Monday, 27 April 2026

(1.30 pm)

THE CHAIR: Yes, Ms Langdale.

MS LANGDALE: May I call, please, Dr Manzar.

DR OMAR MANZAR (sworn)

Questioned by MS LANGDALE

THE CHAIR: Yes.

MS LANGDALE: Dr Manzar, you have provided a statement to the Inquiry dated 17 December 2025. Can you confirm that the contents are true and accurate as far as you're concerned?

A. Yes, it is correct.

Q. Can you tell us about your background in psychiatry and your professional relationship with the Trust?

A. I am a qualified medical practitioner. I finished by medical degree in 1985. Following completion of my initial housework or house job, and associated training, I worked as a physician approved. Came -- when I came to UK, I have completed my PLAB exam, back in 2003, and joined the old SHO training scheme between 2004 and 2006.

Following those completion of those training, I have worked for a year as a staff grade. I have then returned back to training for a short period. Then in 2014, I have completed my membership exam. I have then

entered a higher training courses and I have completed my CCT, both in general adult and older psychiatry around 2018.

I joined the Trust in 2018, and since then have been working as a part-time consultant in old age psychiatry.

Q. In old age psychiatry?

A. That's correct, yes, but also I dual trained both in general and old age.

In terms of professional background and qualification, I have obtained a diploma from Royal College of Physicians of Ireland back in 2008. I have also obtained a Diploma in General Psychiatry from University of Cardiff in 2020. I have associated certificates in medical education obtained from Edge Hill University and also medical and leadership certificate from University of Manchester.

Q. So you have continued to work part-time for the Trust in your consultant role and you also conduct independent work as a Section 12 Approved Doctor. Can you tell us what the role of a Section 12 Approved Doctor is?

A. The role of Section 12 Approved Doctor is to making sure when a medical practitioner in that role is attending a Mental Health Act assessment ensuring that if there is evidence of mental disorder, the doctor should be able to formulate those illness, establish the illness and

establish whether there is a need for detention for that person in hospital setting and also consider the risk associated with those presentation.

Q. What do you do when you're conducting a Section 12 assessment in terms of learning something about the person first?

A. The general sort of rule is that before embarking on such assessment, as a practitioner I should look around and gather information from available sources. In day-to-day practice, this happens as such that AMHP, the Approved Mental Health Practitioner, contacts me and provides me the bulk of information and cases, and then whenever I'm near the Trust computer I do look at the information available in front of me.

Q. The RiO notes?

A. The RiO notes, yeah. On the occasion when those information are not straight away available to me, I tend to sort of gather the information from the practitioner who is attending the mental health assessment with me. Rather, if I am in, for example, in case of safety such as Cassidy Suite or Acorn Suite, I do tend to get information from the staff.

Q. When you say practitioner, do you mean the other doctor?

A. Absolutely.

Q. What does that doctor usually have that you don't have,

coming along to do a Section 12 when you don't know the patient?

A. The normal practice is they are -- approved mental health practitioner usually contacting the first doctor who is familiar with the patients, has got previous acquaintance with the patients. They usually also contact someone who probably know patient very well from the service, such as the local mental health team, it might well be that someone from the Crisis Team, usually they are senior doctors at the level of consultants.

Q. You tell us at paragraph 23 of your statement:

"On average, I usually undertake at least two assessments per week."

By the time you assessed VC in July 2020, how many assessments roughly do you think you would have conducted?

A. This is the minimum number. Obviously it varies, it can go up to eight, ten. I would say probably in hundreds. But, generally speaking, I probably have done in thousands. So yeah, so roughly --

Q. A lot?

A. Yeah, probably a rough, yeah, rough figures.

Q. Paragraph 27, you tell us about CPD activities you've participated in:

"... includ[ing] completing relevant [Mental Health

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

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

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

Q. And you tell us at paragraph 40:

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

How do you say that tension can be resolved?

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

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

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

Q. And to manage risk?

A. To manage risk, yeah.

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

A. Yes.

Q. A clear factual background.

A. Yes.

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

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

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

Q. It tends to be, did you say?

A. Usually, usually.

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

A. That's true. That's true.

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

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

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

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

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

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

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

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

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

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

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

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

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

Why did you arrive at that view? What had you asked about?
A. I think generally when I spoke with him at that point, he did not, from what I remember, he did not acknowledge that he was suffering from a mental disorder. And I didn't think -- so, clearly acknowledged that he would need care and treatment.
So based on those informations and the level he engaged with me, I can't remember the in and out of those sort of full discussion I had with him, I formed my mind that he was lacking capacity to make decision about his care and what I mean by his care is specifically admission to hospital, agreeing to take medications and agreeing to be -- thank you.
Q. Do take a drink when you need one.
A. Thank you. And agree to accept care and treatment.
Q. You say here:
"He appeared not to be using any illegal substances ..."
That was just before the bit where it says:
"... and his presentation appeared to be in line with a relapse."
Why do you say he appeared not to be using any illegal substances?
A. From what I remember, I think I did ask him. I may be

