Witness Name: Geoffrey Culpin

Statement No: WITN0189001

Dated:

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF GEOFFREY CULPIN

I **GEOFFREY CULPIN** 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 July 2020. This was my only work with VC, and the Inquiry has requested that I provide a statement about it.

Personal Background

4 I hold two degrees, one in History & Sociology and the other in Philosophy. I obtained my Diploma in Social Work from the Open University in 2003.

5 I started work for Nottingham City Council in 2005 as a Social Worker. I completed my training as an AMHP in 2009.

6 In my twenty years of practice, I have managed various mental health teams across Nottingham. I previously managed the integrated Assertive Outreach Team, which was part of the Nottinghamshire Healthcare NHS Trust ("**the Trust**"). I held this position until Nottingham City Council restructured its mental health teams in 2015. Since then, I have managed both the Mental Health Social Care North Team and the Community Forensic Team. I consider myself to be very experienced in community mental health work and as an AMHP. I estimate that I undertake over 30 Mental Health Act assessments (**"MHAA"**) a year.

7 My training as an AMHP was a mixture of learning at university and training by participation in mental health assessments that were then analysed.

AMHP – Roles and Responsibilities

8 The AMHP is a statutory function laid out in the 1983 Mental Health Act ("**MHA**"), as amended. We work within a legal framework and the role of the

AMHP is defined by that legislation. We follow the national guidelines, on a local system.

9 The AMHP's job is to determine whether a person, (the "**patient"**), needs to be 'sectioned'. This means detained for an assessment of their mental health (Section 2 MHA), or for treatment in respect of mental health (Section 3 MHA). In making this decision, AMHPs are guided by the principles of the MHA and the guidelines which specify that the "least restrictive" approach must be taken.

10 We (the AMHPs) work closely with colleagues in the healthcare mental health teams and we link up with nearest relatives for an assessment. Our role and function is to communicate with the other parts of the assessment team and to offer a social perspective to the MHA assessment. Based on the least restrictive principle, we are looking to see what alternatives exist to admission to hospital if possible.

11 It is the AMHP's duty to ensure that admission to hospital is done legally. If the outcome of an MHA assessment is detention, the AMHP will make the application for this. The application is made at the AMHP's discretion. The AMHP does not have to make the application, even if the doctors consider that the patient should be detained. As to the other way round: in all the assessments that I have undertaken, I have never come across the situation in which I wanted to detain, and the doctors did not.

12 Turning to the assessments themselves, we aim to achieve a consensus between the AMHP and the two doctors. We see each other as partners and have respect for each other's views. Each assessment is different, but over the course of time AMHPs do get used to working with the same group of doctors. As such, we start to learn each other's styles and approaches.

13 MHA assessments last around 30 minutes or so. Sometimes they are shorter and sometimes much longer. However, the AMHP's primary input is to bring in a wider perspective to the assessment process and to stop it being a purely medical exercise. During an assessment, I will consider whether a person's presentation is triggered by their current social pressures and whether alleviating these pressures would lead us to reach a different decision.

14 Turning to process, Nottingham City Council now has an email portal into which new referrals come. There is a form for this. In 2020 referrals were made over the phone with a form which then caught up. Nottinghamshire Healthcare NHS Trust ("**the Trust**") covers both Nottingham City and Nottinghamshire County Council. Accordingly, the first point that needs to be considered is whether it requires a Nottingham City AMHP or a Nottinghamshire County AMHP.

15 The form indicates who is referring, whether they are a doctor or a Community Psychiatric Nurse (**"CPN"**) and also gives us an idea of urgency. If the person is already in hospital, or in a secure location like a police station, it might be less urgent than a person who is not in a contained or supportive environment. If a person is in custody, a police officer could make the referral for a MHAA.

The Trust have a Liaison and Diversion team based in the custody suite, who are responsible for assessing people who are in custody and are presenting as mentally unwell. Part of their role is to make referrals for MHAAs

16 When the referrals arrive, they are triaged by senior cover (a **"Senior AMHP"**) to see if further information is required. They are then allocated out in accordance with available resources and priorities on that day and the next few days. Prior to the establishment of this role in 2020, an admin worker would contact the next AMHP on the daily rota, who would be tasked with making the arrangements for progressing the assessment.

17 We have always found the resources to respond to the referrals for MHAAs and to complete the assessments requested.

18 Referrals always include enough information on the individual being referred for an AMHP to progress the referral and consider whether an MHAA is needed. This will always include information on where the person is, why the referral is being made, the person referring and the urgency of the referral. Once an AMHP is allocated, they follow up on the referral and speak to the referrer to confirm when the assessment will take place. The process of gathering and clarifying information and arranging the MHAA has an administrative element to it.

