Witness name: Benjamin Lomas

Statement No: WITN0316001

Dated: 02/12/25

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF BENJAMIN LOMAS

I, Benjamin Lomas, will say as follows: -

BACKGROUND

1. I am Dr Benjamin Andrew Matthew Lomas and I am a member of the Royal College of Psychiatrists and registered with the General Medical Council. I am also a member of the British Medical Association and the Medical Defence Union.
2. A summary of my qualifications (including dates) are as follows:
    - BMed Sci (2003), BMBS (2005) The University of Nottingham
    - MRCPsych (2010), The Royal College of Psychiatry

- MSc in Mental Health Science (2012), The University of Nottingham
- Certificate of Completion of Training (CCT) (2013), The Royal College of Psychiatry
- MSc in Health Informatics (2021) The University of Leeds.

3. I do not currently have any other appointments outside Nottinghamshire Healthcare NHS Foundation Trust (NHFT)
4. I first worked in the NHS as a support worker on physical health wards in the summer of the years 2000 and 2001. Between August 2005 and July 2006, I worked as a Foundation Year 1 doctor for Nottingham University Hospitals Trust in medicine and surgery and for NHFT in general adult psychiatry. From August 2006 to July 2007, I worked for United Lincolnshire Hospitals Trust in haematology, general medicine, and accident and emergency medicine.
5. In 2007 I applied for specialist training in psychiatry and was awarded a place on the then run-through training scheme in Nottingham. For ST (Specialty Training years) 1-3 between 2007 and 2010 - what would now be called Core Training - I worked in older adult psychiatry, general adult psychiatry (inpatient, outpatient, and crisis teams), the psychiatry of learning disability, child and adolescent mental health services and specialist substance misuse services as a junior doctor under the supervision of various consultants. I worked my first year in Derbyshire before moving to Nottingham where I completed the remainder of my training.
6. I completed my membership exams and was awarded Membership of the Royal College of Psychiatry. I also satisfactorily completed my training requirements each year meaning I met the requirements to progress on to ST4-ST6, now referred to as higher specialty training.

7. In ST4 I worked under Dr Tuhina Lloyd in Newark across three teams working with patients with psychosis – Early Intervention in Psychosis (EIP), Assertive Outreach and Recovery Teams. ST5 was spent under Dr Graham Worwood, Dr Arun Chopra and Dr Sudheer Lankappa, working in an inpatient psychiatric assessment unit, the Crisis Team, and the Recovery Team. This involved work with acutely unwell, acutely distressed, high-risk individuals from all diagnostic categories, as well as more stable patients with long term mental health problems remaining under the care of secondary mental health services. I completed my final year of training as a Clinical Lecturer in General Adult Psychiatry for the University of Nottingham under Professor Gill Doody where my time was divided equally between academic and clinical work. My clinical work was with an all-female inpatient unit with Professor Doody and an Assertive Outreach team with Dr Mark Steels. My academic work included teaching responsibilities for undergraduate students, research into medical education and work on the Aetiology and Ethnicity in Schizophrenia and Other Psychoses (AESOP) 10 (year follow up) research project, including research on diagnosis in first episode psychosis.
8. After completing my training and obtaining my CCT in General Adult Psychiatry I obtained employment with NHFT as a Locum Consultant Psychiatrist and Clinical Teaching Fellow (CTF). My role for one year included providing clinical input to the Prison Inreach Mental Health Teams at HMP Ranby (male category C), HMP New Hall (women's prison) and to Rushcliffe Community Mental Health Team. My CTF role involved providing undergraduate teaching and organizing student placements prior to entering practice. After one year, I stopped working with Rushcliffe Mental Health Team as the usual consultant returned from secondment and worked additional clinical time in the prisons instead.

9. In 2015 I was appointed as a substantive consultant psychiatrist in general adult psychiatry with the Nottingham City and County South Crisis teams with NHFT as part of an expansion of the crisis care offer at that time. For a brief period, I also offered clinical cover of the local Psychiatric Intensive Care Unit (PICU). I have worked with the crisis teams since April 2015 as part of a team of 3 consultants, providing clinical input to the teams, offering supervision of the wider MDT (Multidisciplinary Team), resident doctors and Allied Health Professionals with prescribing roles, as well as direct assessment and management of patients felt complex or high risk enough to require consultant review.

ROLE AT NOTTINGHAM HEALTHCARE NHS FOUNDATION TRUST (NHFT)

10. There are four aspects to my current job plan: my core clinical work with the crisis teams; and my additional roles as deputy Chief Clinical Information Officer (dCCIO), CTF and Primary Care Mental Health Practitioner (PCMHP) supervisor.
11. In my role as consultant psychiatrist with the Nottingham City and County South Crisis Teams I act as duty consultant for the City and County South Crisis Teams between 9am and 8pm on a rota that operates during normal working days. The timings for what follow are approximate and depend upon demand. A duty day comprises of attending an MDT from 9am until 1030am each morning to discuss cases on Red RAG rating (high risk/frequent contact cases) with the respective teams Band 7 Crisis Care Practitioner (CCP) or shift lead nurse. There will also be other cases raised for urgent discussion and discussions with nursing staff or review of other cases requiring MDT input around specific decisions: for example, which level of doctor is required for a review of diagnosis and medication, whether

PRN ("to be taken when needed" rather than regular dose) medication can be offered, whether the risks of a particular patient are sufficiently contained in the community or require hospital or what action should be taken for patients not engaging with services, etc.

12. In the period between 11am and 1pm, I usually devote to dealing with urgent Mental Health Act Assessment (MHAA) work at the s136 suite. A section 136 Suite is a health-based place of safety where police can take patients requiring further assessment of their mental health. This is also the opportunity to review patients "stepped up" to the Cassidy suite due to the pressing need for admission, for whom the duty consultant acts as responsible clinician (RC) for the first 72 hours of admission. This has been extended beyond the first three days of admission on occasions where transfer of the patient onward to a psychiatric bed has proved difficult for various reasons.

13. The period of 1pm to 2:30 pm is given over to MDT meetings for non-urgent cases (amber RAG ratings - cases with less pressing risk seen 2-3 times each week). This will involve the presentation of new assessments and the discussion of appropriate care pathway for cases under the care of City or County South Crisis Teams.

