Witness Name: Benjamin John Williams

Statement No: WITN0115001

Dated: **7 November 2025**

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF BENJAMIN JOHN WILLIAMS

I **BENJAMIN JOHN WILLIAMS** of Nottingham City Council, Loxley House, Station Street, Nottingham NG2 3NG **will say** as follows: -

1 I am an Approved Mental Health Professional ("**AMHP**"), in the employ of Nottingham City Council.

2 Where the content of this witness statement is within my personal knowledge it is true. Where it is outside my personal knowledge and derived from other sources, it is true to the best of my information and belief.

Introduction

3 During the course of my duties as an AMHP, I saw Valdo Calocane ("**VC**") in May 2020. This was my only work with VC, and the Inquiry has requested that I provide a statement about it.

Personal background

4 I studied at Nottingham Trent University. I graduated in 2017 with a degree in Social Work.

5 I began working for Nottingham City Council ("**NCC**") in June 2017 as a social worker in the Mental Health Social Care South Team.

6 In 2018 I began my training to become an AMHP and undertook a post-graduate certificate in High Specialist Work in Mental Health Services ("**AMHP**"). This was provided by the University of Birmingham. The course comprised of academic work and a work-based placement that took place in two 6-month blocks of studying. 'Stage 1' took place between April and October 2018, with 'stage 2' occurring April to October 2019.

7 In autumn 2019 I officially qualified as an AMHP and started to practice in the role from January 2020. I had been qualified for four to five months when I saw VC for the first time.

8 I found my way into becoming an AMHP because I developed an interest in mental health during the course of my degree. I have recently been a practice mentor assessor for a new AMHP trainee who has just finished the course.

The Role of the AMHP

9 An approved mental health professional ("**AMHP**") is a qualified social worker, nurse, occupational therapist or psychologist with additional training in mental health who carry out Mental Health Act assessments ("**MHAA**") to determine whether a person requires compulsory admission to hospital or not. The AMHP is approved by the local authority to undertake this work.

10 An AMHP is legally obliged to maintain continuous professional development ("**CPD**") and must evidence 18 hours of learning activity per year.

11 A request for a MHAA can come from a variety of sources such as community mental health teams, hospitals (both mental and physical health), police custody suites, or families.

12 When a request for a MHAA is made, it is the responsibility of the AMHP to initially assess whether a MHAA is necessary at that time. If so, the AMHP is responsible for arranging the MHAA, including the attendance of two medics. The AMHP will gather as much necessary information that is available. This could be from relevant case notes or previous assessment, and/or discussions with relevant people such as family, carers, support staff, and medical professionals who know the person.

13 At least one of the assessing medics should be approved under section 12 of the Mental Health Act 1983 ("**MHA**") and it is preferable for one of the medics to

have a previous acquaintance with the person being assessed.

The AMHP needs to ensure that the person being assessed is interviewed in a *suitable manner*.

14 Two medical recommendations are required for a person to be admitted to hospital under the MHA. Once the medical recommendations have been received and a bed has been identified, the AMHP can then decide to complete the application for detention should they feel that the statutory criteria for detention has been met. This is usually a section 2 (assessment order for up to 28 days) or a section 3 (a treatment order for up to 6 months).

Both medical recommendations and the AMHP application are required for a person to be detained under the MHA

15 Whilst it is ultimately the AMHP who decides whether a person is to be detained should two medical recommendations be completed, the decisions are often taken in collaboration with the assessing medics.

16 Once a decision has been made to detain a person under the MHA, it is the responsibility of the AMHP to convey that person to the identified hospital ward. This responsibility can be delegated to another agency. In Nottingham, East Midland Ambulance Service ("**EMAS**") are contracted to convey patients to hospital. A Regional Mental Health Conveyance policy is in place for this [WITN0117004].