19 The AMHP's work begins with interrogating the information that has been provided and looking at the information on the systems available to the AMHPs. The AMHP undertaking the assessment will ordinarily assume responsibility for

confirming which doctors will participate in the assessment. It is the AMHP's responsibility to bring the assessment team together.

20 The AMHP will also contact the hospital trust's Crisis Team as they operate as the gatekeepers for beds within Nottinghamshire Healthcare NHS Trust. The Bed Management Team ("**BMT**") will then put the person's name onto the bed list so that they can begin to look for a bed if someone is liable to be detained. When considering which doctors to invite to undertake the MHAA, the AMHP will seek to have a doctor with prior knowledge of the individual in attendance. It is customary for a member of the Crisis Team to attend the assessment. This may be a doctor from the Crisis Team or a Band 7 CPN. The AMHPs have a list of doctors, including Section 12 doctors, who are available to participate in assessments. The AMHP will also look to contact the patient's GP. Sometimes, (rarely) they are able to attend as one of the doctors. However, it is not frequent. The AMHP will also look at records held on Liquid Logic, Nottingham City Council's case management system, where prior assessments and notes of any previous contact with the authority are recorded.

21 A majority of AMHPs also have access to the Trust's data entry system (**"RIO"**) and can see the contacts a person has had with the Trust in both in patient and community settings. If the patient has previously been detained in hospital, the AMHP will be able to read about the circumstances of that admission on RIO, together with details of all previous detention details and their presentation when detained.

22 The AMHPs will ring GPs (if possible) and ask about history, but there is no direct access to the GP's systems. GPs have always been willing to share information with AMHPs when requested to do so.

Conducting MHA Assessments

23 The starting point is ordinarily to review all the information available on the referral form and to decide if an assessment needs to be progressed and if so t whether it needs to be done immediately – for example, somebody who is on an existing section with a few days to run, is not as urgent as somebody having an immediate episode at A&E.

24 Once we have decided to undertake the assessment, it is necessary to contact two doctors and confirm a time for the assessment to begin. Ideally, I look for a doctor who has previous acquaintance, as advised in the code of practice, because it supports the process of information gathering. I always aim to link in with the person's CPN, if the patient is already in receipt of community mental health services and if they have requested an assessment, to clarify why the assessment has been requested and to gain any additional contextual information. Theoretically I could decide not to do an assessment, but I would be wary of taking that route. I cannot remember ever not undertaking an assessment if the referrer remained convinced that one was required.

25 I look to organise a time to see the patient which will allow for an effective assessment given the number of factors involved. For example, first thing in the morning some people may not be fully awake. It is important that the

assessment undertaken is as good as possible and that patients can participate as fully as is possible given the circumstances leading to the request for a MHAA.

26 The MHAA can be undertaken in a wide variety of locations including police custody suites, hospitals (including A&E). in people's homes and in places of safety following the execution of a warrant. If there is an assessment in a police custody suite it is likely that the PACE clock is running and consequently there is an added pressure to complete the assessment. The PACE clock is the time that the police are allowed to hold people in custody under the Police and Criminal Evidence Act. For all assessments, we ensure that a person is fit to be interviewed.

27 My AMHP Report Referral and Assessment Form shows that the assessment of 14.07.2020 was based on a referral at 10 o clock in the morning. The assessment itself took place at 3pm.

28 I coordinate the assessments initially by liaising with the place where the patient is. That might be Bridewell or an inpatient ward; on this occasion, it was with nursing staff at the Cassidy Suite at Highbury Hospital. I will check if the patient is ready to be seen and clarify any additional information such as their presentation since arriving at the Cassidy Suite. The Custody Liaison Team at Bridewell are employees of the health trust and can therefore see the health trust records (held on RIO). Similarly, the dedicated places of safety like the Cassidy Suite have access to RIO, are staffed by CPNs and can access

medical cover if needed. It is the AMHP's role to ring up the different people involved in the assessments and consequently it is the AMHP who coordinates the assessment. If the person being assessed has a care team, their responsible clinician will be asked if they can participate in the assessment; however due to other commitments it is unusual for them to do. When undertaking MHAAs I aim to consider all the information that is available to me at the time of the assessment. Sometimes a MHAA may begin with the AMHP having very little background information. Consequently, decisions about next steps may be based primarily on information obtained during the assessment itself.

29 Turning to risk, the fact that a person is violent or aggressive does not mean that they are mentally unwell. An assessment of risks to self and to others, and an assessment of how these risks can be managed, is central to the MHAA process. We as AMHPs will also seek to understand the risks identified to enable us to consider how these risks can be managed. An assessment of risk is essentially two-fold; we will consider the risks to the individual (such as self-harm, suicide, deterioration in their mental health or breakdown in social circumstances) but also the risks that a person's mental health presents to others. An AMHP will then consider the likelihood that the risks identified will have a detrimental impact on themselves or others and the magnitude of the risks if realised. I use the process of the MHAA to assemble a chronology and understand the history of the patient, confirming key information, such as what has happened in the period preceding the assessment, what has happened in the past and what were the consequences of these actions within the overall

context of someone being assessed under the MHA. At the time of my assessment, VC had been recorded as having been aggressive and violent in the past which I believed indicated that he had the potential to be so again in the future. If someone has been violent in the past there is a greater likelihood that it could happen again. VC had demonstrated these behaviours on several occasions. We had managed this specific identified risk by admitting him to hospital under Section 3 of the MHA because these behaviours appeared to take place in the context of a deterioration in his mental health.

