Statement of Eleanor Murray Cullen
Statement No: WITN0176001
Statement dated: 13/11/2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF ELEANOR MURRAY CULLEN

I, Eleanor Murray Cullen, c/o, Nottingham City Council, Loxley House, Station Street, Nottingham, NG2 3NG will say:

1. I work as a Social Worker within the Forensic Mental Health Team at Nottingham City Council.

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

Introduction

3. In the course of my duties as an Approved Mental Health Professional (AMHP) while working for Nottingham City Council, I undertook a Mental Health Act assessment of VC on 25 May 2020. The Inquiry has asked that I provide a statement about this.

Personal background

4. I confirm that I hold a degree in engineering from the University of Oxford. Subsequently, I returned to university to complete a Masters in Applied Social Studies with a Diploma in Applied Social Work ("**DipSW**") from Brunel University. This was a two-year course and upon completion in 2005 qualified me to practise as a Social Worker.

5. I worked at a number of Local Authorities prior to joining Nottingham City Council in 2008.

6. I have worked in a variety of different teams during my time with Nottingham City Council but always in a mental health role.

7. I initially worked as a Care Co-ordinator in the Community Mental Health Team, working alongside Community Psychiatric Nurses ("**CPN**"), Psychiatrists, Psychologists and Occupational Therapists who were employed by Nottinghamshire Healthcare NHS Foundation Trust.

8. Following a change to the Integrated Team structure around 2011, the Mental Health South Social Care Team came into existence. From that point on I worked within the Mental Health South Social Care Team with other Social Workers and social care professionals.

9. In 2013 I qualified as a Best Interests Assessor ("**BIA**") under the Mental Capacity Act 2005 ("**MCA**") Deprivation of Liberty Safeguards ("**DOLS**").

10. In 2014 I qualified as an AMHP by completing the AMHP training course at Birmingham University. The course itself took approximately 6 months. Once qualified, I continued working in the Mental Health South Social Care Team and as an AMHP and a BIA before moving into the Forensic Mental Health Team in 2015. I was seconded to the role of Senior Social Worker in the Supported Living Team in 2019 and initially continued my work as an AMHP

while working in that team. This secondment ended in July 2025 when I returned to my substantive role in the Forensic Mental Health team.

11. I ceased work as an AMHP in 2023.

12. In my current role within the Forensic Mental Health Team, I work as a Social Worker. This is a co-located role, meaning that I work under the same roof as clinicians and other professionals from Nottinghamshire Healthcare NHS Trust.

13. Whilst working as an AMHP, I followed the relevant legislation including the Mental Health Acts 1983 and 2007 ("**MHA**"), the Mental Capacity Act 2005 ("**MCA**"), and the DOLS; as well as the relevant Codes of Practice. I also followed local guidance, although I do not now recall exactly what this was due to not working in this role for around two years.

The Referral Process for Mental Health Act Assessments

14. During my time working as an AMHP within Nottingham City Council, referrals for Mental Health Act assessments ("**MHAA**") were typically received via telephone or email and documented using a standardised referral form. Referrals could be made by a range of individuals, including CPNs, General Practitioners ("**GP**"), administrative staff acting on behalf of professionals, family members, police officers, or hospital personnel. The form required the referrer to outline the individual's current presentation, the rationale for requesting an MHAA, any prior interventions attempted, and demographic details relating to the individual and their family. I attach a copy of the referral form at [WITN0176002]. All referral information was recorded within Liquid Logic, the social services case management system.

15. In the case of VC, the standard referral form was not used, as the request for a MHAA was made outside of normal working hours to the Emergency Duty

Team ("**EDT**"). I am not familiar with the specific process used by the EDT to receive and record such requests.

16. As I am no longer employed as an AMHP, I am not aware of the current procedures in place for receiving and processing MHAA requests.

Triage and Allocation

17. AMHP senior cover reviewed the request to determine its appropriateness, conduct triage, request any missing information as necessary, and, if deemed suitable, allocate the MHAA to an available AMHP.