17 As well as the MHA and its associated Code of Practice [NHSE0000312], other local policies and procedures followed when performing AMHP duties are:

a. Section 136 policy - for when people are detained by police under s136 of MHA. [WITN0117003]

b. Section 140 policy - for when an emergency bed is required. [WITN0117006]

c. AMHP Operational Policy [WITN0114004]

d. Trans and Gender Diverse Patients Policy and Procedure. [WITN0117007]

e. Search Warrants - During Court Hours Applications in the Midlands Region of HMCTS [WITN0117005]

f. AMHP Guidelines when Allocated a MHAA [WITN0117010]

g. No Bed Guidance [WITN0114008]

h. Lone Working After Hours Procedure [WITN0117008]

i. EDT and Daytime AMHP Interface Protocol **WITN0115002**

j. Conveyance to Hospital Policy [WITN0117004]

k. Nottinghamshire County Council Guidance – Mental Health Act Referrals to Nottinghamshire County and Nottingham City AMHP Services [WITN0114010]

l. East Midlands AMHP Cross Border Protocol [WITN0114011]

MHA Referral Process

18 Referrals are received, via an online portal, from a number of sources including Local Mental Health Teams ("**LMHT**"), Crisis Resolution and Home Treatment Team ("**CRHT**"), psychiatric hospitals, physical health hospitals, emergency department, police, Liaison and Diversion ("**L&D**") and GPs. Families, including

nearest relatives, do sometimes request MHAAs, but the vast majority come from professionals. To note, at the time of my involvement with VC, MHAA referrals were received via a telephone call.

19 Prior to an assessment going ahead, the Crisis Resolution and Home Treatment Team ("**CRHT**") gatekeep the assessment. This can sometimes mean that someone from CRHT will go and see the person first to see if there is any scope for community treatment and prevent admission. They could also agree the need for MHAA at the point of referral if it is felt these is no scope for community treatment.

20 Once an assessment is going ahead and has been allocated to an AMHP, the AMHP will start to gather information. This will come from as many sources as is available and will often include a conversation with the referrer, any other relevant professionals, such as Community Psychiatric Nurses ("**CPN**"), carers, support staff, ward staff. The AMHP will also speak with family and nearest relative where possible – it should be noted that all attempts should be made to consult with the nearest relative if a section 3 is being considered. Information will also be taken from LA records, such as previous AMHP reports, assessments and case notes.

21 Working at Stonebridge Centre (a Nottinghamshire Healthcare NHS Foundation Trust ("**the Trust"**) site) gave me read-only access to the Trust's records, which gives me access to any up-to-date Care Programme Approach ("**CPA**") documentation and running records from the Trust's perspective. There is an information sharing agreement between NCC and the Trust. It should be noted

that, during the first lockdown of the Covid pandemic – when I had contact with VC – NCC staff were ordered to work from home. At this time, this meant we did not have access to the Trust records due to this access being through fixed PCs at our workplace. Note, not all AMHPs have always had access to the Trust's records. AMHPs who are not based in mental health social care teams, and therefore not based in Trust buildings, did not have access to RIO. However, remote access is now possible. Access requires a team manager to place a request with the Trust.

How I conduct MHAAs

22 When I receive a referral, I start by gathering information as explained in paragraph 19. I then look at sourcing the most appropriate medics. I preferably want my first medic to be one who is already involved in the person's care, i.e. their responsible clinician ("**RC**"). Where they are not available, I ask for a medic from CRHT to be present. The vast majority of medics we use are all s12 approved. For the second medic, I will seek someone who may have assessed the person under MHA before or have a particular specialism (e.g. older people or learning disability). I also take demographics into account, for example, when assessing a female, I will try and ensure I have a female medic present.

23 I will then contact the Bed Management Team ("**BMT**") to ensure that the person being assessed is on the bed list.

24 Sometimes we may choose to wait a period of time before conducting the assessment so that we can assess with who we view is the most appropriate medic but this must be weighed against the need to see the person quickly. It depends on the type of MHAA and the circumstances surrounding it whether you can wait or not for your preferred medics. For community assessments where one of the medics is not a CRHT medic, we may request the attendance of a band 7 nurse from CRHT as they can be involved in community treatment planning if necessary.

25 The MHAA will take place with the AMHP and two medics (and nurse if applicable) all present at the same time. Prior to seeing the person being assessed the team will discuss the case and I ensure that both medics know the pertinent information needed for the assessment. We then see the person being assessed. I will introduce myself and the team to them and explain the purpose and potential outcomes of the assessment. We will then interview the patient.

26 Once the interview is completed, the assessing team will have a separate discussion away from the assessed individual to decide on the best course of action. If we feel that the person may have a mental illness that requires further assess and /or treatment, we then need to be satisfied that the criteria for detention has been met and that detention under the MHA is the least restrictive option.