30 I also need to understand the nature of the risks, and if they come from the patient being mentally unwell. If not, any violence or aggression would have to be dealt with by the criminal justice route.

31 It is worth mentioning here that I also manage the Community Forensic Team. They monitor people with mental health issues who have committed previous crimes. There is a supervision team which deals with Multi-Agency Protection Agreements. This is where people have been discharged from low secure psychiatric facilities. I am comfortable with the concept of assessing risk and its management.

32 I have never previously had a case in which a mental health patient I assessed killed or seriously injured a member of the public following discharge into the community.

My Involvement With and Knowledge of VC

33 The AMHP Report Referral and Assessment Form that I completed in July 2020 was the form that we used at the time and still do [NOCC0000046]. It captures the information that we need to undertake our assessments and to explain what we did. The AMHPs are all familiar with it and it is linked into our operating systems. This is a standard form electronic document. After this length of time, (I saw VC in July 2020), the form is very helpful in aiding my recall of events.

34 I did not have knowledge of VC prior to 14 July 2020. However, several of the AMHPs (South Team), share the same office in the Stonebridge Centre. That is a Hospital Trust building. Because we are in the same area, we do share information. If a familiar name comes in, the AMHP who has dealt before will mention it. Sometimes, the person has been dealt with on a number of occasions, and it is possible to get information about them from several people or sources. That is very helpful, so that it can be cross referenced and checked out.

35 Whilst I do not have a specific memory of this, I expect I would have heard about Ben Williams's assessment because we were both based in the same office. I understand that VC had not been known to services before he met with Ben Williams.

36 On receipt of the referral, I would have interrogated Nottingham's systems, bringing up previous reports by Ben Williams [NOCC0000044] and Eleanor Cullen [NOCC0000045]. Clearly, as part of my preparation, I will look at prior AMHP reports so I am not starting afresh. Indeed, the Inquiry will see from reports that previous information can be 'cut and pasted' over. By this point, it is also worth mentioning that I was working in the office, Covid restrictions having been lifted.

37 That said, after this time, I cannot be sure if I looked at the hospital records. There will always be a hospital trust doctor in the assessment, and they will have RIO open. As a result, the information on RIO would have been available to the assessment team. I cannot say if I saw it though.

38 Whilst this was my only involvement with VC personally, I did forward some emails at the end of July 2020, having been contacted by Ellie Turner at the university (see below). [NOCC0000178]

39 Returning to my assessment of VC, Nottingham's records included details of assessments that were undertaken following VC's arrests on both 23 and 24 May 2020. This means that I will have read the assessment conducted by Ben Williams, (not sectioned) [NOCC0000044] and the subsequent assessment by Eleanor Cullen (sectioned) [NOCC0000045]. The Inquiry has copies of those documents and can see what I had access to.

40 As I said, I have no specific recollection of speaking to Ben Williams about this report, but I would have done so if he was in the office. Eleanor Cullen was based elsewhere. As to the documents themselves, they show what is recorded, namely that events had taken place in the context of VC being mentally unwell. However, they do not show why he behaved as he did. The documents can only describe what the AMHPs found. Nevertheless, these documents provided enough information for me to be able to undertake the assessment in July 2020 properly. I had what I needed.

41 The assessment took place at the Cassidy Suite Highbury Hospital. At this distance in time, I need to rely on my report in which I said:

"When placed Section 136 MHA had been experiencing auditory hallucinations relating to upstairs neighbour which she then confronted – who called police.
Did not fully accept the impact that this had on them – or have actions leading to previous assessment.
V said that he had been non-compliant with his medication primarily as he did not believe he needed to or that he was unwell – he reported that he was finding it more difficult to concentrate on his revision and wondered if this was linked to the medication he was taking". [NOCC0000046]

42 I ensure I listen carefully to what people tell me in the course of an assessment and that I try to clarify what is said to me. I produce an account of the assessment in my AMHP report [NOCC0000046]. Beyond this record, my impression was that VC was someone who presented as being mentally unwell

and that he appeared to be stressed and overwhelmed. It was not my impression that he was looking to hurt people or that he had targeted anyone. VC did not engage with the assessment beyond responding to the questions asked of him and did not seem surprised that he was to be admitted to hospital under Section 3 of the MHA.