wrong, but I didn't believe that he was at that point under influence of any drugs because his conversation didn't come across as someone who may have taken drugs or alcohol, because that's more of a clinical judgement when you see someone.
This is an objective sort of examination, obviously, you still have to have tests done, someone's urine has been tested for presence of drugs or for alcohol been breathalysed.
I didn't have that feeling at that point when I saw him that he would have been taking drugs or using drugs.
Q. There is no time when VC's bloods are taken that they are tested for illegal drugs, not on 23 May, when he presented at A&E, and ambulance staff were querying whether he'd taken drugs. So there's no blood tests at all. Are there any circumstances, as a doctor, that you would request tests for illegal substances in a psychotic patient?
A. I mean, I have to talk in this occasion with my position as a Section 12 Approved Doctor. If I thought in that situation when I saw him on 14 July 2020 that he was under influence of drugs, he was displaying the manner or a behaviour consistent with someone being under the influence, I would actually not embark on that assessment because it is quite clear from Code of

Practice and also quite clear from sort of our daily practice, that if someone is under influence, you should not assess that person under the Mental Health Act.
It's difficult for me to comment why other doctors in any specific time with relation to VC has not done any blood tests, they have not offered any UDS urine drug screening. So I'm unable, I'm afraid, to comment on those.
Q. You say he was refusing an informal admission. You say that at the end of the box on the right. Was that because he didn't think he was unwell?
A. Sorry, could you repeat that?
Q. He was not -- he was refusing an informal admission. You record there he was refusing an informal admission?
A. That's true.
Q. Why was that?
A. I think there was quite clear from the conversation I had with him that he didn't believe that he was mentally unwell and I guess, if he felt that he was mentally unwell, why you should accept an informal admission.
Q. You tell us in your statement that the nature of his hallucinations, they were distressing and intrusive. Did you know what they were?
A. From this particular assessment, I didn't see it was

clearly stated in a manner that applied that he was distressed because of A, B, C. I think generally he gave me a general sense that he was hearing voices and he was distressed. I can't remember the full details from my memory what it was apart from what has been written in the medical recommendation.
Q. Did you know that he had assaulted a flatmate on 5 July, somebody he was living with and that flatmate had called the police? Did you know about that when you were doing this?
A. On 5 July?
Q. Yes. I'm not asking you about the January assessment; I'm asking you about the July one. Did you know that had happened in July?
A. In 5th July, from memory I wasn't aware, but I was aware of the assault previously to this, in May, in 2020, which led up to initial arrest and subsequent detention under the Mental Health Act.
Q. What did you think that happened in the assault in May?
A. The assault in May was in relations to -- the first one was in relation to him being breaking into a flat and the first episodes. And the second one was in relation to him entering a property, in response to hearing voices that his family member was in danger.
Q. Can we have, please, NHFT0000168, page 58. You had done

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

On that particular occasion Dr Seedat was not immediately available to be conducting that assessment with me, so I have seen VC on my own.
Q. If we look at this note of the assessment, Dr Seedat and Geoff Culpin, we see at paragraph 4:

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

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

So were you aware of the event immediately preceding this assessment on 14 July, that he'd gone round to confront a neighbour in these circumstances?
A. I'm sorry, could you repeat that?
Q. Did you know -- if you look at this paragraph 4 -- did you know about this event: that he'd gone round before this assessment to confront a neighbour?
A. I was aware from -- what I was aware that he -- the night before, when the police had detained him, he had broke into, or forced his way to a flat, and that's what I was aware. I wasn't fully aware of the incidents around the 5th July.
Q. And further down in this page, it says:

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

That's similar to the information that you'd gathered: that he didn't want an informal admission, didn't need to be there.
A. That's true.
Q. If we go back to your recommendation please NHFT0000037,

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

"... suffering from mental disorder [and] ...
"... it is necessary for the patient's own health.
"... for the patient's own safety.
And you also tick:
"... for the protection of other persons".

You haven't included more information regarding the circumstances leading to the detention or the risk he was to other persons. Is there a reason why you haven't done that?
A. I guess when you are saying for protection of others, this was quite clear from the presentation he presented at that time. I guess sometime is very difficult to include all the informations in a Mental Health Act paper, but clearly I think from my knowledge and understanding that I completed those paper, that he was posing risk to public.
Q. And similarly, you haven't elaborated on his degree of compliance with medication, have you, or the problems there?
A. If I go back, sorry, to the page --
Q. Yes, of course. Page 12.
A. And your question was that about medication?
Q. Yes, about medication compliance and the need for

treatment around medication.
A. I said: "He is not compliant with his medication." I have to mention:

"His mood, affect & presentation fluctuate & he is not compliant with his medication."
Q. You tell us in paragraph 117 of your statement to the Inquiry:

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

Why was it necessary in a hospital setting?
A. I guess because the level of risk at that point, (a), and (b), I think from what I remember, he was seen by the Community Mental Health Team prior to this assessment. I think he was not compliant with his medications, and I guess the only way for him that he could take medication were to be in hospital, and the hospital setting provide those kind of facilities for him to take medication.
Q. Can we have on the screen, please -- that can go down --

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

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

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

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

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

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

Did you read this document?