27 If it is believed that detention is the least restrictive option, the medics will then complete their medical recommendations and I will seek a mental health bed

for the person to be admitted to. Once a bed has been identified, I will then complete the application for detention and make arrangement to convey the person to that bed. Relevant parties, including the nearest relative, will be informed of the decision.

28 If it is believed that community treatment is possible, then arrangements will be made with the LMHT or CRHT to deliver this. Once the decision has been communicated to the relevant people, including nearest relative, the AMHP no longer has a role to play.

Risk Assessment

29 A part of the detention criteria for section 2 and 3 is that it is necessary for the safety of the person or the protection of others. Therefore, assessment of risk forms a core part of any MHAA. If a person is a risk to themselves or others because of their mental illness, due consideration needs to be given as to whether that risk can be managed in the community. If it is not felt that the risk can be safely managed in the community, then detention under the Act becomes likely.

30 A risk of violence and/or aggression towards others will be a significant factor when assessing that person. If it is felt that other people are at risk due to the violence and/or aggression that is associated with a person's mental illness, there will be a high likelihood that they will be detained under the MHA.

31 As a part of the assessment and subsequent decision, it is important that the assessing team are aware of the risks at that time as this will inform whether a community plan or an admission will be required. Historic risk that is associated with previous relapses of mental illness should also be taken into account.

32 Other than my encounter with VC. I have never been involved in the care of another mental health patient who, following discharge, killed or seriously injured a member of the public.

Involvement With and Knowledge of VC

33 I met with VC on one occasion, to undertake a Mental Health Act assessment, on 24 May 2020. It was a bank holiday Sunday and I was covering additional Emergency Duty Team ("**EDT**") shifts due to staff shortages as a consequence of the first Covid lockdown. I had never met with him before and had no dealings with him after. That said, I did send an email to AMHP Samantha Dooley on 18 January 2022 [NOCC0000151]. I had seen VC's name in the electronic *'in-tray'* on Nottingham's systems. I was aware from office discussion (although I do not recall the specifics of this) that he had been violent during a Mental Health Act assessment previously. I therefore emailed Sam in the following terms:

'Hi Sam,

Sticking my nose in, but noticed VC is in the tray. Just wanted to make sure you are aware that he has been very violent during last MHAA'

34 Samantha Dooley responded [NOCC0000151]:

'Hello thank you feel free to contribute at any time. I am aware thanks, just trying to get hold of Clarisse to discuss it. Sam'

35 As set out below, VC was not violent at any point during the assessment that I undertook. My reference to him being violent during *'last MHAA'* was not to my work with him.

36 Turning to my personal work with VC, I understood that he had been arrested on 23 May 2020, the evening before I met him. The referral said he had been arrested for breaking and entering and criminal damage at a student flat. He had been taken to A&E to rule out any organic causes and was returned to the police custody suite once it was established there were no organic causes. I do not have access to the records of Nottingham University Hospitals NHS Trust records and so was not aware of the specifics of his visit to A&E.

37 The Covid situation had limited my access to records and therefore I only had the referral and my search of Nottingham's records. I might have been able to get something from the Trust if it had been a weekday as our health and social care coordinators were still able to access the records and send them to AMHPs. However, as this was a bank holiday Sunday, I had no such access.

Having said that, this would likely have been limited due to this being his first presentation to services.

38 The AMHP Report Referral and Assessment form dated 24 May 2020 [NOCC0000044] and the Liquid Logic case notes [NOCC0000034] do record there was a delay in the assessment. The referral was made at approximately 09:15 but we were awaiting CRHT gatekeeping assessment which we were informed had happened at 12:12 and allocated to me at 12:23. From Liquid Logic case notes, it appears the delay from 09:15 to 12:23 was due to waiting for CRHT to complete a gatekeeping assessment [NOCC0000034]. I am unclear as to why there was a three-hour gap. However, VC was safely in police custody at the time. The MHAA commenced at 14:00.