43 Some MHA assessments stick in my mind, for example where I feel threatened or it was difficult to decide on an outcome. Nothing about VC's presentation made it harder for the assessment to be undertaken. I tried my best to talk with him and to promote his contribution to the assessment process however the encounter was not memorable of itself. If much more had been said or concerns had been apparent to me, they would have appeared in my report.

44 It is important to bear in mind that I had received information from Dr Manzar prior to meeting VC with Dr Seedat. I would also have looked at his records on Liquid Logic [NOCC0000034] and Rio [NHFT0000168] and possibly spoken with Ben Williams prior to seeing VC. It is possible that I may have been able to talk to the students at VC's accommodation, but this did not happen, and I did not feel that I had a need to do so given the information available to me. Occasionally we also receive information directly from the universities but did not do so on this occasion.

45 I try to approach MHA assessments with an open mind with regards to what the outcome will be, and this is how I will have approached VCs assessment. However, from the information available to me it was evident that admission

under Section 3 (MHA sectioning for treatment) was the most likely outcome of the assessment. This was because he had been assessed recently under Section 2 and, since discharge, there was evidence of emerging risks. Consequently, despite his recent admission, VC required treatment under Section 3 of the MHA and not a further period of assessment under Section 2. VC would have needed to demonstrate a degree of stability and insight in relation to his mental health and a firm commitment to engage with the Crisis Team for him not to have be detained under Section 3 given his recent history. When there have been incidents of violence and aggression, I am more likely to be risk adverse and, as VC had been seen twice recently, I anticipated that I would probably be applying for his detention.

46 At this point, I should highlight that there is a small error in my AMHP Report Referral and Assessment Form [NOCC0000046]. On page 2, I refer to VC having previously been detained on 25 June. In fact, I meant 25 May which was following his assessment by Eleanor Cullen. This is a typo.

47 According to his history, VC had been released from Highbury Hospital on 17 June 2020. I was seeing him at the Cassidy Suite there. The Highbury Hospital is situated in Nottingham.

48 I undertook the MHA assessment with Dr Manzar and Dr Seedat. The latter had previously treated VC and had prior knowledge of him. The ward where VC had been, was adjacent to the Cassidy Suite where our MHA assessment took place. Dr Seedat had firsthand knowledge of VCs mental health needs and

consequently there was no need for me to contact the ward for any additional information. Further, as the assessment proceeded, it was clear to me that this was not a borderline case and that VC needed to be detained. There really was no need for me to see his complete hospital records from previous detentions. The important fact was that I knew he had recently been in hospital under Section 2 of the MHA. I also had Dr Seedat's input. The objective of the assessment therefore was to determine if the criteria for Section 3 of the MHA was met. Looking back, I cannot think of any occasion where I have detained someone and thought that that was the wrong thing to do. It was clear here that VC needed to be in hospital under Section 3 of the MHA and that is what happened.

49 One small point to note is that Dr Manzar completed his assessment prior to VC being seen by me and Dr Seedat. This was due to his availability. My notes indicate that VC had been prescribed aripiprazole, but I would not have discussed what medication he might be moved onto at hospital [NOCC0000046]. The medications used are not really the focus of an MHA assessment. They can be a factor, but it is rare for them to be a key aspect of decision making.

50 Turning to the referral, VC had been detained under Section 136 of the MHA on 13.07.2020. The referral then came to us from the Cassidy Suite. When the team at the Cassidy Suite request a MHAA, they provide some basic information and will confirm if the person has been detained under Section 136.

Once a person has been detained under Section 136, a MHAA must be undertaken.

51 On arrival at the Cassidy Suite, the nurse in charge told us about the events leading up to VC being placed on Section 136. This information would also have been recorded on RIO. The police do not contact us to provide any background information. When the police use their powers under Section 136, they will escort the person to the Cassidy Suite, who will then request a MHAA. I do not recall exactly what was discussed relating to this Section 136, but I would have taken the details of the detention into consideration as part of my preparations on how services should potentially respond to VC being placed on Section 136.

52 Before I met with VC, I was aware of VC's previous presentation and the incidents of aggression and violence because of Ben Williams and Eleanor Cullen's involvement. I knew what had happened but was unsure of why he had displayed the behaviours that he had done. Ben Williams's view when he had seen him previously was that this was in the context of a psychotic episode. Consequently, I thought that it may have been the case that VC had or was experiencing a psychotic episode and his actions were linked to this

53 When I questioned VC, he told me that he was stressed about his academic life and the pressures of being a student. This was not his first contact with mental health services. However, he did not state that his behaviour was in the context of a mental health issue nor did he demonstrate any insight about how his

actions had impacted on the others in the flat. This is what I recorded in my form:

"When placed Section 136 MHA had been experiencing auditory hallucinations related to upstairs neighbours which he then confronted – who called police. Did not fully accept the impact this had on them – or of actions leading to previous assessment". [NOCC0000046]

54 Turning to the assessment itself, it was Dr Seedat and me who were present. Dr Manzar had seen VC earlier and had completed a medical recommendation for detention under Section 3 of the MHA. I do not recall much about VC's body language. There was nothing particularly unusual about him. Dr Seedat and I saw him in his room without the need for any additional support and neither of us felt threatened. In our discussions with VC, Dr Seedat and I would have explored the key aspects of his presentation and considered whether VC needed to come into hospital. VC could not say anything that would indicate that he did not need to come into hospital.

