.

2 **Q.** -- if we can see it on screen. So WITN0350001, and it's

3 page 39, please. So paragraph 166 there and the last

4 three lines of that paragraph.

5 **A.** Sure.

6 **Q.** Perhaps if those --

7 **A.** Could I read for a second, please?

8 **Q.** Thank you. (*Pause*)

9 **A.** That's true, yes.

10 **Q.** And so it was your view, was it, that it was his

11 psychotic processes that led him to cause harm, then?

12 **A.** Yes, yes. I believe so, yeah.

13 **MR STRAW:** I've run out of time so I'll leave it there.

14 Thank you very much.

15 **THE CHAIR:** Thank you.

16 Yes, Mr Beer.

17 **Questioned by MR BEER**

18 **MR BEER:** Just three short topics, Dr Manzar.

19 The first is about information and the obtaining of

20 information.

21 You were taken to Dr Seedat's summary of the

22 20 pages of notes that VC's brother had supplied, which

23 was a combination of narrative and quotes from text

24 messages; do you remember that?

25 **A.** Yeah.

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1 Q. You were asked about your knowledge of it in July 2020
2 when you were undertaking the first Mental Health Act
3 Assessment.
4 A. *(No audible answer given)*.
5 Q. When you see this kind of information on RiO,
6 Dr Seedat's summary, in the context of a Mental Health
7 Act Assessment, do you rely on what has been summarised
8 by a previous clinician, in this case a consultant,
9 rather than investigating for yourself whether their
10 summary is accurate and complete?
11 A. Could you repeat that again, please?
12 Q. Yes, it's a long question. When you see a summary like
13 this by a previous clinician, do you take at face value
14 what here the consultant has written as a summary, or do
15 you go back and look at the underlying material?
16 A. As I said early on, I can't recall exactly that I've
17 seen those, but they the hypothetical question is that
18 if I would seen those, at that point I would become
19 probably more curious to find out a bit more about --
20 Q. That's a slightly different point, Dr Manzar. Let's
21 take it away from these circumstances.
22 A. Yeah.
23 Q. This could be a note of what a clinician has been told
24 by a family member.
25 A. Yeah.

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1 Q. Is there a facility on RiO to upload a document like
2 this?
3 A. I think from what I can see, I mean some of this risk
4 informations are there on the RiO, flagged up. But I'm
5 not quite sure if there is any specific things there,
6 such that you could upload those documentation there, so
7 the clinician can look straight away.
8 Q. Okay. Broadening out the topic of information obtaining
9 more generally, can we look, please, at WITN0350001.
10 This is your witness statement. If we can go to
11 page 46. If we start at paragraph 194, just by way of
12 context, we've moved forwards to January 2022 and you
13 tell us in 194 that:
14 "The records suggest that Clarisse Bagtas, an AMHP,
15 had applied for a warrant under s[ection] 135 of the
16 [Act] ..."
17 In 195 you tell us that:
18 "The records note that [you] participated an
19 [assessment] of VC on 19 January ... with [Ms Crane] ...
20 the AMHP, and Dr Skelton. [you] cannot recall having
21 any discussion with [Ms] ... Bagtas about her obtaining
22 the warrant. ... on the day of the ... [assessment]
23 Ms... Crane had phoned and briefed [you] about VC's
24 presentation. From what [you] ... recall, this was in
25 relation to the warrant she [had] obtained from the

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1 Q. It could be what a clinician has been told by
2 an employer, by a close family friend, by the police.
3 When you come along here, months later, do you go
4 back and examine the underlying material, if there is
5 any, or reinvestigate, or do you take at face value the
6 summary provided by the clinician?
7 A. Yes.
8 Q. Which of those two things?
9 A. I mean it's just matter of curiosity, isn't it, sir, how
10 you then become involved in getting more information in
11 terms of what is correct -- if I'm getting the
12 information, which is correct, which is not correct.
13 Q. So which of the two propositions that I put: do you take
14 at face value or do you go back and investigate for
15 yourself?
16 A. Well, of course you have to investigate. You have to
17 investigate.
18 Q. So in this circumstance, what would you have
19 investigated in the Dr Seedat's summary of the notes?
20 A. Well, I would have looked more in details what exactly
21 has happened, what these exchanges were, and what
22 context they were.
23 Q. Would you have looked to see whether the notes
24 themselves had been uploaded to RiO?
25 A. I would say yeah.