18. Upon receiving a request for a MHAA, I first determined whether the individual was known to Nottingham City Council Social Services. If they were, I reviewed any available historical records of prior interactions. Due to time constraints, it was often not feasible to examine all documentation in detail; in some cases, only a cursory scan of the available information was possible.

19. If the individual was not known to Nottingham City Council Social Services, I relied solely on the information provided within the referral.

20. Prior to the COVID-19 lockdown in March 2020, I also accessed supplementary information via RIO, the case recording system used by Nottinghamshire Healthcare NHS Foundation Trust. From March 2020 onwards, my access to RIO was suspended due to remote working restrictions. In my professional opinion, access to RIO is highly beneficial for AMHPs, as it contains comprehensive records of prior contact with the Trust, including formal Care Programme Approach ("**CPA**") documentation and risk assessments. However, even with access to RIO, the time available prior to conducting an assessment limits the extent to which this information can be reviewed.

21. If the individual had previously been subject to an MHAA conducted by Nottingham City Council, all AMHP reports were accessible via Liquid Logic. In the case of VC, I reviewed the AMHP report completed the previous day by Ben Williams [NOCC0000044]. Additionally, Dr Malik, one of the doctors involved in my assessment, had also participated in the previous day's assessment and therefore had prior acquaintance with the patient.

Contacting Relevant Parties

22. Upon receiving a referral, I would contact the referrer to obtain further details regarding the individual's presentation and circumstances. Where time permitted, I also sought additional information by reaching out to the individual's GP, family members, and any allocated professionals involved in their care. This was done both to gain a fuller understanding of the individual's condition and, where necessary, to facilitate access to the property for the assessment.

23. I was responsible for coordinating with two Section 12-approved doctors to attend the MHAA. In line with the MHA Code of Practice, I prioritised identifying doctors who had prior acquaintance with the individual, even if this occasionally resulted in delays to the assessment. Where such doctors were unavailable, or if the individual was not known to mental health services, I attempted to contact the individual's GP. However, in most cases, the GP was not available to attend.

24. In situations where no doctor with prior acquaintance could be identified, I proceeded with Section 12-approved doctors who had no previous knowledge of the individual.

25. Wherever possible, I preferred to work with psychiatrists employed by the treating NHS Trust. In my experience, Trust-employed doctors demonstrated a greater sense of responsibility towards the patient and were less likely to recommend hospital admission unless clinically necessary. Conversely,

doctors unfamiliar with the patient and not employed by the Trust tended to adopt a more risk-averse approach, often recommending admission as a precautionary measure.

26. Depending on the circumstances of the case, some logistical arrangements may have already been in place, or I would need to organise them. If voluntary access to the individual's property was not possible, I would arrange for a Section 135(1) warrant and police attendance. This involved attending Magistrates' Court to request the warrant, unless it had already been obtained by a colleague.

27. The use of a Section 135(1) warrant could require the identification of a designated Place of Safety, although this was not always necessary. At times, securing an appropriate Place of Safety presented significant challenges as none were available. This could significantly delay the progress of the assessment.

Bed Management and Crisis Team Involvement

28. I informed the Nottinghamshire Healthcare NHS Foundation Trust Bed Management Team of the assessment timing, though beds were only allocated post-assessment. At times, the Nottinghamshire Healthcare NHS Foundation Trust Crisis Team acted as gatekeepers for bed access, therefore they were invited also to the assessment. At this time no bed would be allocated unless and until they had performed gatekeeping (which could be done remotely) and recorded this on Rio. If home treatment had failed, the Crisis Team might decline involvement, as in VC's case, however they would still complete their bed access gatekeeping procedure on Rio.

Conducting the Assessment

29. The assessments were conducted in person with two doctors, often in challenging environments (e.g., police cells, street corners, tents, homes in

states of disrepair). I would evaluate the patient's mental state, capacity, and presentation. In VC's case, the assessment was brief but clearly indicated acute mental illness.