55 I find that I can get the information I need from people to appropriately decide what should happen at the conclusion of an assessment. This was not an assessment that was particularly challenging to undertake. VC had engaged to such an extent that we were clear that he needed to be detained under Section 3 of the MHA and the assessment had proceeded without an incident arising.

56 It was clear, (Dr Manzar having completed his assessment) that VC did need to be detained and he was taken to an acute ward, following our decision to detain, and admitted.

57 During the assessment process, I had no direct contact with the street triage team. Their notes would have been entered onto RIO, so I would have been able to see their concerns if I accessed that system. The decisions I take are evidence-based and informed by my professional training and my experience working in mental health. It was clear to me that VC met the criteria to be admitted under Section 3 of the MHA and that his mental ill heath could not be safely addressed in the community.

58 The question of risk is dealt with on page 4 of my AMHP Report and Referral for Assessment [NOCC0000046]. I have recorded the risks as follows: -

Risk	**Evidence**	**Risk Level**
Risk to self	Further MH deterioration Lack of sleep/self-neglect	Likelihood: High – Severity; high High
Risk to others	Aggression towards neighbours	Likelihood: High – Severity; High
Other	Disruption to studies	

59 My conclusions on risk were based upon a combination of the available history and the assessment just undertaken. I was applying my own experience and that of the two doctors – Seedat and Manzar. It was apparent that VC, at the point we saw him and from his recent history, was someone who was mentally

unwell and presented clear risks both to himself and to others. Of significance was the fact that he had recently threatened people in his flat. His mental ill heath was having a detrimental impact on his life as he was in danger of disrupting his university studies. We see numerous students and are conscious of the impact of being unwell can have on their studies and life chances. If an episode of mental ill heath is addressed early on, treatment can be effective and so less disruptive to a person's life. We do not want to see their lives being interrupted by becoming mentally unwell.

60 My views on aggression and violence are that they are similar. I regard them as meaning much the same thing. I am more likely to detain someone who is violent because of the associated risks which, by their very nature, are difficult to mitigate. If violent acts are a result of mental illness, detention and treatment under Section 3 of the MHA can be an effective response as it mitigates the likelihood of these actions taking place again. If a person's violent behaviour is not linked to mental illness (and sometimes when it is) consideration should be given to arresting them and processing them through the criminal justice system.

61 The way I have expressed risks on my report (see above) [NOCC0000046] is primarily to identify risks and not to hypothesise on what may happen in the future unless established patterns have been identified. Both during and after an assessment, with the information I have available to me, I seek to identify the nature of risks to the person being assessed and to others. The grid-based approach assists with this formulation. With VC, it was valuable to know about

his previous contact with mental health services and of recent events. Other factors can also impact on how risks are contextualised:

- If VC had not been sleeping well for whatever reason, this could have impacted his mental health; and
- The fact that his behaviour had terrified people, which gave us some understanding of his levels of insight about the impact that his actions had had on other people.

62 Later in the form, I describe the risks of discharge being obvious [NOCC0000046]. What I mean by this is that both his presentation and history of contact with services strongly indicated that he would not successfully engage with mental health services if he was discharged. If admitted under Section 3 of the MHA, VC would have been treated even if he did not consent to accepting the proposed treatment. Previously, he had been had not been admitted following a MHAA and the plan was for him to be monitored by the Crisis Team, which did not happen. It is not possible for the Crisis Team to impose treatment on somebody in the community and successful community treatment requires VC's active engagement. As part of the outcome of the assessment, I wished to ensure that he received the treatment he needed which only seemed possible to achieve in an inpatient setting.

63 I was clear that the risks of discharge were obvious, and I was confident in my decision making and I believe that is why I used unambiguous language on the form.

64 Within the legal framework of the MHA, AMHPs do not have to quantify risk or determine the likelihood that the risks identified will take place but AMHPs do have to be satisfied that risks associated with a person's mental illness satisfy the criteria for 'sectioning' under the MHA; specifically that treatment cannot be provided unless they are detained in hospital for the patient's own health, for their own safety and potentially for the protection of others. It is for the doctors to determine if these criteria apply and critically if the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for the patient to receive treatment in a hospital. The assessing team will then consider the extent and the specific relevance of identified risks, which will inform the decision about whether a patient should be admitted to hospital. In this case I reviewed the doctors' medical recommendations and was satisfied with what the doctors had written on their medical recommendations 'Form A8' [NHFT0000037].