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

Q. Would you be interested in assessing risk to understand

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

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

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

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

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

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

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

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

If we go to page 17:

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

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

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

If we go over the page, page 18:

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

Do you know what "red rum" means?

A. Sorry, could you repeat that?

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

A. Yes.

Q. "I was thinking about red rum not 120 minutes ago." Would that make you think of anything, that sentence?

A. Yes, absolutely. Yeah, absolutely.

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

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

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

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

A. Yeah, absolutely.

Q. Why do you say "absolutely"?

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

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

A. Yeah.

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

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

Q. You formed the opinion:

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

property in anticipation of being assessed ..."
You thought he'd left because he didn't want to be assessed; is that right?
A. Yeah, this is -- yeah, this is -- yeah, that's right, yeah.
Q. The plan was to go back on the 3rd, wasn't it?
A. Yes.
Q. Can you tell us -- and if it helps you we can have on the screen your statement, which is WITN0350001, page 30 and 31. If we have page 30 and 31 on the screen, if it helps, Dr Manzar, because it was some time ago, when you first encountered VC he was standing outside his flat:
"A short while after, a car pulled over beside us."
What did he say to you? What happened then?
A. Actually, when we went to execute that warrant on that particular day, when we were successful finally to manage to see VC, we were congregating outside his flat, not immediately to the flat, but a few steps away. To the vicinity of a courtyard. So I was standing there with my colleagues, Dr Lomas and Amie, when a car pulled over.
And I forgot the question, but that was the time when I saw VC. If you could repeat.
Q. Just tell us what happened.
A. Yeah. So when he came, obviously we have seen a car

pulled over, he lowered the windows and he asked some questions "Why you are here?" I can't remember the exact wording, or "What are you doing here?"
I think then Dr Lomas has said -- Dr Lomas has stepped in to say, "We are here" or something along the line, I can't remember the exact wording, but apply that to him, "Are you VC? Are you the person?" If I'm right and I can remember correctly. And then what happened is he just disappeared for a short period. He parked his car and he came on foot.
When he came on foot, the first thing he said, he turns to me and says, "Are you Dr Manzar?" And by that point I was a little bit frightened, scared "What do you mean by me, Dr Manzar?" So I suppose he's not going to have a rant at me or, I said, "Yes, I am" and then I think Dr Lomas has taken over the conversation. I can't remember his word by word what has happened. I think we followed him to the flat, and there we explained, I think Amie explained from what I remember, and Dr Lomas as well, the reason why we are there.
Q. He said that the assessment wasn't going to take place, he didn't want the assessment, did he?
A. Exactly, yeah. I think the word I remember quite clearly -- I think the wording probably I remember clearly because he said, "This assessment is not going

to happen." And he was quite resolute with that conviction, that he didn't want to see anyone.
Q. So the police were called to assist?
A. That's correct.
Q. The police are very important, aren't they, for mental health professionals in a situation like this?
A. Yes.
Q. Because what would you do if they weren't there and you had their assistance: you wouldn't persist, presumably?
A. I mean, the Section 135 warrant is needed for the police to be present and also for the Approved Mental Health Practitioners and AMHP. I guess, yes, it is true, yeah, the police has to be present, yeah, and the risk could not be contained otherwise.
Q. We have seen the body-worn video footage of what happened and the attack, but you were there, what do you remember about that?
A. I think it's what happened initially when we went even to doorstep, and from what I remember, he allowed Dr Lomas to enter the little corridor adjacent to his bedroom or the flat. But then he stopped us from entering the property and he was quite clear and stating that he doesn't want to see us.
And I think from what I remember, Dr Lomas has explained to him that the reason why we are here,

because of this concern about his mental health.
I think Amie, from probably what I remembered, also explained things on the same line. I can't remember the exact wording, but it's a general sort of thing when the AMHP introduced the reason for why we are here.
And I think the next things we say to him that if he doesn't comply to this assessment, obviously police will be called. And he said, "Let that process happens."
Q. Let that process happen?
A. Yeah.
Q. So the police did come, and what happened then?
A. I can't remember how long later the police came. When the police came, again a similar process has happened. We knock on the flat door. I think Amie, if I can remember correctly, and Dr Lomas and the police followed off the road. I was there sort of joining the team. And, again, the same conversation started again, to say that "The team is here to assess you, and there is concern about your mental health."
Q. You were outside of the room, weren't you? Could you see what happened?
A. I think from what I remember, and I couldn't hear clearly, first of all, because there was quite a few people around. I could hear that conversation initially went well. I think all the professional were trying to

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

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

Q. Scuffle?

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

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

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

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

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

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

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

A. Yes.

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

A. Yes.

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

A. That's true.

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

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

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

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

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

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

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

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

A. No.

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

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

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. I can't recall that.

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

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

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

A. Sorry, could you repeat that?

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

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

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

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

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

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

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

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

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

say he attacked four officers. So you knew it was significant, that event.

A. That's true, yeah.

Q. Here at 153, you say:

"[VC's] language remained assertive, and he appeared resolute in his conviction that he neither required hospitalisation, nor any form of medication ... guarded and reluctant to engage, offering little in the way of meaningful dialogue about his symptoms or mental state".