30. Following the interview with the patient, I would discuss the case with the assessing doctors, and we would reach a consensus. The outcome was decided based on the interview of the patient, the medical recommendations and taking all relevant information into account. As per the MHA Code of Practice, the least restrictive options were always considered, such as community treatment via secondary mental health services, short-term intervention via the Crisis Team, referral back to GP or signposting to another community service. If these were not appropriate and admission was deemed necessary, then informal admission was considered. If the individual lacked capacity, then informal admission was not an available option as they were unable to consent to this. Where all other options have been explored and ruled out, then detention was pursued.

Application and Admission

31. Where admission was deemed necessary, I liaised with the Bed Management team to request that a suitable bed be identified. If the Mental Health Act was being used, then I completed the relevant application form. I also oversaw all logistical and practical issues, such as conveyance arrangements, care of pets/children, locking up the house, and followed up on any complications.

Risk Assessment

32. In all cases, I applied my professional experience and training to assess the risks posed by the individual. This involved evaluating both the likelihood of each identified risk occurring and the potential severity of its impact. These considerations were documented in detail within the AMHP report.

33. The risk of violence was assessed in the same manner as other types of risk. It formed part of a comprehensive risk assessment process, which included risks to self and risks to others.

34. In the case of VC, the relevant risks were clearly outlined in my AMHP report [NOCC0000045]. From the moment I received the referral, I continuously reviewed and updated the risk assessment, viewing all aspects of my role through the lens of risk management.

Experience with High-Risk Cases

35. As stated above, I work as a Social Worker in the Forensic Mental Health Team. The Forensic Mental Health Team provides support to individuals with a mental disorder who are known to the criminal justice system or are otherwise at risk of criminality; thus, I have been involved in the care and management of numerous individuals who have committed serious offences while in the community. My involvement in these cases has informed my practice and enhanced my ability to assess and manage complex risk presentations.

36. In relation to my work as an AMHP, I have not, to my knowledge, been involved in the care of any other individual who has killed or caused serious injury following discharge or when in the community.

Knowledge of VC

37. I confirm that I had no prior knowledge of VC before 25 May 2020.

38. Following my MHAA on 25 May 2020, I undertook follow-up actions to address issues identified during the assessment, specifically relating to VC's conveyance to hospital and police involvement. I did not have any further direct contact with VC after that date.

39. I was aware that VC had been arrested on 23 May 2020, prior to his release from custody on 24 May 2020, and was subsequently re-arrested on the evening of 24 May 2020. This information was available to me via Liquid Logic - the social care recording system[NOCC0000034]. I reviewed the information recorded on Liquid Logic and also examined the AMHP report completed by Ben Williams [NOCC0000044]. As previously explained, I did not have access to Rio.

40. The history section of my AMHP report was drawn directly from Ben Williams' report [NOCC0000044]. I was also able to review the details of the MHAA he had conducted through that documentation.

Assessment of VC

41. Due to the passage of time, I do not retain a full recollection of the assessment of VC. However, I have reviewed the available records to refresh my memory in preparation for this statement [NOCC0000045; NOCC0000034; NOCC0000092; NOCC0000093; NOCC0000108; NOCC0000091; NOCC0000182].

42. Prior to conducting the assessment, I consulted with the doctor who had completed the MHAA the previous day (Dr Malik), spoke with the Crisis Team, and liaised with the Bed Management Team. I also spoke with Dominic Lloyd, a CPN from the Nottinghamshire Healthcare NHS Foundation Trust Liaison and Diversion Team, based at the Police Custody Suite.

43. I was unable to speak with VC's mother prior to the assessment, but I did update her regarding the outcome afterwards. I do not believe that speaking with her beforehand would have been beneficial or changed the outcome, as she had already spoken with Ben Williams the previous day, and I had access to the notes from that conversation in his AMHP report.