65 Turning to capacity, this was not really an issue because I was not considering an informal admission. It was clear we were considering a compulsory admission and therefore capacity was not really a question. Capacity itself does not necessarily determine the route that will be taken with a patient. VC was going into hospital under Section 3 of the MHA, so capacity was not the point. I could have written some commentary about capacity on the form but there was no need because the position was obvious. VC did not offer to come into hospital and it was not proposed to him.

66 Turning to insight, he did talk about his medication, which showed a degree of insight that we were focussing on concerns about his mental health, and he was aware that concordance with medication was an aspect of this discussion.

67 If a patient has insight, the nature of an assessment can change, becoming more of a dialogue which then informs our assessment. Whilst potentially there might have been more discussion about how he came into hospital, the risks and history were so apparent that the doctors and I were clear it should be a Section 3 admission. Again, insight was not relevant to this decision.

68 When detaining someone under Section 3 of the MHA, the AMHP is required to consult the nearest relative. Here, I identified VC's mother as being his nearest relative, which is noted on my AMHP report [NOCC0000046] and on the 'Form A6' Section 3 application [NHFT0000037]. VC's mother had previously been identified as being his nearest relative and colleagues had told me that VC was single and did not have children. I spoke to his mother to determine what she knew about VC's circumstances and how he had been brought to the Cassidy Suite. Mum told me that she did not object to him being admitted to hospital under Section 3 of the MHA.

69 I would have spoken with VC's mother after the MHA assessment with Dr Seedat (Dr Manzar having seen VC earlier and having completed his medical recommendation), I do not recall anything very much about the conversation beyond what I recorded: -

"Contact made with mother NR who had become concerned over the weekend that V's mental health appeared to be deteriorating. Did not object to V being admitted to hospital and if this could be under section of the MHA including S.3". [NOCC0000046]

70 I do not specifically recall the conversation; I would have done so if I had been unable to contact her or if she objected to him being detained under Section 3 of the MHA. VC's mother did not object to his detention which is recorded on the form [NOCC0000046]. Generally, I speak to nearest relatives to seek their perspective on their relative's mental health and to see if they have any information relevant to the assessment but also to ensure they are aware of what happens during a MHAA. I see that page 6 of my AMHP report indicates that mother provided care. I do not, following the lapse of time, recall precisely what I meant by this [NOCC0000046].

71 Dr Seedat observed that VC was not willing to come to hospital voluntarily and had poor insight. This meant that community treatment was not an option due to poor insight and poor concordance with medication. The starting point of these observations is that Dr Seedat knew VC much better than me and I had no reason to disagree with him. In terms of his assessment of the treatment he would require on admission I respected his assessment which would have impacted on my decision to make an application. On medication, I would have asked VC if he had been taking the medication he been prescribed and his views on taking medication in the future. Decisions about medication are the remit of the doctors involved in a person's care and not AMHPs. From the

evidence available to me, including a discussion with Dr Seedat and a review of Dr Manzar's medical recommendation, it was clear to me that VC had not engaged effectively with the Crisis Team when he was living in the community.

72 Engagement with the Crisis Team can sometimes be a way in which an admission to hospital can be avoided or delayed. We were aware of how VC had presented to his flatmates and how frightening they must have found that. Consequently, I did not think it would be safe for VC (in terms of further deterioration in his mental health) or for his flatmates to re-attempt treatment within the community to see if he would engage with the Crisis Team, as there was not a viable environment for this to take place and because of the acute nature of his presentation.

73 An MHA assessment is primarily focused on a person's mental health at that particular point in time. If a person is known to mental health services and if it appears their mental health is deteriorating, it may be possible to rely on the nature of a person's presentation rather than the degree of their mental ill health when detaining a person. On this occasion, we agreed that VC satisfied the conditions for detention in relation to both the nature and degree of his mental illness and in order to manage the risks to others. The fact that VC's assessment was triggered by him being brought to a place of safety by the police under Section 136 did not have a material effect on the outcome of our assessment. I believe we would have placed him under Section 3 had we assessed him in another environment, such as his flat or in a hospital setting. VC had recently had an assessment of his mental health and suitable treatment was available to him.

74 Turning to communication with professionals going forward, I wrote up the AMHP Report Referral and Assessment Form and saved it to Liquid Logic [NOCC0000034]. It would then have been forwarded to the Trust's Mental Health Act office who place these documents onto RIO. If I needed to, I could communicate directly with clinical staff including medics and can follow a person's inpatient journey by looking at entries made on RIO. Once the assessment was over, I was not involved in any of the treatment received by VC, which is consistent with how MHA assessments are undertaken. The AMHPs role is specifically focused on completing a particular assessment and ensuring if they are detained that they are safely admitted to hospital.