14. The hours between 3pm to 8pm are the main opportunity to carry out face to face clinical work, telephone calls and supervision of other clinical staff. This staff includes all members of the nursing team, 4 to 5 junior medical staff, non-medical prescribers, an ACP (Advanced Clinical Practitioner), and a GP (General Practitioner) with a special interest in psychiatry. Work will mostly be identified in the days before by the crisis team, and often that day depending on the cases discussed at the morning MDT. In addition to this, any community assessments

under the MHA for patients either open to the crisis team, or new to services in the whole of Nottingham City and County South (including out of area) falls to the duty consultant for the CRHTs in the first instance. These assessments take place at patient's homes, at the Bridewell Police station and occasionally other locations. Since 2018, we have also undertaken any MHAA for patients under the care of community mental health teams where the AMHP (Approved Mental Health Professional) is unable to arrange for the patients' regular consultant to attend. We do so as long as admission to a general psychiatric acute ward is being considered. Administration time is included within these hours.

15. As dCCIO, I provide support to Dr Chris Packham in his role as Chief Clinical Information Officer for the Trust. Responsibilities include acting as a Clinical Safety Officer for IT projects, completing Clinical Safety Case Reports and maintaining Clinical Risk Management Files for clinical IT systems around the Trust. I will also support the CCIO in providing clinical input and strategic advice to meetings and work groups overseen by Digital, Data, and Information Technology Services for the Trust. This serves as a link between digital services and frontline clinicians.

16. Primary Care Mental Health Practitioners are mental health specialists based in primary care to support the care pathways and management of patients who remain under their GP but who require additional specialist support without necessarily requiring secondary services. In my role, which I share with a colleague, we offer supervision in terms of prescribing, formulation (that is attempting a psychological understanding of a patient and their difficulties), and management of cases which present with a level of complexity. This is to ensure that each practitioner has access to consultant psychiatrist advice as required.

17. Lastly, as a CTF, I provide group teaching to undergraduate medical students who are on their psychiatry clinical placements, either through lectures, skills sessions, or case-based learning approaches.

TRAINING

18. As a trainee in psychiatry, I obtained my section 12 registration by completing the RCPsych membership exams and a two-day induction course in the role and responsibilities of a section 12 approved doctor. I completed this towards the start of my ST4 year. As I neared the end of my training, I completed a two day Approved Clinician induction course. I also met all the other requirements of the local approval panel towards the end of my ST6 year. I have undertaken the required one-day refresher courses every 5 years, with the last instance being in 2020. I have submitted the necessary supporting evidence to the local section 12 panel. (I am not due to renew again until September 2026 as an extension was granted to the need to renew RC status during the pandemic).
19. I should also say that the whole of my specialty training as a junior doctor included almost daily training on the management of patients detained, or with a history of being detained, under the MHA. My membership examinations and the MSc I obtained in 2012 also developed and tested my knowledge of the management of severe and enduring mental illness, including the management of patients detained or with a history of being detained under the Act.

RESPONSIBILITIES UNDER THE MENTAL HEALTH ACT 1983

20. I am an Approved Clinician (AC) and section 12 Approved Doctor pursuant to the meaning of such terms as defined in the MHA. I have undertaken the necessary training to work in these roles as set out by the Midlands & East of England Approvals Panel. In the past I have worked as RC (Responsible Clinician) for the Trust's male PICU. I continue to share the RC role with Crisis team colleagues for "step up" patients admitted to the Cassidy Suite place of safety whilst awaiting transfer and for those patients who have spent prolonged periods on the unit due to difficulties sourcing an appropriate bed.

21. Since registering as a section 12 Approved Doctor in late 2010, I have been involved in assessing patients under the Act in a multitude of settings. These include private homes, supported living placements, nursing homes, psychiatric hospitals, general hospitals, police custody, prison, public spaces, accident and emergency departments, health-based places of safety, etc. These assessments have been for patients experiencing the whole range of psychiatric symptoms and have been undertaken as an emergency and in circumstances that allow more planning. There have been periods where I have been involved more or less frequently in undertaking MHAAs, but my involvement has been generally steady over the decade I have worked in my current role. A conservative estimate, assuming an average of 2-3 assessments per week for 46 weeks per year would suggest I have been involved in 920 to 1380 MHAAs in my time as a consultant with the crisis teams alone.

22. My 6 years of training in psychiatry which encompassed a range of specialties, along with the specific training requirements of practicing as a section 12 approved doctor and then as an Approved Clinician, provide a grounding that enables me to

undertake specialist assessment of patients presenting with mental disorder. There are mandatory induction and refresher courses, plus a process of renewing my registration as an Approved Clinician every 5 years that is superimposed on my psychiatric training.

GUIDANCE, POLICIES AND PROCEDURES

23. There is a range of guidance that may be relevant to the assessment of a patient under the Mental Health Act. The most immediately relevant is the Mental Health Act Code of Practice, but other relevant sources of information may include guidance on other legislation pertaining to mental disorder such as the Mental Capacity Act Code of Practice, clinical guidance from the National Institute of Clinical Excellence, the Royal College of Psychiatrists, or local policy and procedures such as Standard Operating Procedures for assessing patients on the s136 suite, procedures around identifying an inpatient bed and making referrals to community teams etc.

MENTAL HEALTH ACT ASSESSMENT (MHAA)

24. I receive a request from the AMHP allocated to the assessment to attend if I am able, either by phone call, text message, Teams, or email. I will then check on the patients details and discuss with the AMHP if I am able to undertake the work. As described above, the Crisis Team duty consultant will support an assessment where able, prioritising patients under the care of the team in the first instance.

25. The way that registered medical practitioners (RMPs) work alongside AMHPs in the MHAA process varies case by case. It depends on the AMHP's view of the appropriateness of the referral and whether there are any complexities to the assessment that require further discussion. Where a patient is well known to both mental health services and the AMHP team, there might be a simple agreement as to the practicalities of the assessment, a short discussion about the case prior to meeting with the patient and then another short discussion after the assessment to consider the appropriate outcome. Where a patient is not known, or the case is particularly complex, there can be more in-depth discussions about the case with the AMHP or mental health team involved seeking further information before reconvening and considering how to go about setting up the assessment.

ASSESSING CAPACITY IN RESPECT OF CARE AND TREATMENT

26. I have extensive knowledge of assessing patients under the Mental Capacity Act since its implementation in 2005. I have been to numerous training sessions on the Mental Capacity Act and its use as a junior doctor in my foundation years and this subject was covered in my postgraduate qualification, AC training courses, Trust mandatory training and as part of continuing professional development.