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1 Court to remove VC to a place of safety ... [you] cannot
2 recall the ... details of the conversation."
3 196, you say:
4 "[You] cannot recall the details of the conversation
5 ... [but you] rely on the [AMHP's note] that VC
6 assaulted his housemates in the flat the night before,
7 trapping them inside ... which resulted in police
8 involvement. No charges were made against him by the
9 police."
10 Then lastly, skipping 197 and going to 198:
11 "The information available to me at the time had
12 been briefly relayed over the telephone by the AMHP.
13 I am unable to recall the full details of the
14 conversation. ... it was a concise account indicating
15 [he'd] ... been involved in an incident the previous
16 night at his accommodation ... [in] which he reportedly
17 assaulted his housemate and confined him within the
18 flat, an episode that involved police attendance."
19 So two things arising from that: you were here in
20 this case present at the execution of a Section 135
21 Mental Health Act warrant, and then later, undertook
22 a Mental Health Act Assessment, and you say the
23 information about VC's underlying condition, or conduct,
24 rather, came from the AMHP; is that right?
25 A. That's right, yeah.

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1 Q. Is that the usual route of information about the alleged
2 conduct, in particular where it's involved the police:
3 that it comes through the AMHP?
4 A. That's true.
5 Q. And so it's not just in this case; that's the usual flow
6 of information.
7 A. In normal situation we do attend the Mental Health Act
8 Assessments, as I stated earlier on in my evidence, that
9 most of the information, just part of the information
10 comes from the AMHP because they are at the first line
11 where the Mental Health Act Assessment information has
12 been conveyed to them, yes.
13 Q. Even though they are providing the information, do you
14 go about any separate information gathering, going
15 behind what they've done? Ie, going back to the police?
16 Or do you rely on what they provide you?
17 A. I think it just where information available from the
18 AMHP, and what information is available from other
19 agencies, and that's including the police, yes.
20 Q. Here, the police were present at the Section 135
21 execution?
22 A. That's right.
23 Q. Did they provide any additional information about what
24 VC had done or was said to have done?
25 A. To my knowledge, nothing -- could outstand. The reason

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1 within it in broad terms, asking openly, whose
2 responsibility is it to ensure that information like
3 that, which students had passed to the University, made
4 its way through to you when conducting the Mental Health
5 Act Assessment?
6 A. Yes, this is all relevant, and I guess sharing
7 informations coming to the team, it's a highly, you
8 know, valuable.
9 Q. I'm not asking at the moment whether its relevant or
10 valuable; I'm just trying to pin down what the
11 information flow should be, ie, how it should make its
12 way through to you.
13 The University to the police, the University to the
14 AMHP, the University to the clinicians directly. For
15 the AMHP to find out for themselves, for the clinician
16 to find out for themselves, what's the expected flow of
17 information, please?
18 A. Well, first of all, I mean, when the Section 135 warrant
19 has been executed, the process goes through the court,
20 and the information is provided by the AMHP to the court
21 and I guess in those lines, informations is shared to
22 police as well and police vice versa has to share this
23 information. It's two-way traffic. It's not just one
24 party.

And those sharing informations between police and

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1 why I'm saying is because if there is any information
2 given to me at time, because a long period, I would have
3 remembered those information correctly. But it's not.
4 It's a general discussion but not specific information
5 on those occasions when I've seen VC.
6 Q. Secondly, you tell us here that you knew that the police
7 had decided not to charge VC with any criminal offence
8 arising out of his interactions with his flatmates, yes?
9 A. That's right.
10 Q. To what extent, if at all, was that relevant
11 information?
12 A. I think that would make a differences, because, as
13 I said earlier on, is that if someone is so unwell,
14 mentally so unwell and the risk is so significant, why
15 not criminal justice systems? Why not the person should
16 not go through the route of criminal justice system
17 rather than just being detained under the Mental Health
18 Act? That would certainly put a lot of weight into that
19 assessment.
20 Q. Then by way of a third example, turning to the
21 information that the students had passed to the
22 University, do you remember being shown that document
23 which said the statement from flat 15 on it --
24 A. Yes.
25 Q. -- which included the screaming and the trespassing