Yes?

A. That's true.

Q. If we go, please, to NHFT0000168, page 167. And we can have, please, 168 as well next to it. So it's 168, 168. You record at 168 at the top:

"... highly likely to deteriorate in the community without treatment, with subsequent social harm and ... neglect."

So you're referring to the need for treatment here, aren't you?

A. Yes, this is Dr Lomas writing, yes.

Q. And if we go to "Discussion" on page 167:

"[VC] appears to be experiencing a relapse of his psychosis, though we could not establish the full nature of his psychopathology due to his refusal to discuss this with us."

Why did you say he needed admission for assessment at this point?

A. I think when at the time he presented on that particular occasion, it surprised me. Giving the previous presentation when I've seen him at the Cassidy in, in -- on 14th July 2020, this was a very sudden outburst, I guess, very sudden aggression. I can't remember the full details of what went in my mind there. I think one of the things went to my mind whether he has been using any drugs. The other thing was whether any medications, the issue was there as such that he -- the medication didn't work for him. I can't fully recall why this would have been but those were the few things.

And again, we have not had appropriate -- not a good time, really, to interview him, because he was just came at a lot of police and there was a lot of fear into atmosphere, how did he presented then.

So I guess there was a lot of not in-depth assessment we had, apart from what we knew that -- what the headlines were.

Q. If we go, please, to your statement, that can come down, and if we go to WITN0350001, page 41. So we're going to go to paragraph 174 of your statement at page 41.

"When comparing this presentation with my early assessment in July 2020, no specific new features

immediately stood out; rather, this appeared to be a repetition of his established pattern of relapse."

Yes?

A. That's true, yeah.

Q. So why not a Section 3 detention, then? Just go to Section 3. You had previously suspected schizophrenia. Nothing here told you that it was completely different from that, did it? Or needed further assessment?

A. I think I would apply -- what I was trying to apply to this is that yes, he relapsed. He became unwell. He has -- he had diagnosis of schizophrenia. But at that particular time, I think my general sort of view was that I didn't have that opportunity to explore fully his symptoms and how he presented then. The risk was completely out of character, not in --

Q. The risk was out of character?

A. Yeah, just from what he presented very calm and then suddenly he -- that's the bit that I apply to. And I know in the past he presented in an aggressive manner, but at that particular time, when I've seen him from 135 warrant, to a point when I've seen him at the Cassidy, I was very shocked and surprised.

Q. You'd seen him go from nought to 100 when he'd appeared calm, you'd seen that when he attacked the police officers. So how calm he appeared --

A. Exactly, that surprised me as well that why -- how this has happened, so I wasn't quite sure. As a clinician, this surprised me that how polite was he just before the 135 warrant, and how did suddenly he become so violent and aggressive. He wasn't matching and marrying his presentation of -- at a time when I've seen him and he suddenly become so subdued and become quiet.

Q. Can we have, please, page 44 and 45 of your statement on the screen. And if they go next to each other it's the assessment under Section 2, and the reason for that and you say under 185:

"My clear recollection is that the immediate clinical priority was to secure an urgent hospital admission under the [Mental Health Act], as the situation necessitated swift containment and assessment. From my recollection, the detention was primarily intended to facilitate assessment and short-term treatment ... This approach was supported by the historical pattern of responding well to treatment within a short period, with previous admissions being brief and often resulting in relatively rapid stabilisation and discharge."

That is relevant to an inpatient, being an inpatient, isn't it, that you say there he appeared to respond well to treatment in hospital when he had to

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

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

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

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

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

"It was poor judgement on my behalf, I didn't feel like talking ... I felt frustrated I was being forced into custody when I had done nothing wrong."
That's why he says that happened, yes?
A. Yes.
MS LANGDALE: Chair, I wonder if that's a good time for the 15-minute break.
THE CHAIR: Yes, we'll take a break now until 3.00. Thank you.
(2.42 pm)
(A short break)
(3.00 pm)
MS LANGDALE: Dr Manzar, you were involved again in January, weren't you, January 19.
A. That's correct.
Q. And we know by way of background that VC is disengaging with the EIP team, and also they have been sent a report from the University of him assaulting a flatmate, another flatmate in January.
Did you know about the assault of the flatmate in January?
A. I was aware of the assault.
Q. If we go, please, to NOCC0000040, page 5. This is a Report for Referral and Assessment on 19 January 2022, prepared by Roseanna Crane.

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

[VC] stated he had been taking his medication as prescribed."
Did you find out what had happened in fact?
A. At that point of my assessment, this was all the information I had. I didn't have no further information.
Q. Surely it was essential to have further information about this event when you made this decision?
A. Yes.
Q. So why didn't you obtain it?
A. If I can take you a little back to what exactly has -- I have been involved and how did this came to me to see him subsequently after Section 135 warrant has been executed, what information I have exactly, what information has been here produced in this AMHP report. When you arrive to the vicinity of the University, if I am -- if I can recall the events correctly, we were sort of accompanied by three police officers, and I think from that point onward I was uncomfortable, the reason why because I have seen VC before, and I had a great degree of anxiety about how this may have escalates, he might escalate the same manner. I did speak from what I remember with all my honest answer, I spoke with the police officer. I can't remember the, you know, nitty gritty or the full details I had with

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

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

A. I think for protection of everyone.

Q. Everyone, sure.

A. Yeah, yeah.

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

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

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

that?