RISK

27. Broadly speaking, risk in the mental health context relates to the extent to which our patients pose risk of harm to themselves and to others; and how this risk interacts with and is influenced by their mental disorder.

28. Assessing risk requires a knowledge of the evidence base and national guidance surrounding the assessment of that risk. There are many sources of information on

risks of particular concern such as suicide, self-harm, homicide, safeguarding concerns around abuse or neglect of children or vulnerable adults, and other criminal behaviour. There are fewer sources of information on risks that are not as easily defined such as for example, self-neglect, social harm, damage to relationships and financial harm.

29. When assessing a patient's risks, I would take into account all information regarding their history that I am able to obtain from any source, paying particular attention to any risk incidents occurring during episodes of mental disorder or distress and then gather as much information as I am able to obtain from any source about their current circumstances and mental state. I would then evaluate this in light of my understanding and knowledge of the evidence and guidance available on the risk in question and consider the patient's risk in light of relevant risk factors. I generally divide these into static and dynamic factors. The static factors include matters such as gender, employment status, housing status, history of abuse, history of the patient engaging in acts which result in the risks in question. Dynamic factors include matters such as their current mental state, stated attitudes towards the risk in question, the current degree of their mental disorder and the nature of their mental disorder.

30. I then arrive at an understanding or formulation of their current risks and try to record this as a clinical judgement in a form recommended by relevant guidance or evidence. Historically, this has always tended to be stratification of risk into low, medium, or high, with a reference for the time frame in which the risk may occur (immediate, short, medium, or long) but has changed in recent years with regard to assessment of suicide risk. Guidance now explicitly states that we should not

attempt to stratify risk and instead focus on mitigations of the perceived drivers for the risk [NHFT0002229].

31. In terms of risk of violence or aggression, I follow the approach laid out above, considering factors, such as: the particular risk history of the individual the demographics associated with increased risk of violence such as history of violence, gender, age, presence or absence of substance or alcohol use; presence or absence of personality disorder; previous failures of supervision; whether they carry weapons; the exact nature of their psychopathology (for example threat/override symptoms or delusional misidentification); presence of persecutory beliefs; and the patient's attitude towards managing risk themselves. I would then attempt to formulate what risk the individual poses, going forward, in terms of what types of violence or aggression seem likely. In general, I still apply a stratification in the terms of violence of low, medium, or high and what may be proportionate to mitigate this perceived risk.

32. This risk assessment exercise is undertaken to inform the patient's safe management and requires balance with their autonomy, legal rights, and the tools available to us in the form of effective treatments. It also needs to be balanced against the knowledge that in the case of extreme violence like homicide, it is impossible to predict which individuals will go on to commit such acts. Any risk assessment will include inaccuracies influenced by the base rate of the behaviour under scrutiny and the statistical properties of the risk assessment process used.

REVIEW OF RISK ASSESSMENT TOOLS WITHIN TRUST

33. In my role as dCCIO I agreed to revise the assessment documentation contained in the Rio electronic patient record (EPR). The aim was to simplify the document and reduce the time it took to complete whilst keeping the essential elements necessary to allow documentation of a new patient assessment, including the section on risk. This included reviewing which elements of the existing forms were mandated by either local or national requirements and reviewing existing guidance around the documentation of risk to allow our records to keep up with recommended practice. I then designed some relatively simple pro-formas for circulation with clinical colleagues for approval [WITN0316002; WITN0316003; and WITN0316004].

34. I was Chair of the Local Partnerships Senior Medical Staff Committee (SMSC) for a period of 3 years from June 2017 to June 2020. This committee served as the main consultants committee for the Local Partnerships Division, which covered all mental health services that were not forensic. One issue that kept being brought to the committee was the administrative burden involved in the documentation of patient assessments in the Rio electronic patient record (EPR). As I was stepping down, I agreed in my role of dCCIO to attempt to revise the documents as described above as I felt I would have the capacity to do so. This is how I came to be involved in reviewing the core risk assessment document.

35. There were no changes from my review. I was unable to produce documentation that was satisfactory across such a large organisational group. I spent time over the course of 18 months working through possible revisions and seeking their approval from consultant colleagues through the SMSC, as well as from nursing and allied health professional colleagues in other governance meetings/forums. Ultimately the request was always for more changes before they were satisfactory.

I wrote a paper which I submitted to Dr Chris Packham detailing the difficulties and resultant failure and the approach I thought might address these. I also ceased to be involved in this work at this point, as I did not have the capacity to contribute as required.

36. I do not know how this review work may have interacted with the care provided to VC, as it was occurring during the period of time that VC was receiving care from services. The aim of reviewing the documentation was to reduce unnecessary administrative burden whilst improving the quality of recording of risk assessments. I do not know whether this would have made any difference in the decisions made in VC's care.

MANAGING RISK OF AGGRESSION AND VIOLENCE

37. I am not sure that there is much to distinguish between "aggression" and "violence" in assessing and managing risk. The nub of the matter appears to be the patient's potential to cause harm to others, and the severity and likelihood of that harm.

38. The AMH QIP (Adult Mental Health Quality Improvement Project) working group document ("Risk assessments and care planning" NHFT0007087) references guidance issued by the National Institute for Health and Care Excellence ("NICE"): "Violence and aggression: short-term management in mental health, health and community settings (NG10)" and commented that the guidance was not "*particularly explicit or helpful*". In my view, it is not particularly helpful in that it does not detail or prescribe the format or structure of risk assessment documentation in the clinical record, which was the focus of the review work I was undertaking with regards to the structure of the core assessment documentation and the reason for

my input into that workstream. For further clarity, I would add that the guidance "CG 133 self-harm in over 8s: long term management" which is also mentioned in the same context (and subsequent guidance provided by NHS England on Staying Safe From Suicide) is clear and useful in describing how risk should be documented, so I would disagree with reference to the guidelines around self-harm. In respect of risk of violence and aggression to others, I rely on NICE Guidance, Royal College of Psychiatry Guidance (NHFT0015099, derived from WITN0058002).

39. Excluding the VC case, I can recall 2 patients I have been involved with who have harmed members of the public. In a 2022 incident, the perpetrator had been under the care of the crisis team for one month in 2017 and was subsequently referred to long term mental health services. In a 2023 incident, I was part of the assessment team for a patient assessed under the Mental Health Act in 2022. The patient in this 2023 incident was not detained and referred on to community teams for further monitoring and treatment. To put these occurrences in the context of my career, in the 10 years I have been a crisis team consultant, 12,169 individuals have been assessed by the crisis teams, and I have personally seen 1,506 individuals.