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1 the AMHPs and subsequent that flow goes to the Mental
2 Health Act team, it has to be conducted in that manner,
3 and clearly the information which you are stating about
4 the University.
5 Q. Thank you. Second topic, the assault on PC Pritchard on
6 3 September 2021. You were asked some questions about
7 whether you were asked to provide a witness statement
8 for criminal justice purposes in relation to the assault
9 on PC Pritchard, on 3 September 2021; do you remember?
10 A. I was not asked directly to provide any statements on
11 PC, yes, but I witness how serious it was.
12 Q. If you had have been asked to make a witness statement
13 about what you had observed as to VC's conduct at the
14 property on 3 September 2021, would you have been
15 willing to do so?
16 A. Absolutely.
17 Q. Were you aware that the police had asked Dr Lomas to ask
18 witness statement about what he had observed at VC's
19 property and his conduct on 3 September 2021?
20 A. Sorry, could you repeat that?
21 Q. Did you know that the police had asked Dr Lomas to
22 provide a witness statement?
23 A. I'm not sure. I think, I can't answer that question
24 because I'm not aware that whether he was asked --
25 Q. You don't know --

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- 1 A. -- but I was not asked. I was not asked.
- 2 Q. Thank you. The third question: the decision to admit in
3 September 2021 under Section 2 rather than Section 3 of
4 the Mental Health Act. Do you agree that a patient can
5 be admitted under Section 2 even if they've been
6 detained under Section 2 previously?
- 7 A. It is, yes. There's -- yes, yes. That's right.
- 8 Q. Do you agree that the law doesn't prohibit the repeated
9 use of Section 2?
- 10 A. No.
- 11 Q. Instead, would you agree that what matters most on
12 whether the criteria for admission under Section 2 are
13 met at the time of assessment informed but not dictated
14 by the admission history?
- 15 A. That's true, yes.
- 16 Q. Is Section 2 specifically for assessment and initial
17 treatment?
- 18 A. It is both for assessment and treatment, yes.
- 19 Q. Would you agree that a repeat Section 2 may be
20 appropriate where, for example, the situation is unclear
21 or has changed at the time of the current assessment as
22 compared to the last, and a fresh period of assessment
23 is justified?
- 24 A. That's true.
- 25 Q. Where a patient is displaying different symptoms?

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- 1 **THE CHAIR:** Can we have up NHFT0000168, 0204 and 5 together,
2 please. Sorry, 0204 and 0205, thank you.
- 3 Thank you. Just looking at the timing of this when
4 we get the 0205 up next to it, so at -- on the 19th --
5 sorry, on the 18th, 19th, just before you carry out the
6 assessment, there's a question about whether there were
7 any beds available there. Would that have been answered
8 by the time you did your assessment at 3.40 pm?
- 9 A. Chair, that, from what I can gather, I think this bed
10 was in relations to place of safety, for purpose of
11 assessment.
- 12 **THE CHAIR:** So it wasn't for a place for assessment?
- 13 A. If I could read the -- Chair, you're referring to entry
14 18 January; am I right in thinking?
- 15 **THE CHAIR:** I can't see. I think it says 19 January. It's
16 Abby Parsonage at the bottom of the page.
- 17 A. Yes, that's right, yeah.
- 18 **THE CHAIR:** Were you aware whether there was a bed
19 available, for a start?
- 20 A. I can't recall. I think that's true, there was no bed
21 for -- rang social care beds available, that was not
22 done yesterday.
- 23 Yes, I think from what I remember there was some
24 issue around the bed, yes.
- 25 **THE CHAIR:** All right. So there's then the assessment that

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- 1 A. That's true.
- 2 Q. Where there's a possibility that they have relapsed
3 after discharge?
- 4 A. That's true.
- 5 Q. For example, if the patient has been discharged under
6 a previous admission and reappears under a different or
7 unclear clinical state?
- 8 A. That's correct.
- 9 Q. Or where there's a need to establish whether this is
10 truly a relapse?
- 11 A. That's correct.
- 12 Q. Or where the presentation is acute and risky --
- 13 A. That's true.
- 14 Q. -- and there hasn't been a recent sufficient assessment
15 to guide longer term planning?
- 16 A. That's right.
- 17 Q. Do all of those issues come before you get to consider
18 the principle of applying the least restrictive measure
19 to the patient?
- 20 A. Yes.
- 21 **MR BEER:** Thank you very much.
- 22 **Questioned by THE CHAIR**
- 23 **THE CHAIR:** Thank you.
- 24 Just a couple of questions, Dr Manzar.
- 25 A. Yes.