75 In this case, the use of medication was failing as a way of addressing or resolving the acute risk levels presented by VC. In many cases a period of focused support from the Crisis Team has proven to be successful at alleviating need and reestablishing a person's contact with their care team. While not the case in this instance, Crisis intervention is an established mechanism for avoiding admissions. It was clear that the interventions including promoting concordance with medication had been unsuccessful in maintaining his mental health.

76 As indicated above, I had formed an early preliminary view when I initially reviewed the request for an MHAA [NOCC0000100]. It appeared to me that the outcome of the MHAA would be an admission to hospital under Section 3 of the MHA, as VC had only just been discharged from hospital following admission

under Section 2. There was not a need for VC to have a further period of assessment, and his wider care team appeared to be clear about the treatment he required which was available to him.

77 VC's mental health had recently been assessed whilst he was detained under Section 2 of the MHA and the treatment plan was clear. Being placed on a Section 3 would mean that he could begin his treatment straight away if they decided to do so. VC appeared to be acutely unwell and a Section 3 would afford the ward a longer period of time to support his recovery, as a Section 2 lasts for 28 days. Both Dr Manzar and Dr Seedat had proposed that VC should be placed on Section 3 which I agreed with.

78 The fact that VC had recently been placed on Section 2 had an impact on our decision as it appeared that he required a longer period of detention in hospital to embed his recovery prior to potentially being placed on a Community Treatment Order ("**CTO**"). An informal admission was not indicated as the assessment undertaken indicated that he needed to be in hospital under Section 3 to ensure that he received the treatment he clearly needed. I do not believe that VC would have consented to an informal admission even if we had offered one to him.

79 I recorded that VC had not worked effectively with the Crisis Team previously, as I was aware that the Crisis Team's recent work with VC was unsuccessful, not least because of the events leading up to him being placed on a Section 136. The Trust's Crisis Team are tasked with seeking to avoid the need for an

admission. At every assessment in the community, we will consider whether the Crisis Team can work with the individual to address mental ill health and the risks presented. We would take into consideration:

- The likelihood of engagement with the Crisis Team
- Whether the Crisis Team's work could have a material impact on the patient's mental health, either by providing additional reassurance during a period of mental distress or by supporting concordance with medication over a period of time whilst reviewing its effectiveness.

80 Here, it was clear that the Crisis Team had not had the desired impact. VC appeared to be mentally unwell and the Crisis Team had not engaged with him effectively. Consequently, we did not consider using the Crisis Team on this occasion due to his current level of risk and the likelihood that he would not engage with them. The risks that our assessment identified could only realistically be managed by an admission to hospital.

81 For context, the Crisis Team will visit patients for about one hour a day for a limited number of days, they are a 24/7, 365 service. team. However, the Crisis Team is not designed to work with people who are acutely unwell and actively presenting risks. We were therefore satisfied that the appropriate response to his presentation was an admission to hospital under Section 3.

82 Once it had been decided to detain, I made the application for VC to be admitted to hospital under Section 3 [NHFT0000037]. I will have spoken to the

BMT when organising the assessment as a dedicated bed is need for an application to be completed. By the time the assessment had been completed and that it had been confirmed that VC was to be placed on Section 3, the BMT had identified that a bed was available on Rowan 1. Rowan 1 is an inpatient ward and provides treatment to men experiencing acute mental health crises. The Cassidy Suite is used specifically as a place of safety and is not an inpatient ward however on some occasions it can be '*stepped up'* so people can be admitted to the Cassidy Suite.

83 I do not recall if I admitted directly to the Cassidy Suite on this occasion; however, it is clear that he was placed on Ward Rowan 1 at Highbury shortly after the completion of the assessment. I expect that VC was walked over from the Cassidy Suite to Rowan 1. If there had not been a bed available, he would have remained at Cassidy until a bed became available.

84 I would have then made the application for VC to be placed on Ward Rowan 1. Once the decision to detain someone has been made, it is important that the application is made promptly so that arrangements can be made to convey the patient to the ward. Dr Seedat, as a Trust Doctor, will have made an entry on to RIO so that Rowan 1 would have been aware of the details of the assessment.

85 AMHPs do not have any involvement in decisions about treatment. An AMHP would however be involved in a person's care if a request was made to discharge a person on a CTO. For a person to be discharged on a CTO, they must be in hospital under Section 3 of the MHA at the point of discharge. An

AMHP would need to be invited to the CTO meeting and agree that a CTO was indicated.

86 Social workers are invited to attend Section 117 discharge meetings. There is no requirement for an AMHP to attend these.