39 A band 7 nurse from CRHT, Annette Palmer, agreed to attend the MHAA [NOCC0000034].

40 When I met with VC he was clearly confused.

41 When assessing people in police custody, we sometimes interview them in the cells. Sometimes, if there is a higher risk of violence, we will only observe them through the cell door observation hatch. VC was brought to us in an interview room. It was clear the police did not feel that he represented any danger to us. He looked confused, scared and quiet. He explained that he thought his mother was being raped in the flat next door and he was trying to prevent this. He had not slept for several days and was hearing voices. When asked about treatment he stated that he wanted things to go away and was accepting of

treatment. He provided the information, which is shown in my notes, but was not agitated or aggressive [NOCC0000044]. He was a large powerful man, but his demeanour was almost childlike. We discussed reality and psychosis. VC was confused by what was real and what was not. He also presented with other symptoms of psychosis such as paranoia; he was guarded when asked whether he believed he was being monitored, and thought disorder; taking periods of time to answer questions as if ordering his thoughts was a challenge for him at that time.

42 I then spoke to the police about the circumstances of the arrest and checked if he had been violent after the arrest itself. I spoke with VC's mother after the assessment. She told me that he had never suffered with mental health difficulties in the past, had never been violent or aggressive. I do not recall if I spoke to the CPN at the police station. I was not able to speak to the university because it was a Sunday.

43 The police told me that he had broken into a flat which was aggressive behaviour. However, they were clear he had not been violent to anyone and had not harmed anyone. I do not recall being told where he was arrested.

44 My AMHP report record indicates that VC had no previous mental or physical health issues [NOCC0000044]. This was drawn from Nottingham's records, which did not show anything about him, and his mother's account – that there had been no previous mental health problems. This summarises the best information available at that point.

45 The fact that this was a first presentation and there was no history of mental health issues did influence my assessment and decision making. As indicated, those undertaking an MHAA are required to devise the least restrictive plan. It is a legal presumption that the patient will be dealt with in accordance with the "*least restrictive principle*". From discussions, VC knew that he had a problem and agreed that he needed help [NOCC0000044]. He had agreed to be treated, and he had agreed to take medication. This was a first referral with no history of significant mental health problems. With that in mind, we landed on a community treatment plan. On the information available to us this was the appropriate, and least restrictive, option. VC had not threatened a person, had shown no signs of violence whilst with the police, engaged with us and was prepared to accept treatment. In the circumstances, there was no justification for depriving him of his liberty under either Section 2 or Section 3 of the MHA. Anette, CRHT band 7 nurse, agreed that CRHT could implement the community treatment plan.

46 As my notes record, we met with VC at the Bridewell Custody Centre [NOCC0000044]. This meeting involved me, Dr Ghandi, Dr Malik and Annette Palmer.

47 We saw VC in a room, not a cell [NOCC0000044].

48 I recall that VC was very cowed, hunched up and childlike, almost like a naughty child. His head was down; he was quiet and afraid – especially of the voices that he had been hearing. He was confused and frightened. He spoke to us in a quiet monotone. He did not say much. He spoke in short sentences

and gave short answers. He sat very still and barely moved. I believe his behaviour during the assessment was genuine.

49 Dr Ghandi asked him a question about whether he felt he was being watched (to ascertain if VC was paranoid). VC responded defensively with a question to the effect of "*how do you know that*" [NOCC0000044]. When he was asked this question, he looked up. It had clearly got his attention, and this was the most engaged that he became during the interview. However, at no point did any of us feel that he represented a risk. The answers were guarded. They showed a slightly paranoid mindset, and he shut back down afterwards.

50 Throughout the interview, I felt entirely safe. I cannot speak for the others, other than they did not express any concerns for their safety at any point during the interview.

51 I recorded details of the interview on my AMHP Report Referral and Assessment Form [NOCC0000044], completed the same day. My description of the interview is as follows:

> *"V came upstairs and joined us in a meeting room. I explained the purpose of the meeting and the potential outcomes and introduced the assessing team.*
>
> *V seemed to struggle to follow the thread of conversation – it would often take him a number of seconds to respond to a question. He often also, at times, didn't register the question that was asked and so it would have to be repeated.*

V stated that he had not slept for seven days and that he feels confused and tired. He explained the situation that led to him being at Bridewell. He said that he could hear screaming and that he could hear voices telling him that it was his mother and she was being raped. This is why he broke into the flat.

When asked about the voices, V said that he had been hearing them for a few days now. He explained they did not talk directly to him, but he can hear them talking about him and his family.