INVOLVEMENT WITH VC

2020

40. I do not recall having any knowledge of VC prior to 17 June 2020. The records indicate that I had some involvement in VC's care following his release from

hospital on 17 June 2020. Valdo was referred to the city crisis team for 3 day follow up and further monitoring in the community. I was involved with him as a crisis team consultant as the caseload is team-held. Unless his case was brought to my attention through MDT or a request for supervision I would have been unaware of his case or the details at that time.

41. I have seen records which indicate that on 22 June 2020, shortly after VC's release, I was contacted by Dr Seedat Consultant Psychiatrist for Rowan 1, who requested that VC be seen "*face to face as he is likely to down play any symptoms/problems*"; and that I passed this information on to a support worker, Shawn Wilford, shortly afterwards (NHFT0000168, p.51). Dr Seedat forwarded an email from Celeste Calocane stating that VC had not been seen face to face for follow up and wondering if this was normal. Dr Seedat had had concerns that this was insufficient. I was likely to be the duty consultant that day and passed the request on that the next contact be arranged face to face. The email exchange (which I don't seem to have taken part in) is reproduced below (WITN0163046):

> Seedat Faizal - Consultant/ Clinical Director
>
> Di-Mambro Ben - Consultant;Lomas Benjamin - Consultant;Skelton Mike - Consultant
>
> Taylor Sarah - Service Manager
>
> *Thank you Ben and we need to check if this is a wider issue and whether the advice to staff needs to change and reinforce face to face contact.*

Faizal.

From: Di-Mambro Ben - Consultant GRO-B

GRO-B

Sent: 22 June 2020 08:55

To: Seedat Faizal - Consultant/ Clinical Director

GRO-B >; Lomas Benjamin - Consultant

GRO-B k>; Skelton Mike - Consultant

GRO-B

Cc: Taylor Sarah - Service Manager

GRO-B

Subject: RE: Crisis team visiting Valdo

I spoke to the team on Friday and was told he was being seen later that day

Will investigate

Ben

From: Seedat Faizal - Consultant/ Clinical Director

GRO-B

Sent: 22 June 2020 08:50

To: Di-Mambro Ben - Consultant GRO-B

GRO-B ; Lomas Benjamin - Consultant

GRO-B ; Skelton Mike - Consultant

GRO-B ;

Cc: Taylor Sarah - Service Manager

GRO-B

Subject: FW: Crisis team visiting Valdo

Dear all

Please see email form mother of patient.

Ben D, I am not sure if you are at work. I briefly discussed this young man, Valdo Calocane.

I recently discharged him from the ward and crisis were going to do 3 day follow up and short term until he decided if he was staying in Nottingham or going to Birmingham as he needs EIP follow up.

I am not sure why face to face visits are not happening, the message given was that it is due to the COVID situation. When I spoke to the crisis staff , Izzy was assured that he would be visited at home.

I feel follow up needs to be face to Face with this chap as he does not let things out and will give the impression that all is well.

Please can you guys look into this.

Also please let me know if crisis team are taking the view to minimise face to face contact due to COVID, which I feel should not be the case and we should be getting back to more and more faced to face contact.

Faizal.

From: mendesceleste@ **GRO-B**

GRO-B

Sent: 19 June 2020 23:04

To: Seedat Faizal - Consultant/ Clinical Director

GRO-B

Subject: Crisis team visiting Valdo

Dear Dr Seedat,

As per our conversation on Wednesday the crisis team was supposed to visit Valdo on Thursday between 12:00 and 15:00. However, they didn't come to visit him and instead made a phone call due to Covid-19. I was just wondering if this procedure is normal after someone is discharged from hospital during this time and whether support and a fair assessment of his condition can be given.

Kind Regards

Celeste Calocane

42. This type of information is normal in terms of communication by email, rather than being indicative of something that required entering into the clinical record. This matter was discussed in the context of the general functioning of the crisis team at that time (COVID restrictions) as well as in relation to VC's care. A patient being guarded or minimizing their symptoms is a common feature of psychosis, and

something that all experienced staff would be aware of and attempt to account for, though this is challenging.

43. I cannot recall any details of conversation with either Dr Seedat or Shawn Wilford, beyond the documentation in the patient record. The issue of VC downplaying symptoms was important as it would make assessment of mental state remotely, either through telephone calls or video calls, more of a challenge. The assessment of a person's mental state is informed by the entirety of their surroundings and behaviour. Remote communication is therefore limited

44. I see from the records that VC was reviewed in-person the following day (23 June 2020) by nurses Jo Baker and Daisy Coleman (NHFT0000168, pp. 51-52). I can't recall any conversation taking place with me regarding VC or his care.

45. The records also indicate that VC was released from hospital for a second time on 31 July 2020, following another admission on 14 July 2020 (this time under section 3 MHA 1983) (NHFT0000222). I did not have any input or involvement in VC's care, treatment and discharge in respect of this second admission to hospital.

46. I do not remember what I knew of VC's care at that time, but from the record I can see that VC was referred to the crisis team again at the point of discharge for monitoring given his previous rapid deterioration. I discussed his case on one occasion on the 5th August and suggested continuing with daily monitoring at that point. I would not document a comprehensive history each time a patient was discussed in MDT, but would have reviewed the patient record including basic demographics, referrals history, risk history, impressions from medical or senior nursing reviews, recent records, and received a handover form the band 7 or shift lead nurse regarding each case, involving staff who had seen the patient where possible. The team on accepting the referral would have taken details on the

nature of the patient's current presentation, risks, history, and aims of crisis team involvement, and this would form part of our handover process.

47. I attended a multi-disciplinary team meeting ("MDT") on 5 August 2020 at which VC was discussed and have seen a note of this meeting that reads as follows: "*MDT Dr Lomas BP AB. presentation with history of psychosis, with related increased risk to others and himself. has stopped medication, though seemingly appears symptom free from last visit. remain red RAG for concordance, further assessment. long term – FEP. remain red RAG for concordance*." (NHFT0000168, pp.123-124). I would have discussed VC's case as he was on red RAG as I was the duty consultant for the team. I was aware VC had been prescribed oral antipsychotic medication and had previously stopped it; and that the crisis team were involved in order to monitor and encourage concordance going forward. My understanding was that he would also require longer term follow up with mental health services with the Early Intervention in psychosis team. I would not have face to face reviews with all patients on red RAG in the crisis team. This is not possible in the course of my practice.