44. My understanding of VC's behaviour on the previous day was based on Ben Williams' AMHP report and the request for a second MHAA received by EDT the evening before. It was also formed from my conversations with the Crisis Team and Liaison and Diversion Team.

45. I do not recall speaking directly with Ben Williams about his assessment. However, I did not consider this necessary, as his report contained a clearly documented history and comprehensive information [NOCC0000044].

46. The significance of conducting a second assessment within such a short timeframe was that home treatment had already been attempted and had not succeeded. This limited the options available to me following my assessment.

47. Informal admission was not a viable option, as VC did not appear to have the capacity to make decisions regarding his mental health and therefore could not provide informed consent.

48. Given VC's acutely mentally unwell presentation, the recent failure of community-based treatment, and the impracticality of informal admission, detention under the Act was the only remaining option. I therefore regarded the decision as relatively straightforward.

49. To my knowledge, there was no additional information available at the time that I could have accessed but did not. As previously noted, I was unable to access RIO due to remote working restrictions during the COVID-19 pandemic. VC was not registered with a GP, so contact with a GP was not possible.

50. The assessment was conducted in a police station cell. I believe VC remained lying on a bench throughout the assessment. Due to the passage of time, I do not recall specific details regarding his body language or demeanour. He did speak sometimes when prompted, although I cannot recall his tone of voice. The content of the conversation is recorded in my notes and report.

51. The cell door was open during the assessment, which was conducted by two doctors and me. A police officer was also present. I cannot recall whether I was fully inside the cell or standing at the doorway, as the space was very small and could not accommodate all four individuals comfortably. The assessment lasted approximately 10 minutes. It was immediately apparent to me that VC was acutely mentally unwell.

52. VC appeared distracted and did not register or respond to some questions. He seemed distant and was unable to engage in a coherent conversation. He did not give any details of his behaviour over the previous 48 hours and could not account for this. Based on his presentation, I formed the view that VC was mentally unwell and possibly experiencing psychosis.

53. I did not feel unsafe in VC's presence as he did not move during the assessment and a police officer was present throughout.

54. I formed the view that VC had never experienced any mental difficulties in the past from the fact that he was not previously known to Adult Social Care. Additionally, the referral information from Dominic Lloyd for the first MHAA on 24th May 2020 stated that VC was not known to health or social care. Finally, it was recorded in Ben Williams' AMHP on 24th May 2020 that he had spoken to VC's mother and that "*she confirmed that he has never experienced any difficulties with his mental health in the past and that he has never been violent or aggressive*" [NOCC0000044].

55. This information influenced my decision-making in that there was very little information about VC to go on when deciding on the outcome of my MHAA. It led me to believe that assessment of his mental health would be beneficial to VC, so that an understanding of the causes, diagnoses and recommended course of treatment (if any) could be established.

56. Following the assessment, I discussed the case with the two doctors present. They completed their medical recommendations, and I provided my professional opinion. The doctors both felt that VC was suffering from a psychotic episode, based on their interview with him and the information from Ben Williams' AMHP report. We jointly agreed that VC required detention under the Mental Health Act for assessment in a hospital setting and for potential treatment. Had VC not exhibited signs of mental illness/psychotic episode, detention under the Act would not have been possible, as the necessary medical recommendations would not have been completed. In this case, VC would have proceeded through the criminal justice system.

Risks Relating to VC

57. Through my information-gathering process and professional judgment, I concluded that VC presented a clear risk of further mental health deterioration, sleep deprivation, self-neglect, aggression towards neighbours, potential criminal behaviour, and disruption to his studies. These risks were consistent with my experience that untreated mental health conditions can escalate over time.

58. The risks arising from VC's mental ill health led me to determine that a period of hospital-based assessment was necessary to safeguard both his health and safety, as well as the safety of others.