Dr Ghandi asked whether V feels he is being watched in his apartment – whether he feels there may be cameras or microphones listening and watching him. V asked how we knew this in a defensive manner. He then became guarded and suspicious of us. We reassured V that we know nothing of this situation and are merely asking questions to better understand his mental health.

When asked, he was unable to pinpoint any social stressors. He said he had been keeping up with his university work and regularly attends online lectures. He is in contact with friends via video conferencing and regularly speaks with his mother over the phone.

V said that his experiences are abnormal and that he would like help with them. When asked whether he would consider taking medication, he agreed.

We asked V whether he had any more questions – he asked us whether his mother is OK, at which point he became tearful. We said that we have no contact with his mother, but that we would like to speak to her. He gave us permission to contact his mother, C, if Bridewell staff were able to give us her number.

We then sent V back to his cell."

52 Our interview was an important source of information on the question of what we should do with VC. Struggling to follow the thread of conversation showed evidence that he was distracted. Medically, that could be evidence of thought disorder, a symptom of psychosis and was a factor that led us to believe he was experiencing this [NOCC0000044]. VC reported that he had not slept for seven days and that he could hear screaming and voices. All these factors suggested he was struggling. They fed into a decision that he was suffering from psychosis and, therefore, needed treatment. The symptoms of illness that he was describing are sometimes associated with schizophrenia. However, it is not appropriate to diagnose schizophrenia on the basis of the first episode. At this first presentation, it was clear VC was thought disordered, feeling paranoid, and experiencing hallucinations. The combination of these matters led us to psychosis.

53 AMHPs are required to assess the risk presented by people with mental health issues. The risk factors are set out on page 5 of my AMHP Report Referral and Assessment [NOCC0000044]. Earlier in that document, I say that it is unclear what the risk factors were. That part of the document refers to a discussion I was having with the police officer before I saw VC. I wanted to know what the risk factors were and had asked. It is important to bear in mind that the assessment process was ongoing. I spoke first with the police, then we saw VC, then I spoke with his mother.

54 Returning to the risk factors, I recorded the following [NOCC0000044]:

Risk:	**Evidence:**	**Risk Level:**
Risk to self	Further MH deterioration	Likelihood: high – Severity: high
Risk to others	Aggression towards neighbours – broke into neighbour's flat	Likelihood: medium – Severity: high
Other:	Disruption to studies	

55 Clearly, the risks were further deterioration in his condition and aggression to others. I knew what people had told me at this point. He had tried to break into a neighbour's flat. It is important to note - with these records, when we are told something, we will write it down. Accordingly, my notes represent the information that I had.

56 The significance of these risks was that VC was suffering from a mental health episode. He was unwell and needed treatment. These episodes do not heal themselves and he would get worse if untreated. The break in was significant

because it had happened. It was clear that these events had the capacity to disrupt his studies and quality of life.

57 I use the word '*aggression'* in my notes because he had tried to break through a door and had done that [NOCC0000044]. I view this as an aggressive act. This was not physical violence to a person. He wanted to break into a room to see if his mother was in there. This is how I differentiate between the words violence and aggression. In this instance, VC had no intention to cause anyone harm but did use aggressive means to gain entry to the flat to see if his mother was there.

58 Turning to the risk assessment itself, what I was saying was [NOCC0000044]:

- Deterioration. If he was not treated, he would become worse.
- Neighbours. On reflection, I think this risk should, perhaps, have been graded as high as it had already happened. I suspect my approach at the time (and I am having to think back five years) was that the likelihood of further problems was low if VC was treated. That is why I think I recorded the risk as medium.

59 Moving forward, we had to look at the question of treatment. It was clear to me that VC lacked capacity to consent to treatment. As I recorded in my notes, he was *"agreeable to taking medication and accepting of CRHT input, stating that he did want help"* [NOCC0000044]. I also recorded *"he lacked insight …. however, it is in V's best interest to pursue home treatment at this time"* [NOCC0000044]. I ticked the "yes" box in response to the question *"Does the*

citizen have capacity to make this decision?" [NOCC0000044] I acknowledge that I should have ticked "no" in this instance.

60 This requires me to explain the principle of "*best interests*" treatment and the interaction between the MHA and the Mental Capacity Act 2005.