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

Q. You've seen it now?

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

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

A. Yeah.

Q. -- video?

A. Yes.

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

A. I would say that was significant.

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

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

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

A. Yes.

Q. You should have had it?

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

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

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

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

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

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

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

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

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

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

Q. In the September?

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

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

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

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

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

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

A. That's true.

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

would see that was not an altercation; it was a significant event of intimidation and aggression. You agree with that?

A. Yes.

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

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

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

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

A. Could you repeat again, please?

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

A. Yeah.

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

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

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

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

that yourself.

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

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

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

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

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

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

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

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

A. Yes.

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

A. Yes, that's true.

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

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

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

So that was the position from the University --

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

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

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

Q. Of course. *(Pause)*

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

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

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

A. Yes.

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

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

A. Yes. That's correct.

Q. We can see at paragraph 3:

"[VC] did not believe he was mentally unwell ... continued to question why he was at Highbury when he was doing what was expected of him. Dr Lomas again explained that he has been seen by at least seven different professionals in the past 9 days and 5 of them could not be certain that he had taken his medication."

So once again, just as you had known in your first assessment some time back, he was not taking his medication, was he?

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

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

A. Yes.

Q. Because they'd moved out?

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

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

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

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

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

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

What did you mean by that?

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

Q. Further down you say: "Very suspicious and paranoid."

Yes?

A. Yeah.

Q. You say at the bottom:

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

A. Yes.

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

A. This is Dr Lomas.

Q. Dr Lomas's. Dr Lomas records:

"[VC] presents as possibly experiencing psychosis. He has behaved threateningly to his flatmates ... guarded or superficial in his interaction with healthcare [about him] ...

"Attempts at further assessment have been unsuccessful in the community."

So once again, Section 2 assessment rather than Section 3 treatment is recommended. Why do you say Section 2 at this point when it's clear he needs medication and treatment?

A. Just to explain a little bit further from before he came to the place of safety, he -- when the Section 135 warrant was executed, I wasn't in that warrant present. My colleague Dr Lomas has attended that warrant. And he voluntarily came to the place of safety.

From what I remember during that presentation, during that time, apart from seeing him that he has been guarded, perhaps, and suspicious, which over the years of his presentation, that was how knowledge we have that VC has presented to all these years.

I don't think I have found symptom -- the risk is yes, but the symptom-wise, I could not find any clear psychopathology to explain that, to find out, and during that assessment as clearly documented by Dr Lomas that after days of admissions when he settled, he become more

open, talking about his symptom presentation.

I think based on that and based how I have seen him then, I wasn't confident that what kind of treatment plan I could put, because I wasn't entirely sure about this symptoms at that point.

Q. So were you, when you say "possibly experiencing psychosis", did you observe any symptoms of psychosis in this assessment?

A. I mean he was guarded and I was suspicious, and from what I remember I couldn't see floridly that he was responding to unseen stimulis, he was saying things underline that suspect me that he was experiencing significant psychotic symptom at that point.

Q. If we can have, please, your statement on the screen, that can come down, WITN0350001, page 64, during this Mental Health Act Assessment you did raise depot medication with him, didn't you?

A. Dr Lomas explained that, yes, explained that.

Q. So "Dr Lomas" -- we'll have it on the screen --

"... suggested ... he have a long acting injection if he was happy to take the medication - ... explained patient [who] ... work with secrete or palm [medications] frequently, or will not take them orally, and this assures clinicians ... there are no issues with concordance."

Was that how it was explained to him, by the way?

A. I can't remember word by word, but I suppose I've got no doubt that this is not accurate. I think he would have explained this in the manner that has been written in this record.

Q. That can come down, please, and if we can have TCLT0000818, page 14. It's the level 2 comprehensive investigation report by the Trust. Learning point 3:

"... whether Section 2 or 3 ... should have been used."

That sets out -- I'm not going to take you through them -- the reasons why the Section 2 detention was an incorrect decision. Do you agree with that or not?

A. I think with the benefit of hindsight, if you were, as I mention in my statement, if you are not going to diverted by the lack of clear psychopathology at that point, I would say yes, Section 3 would have been a better outcome.

Q. Page 15, as well, if we put that alongside it.

"... the detention was required for the health and safety of VC as well as the protection of others."

It's the protection of others, there was no plan, was there, no management plan for risks in the community towards others, towards his neighbours, towards other students?

A. I think, given the fact that I so worried about him at that point that I detained him under Section 2, is that mean I still compelled him to hospital, to be in hospital. Yes, as I said early on in my evidence, that the benefit of hindsight should not conflate with the fact that what we decided at that point and what we agreed at that point, but the issue was that -- I mean, still with Section 2, you still can enforce medication, you can still give medication, you can still give the person psychotic medication.

Probably I was myself I was not quite clear in terms of a clear treatment plan at that point. To detain him under Section 2, my honest thoughts was at that point, is that aripiprazole is working; yes, depot and psychotic medication has been discussed.