59. I assessed the risk of aggression towards VC's neighbours as both high in likelihood and high in severity. This assessment was based on two incidents that had occurred within the previous 24 hours. I was aware that VC had broken into his neighbour's flat, resulting in the neighbour jumping out of a window due to fear. While I did not have confirmation of physical injury, the incident clearly indicated extreme emotional distress/alarm on the part of the neighbour. Had she not jumped, the outcome could have been significantly more serious.

60. In my professional understanding, violence involves the capacity and intent to cause harm, while aggression encompasses a broader spectrum of behaviours, some of which may be linked to mental ill health and therefore there is a lack of capacitous intent to harm. Aggression can include lower-level behaviours such as loud or disruptive actions, which may not meet the threshold for violence but still pose concern. Although I do not have formal definitions, I considered "aggression" to include any and all alarming behaviour in this context.

61. The terms "*aggression*" and "violence" are often used interchangeably. As noted, I was aware that a woman had jumped from her flat window due to fear of VC, although I did not have further details of the incident.

62. VC also exhibited signs of self-neglect and sleep deprivation. He appeared unkempt and did not seem to be caring for himself adequately. I believe the information regarding his lack of sleep was obtained from Ben Williams' AMHP report [NOCC0000044]. Based on my professional judgment, the risk of self-neglect was high.

63. There was nothing specific about VC that made me believe he was more susceptible to severe mental deterioration than others. However, his presentation was clearly indicative of significant mental illness. Had any individual presented with similar symptoms, I would have assessed both the likelihood and severity of deterioration as high if left untreated.

64. In light of these factors, I concluded that detention under the Mental Health Act was necessary. No other options were available or viable to manage the risks to VC's health and safety or to protect others.

Capacity

65. It was my professional opinion that VC lacked capacity to consent to treatment. I deemed that he could not understand the relevant information

salient to the decision. Typically, in order to demonstrate capacity to make this decision an individual would need to evidence that they understood:

a. Why he would be admitted (e.g., for mental health assessment, treatment, or care).
b. What the admission would involve (e.g., staying in a hospital, interacting with staff, receiving treatment).
c. The potential risks and benefits of informal admission versus not being admitted versus being detained under the MHA.

66. I formed the view that VC lacked capacity to make a decision about mental health admission from my interview with him. He did not answer all of my questions, appeared distracted and was not able to give an account as to how he was. He was not able to reasonably explain his actions that led to his arrest. He did not recognise that he could have been suffering from symptoms of a mental illness. I came to the conclusion that if he did not understand that he was experiencing symptoms of a mental illness then he could not understand why he would need admission to a mental health ward for mental health admission and treatment.

67. Mental health "*insight*" in psychiatry refers to a person's awareness and understanding of their own mental health condition, including:

- Recognition that they have a mental health problem.
- Understanding of the nature and symptoms of the condition.
- Awareness of the need for treatment and its potential benefits.
- Acknowledgment of the consequences of untreated illness.

68. I formed the view that VC lacked insight into his mental health condition from my interview with him. I did not consider this to constitute a risk to anyone other than himself. The risk to VC was that he could be illegally detained in a mental health institution without the rights afforded to him under the MHA or

MCA, and/or that his mental illness may be left untreated if he lacked understanding that he required such treatment.

69. My assessment that he lacked insight into his mental health influenced my decision that he lacked capacity to consent to informal admission, as by definition lacking insight into his mental health meant that he did not understand the relevant information salient to that decision.

70. The consequence of this was that it eliminated the option of an informal admission. If VC required admission, which we believed that he did, then the MHA would need to be used to detain him.

Nearest Relative

71. I do not believe that I spoke to VC's father. At the time of writing the application form A2, I believed that VC's father was his Nearest Relative for the purposes of the MHA. This is because he is the elder parent and VC does not have any wife, civil partner or adult children and lives alone.

72. Having then spoken to VC's mother on the telephone, I formed the view that she provided care which led me to change my opinion on the Nearest Relative. This is because a person providing care would leapfrog the elder parent in the hierarchy set out in Section 26 of the Act.