48. I can confirm the attendance of Bina Pathak, B7 Crisis Care Practitioner and Andy Bullock, B6 Crisis Care Practitioner at the MDT. I would have received a hand over from the nursing team. In the course of an MDT, we would review material such as the patient's demographics, referrals history, risk history core document, medical entries, care coordinator entries and most recent entries in the notes.

49. I cannot recall exactly how I became aware that VC had stopped taking his medication, but it was likely obtained from some combination of the information gleaned from the MDT process. He had stopped medication following his previous admission and this was well documented. The plan from discharge had been for

medication concordance (to directly observe VC taking medication) to try and mitigate against this happening again.

50. From my documentation it was not accepted as fact that VC was symptom- free. Instead, the fact was that VC *appeared* to be symptom-free. This reflects the challenging nature of assessing for psychotic symptoms in a person who may be able to mask or minimise these. There was also awareness that VC had verbally reported concordance but that we had not directly observed this. The reference to "*red RAG for concordance, further assessment*" indicated that the crisis team should continue to attend each day and attempt to directly observe VC taking his medication and continue the assessment of VC's mental state and response to treatment, looking for signs of deterioration.

51. Part of the role of MDT is to ensure we have identified an appropriate care pathway for each patient based on their formulation and level of risk – for example primary care and psychological treatment through Improving Access to Psychological Therapies (IAPT) services, or referral on to specialist personality disorder treatment pathways. In this case VC presented with psychosis and was eligible for EIP services/FEP pathway. At the MDT, the decision made was that we should continue to meet with VC daily and attempt to monitor his medication concordance, further assess his mental state, and in the longer term to transition his care to the EIP team. I can confirm that I had no further involvement or input into VC's care up to September 2021.

2021

52. I can confirm that on 2 September 2021, I was involved in an attempted MHAA of VC with Jen Shaw (AMHP) and Dr Omar Manzar. This is accurately captured in the following notes:

> The note in VC's "RiO" medical records reads as follows:
>
> *"MHA assx Dr Lomas, Dr Manzar, Jen Shaw AMHP. Jen Shaw had spoken with Valdo's mother who had not had contact with him recently. She reported that he was currently working nights, but that they did not know where or who for. He had not been in contact with them about returning home. Mum tried him on his phone and rang Jen back - he hadn't responded which was felt to be very unusual and concerned mum, hence a further attempt at a MHA this evening. We attended the property and there was no answer. Looking through the windows the flat appeared clean and unlived in. At the back of the property was a bedroom window which seemed likely to belong to flat two and also appeared completely emptied - no personal belongings were visible. From recent contact, it seemed likely that Valdo may have left the property in anticipation of being assessed under the mental health act. Plan we agreed that a warrant would be sought and executed tomorrow." (NHFT0000168, p.164).*

The Nottingham Adult Social Care Team case notes read as follows:

> *"MHAA attempted again at 6.30pm - Dr Lomas and Dr Manzar. No answer at the door. Neighbour left her flat and confirmed she had not seen him. We looked through windows and flat looks*

empty. Dr Lomas climbed up at the back of the flat and again the flat looked empty - n bedding or possessions could be seen. It looks like Valdo may have left his flat. Agreed that I will hand over to daytime AMHP team for further follow up tomorrow. Message left with Bed Management to confirm that bed not required this evening. Text sent to Celeste, Mum - confirming that Valdo was not home. I asked her to encourage him to contact his MH team if she does speak to him. I advised her to contact Emergency Services if she has immediate concerns and provided her with EDT number for overnight/weekend. She has the office number to contact the daytime AMHP team." (NOCC0000034, pp.9-10).

I don't have any memory of this attempted assessment that contradict or add to the aforementioned notes.

53. I can also confirm that I did not interact with VC, at all, on 2 September 2021. I also cannot remember what I knew of his care and treatment up to that point, but prior to assessing patients under the Act, I have typically sought information from the running record and a handover from the crisis team about the patient, similar to that of MDT (often in more detail if time is available). This is not always possible, but from the circumstances of this assessment, it is likely this is what I would have done prior to attending.

54. I do have a memory of speaking with Rachel Masterson, a band 7 crisis care practitioner, who had attended the earlier mental health act assessment and had spoken with VC's care coordinator, Claudia Birtles, at the time. Rachel passed on

that Claudia reported that VC had had a typical "*psychotic stare*" of someone who was unwell.

55. I did not discuss VC with his mother or any member of his family at any time. From my documentation and the recent notes in the patient record, it seemed likely VC was experiencing a relapse of symptoms and was able to anticipate that his interaction with Claudia Birtles would result in an assessment and possible detention to hospital. This is not unusual in patients where use of the Mental Health Act is being considered.

56. I was involved in the MHAA which successfully took place on 3 September 2021 ("the 3 September 2021 MHAA"), with Amie Staples (AMHP) and Dr Manzar. An "AMHP Report Referral and Assessment", signed by Amie Staples, was produced shortly afterwards (NOCC0000050) ("the 3 September AMHP report"). I also see from the records that prior to the 3 September 2021 MHAA, a warrant had been obtained (NOCC0000048), following an application by Amie Staples (NOCC0000049). This no doubt, was to facilitate an assessment under the Mental Health Act, permitting us to remove VC to a place of safety for further assessment if necessary, in light of the two failed attempts already being made.

57. I cannot recall exactly how I came to be involved in the 3rd September 2021 MHAA, but the ordinary way would be for me to receive a request to attend from the AMHP arranging the assessment and to agree to a time we were both able to attend. I cannot recall whether I had knowledge of any further events pertaining to VC but would usually have at least checked the Rio running record and asked if there was anything new known to the team as I would for any MHAA.

58. I have seen the following record by Amie Staples on the 3 September 2021 AMHP report (p.2):

"Planned for 6pm.

Whilst we were waiting for the police to arrive, a man pulled up in a car and got out and approached us. He asked if we were from the hospital and then said he knew Dr Manzar. He confirmed that he was Valdo. I explained that we had come to see him and asked if we could speak to him in his flat. He initially agreed and let us in; however as Dr Lomas entered he then changed his mind and asked us to leave. We came out but explained about the warrant and need to complete the assessment. Valdo could not be persuaded to allow us to assess him in his home without the use of police presence. He did not accept any of reasons for being concerned. He said he would rather wait for the police to arrive and then "let the process go ahead". Our impression was that he would allow the police to remove him from the flat.