61 The starting point here was that VC lacked capacity. This was because I had formed the view he was suffering from a thought disorder, and it was unclear how much of our discussions he was taking in. He had some understanding of what was being said but not capacity. He was, however, prepared to accept help from the Crisis Team and medical professionals. This meant it was permissible for us to treat him in his "*best interests*" under the Mental Capacity Act. This is the situation in which a patient lacks capacity but is willing to take medication. It is in their best interests to take the medication and, therefore, you allow them to do so. If VC had refused treatment the MHA would have been a more appropriate legal framework. Here, it was in his best interests to treat him and for him to take medication. The Crisis Team would be visiting him two times a day to ensure that it was taken – in this case an anti-psychotic drug [NOCC0000044].

62 Returning to the "*least restrictive approach*" there was no current risk that would require him to be brought to Hospital because he had agreed to take anti-psychotic medication.

63 My notes recorded that VC lacked insight [NOCC0000044]. This is a term more commonly used by medics which means he could not distinguish between

reality and his psychosis (the voices). VC had genuinely believed his mother was in the room next door and that is why he tried to break in there. Lack of insight is clearly a risk. This is why I had asked the police about whether he had been violent to a person. If they had confirmed he was, that would be an increased source of danger. This is the point about adopting a least restrictive approach. VC lacked insight but he was happy to accept treatment. We were confident that when the Crisis Team turned up with his medication, he would take it.

64 It is important during an assessment process that a nearest relative is identified. We are required to notify the nearest relative of assessment for possible detention. We learned that VC was not married, lived alone, had no children over the age of 18. That meant one of his parents was nearest relative. At this distance in time, I cannot be specific as to why I concluded it was mother rather than father. My notes record that I spoke with her as part of the process [NOCC0000044]. I do not recall the details of that conversation – beyond what I have written. The only aspect that sticks in my mind is that she was on her way to Nottingham because she had been concerned about him after his arrest. That would have influenced our decision that community treatment was appropriate because a mother was on her way to provide support to VC. I do not recall how she presented to me on the telephone. If there had been anything unusual, I would have written it down. On that basis, I have to assume that she presented as an ordinary concerned parent would in these very difficult circumstances.

65 My discussions with mother were useful in the assessment process. First, she confirmed there had not been any previous mental health episodes and second, that she was coming to Nottingham [NOCC0000044]. That would give VC a support network and a support person.

Assessment Outcome

66 It is important to bear in mind that the legislation, and guidance issued under it, requires clinicians to devise the least restrictive option for mental health patients.

67 Here, the information that we had confirmed that VC had no history of violence, was agreeable to taking medication and we felt (from our assessment) that a best interests decision could be taken to prescribe medication to him [NOCC0000044]. The medication in question would be olanzapine, which prescribed by Dr Ghandi. When assessments are undertaken in police stations, there is not often access to drugs. Accordingly, the plan was that VC would be released, and the Crisis Team would visit him to supervise the taking of olanzapine that evening. This would be done twice daily for the foreseeable future.

68 This plan was in line with the least restrictive approach. VC would be released to the community and seen by the Crisis Team two times a day – to ensure he took medication. Olanzapine is often the first medication that I see prescribed in respect of psychosis. As such, I was not concerned that Dr Ghandi was proposing to prescribe anything inappropriate.

69 I mentioned that a Band 7 nurse from the Crisis Team joined our discussions with VC (Annette Palmer) [NOCC0000044]. Importantly, she was in agreement with the suggested treatment plan and suggested that two visits from the crisis team was an appropriate way forward.

70 My notes do not record the discussions, but it is inevitable the four of us would have discussed Hospital options, versus community treatment. There was no disagreement. If one of the medics (or Annette) had expressed a different view, that would be recorded in the notes. If I was taking an independent decision to go against the views of the medics, I would record that in the notes. That can sometimes happen where the doctors have a difference of opinion on detention – where one wants to detain and one doesn't. My notes for this occasion record no areas of disagreement [NOCC0000044]. It should also be noted that a medic can still write a medical recommendation for detention even if the AMHP is not wanting to sign an application and that had not happened on this occasion.

71 Based on the tragic events that happened later, I have reflected on this encounter and asked myself the question "*would I do this differently?*" Looking back, on the information that was available to us at the time, I would expect the same decision would be made now if the events of May 2020 were repeated today. I cannot see, on the basis of what was known then, that an AMHP and two doctors would have detained VC under either Section 2 or Section 3 of the MHA.