As a clinician myself, I mean clinician, psychiatrist, have got different preferences about antipsychotic choices. Aripiprazole wouldn't be one of my best choices when I see someone who may present quite markedly agitated and aggressive at one point, someone who may not be sleeping very well. I would rather choose something completely different than aripiprazole. That is my personal experiences and my personal preferences.

Do I have clear evidence that someone has got heart

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

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

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

A. I --

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

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

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

We see at the bottom:

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

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

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

Do you agree with that?

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

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

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

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

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

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

Q. Sorry, I missed that.

A. It was not solely the least restrictive --

Q. Not solely, but it was a factor.

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

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

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

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

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

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

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

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

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

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

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

Q. At (c) you say:

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

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

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

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

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

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

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

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

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

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

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

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

forensic service, admitting someone to low secure unit, you have to really work very hard and to prove to them that this person is really posing significant risk to people in the community and you need to really take this person on board.

MS LANGDALE: Thank you. Those are my questions, Dr Manzar. There are a few more.

THE CHAIR: Yes, Ms Patrick?

Questioned by MS PATRICK

MS PATRICK: Good afternoon, Dr Manzar.

A. Good afternoon.

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

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

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

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

A. Yes.

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

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

A. That's correct, yeah.

Q. You can see it reads:

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

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

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

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

A. That's true.

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

A. Yes.

Q. -- when the fight happened?

A. Yes.

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

A. That's right, yeah.

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

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

Q. Went back to how he was before?

A. Yes.

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

A. Oh okay, okay.

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

A. January 2022, yeah.

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

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

A. Yeah, yeah.

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

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

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

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

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

somebody is presenting; is that fair?
A. Yes, yeah. In a context of Mental Health Act, yes.
Q. Now if you don't know, as an assessor, everything that's happened to prompt the assessment, can you properly consider what the least restrictive option is?
A. I mean, least restrictive option in this context there is that, when you consider least restrictive options in -- for a person to be treated in the community, of course you have to look at the level of those risks, how they could be contained. But under no circumstances, I think the least restrictive options has been agreed that he just walked out without any support, and the time when, if you're referring specifically to the assessment around 19 September, this was, as I said earlier on in my evidence, that when he was released from the Cassidy Suite and he went to the community, he was under the team.

I understand where you're coming from but it's difficult for me to fully elaborate on, as a Section 12 Approved Doctor, how the risk of -- how these risks could be further mitigated if the Crisis Team saying that: we want to do A, B, C, and we have got contingency plan should things escalate, we would have called for a Mental Health Act Assessment and we will admit him to hospital.

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

questions for you.
THE WITNESS: Thank you.
THE CHAIR: Yes, Ms Cartwright.

Questioned by MS CARTWRIGHT

MS CARTWRIGHT: Good afternoon, Dr Manzar.
A. Good afternoon.
Q. I've got some brief questions on behalf of the survivors, and perhaps just building on general principles and the matters that you've just been asked about, it's right, isn't it, that appropriate medical treatment as the concept for detention under the Act is treatment that is appropriate for a particular patient, determined by the patient's medical condition and the risk a patient presents as a consequence or feature of that condition; would you agree?
A. Yeah.
Q. So as a treating or assessing consultant, you need to have the full knowledge as to risk when making decisions for detention or discharge.
A. That's true.
Q. Thank you. And so can I then just finally pick up on one of the matters that you've addressed in your evidence, and I think it's the significant evidence as to risk that you've been sharing with Ms Langdale that are in the notes that the family had provided to

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

A. That's right, yes.

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

A. Yes.

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

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

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

A. That's right, yeah.

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

A. Absolutely, absolutely.

Q. The police.

A. Yes.

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

it's relevant to risk assessments --

A. Yes.

Q. -- the contact.

A. Sure.

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

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

you, when you had your interactions with VC and your assessment, is it deprived you as a consultant of highly relevant information as to risk?

A. Could you repeat that last bit?

Q. So with you -- there not being the information as to risk in the medical records, first of all, and you not having those notes --

A. I didn't have that, no --

Q. -- that were provided by Dr Seedat, it deprived you, as a consultant in your interactions, of highly relevant information as to risk?

A. That's true.

Q. Highly relevant information as to appropriate medical treatment --

A. Yes.

Q. -- and decisions you made at various times about detention; and would you agree?

A. If -- I mean, the information I had on that point -- and just to clarify, if I'm getting the question right, and answering your question correctly -- if I knew about this information, of course it will -- I will be incorporating those risks into my decision-making, yes.

Q. Thank you. Then finally, we know that you attended Salisbury Street in September 2021 as one of your assessments, when the attack on the police officers took

place.

A. Yes.

Q. Again, just by way of information that had been available, had you been made aware that VC had had that accommodation before he moved to Brook Court where there was the incident in May of 2020 where he attacked other neighbours and then the neighbour jumped out of a window?

A. That's right, yeah, I was aware.

Q. Were you aware that he had been previously at Salisbury Court --

A. Yes, that's right.

Q. -- and he had left there and moved to Brook Court because he thought he was being monitored and listened to at Salisbury Court; you were aware of that?