73. I identified in my report that VC's mother "*provides care*" [NOCC0000045]. That phrase comes from the Mental Health Act, albeit there is no definition for that in the Act itself. The Code of Practice states that a person can be considered to provide care if they:

    a. Regularly support the person with daily living activities (e.g., cooking, cleaning, personal hygiene).
    b. Offer emotional support or helps manage the person's mental health condition.

c. Assist with medication, appointments, or liaising with professionals.
d. May or may not live with the person but has a consistent and active role in their wellbeing.
e. This can include family members, friends, or neighbours, and is not limited to professional carers.

74. From my conversation with VC's mother, I formed the view that she assisted VC with medical appointments, liaising with professionals, provided him with emotional support and had a consistent and active role in his wellbeing. My impression was that she was caring and had VC's best interests at heart.

75. I spoke to VC's mother after the decision had been reached to detain VC under Section 2 of the Act. I did not consider that it was necessary to speak to her prior to making my decision as firstly she was unable to care for him as she resided in Wales, therefore any input into his care in the community would be limited to telephone support. Secondly, she was not a professional and, in my view, VC required professional intervention to manage his health, safety and the protection of others.

76. I did discuss with VC's mother her wishes to come to Nottingham to support him during his mental health hospital admission, however she told me that she could not book a hotel due to lockdown restrictions in place at the time.

77. The involvement of VC's mother as the Nearest Relative was clear to me, but it did not influence my decision or the outcome of the assessment. Her location in Cardiff did not influence my decision as I was of the view that VC required professional intervention.

Application to admit

78. I confirm that I made an application to admit VC to hospital under section 2 MHA.

79. The diagnosis would have been for the two doctors to determine and to thereafter write in their medical recommendations. My application and decision were based upon their medical recommendations. VC warranted detention, due to the fact he appeared to be suffering from a mental illness which required formal assessment and possibly treatment, and community treatment was not an option as it had been recently tested and failed due to VC having been arrested again within a very short period. This development marked a significant change from the previous day's assessment and directly influenced my decision-making.

80. There is no disagreement recorded within my AMHP Report [NOCC0000045]. If there had been a disagreement I would have recorded it accordingly.

81. The presence of two completed medical recommendations indicates that both doctors were in agreement that VC required detention [NHFT0000004]. They would not have completed their recommendations had they believed detention under the Act was unwarranted.

82. I agree with Dr Malik's conclusion that community treatment was not an appropriate option due to the risks VC was posing to others (and himself) at that time. There was clear aggression against neighbours because of the two incidents that had happened on the previous day. I do not believe there are any other documented incidents at that time and the risks of violence/aggression identified were based solely upon the two incidents that I was aware of then.

83. I do not recall anything further from discussions with the Crisis Team or the Bed Management Team. The purpose of me speaking to them was to invite the Crisis Team to my assessment and also to inform the Bed Management Team of a possible need for a bed. The Crisis Team had to follow up the Gate Keeping process in order for a bed to be identified.

84. My understanding is that VC would not have been seen by the Crisis Team prior to my assessment, as I understand that he was re-arrested within approximately one hour of being released from custody.

85. The Crisis Team did not attend my assessment. I have already indicated that in their opinion, community treatment was not an option, and this clinical judgement is all that I needed in order for my assessment to proceed.

86. I was aware that VC had been prescribed Olanzapine from Ben Williams' AMHP report [NOCC0000044].

87. I have no recollection of whether VC had taken this medication or even been in receipt of it. I consider it highly unlikely that VC would have had an opportunity to take the medication as he was re-arrested within an hour of his initial release.

88. While Dr Rahul Ghandi appears to have prescribed the medication during the assessment with Ben Williams [NOCC0000044], there would have been a logistical requirement to obtain the medication from a pharmacy, give it to a CPN and thereafter to take it to VC. This process takes some time and I suspect that there was not sufficient time for this process to have taken place.