However when they arrived around 20 minutes later, he did not initially answer the door. After repeated heavy knocking, he came to the door and opened it. We explained again that we had a warrant to undertake an assessment of his mental health and that either we could do this in his flat if he consented or if not we would need to remove him to hospital via ambulance. The police reiterated that he was not in trouble but that he just needed to come to the hospital for his health assessment. Valdo then went to go back in the flat. Police followed him. He reiterated that he would not accept the assessment. I showed him the warrant

paperwork but he declined a copy. He was insistent that he would not go to hospital or speak to us there. The police again explained the need to accompany him to hospital. He then stated that the male officer should step forward; this officer agreed and offered for Valdo to walk with him to the ambulance. However at the point that the officer stepped forward, Valdo attacked him hitting him repeatedly. The other officers sought to restrain him but couldn't do so and he violently resisted. He managed to obtain the handcuffs and used these to hit to male police officer.

Police used CS gas to attempt to subdue him with no effect. He was then tasered three or four times; at which point police were able to restrain him in handcuffs and leg restraints.

Valdo was taken to A&E to be assessed before being transferred to the Cassidy Suite. Dr Lomas and I switched off the lights and locked the door. There was a bag of unused medication dating back to February 2021. Police have taken his door key / car key and bank cards to the Cassidy Suite where nursing staff have received these. I have placed a copy of the completed warrant with his belongings there."

I recorded the following in the "RiO" medical records (NHFT0000168, pp.166-168):

"We were congregating around the corner from his flat when we were approached by a young black male who

asked us who we were. We explain we were waiting for colleagues, and established that he was Valdo. We then explained we were here to see him, and wished to conduct a mental health act assessment. He was polite and calm, and asked us what this would entail – we explained we would either see him in his flat, or if he was not willing to allow this, that we had legal authority to remove him to a place of safety to conduct the assessment there. He initially invited us in to the property, and we went with him. When we were in the hall, he stopped and asked if he had to allow us in. We said he did not have to until the police arrived. He asked us to leave and come back when the police were here.

We then attended with the officers who arrived a short time later. He answered the door and remained polite. He listened to the explanation of the s135, but answered that "it was not going to happen" and that he was not going with us or the officers. He allowed the officers entry in to the flat but politely repeated his assertion that he wasn't going anywhere. We tried repeatedly to explain he had to come, otherwise force would be used but he continued to refuse to cooperate or to travel in either ambulance or police car.

The officers went to restrain him and he seriously and repeatedly assaulted the male police officer particularly.

He punched and headbutted him several times, and was able to wrestle the handcuffs off a female officer to use as a weapon. He was eventually subdued after police used CS gas and a tazer (2 or 3 discharges were required).

Multiple officers then attended along with a van to transport Valdo, but he required a check up at A+E first given he had been tazered. Valdo was removed from the property in handcuffs and ankle restraints. There was a general discussion about next steps – he had seriously assaulted an officer, and initially talk was of charge at the bridewell; ultimately it was agreed he would be escorted to A+E by police for his check up and then transported to Cassidy Suite. There may be charges that result at a later date.

We met Valdo at the Cassidy Suite after he had been declared medically fit from A+E. He was seen in the presence of the restrain team. He again politely stated that "no assessment is going to happen" and that we "were not going to admit him to any hospital or give him any medication".

We could not draw him in to a discussion about his beliefs or experiences, or why he chose to fight so vehemently with the officers given he is normally a gentle law abiding young man. His eye contact was staring and clearly meant as a challenge."

I do not remember the assault taking place in the way described in Amie Staples' report. In my memory, it is not until the officer laid hands on VC in the process of attempting to escort him to the ambulance that he began attacking the male officer. That is how I describe it in my record.

59. When I first encountered VC, he approached us on a street corner where he was polite and coherent, but his eye contact and affect suggested subtle indications of psychosis. His eye contact was staring, though not threatening, and his affect – that is, the range of emotional expression communicated through facial expression - was blunted. Prior to the arrival of the police, I did not have concerns that VC would become aggressive or violent. I was happy to assess him in his home without police presence initially, as long as he was in agreement with this. Prior to the arrival of the police, I can only recall discussing the assessment and the warrant with VC as I describe it in my clinical note.

60. I considered that VC had "*seriously*" assaulted the officer based on the description in my note. The male officer attempting to restrain VC was punched and headbutted. VC managed to wrestle the handcuffs from the female officer and used these as an improvised weapon to attack the officer further.

61. I do not recall seeing medication in VC's flat nor discussing the topic of medication with him. I recall his flat was tidy and clean. I did not accompany VC during the journey from his flat to the hospital. VC is described as personable, kind, polite and gentle by his then Care Coordinator Claudia Birtles in her entry on the 31st of August, and outside of episodes of psychosis he did not have a history of offending. This is what was meant when I described him as "*normally a gentle law-abiding young man*". In my clinical note where I made this description, I was mindful of incidents of May 2020 (NOCC0000044, NOCC0000045) and July 2020

(NOCC0000046). I also do recall being aware of these incidents because of the nature of the second arrest where a person sustained injury fleeing from him and wondering whether this should have led to a charge rather than diversion to mental health services. In my entry for the Mental Health Act assessment, I document no violence resulted from these incidents, but it would have been more accurate to state no direct violence. Given no charge had resulted, I had to presume the incident did not reach the level of violence such that criminal charges were warranted rather than diversion to general adult psychiatric services as occurred on that occasion.

62. I wrote that I considered that VC's eye contact was "*clearly meant as a challenge*". His demeanour on removal to the Cassidy Suite place of safety had changed and he was behaving violently towards those involved in coercing him into a psychiatric hospital. Unlike our first interaction, his eye contact here involved squaring up to me, moving into my personal space and indicated anger on his part at being detained.

63. Prior to assessing patients under the Act, I typically seek information from the running record and a handover from the crisis team about the patient, similar to that of MDT (often in more detail if time is available). I cannot recall what I knew at the time, but the reason I record a background at the start of my clinical entries is to summarise the knowledge I have at that point.

64. I could have spoken to VC's regular community team for their views on the case, but my diary indicates I had 3 other assessments both Thursday and Friday and I would have taken part in the morning and lunchtime MDTs limiting my time to do so. Likewise, this would depend on that team's members availability, if they had other clinical commitments, were less than full time, etc.