A. Yes, I was aware of that.

MS CARTWRIGHT: Thank you very much, Dr Manzar.

THE CHAIR: Yes, Mr Straw.

Questioned by MR STRAW

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

First issue, medication. In your witness statement at paragraph 65, you say the 13 July 2020 incident, you say of that:

"... relapse was highly likely due to his medication non-compliance."

Then paragraph 122, you address the 3 September 2021 incident, and you explained there: "He [also] stopped his ... medication .." at that point. So prior to that incident.

Then at paragraph 289 of your witness statement, you refer then to the next one, the 28 January 2022 assessment and you say at that point:

"... out of many CHRT [many crisis resolution team visits] he had only taken a few tablets of antipsychotic[s] ... the rest he either [threw] away or [spat] them [out]."

Now, in light of that history, would you agree that stopping medication was a clear relapse warning sign?

A. Just giving the facts that has been recorded, yes.

Q. You explain in respect of two of those incidents, so in your witness statement, you explain in respect of the 13 July incident and also the 28 January 2022 incident, so it was 2020 then the 2022 incidents, he told you he was taking his medication when in fact he wasn't. Would you agree, you couldn't rely on his assurances that he was taking his medication?

A. I think was difficult with certainty to say he was taking his medication, but the record has been indicated that he was not fully compliant with his medication even if he was partially.

Q. Thank you. That's medication.

The next issue is the 3 September 2021 incident. Could we have NHFT0000168 on screen, please. It's the RiOs, and page 164. Thank you.

So there's an entry there at 8.58 pm on 2 September, 2021 and it refers to the assessment that you and Dr Lomas carried out and the notes that Jen Shaw, the AMHP, spoke to VC's mother. Then one paragraph down:

"Mum tried [to speak to] him on his phone and rang Jen back - he hadn't responded which was felt to be very unusual and concerned mum, hence a further attempt at [Mental Health Act Assessment] this evening."

Do you see that?

A. Yes, that's right, yeah.

Q. Were you aware of that at the time? Was it your understanding that it was that phone call from Mum that had led to that assessment?

A. I can't fully recall, but I guess this is correct information, yes.

Q. Thank you. Then the next entry which is 3 September at 1.58 pm notes Mum said:

"Celeste ... had spoken to [VC] for an hour last night. ... [VC] had spent much of the call talking about the Government monitoring him and it was difficult for her to challenge these beliefs as [VC] appeared quite

fixated on them."

Do you recall hearing about that information?

A. I can't recall with the full details. From what I recall from the time when I have attended to do the assessment, those information was given in line to me that he was paranoid, he was suspicious, he was talking about conspiracy against him, but I can't, with all honesty, I can't remember word by words what I hear. But yes, this is just because of time lapse.

Q. The entry in your assessment on that date was read out earlier when you record him talking about the conspiracy by Highbury Hospital, he thinks mental health workers are working with the judicial system against him.

A. That bit I remember clearly, yes.

Q. Was that part of his illness, that delusion that the mental health services were conspiring against him?

A. I guess so.

Q. Is that one of the things that led him to be guarded and disengage, and so on?

A. Yes, with subsequent more information, which I can't see right now, I think that view is now completely evolved with change because a lot of informations which we didn't know before confirming how severely he was indulged with those conspiracy theories and theories about how mind -- and his mind was controlled and how he

was affected by those delusional beliefs.

Q. And one thing you say later, paragraph 297 of your statement, about the January 2022 incident, is to indicate that is correct he disengaged at that point, and that was a sign of relapse. Would you agree with that, that disengagement was a sign of relapse?

A. I mean one can argue sign of, yes, but again, what has led to what? That medication non-compliance has led to relapse, that medication didn't work. Was there any other factors may have caused his relapses? Because what schizophrenia and psychosis, yes, medication is one factor in a person can relapse. Stresses can cause relapse. Drugs can cause relapse. Personal conflicts can cause relapse. So there's many factors.

I can see why you stating that the medication non-compliances may have been, or have been, partially or fully, implemented in his relapse, without a doubt, yes.

Q. The way you put it at 297 -- and again, sorry to jump around, this is about the January 2022 assessment, you say:

"Superficial engagement with the crisis team indicated that VC was in an acute phase requiring close community input for stabilisation ..."

So there that indicates, doesn't it, his

disengagement, his superficial engagement, was an indication that he was in a state of acute relapse; would you agree with that?

A. Yes, I mean, whether that note is I think you're referring to what Dr Lomas has noted, stated to record it in his RiO -- it's in the RiO notes. I think prior to that assessment, the information was that out of many Crisis Resolution Home Treatment Team visits, he had been seen either he's taking partially the medications or either not swallowed it but the water was spitten out.

As I said, I'm -- I wasn't working with the Crisis Team so I'm not fully aware of what exactly has happened, but information was giving, recorded, it looks like applying *(sic)* that he was not taking his medication.

Q. Okay and thank you, and the last question, and this is going back to 3 September 2021 incident, in your witness statement, para 166, you say that:

"... [VC's] actions were dominated by psychotic processes rather than rational control."