87 Ordinarily, I would not have any further involvement with a person who I had assessed under the MHA once they have been admitted to hospital. However, the papers indicate that I became involved in an email exchange with Dr Seedat at the end of July 2020. It began with an email from Ellie Turner of Nottingham University (to me) on 30 July at 11.47 hours. She expressed surprise that VC was being discharged by the hospital to the same address that he had been detained from. Ellie was concerned about what this would mean: -

"Following the most recent incident, I was surprised to learn that V is being discharged tomorrow to the same address. I remain concerned for the residents but I'm also increasingly concerned for V in terms of other residents and their fears around his mental health. If this was university managed accommodation, we would be carrying out a detailed risk assessment and it is likely we would be supporting him to return to Wales. V is citing his academic work as rationale for staying in Nottingham but his work is now online and there is no need for him to be located near the university. I am going to continue to try and engage him with our team". [NOCC0000178]

88 I sent this email onto Dr Seedat at 12.17 hours. He responded about half an hour later:-

"Not sure what to say.

I cannot dictate where people go and live, he has a paid-up tenancy, the landlords will not give him his money back and he has no income.

Maybe that is the work Eleanor needs to do is to work with landlords and see how they support their students in such situations…he is well, he is taking his meds, he will have close follow-up and not sure what else she wants. You <u>can</u> just tell people where they should go, he is an adult". [NOCC0000177]

89 I suspect Dr Seedat was trying to say, 'you <u>cannot</u> just tell people,' but that his email contains a typo.

90 The reply concerned me, and I returned to Dr Seedat: -

"It's the well bit that is important is he on a depot? Oral meds?

Will he have a team following him up – or Crisis? [NOCC0000177]

91 The exchange ended with Dr Seedat emailing me at 12.53: -

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

He is going to be followed up by Crisis team and also his LMHT, City South, he has CCO Claudia Birtles". [NOCC0000177]

92 To some extent, this email exchange could be viewed as unusual. There are thousands of university students in the city and, when I am asked to undertake an MHAA with a student, I will often link with the University counselling services so that a person's mental health difficulties do not unduly affect their studies. In my experience, the university counselling services are responsive and ready to work effectively with mental health services, and they know how and when to flag up concerns. In this exchange, I was acting as a conduit and trying to pass on the University's concern. I was not anticipating getting involved and it was not the case that VC was to become an active case to me. I was helping to clarify aspects of VC's life which were relevant to a number of parties and felt it was important to do so. I wanted Dr Seedat to see the information I had been sent, which appeared to be new to mental health services.

93 After a person has been admitted under Section 3 of the MHA, they can be made subject to a CTO on release. Following this detention, I was not consulted about whether a CTO would be used for VC on release. I do believe a CTO should have been considered in VC's case and that is appropriate for people who has struggled to be concordant with medication or to maintain contact with their care team. For many people a CTO does help to establish concordance over time.

Recommendations

94 I would not want to see a more punitive mental health system emerge from the events involving VC. Locally, the system is well organised, and we can assess

risk as part of our wider decision making. If VC had an allocated CPN who was seeing him on a regular basis, and who had been able to develop an understanding of his relapse signatures, services may have been able to work with him more successfully

95 Forensic psychiatry mental health services use a risk assessment tool called HCR20 which is the most robust assessment tool I am aware. I think there could be a value in embedding some of the learning in the process of how risk is assessed in MHAA.

96 It is extremely important that AMHPs continue to fulfil their role in MHAAs and that their work is supported. We are always looking for alternatives to admission when it is indicated and the least restrictive options, taking into account a variety of different factors, including the rights of the individual and safety of others.

97 Overall, however, the system did provide a coherent response to the deterioration in VCs mental health. VC was known to services, who responded promptly. There was a core team of people around him and he had a team who knew of him. VC was assessed and sectioned when it was appropriate to do so. The services in Nottingham are well-joined up and this is not a matter of poor communication or established systems not working.

98 The AMHP service undertook 1,229 MHAAs in 2024. This remains a busy and challenged function in Nottingham but one which is well-regarded for its resilience and resourcefulness. In my career as an AMHP, VC is the only

example of a patient who has gone on to commit murder because of mental illness.

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.

GRO-B -B

Signed: .....

Print name: .....Geoffrey Culpin .....

Dated: ...10/11/25.....

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1	NOCC0000046	AMHP Report by Geoff Culpin, 14 July 2020	
2	NOCC0000044	AMHP Report by Benjamin Williams, 24 May 2020	
3	NOCC0000045	AMHP Report by Eleanor Cullen, 25 May 2020	
4	NOCC0000178	Email Chain between Geoff Culpin and Eleanor Turner, 30 July 2020	
5	NOCC0000034	Liquid Logic Case Notes	
6	NHFT0000168	Rio Records	
7	NHFT0000037	Medical Scrutiny of MHA Section Papers, 16 July 2020	
8	NOCC0000100	Contact Record, 14 July 2020	
9	NOCC0000177	Email Chain between Geoff Culpin and Seedat Faizal, 30 July 2020	