72 At the time, we made a consensus decision, and we were all in agreement with the plan going forward. This is why my notes record that the risks were deemed low enough for home treatment to be explored [NOCC0000044].

73 I have mentioned that olanzapine was prescribed by Dr Ghandi. That was not my decision and is not my role. I am not a doctor. However, when undertaking assessments, the doctors are at liberty to prescribe if they think that is appropriate.

74 Medication was discussed with VC. We told him that we thought he was experiencing psychotic symptoms, and an anti-psychotic medication could be prescribed. He was agreeable to that. He stated that he "*wanted it to all go away*" [NOCC0000044]. That was his response to us on medication. He was willing.

75 Olanzapine is normally an oral tablet. The plan was that the Crisis Team would attend VC's home with this and observe him taking it. Medics do not routinely bring medication with them to MHAAs. As such, I was not in a position to observe the olanzapine being distributed or taken. There is always going to be a concern that patients will not take medication. However, we addressed that here with our plan for the Crisis Team to visit and observe the medication being taken [NOCC0000044].

76 I did not make a separate referral to the Crisis Team. CRHT had been aware of VC's arrest from the outset and operated as gatekeeper for the question of assessment. Annette Palmer was also at the assessment itself.

77 After the MHAA, I did not have any further communication with CRHT or other medical professionals involved in VC's care. My job was to organise the assessment and get the appropriate professionals to it. Once the assessment was done, my role had ended.

78 I am aware (from documents) that our plan for VC was overtaken by events. He was arrested shortly after having been released. He was then subject to a second MHAA conducted by AMHP Eleanor Cullen [NOCC0000045 – AMHP Report Referral and Assessment dated 25 May 2020]. I did not have any discussions with her. However, I had written up my notes of the assessment before she saw VC. As such, my notes were on the system for her to view [NOCC0000034] [NOCC0000044]. My assessment had taken place on a Bank Holiday Sunday, and Eleanor's on a Bank Holiday Monday. We had volunteered for these shifts outside our normal working patterns to help out during the first lockdown due to staff shortages. If the assessments had taken place during ordinary working hours, Eleanor and I would have been more likely to have had a discussion before her assessment.

Recommendations

79 With regards to my MHAA with VC, it is hard to make recommendations given the circumstances of the first covid lockdown presenting us with unique challenges. I therefore have no recommendations based on my one piece of work with VC.

80 On a more general basis, I do feel that mental health services require more resources that would offer an *assertive outreach* approach that could offer

support to those with longer-term mental illnesses and are harder to engage with in the community.

81 I would also recommend more integrated working between agencies such as health and social care, and better avenues of communication with other agencies such as police, GPs, private hospitals etc…

Statement of truth

I believe that the facts stated in this witness statement are true. I understand that Proceedings for Contempt of Court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: GRO-B........................

Print name: Benjamin Williams……………………

Dated: 07/11/2025………………………..

Index to First Witness Statement of Benjamin Williams

No	Inquiry URN	Document Description	Your reference
1	NHSE0000312	Mental Health Act Code of Practice	
2	NOCC0000034	Liquid Logic Case Notes	
3	NOCC0000044	AMHP Report Referral and Assessment dated 24 May 2020 (by Ben Williams)	
4	NOCC0000045	AMHP Report Referral and Assessment dated 25 May 2020 (by Eleanor Cullen)	
5	NOCC0000151	Emails between Samantha Dooley and Ben Williams dated 18 January 2022	
6	WITN0114008	No Bed Guidance	

WITN0114004 **AMHP Operational Policy**

No	Inquiry URN	Document Description	Your reference
7	WITN0114010	Nottinghamshire County Council Guidance – Mental Health Act Referrals to Nottinghamshire County and Nottingham City AMHP Services	
8	WITN0114011	East Midlands AMHP Cross Border Protocol	
9	WITN0117003	Section 136 Policy	
10	WITN0117004	Conveyance Policy	
11	WITN0117005	Applications for Search Warrants Guidance	
12	WITN0117006	Section 140 Policy	
13	WITN0117007	Trans and Gender Diverse Patients Policy and Procedure	
14	WITN0117008	Lone Working After Hours Procedure	
15	WITN0117010	AMHP Guidelines when Allocated a MHAA	
18	WITN0115002	EDT and Daytime AMHP Interface Protocol	BW1