65. It appears from the 3 September 2021 AMHP Report that Dr Manzar was recorded to be a "*previous acquaintance*" of VC within the meaning of the MHA 1983, but I was not. For patients I have not met before, I am more thorough in my review of their records and pursuit of collateral information, but the conduct of the assessment is essentially the same. I would have sought Dr Manzar's views on the patient's previous presentations and how their current mental state compares with previous assessments.

66. It is recorded in the 3 September 2021 AMHP report that the MHAA subsequently took place in the "Cassidy Suite" at around 20:00 (p.3). It is noted: "*Assessment re-convened with Dr Manzar, Dr Lomas and Amie Staples AMHP at 8:20pm in the presence of the restraint team due to recent aggression*.". I can recall his squaring up to me, invading personal space, and staring in a way that felt threatening. From memory, his speech was coherent, but his responses limited beyond stating he would not engage with the assessment, allow his admission to hospital, or accept any treatment. I have not commented explicitly on what he was doing, but from memory I think he was just standing in the middle of his room on Cassidy Suite. I documented that his clerking into hospital should only be undertaken with support of numerous members of staff and if safe to do so.

67. It is recorded that VC "refused to comment on the delusional ideas that he had expressed to Claudia (CPN) earlier in the week" (p.3 of the 3 September 2021 AMHP report). During the conversation I would have attempted various means of engaging VC in conversation around his experiences, by acknowledging his dissatisfaction at being detained, that he would have different views about what was happening to him, that he would disagree with any suggestion he was unwell etc, whilst attempting to reassure him that we were healthcare professionals

interested in his wellbeing, with a common goal of improving his quality of life. There are various lines of conversation that can sometimes yield results but from the clinical note I was not successful on this occasion. Those described by his CCO Claudia Birtles in her entry on the 31st August include: "*complex delusional system in which he believes we are working in collaboration with the judicial system and the hospital (highbury) and we've created technology to cause his voice experiences / monitor him. He accused me of knowing exactly what is going on but being dishonest with him about this. He would not accept any assurance that we have always been here for his well-being and feels like we have been mocking him since his referral to our service following his admission*".

68. I agreed with the following summation of VC's delusions: "*Valdo appears to be suffering from a relapse of psychosis, characterised by conspiratorial delusions and auditory hallucinations. He appears suspicious and paranoid of others. He is refusing treatment in the community and presents a risk to others when feeling under threat*." (p.4 of the 3 September 2021 AMHP report).

69. I acknowledge that I recorded a number of risks in the "RiO" records (NHFT0000168, pp.167-168): *"Risk To self: male, single, SMI, ?hx self harm, evidence he is unwell. Protective: not suicidal, not depressed, no drug or alcohol misuse, not hopeless etc. The risk of deliberate self harm appears low. Self neglect/to his health: He is highly likely to deteriorate in the community without treatment, with subsequent social harm and self neglect. To others: male, <35, SMI, marked agitation and clear focused aggression at police and healthcare staff attempting to coordinate his assessment in the community. He has required CS gas and repeated tasers to subdue him, and handcuffs and ankle restraints to transport him. His mental state is unchanged from prior to his transportation to*

hospital, and the risk of serious assault to hospital staff is high and immediate." I also acknowledge a number of risks are listed on p.4 of the 3 September 2021 AMHP report completed by Amie Staples: "*moderate" risks to self ("Risk of further deterioration of mental health", "Risk of reprisals for his behaviour*", and "*Risk that if untreated he will be unable to engage with his university studies which are due to resume in October.");* a "*high" risk to others* ("*Serious risk of physical harm to police officers in the context of a MHA assessment*"); and a "*moderate*" other risk ("*Risk of harm through resisting police intervention*").

70. I did particularly consider that VC was "*highly like to deteriorate in the community with subsequent social harm and self-neglect*", and that Amie Staples recorded a "*moderate*" risk to self. I am broadly in agreement with the risks as set out by Amie Staples, as I believe she would be broadly in agreement with mine. The assessment of risk is not an exact science with a clear and correct answer and differences in professional opinion are to be expected. Stratification of risk into low, medium, and high is often subject to differences between different practitioners. This reflects the difficult nature of risk assessment, particularly in assessing the risks associated with the behaviour and actions of persons presenting with mental disorder. I do not think that the difference in assigned level is significant or that different professionals can be expected to arrive at identical conclusions. It is perhaps worth noting that healthcare professionals are now advised explicitly against stratification into low, medium, and high when assessing a persons risk to themselves. This is laid out in current NHS England guidance on staying safe from suicide [NHFT0002229].

71. I would first comment that the risks were identified through knowledge of VC's history, of the observed events of the day, the understanding of the consequences of untreated episodes of psychosis and all informed by my training and clinical experience. The risks that I outlined were significant in that they indicate the potential impact on VC and those around him of his current behaviour and need to be taken in to account when determining how best to manage and further assess VC going forward. The risks identified in an assessment are balanced against possible mitigations of these risks through treatment, supervision, and support that might be available. In this case regarding VC, it was clear that further assessment and treatment in the community was not feasible due to VC's clear refusal of this, and the risks associated with attempting to provide this given his response to being transported to hospital indicated that further assessment and treatment was only feasible in an inpatient setting using the Mental Health Act.

72. I acknowledge that Dr Manzar and I each completed and signed a "Form A4" for the purposes of making a medical recommendation to admit VC to hospital for assessment (PAGR0000153, pp. 7-10). My medical recommendation appears to read as follows: "*Valdo presents as experiencing a relapse of psychosis secondary to collateral history. He has not engaged with the assessors and has violently resisted efforts to execute a s135 including assaulting officers and threatening healthcare staff. He does not accept he is unwell and is refusing all intervention. He will not agree to informal admission or less restrictive alternatives. He requires assessment and treatment including 24 hour nursing observation and care. This is only possible using the act." (p.10).* By "collateral history", I meant information from medical records, not gathered directly on assessment. I was referencing his behaviour towards me during our interaction on the Cassidy Suite. I also recorded

in the "RiO" notes (NHFT0000168, p.168) that VC was *"highly likely to deteriorate in the community without treatment, with subsequent social harm and self-neglect*".

73. In the circumstances, less restrictive alternatives would have been attempts at further assessing VC in the community, which would have included reinstating antipsychotic medication in some form, close monitoring of his mental state with regular visits from the crisis team, and agreement on his part to engage with EIP services going forward. Given the struggle to even speak with VC and his repeated statement that he would not engage with anything from mental health services going forward meant that these would not have been feasible.