89. I have no recollection of whether I was told or was aware that VC had not taken the prescribed Olanzapine. I do not consider that would have affected my decision making. Even if he did have an initial tablet, 2.5 mg is a small dose and that is unlikely to have affected his mental health immediately.

90. I have no recollection of VC discussing with us that he was resistant to taking medication. He did not discuss that with us when we asked about his mental health and treatment. He simply would not answer any questions. I did not form a view as to whether VC was resistant to taking medication or not as this was not immediately relevant.

91. Medication was not discussed or prescribed as part of my assessment as VC was admitted under Section 2 for the purpose of being assessed by a Psychiatrist, and thereafter a Treatment Plan would have been developed by the inpatient team.

Admission Process

92. Following the assessment, I made an application to detain VC under Section 2 of the Mental Health Act to Nottinghamshire Healthcare NHS Foundation Trust, Highbury Hospital, Highbury Road, Nottingham NG6 9DR [NHFT0000004].

93. I contacted Highbury Hospital by telephone to confirm the bed allocation for VC. I was informed that another patient was also due to arrive, and the hospital requested that we stagger the timing of the admissions. I provided a summary of VC's recent history, including details of his arrests, assessments, and the outcomes over the preceding 48 hours.

94. I completed my AMHP report on the evening of 25 May 2020 [NOCC0000045]. This was subsequently sent to the Trust on 27th May 2020 by Beverly Shepherd, Health and Social Care Coordinator.

95. I had no involvement in VC's ongoing treatment following his admission to hospital.

96. There was a miscommunication and error regarding VC's conveyance to hospital. I was informed by the Nottingham City Council Emergency Duty Team that VC had died en route to hospital in an ambulance. I attempted to contact the police officer immediately upon receiving this message but was initially unable to get through.

97. When I eventually spoke with the police, they clarified that VC had not died. Instead, the ambulance had been sent away after waiting for 90 minutes. The

police requested that a new ambulance be ordered with lifesaving equipment; however, I did not have the authority to arrange this. It is my understanding that this request stemmed from confusion related to a previous inquest ruling involving an unrelated case, where an individual had died while being transported in an ambulance. As a result, the officers believed that any future ambulance conveyance should include lifesaving equipment.

98. A second ambulance was arranged by me, and VC was subsequently transported—without lifesaving equipment—to Highbury Hospital for assessment. I understand that VC left police custody in the ambulance at approximately 11:00 p.m. on 25 May 2020. My AMHP report does not record the time of VC's arrival at the hospital ward.

99. This miscommunication resulted in a delay in VC's admission and treatment, and he remained in the police cell for longer than anticipated.

100. I continued working late into the evening to ensure the transport issue was resolved. I later raised concerns regarding communication with the Police Sergeant and Police processes following these events [NOCC0000182].

Recommendations

101. I no longer work as an AMHP. I have no general observations or comments to make here. There is nothing specific to raise from my assessment of VC for future recommendations.

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: Eleanor Cullen .....

Dated: 13/11/2025 .....

Index to First Witness Statement of Eleanor Cullen

No	Inquiry URN	Document Description
1	WITN0176002	Referral Form for MHAA
2	NOCC0000044	AMHP Report of Ben Williams, 24 May 2020
3	NOCC0000045	AMHP Report of Eleanor Cullen, 25 May 2020
4	NOCC0000034	Case Notes
5	NOCC0000092	Email to EDT team enclosing EDT Form date 25 May 2020
6	NOCC0000093	EDT form dated 25 May 2020
7	NOCC0000108	Email to Celeste Calocane enclosing Nearest Relative Factsheet, 25 May 2020
8	NOCC0000091	Email chain concerning conveyance of VC, dated 2 June 2020
9	NOCC0000182	Email chain concerning conveyance of VC, dated 16 June 2020
10	NHFT0000004	Application for Detention under MHA by EC on 25 May 2020