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- 1 you made. If we can just go back one page to 0203, yes,
2 you can see the note there at the bottom of the page,
3 which is what the student was saying about the assault.
4 Were you aware of that? It's in the RiO notes. Do you
5 want to read that?
- 6 A. Sorry, I just need to see the highlight. Yes, sorry,
7 I just read this in a second. *(Pause)*
- 8 Thank you.
- 9 *(Pause)*
- 10 Yes, Chair I can --
- 11 **THE CHAIR:** Do you remember reading that before you did your
12 assessment? It's in the notes.
- 13 A. I can't, with all honesty, I can't recall the full
14 details of this on the notes.
- 15 **THE CHAIR:** Because he gives an explanation as to why the
16 police didn't proceed, doesn't he?
- 17 A. That's right, yeah.
- 18 **THE CHAIR:** And he also says that he had exams, couldn't
19 focus, and couldn't feel safe, and gives an account of
20 what happened.
- 21 A. Exactly. I can see from these notes, yes.
- 22 **THE CHAIR:** Did you take that into account?
- 23 A. I can't remember whether I have seen this in full
24 details, Chair, at that time when I was conducting
25 Mental Health Act Assessment. I knew that there was an

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1 instance, but with all honesty, just because of the time
 2 lapse, I can't remember the full details.
 3 **THE CHAIR:** You've referred to him being managed, VC being
 4 managed in the community, several times. What did you
 5 understand "the community" to mean, in that case where
 6 you were dealing with whether he should be admitted or
 7 not, management in the community?
 8 **A.** The one assessment, Chair, which I refer to the
 9 community assessment was on the 19th January --
 10 **THE CHAIR:** Yes.
 11 **A.** -- and that was when we've seen with the Crisis Team,
 12 and I wasn't aware of the exact details of what has
 13 happened to the flatmate --
 14 **THE CHAIR:** Because somebody's community includes those
 15 they're living with, doesn't it?
 16 **A.** Sorry?
 17 **THE CHAIR:** It includes those who they're living with.
 18 **A.** Yeah, but I wasn't --
 19 **THE CHAIR:** In this case he was living in a flat with the
 20 students --
 21 **A.** With the student.
 22 **THE CHAIR:** -- some of whom, one of whom had complained
 23 about the incident which was in the notes.
 24 **A.** Yes, I --
 25 **THE CHAIR:** So how did you understand that the management of

1 hadn't you, in -- as a result of the incident with
 2 PC Pritchard.
 3 **A.** Yes, with -- yes, with everyone including --
 4 **THE CHAIR:** So you'd wanted the police to go along with
 5 you --
 6 **A.** With everyone, yes.
 7 **THE CHAIR:** -- yes, the next time. It may seem an odd
 8 question, but would you have been content, being the
 9 student, to have gone back into the flat with VC?
 10 **A.** Of course, of course.
 11 **THE CHAIR:** You would have done?
 12 **A.** I would be worried, yes, if someone was there in the
 13 flat --
 14 **THE CHAIR:** You would be worried. And that was because of
 15 the risk he posed, wasn't it?
 16 **A.** Yes.
 17 **THE CHAIR:** Thank you. Well, we'll finish there for today.
 18 Start again tomorrow at 10.00.
 19 (4.31 pm)
 20 (The hearing adjourned until 10.00 am the following day)
 21
 22
 23
 24
 25

1 that could be achieved?
 2 **A.** I wasn't fully aware of what I was -- I mean the
 3 information came, Chair, at that time was to me that the
 4 student has been temporarily accommodated somewhere, but
 5 I wasn't quite sure that the person was still there. If
 6 I am getting this correctly, I wasn't aware of the fact
 7 that someone was still there.
 8 **THE CHAIR:** So the only way that this could be managed was
 9 by moving all of the students out and leaving VC in the
 10 flat on his own, wasn't it?
 11 **A.** Yes, in a way, yes, yeah.
 12 **THE CHAIR:** And did you think that that was an appropriate
 13 management in the community of the risk?
 14 **A.** I guess at that point what the informations relate to
 15 me, and what I know, I mean I can't assess it in the
 16 sense that I can't remember the full details of this,
 17 but, as I said early on in my evidence, Chair, some of
 18 these information came after the Mental Health Act
 19 Assessment was completed, and by that point I wasn't
 20 there. But it doesn't mean that they should not contact
 21 me. I was available if I knew that this was a carrier
 22 in terms of this risk assessment could not be managed
 23 appropriately, of course I would have acted on those
 24 appropriately.
 25 **THE CHAIR:** You'd been concerned about your own safety,

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