Can you explain what you meant by that?

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

Q. Of course. It's Dr Manzar's witness statement, please, if that --

A. Oh it's that one, yeah.

Q. -- if we can see it on screen. So WITN0350001, and it's page 39, please. So paragraph 166 there and the last three lines of that paragraph.

A. Sure.

Q. Perhaps if those --

A. Could I read for a second, please?

Q. Thank you. *(Pause)*

A. That's true, yes.

Q. And so it was your view, was it, that it was his psychotic processes that led him to cause harm, then?

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

MR STRAW: I've run out of time so I'll leave it there. Thank you very much.

THE CHAIR: Thank you.

Yes, Mr Beer.

Questioned by MR BEER

MR BEER: Just three short topics, Dr Manzar.

The first is about information and the obtaining of information.

You were taken to Dr Seedat's summary of the 20 pages of notes that VC's brother had supplied, which was a combination of narrative and quotes from text messages; do you remember that?

A. Yeah.

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

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

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

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

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

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

within it in broad terms, asking openly, whose responsibility is it to ensure that information like that, which students had passed to the University, made its way through to you when conducting the Mental Health Act Assessment?
A. Yes, this is all relevant, and I guess sharing informations coming to the team, it's a highly, you know, valuable.
Q. I'm not asking at the moment whether its relevant or valuable; I'm just trying to pin down what the information flow should be, ie, how it should make its way through to you.

The University to the police, the University to the AMHP, the University to the clinicians directly. For the AMHP to find out for themselves, for the clinician to find out for themselves, what's the expected flow of information, please?
A. Well, first of all, I mean, when the Section 135 warrant has been executed, the process goes through the court, and the information is provided by the AMHP to the court and I guess in those lines, informations is shared to police as well and police vice versa has to share this information. It's two-way traffic. It's not just one party.

And those sharing informations between police and

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

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

A. That's true.
Q. Where there's a possibility that they have relapsed after discharge?
A. That's true.
Q. For example, if the patient has been discharged under a previous admission and reappears under a different or unclear clinical state?
A. That's correct.
Q. Or where there's a need to establish whether this is truly a relapse?
A. That's correct.
Q. Or where the presentation is acute and risky --
A. That's true.
Q. -- and there hasn't been a recent sufficient assessment to guide longer term planning?
A. That's right.
Q. Do all of those issues come before you get to consider the principle of applying the least restrictive measure to the patient?
A. Yes.
MR BEER: Thank you very much.

Questioned by THE CHAIR

THE CHAIR: Thank you.
Just a couple of questions, Dr Manzar.
A. Yes.

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

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

instance, but with all honesty, just because of the time lapse, I can't remember the full details.

THE CHAIR: You've referred to him being managed, VC being managed in the community, several times. What did you understand "the community" to mean, in that case where you were dealing with whether he should be admitted or not, management in the community?

A. The one assessment, Chair, which I refer to the community assessment was on the 19th January --

THE CHAIR: Yes.

A. -- and that was when we've seen with the Crisis Team, and I wasn't aware of the exact details of what has happened to the flatmate --

THE CHAIR: Because somebody's community includes those they're living with, doesn't it?

A. Sorry?

THE CHAIR: It includes those who they're living with.

A. Yeah, but I wasn't --

THE CHAIR: In this case he was living in a flat with the students --

A. With the student.

THE CHAIR: -- some of whom, one of whom had complained about the incident which was in the notes.

A. Yes, I --

THE CHAIR: So how did you understand that the management of

that could be achieved?

A. I wasn't fully aware of what I was -- I mean the information came, Chair, at that time was to me that the student has been temporarily accommodated somewhere, but I wasn't quite sure that the person was still there. If I am getting this correctly, I wasn't aware of the fact that someone was still there.

THE CHAIR: So the only way that this could be managed was by moving all of the students out and leaving VC in the flat on his own, wasn't it?

A. Yes, in a way, yes, yeah.

THE CHAIR: And did you think that that was an appropriate management in the community of the risk?

A. I guess at that point what the informations relate to me, and what I know, I mean I can't assess it in the sense that I can't remember the full details of this, but, as I said early on in my evidence, Chair, some of these information came after the Mental Health Act Assessment was completed, and by that point I wasn't there. But it doesn't mean that they should not contact me. I was available if I knew that this was a carrier in terms of this risk assessment could not be managed appropriately, of course I would have acted on those appropriately.

THE CHAIR: You'd been concerned about your own safety,

hadn't you, in -- as a result of the incident with PC Pritchard.

A. Yes, with -- yes, with everyone including --

THE CHAIR: So you'd wanted the police to go along with you --

A. With everyone, yes.

THE CHAIR: -- yes, the next time. It may seem an odd question, but would you have been content, being the student, to have gone back into the flat with VC?

A. Of course, of course.

THE CHAIR: You would have done?

A. I would be worried, yes, if someone was there in the flat --

THE CHAIR: You would be worried. And that was because of the risk he posed, wasn't it?

A. Yes.

THE CHAIR: Thank you. Well, we'll finish there for today. Start again tomorrow at 10.00.

(4.31 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X