74. I considered that VC required "*24 hour nursing observation and care*." Any admission to psychiatric hospital under the Act involves that individual being under the continuous care of the staff on the unit and supports the further assessment to understand the extent of a person's mental health problems. I would have envisaged this being through a psychiatric intensive care unit in the initial period given the perceived risks and later as VC recovered through a general adult psychiatric ward.

75. I note that Dr Manzar recorded that VC has "*poor insight and is lacking capacity*" (PAGR0000153, p.8). I can understand Dr Manzar drawing these conclusions from the assessment, but I cannot recall what I would have concluded on these subjects at the time. Capacity is decision specific and I am not sure which decision is being commented on. Likewise, insight can be described in many different ways with greater or lesser attention to detail. The main drivers of decision making would have been the challenge in engaging VC, his history of psychosis and the level of aggression shown in resisting transportation to hospital.

76. I cannot recall speaking with relatives. I would normally rely on the AMHP doing so in the course of a Mental Health Act assessment.

77. In the "RiO" notes pertaining to the 3 September 2021 MHAA, I recorded the following under the hearing "Discussion": "*Valdo appears to be experiencing a relapse of his psychosis, though we could not establish the full nature of his psychopathology due to his refusal to discuss this with us. The history from his CCO was strongly suggesting of a schizophreniform pattern of psychosis*" (p.167). I refer to the nature of VC's psychotic symptoms as being consistent with the Category A symptoms of paranoid schizophrenia from the ICD 10 Classification of Mental and Behavioural disorders. It is worth noting that the description has changed slightly in the new ICD 11 diagnostic criteria. I would not assign special significance to schizophreniform symptoms of psychosis over other types of psychosis, as all psychotic disorders are associated with common issues: the patient's lack of recognition that they are unwell, a number of attendant risks to themselves and to others, of social harms, potential vulnerability and so on, depending on the exact nature, degree, and content of the individual's psychopathology and other personal characteristics.

78. The outcome of the 3 September 2021 MHAA was an application to admit VC to hospital under section 2 of the MHA 1983 (p.6 of the 3 September 2021 AMHP report). Even before the assessment - which I would suggest began from the moment we met with VC outside his flat and continued until we made our decision to detain under a section II at the Cassidy Suite - we knew there was a history of psychosis, including incidents involving the police, and periods where he had been discharged and rapidly disengaged. There was also seemingly a more sustained

period of improvement and concordance with treatment from his discharge in summer 2020 until the summer of 2021.

79. Personally, it was the first time I had met with Valdo and the situation in which we met was chaotic to say the least. We were caught up in the pepper spray during the police response. The restraint was prolonged and required making decisions in pressing circumstances. When transporting VC, there was first a discussion amongst the mental health professionals present and the senior police officer about whether or not charges should result for the assault, rather than the civil process of the Mental Health Act taking precedence. The ultimate decision was that charges may result at a later date but that VC would be transported to A+E and then to the place of safety to complete the Mental Health Act assessment.

80. When assessed at the place of safety, VC's level of resistance necessitated the presence of a restraint team and hampering the assessment process. VC remained unwilling to answer direct questions. He politely refused but later violently resisted his conveyance to hospital. At hospital, we could not elicit the detailed psychopathology that would clearly demonstrate to the assessors the full extent of the nature and degree of his illness.

81. Discussion amongst the assessors revealed it was clear that hospital admission was necessary to complete a full assessment of Valdo's mental health. The objective was to clarify the full extent of the nature of VC's mental disorder and its relationship to his risk to others and determine what may be proportionate going forward. This included whether the appropriate means would be through the criminal justice system, within mental health services alone or both.

82. The essential elements of a treatment plan for VC were not clear to us beyond the immediate management of his violence and aggression and the need to restart the

antipsychotic prescription. The eventual likelihood of his accepting the required treatment was equally uncertain as he had seemingly made reasonable recoveries previously from episodes of psychosis with oral treatment previously.

83. Given the limited discussion about treatment and his current experiences, it was difficult to gain a sense of what was necessary and proportionate going forward. Equally, there was a sense that choosing section 3 without being confident of a treatment plan would go against the least restrictive principle, as the patient would be forced to wait longer for an opportunity to challenge their detention through the tribunal. Hence it appeared reasonable to detain on a section 2.

84. I wrote my observations regarding "assessment and treatment" on section 2 medical recommendations. I would include VC's presence in a psychiatric inpatient environment as treatment in so far as it will at least allow management of incidents of violence and aggression, without representing a clear longer term treatment plan.

85. I do not recall discussing the role of a Community Treatment Order (CTO) in the possible long term management of VC at this assessment. A patient is only eligible for a CTO if detained under a section 3, which given we were not clear about the full extent and nature of his illness, or the essential elements of a treatment plan as described above we had not recommended. There were no disagreements or particular controversies from my recollection of that assessment. Nor do the records of the assessment suggest any. Disagreements within assessing teams are rare but not unheard of, and result in significant documentation by the involved practitioners explaining their differing viewpoints. This was not the case for either of the assessments of VC that I was involved in. I remain of the view that section 2 admission of VC was the correct decision at the time.

86. The records indicate that I issued a prescription at around this time (NHFT0000047) as recorded in the "RiO" notes (NHFT0000168, p.168); and that I also recorded a "plan" that included detaining him under section 2; prescribing haloperidol and lorazepam; and nurse him in seclusion, monitoring him by line of sight. Haloperidol is a sedative antipsychotic medication used in the management of behavioural disturbance in psychotic disorder and as a potential long-term treatment for psychotic disorders. Lorazepam is a benzodiazepine prescribed for marked anxiety but also used in rapid tranquilization in patients with psychotic disorders.

87. I prescribed haloperidol on the assumption he required antipsychotic treatment given his history and because of the need to manage the immediate risk of violence and aggression. I saw VC on the 10th of September 2021 as he had remained on the Cassidy Suite awaiting transfer to a PICU and documented that at this time he had been accepting medication. He was calmer and more able to engage in a conversation with me about his mental state at that time, which indicated some improvement, and revealed that he was indeed experiencing clear symptoms of psychosis. The exact content of his psychosis was yet to be divulged.

88. In the short term, VC's clear statement was that he would not take medication and would not be admitted to hospital. I was of the view that haloperidol and lorazepam should be administered by "IM" or as "intra-muscular" medication. This was so because of the immediate risk of aggression. The haloperidol and lorazepam would serve to sedate and reduce the agitation. Nursing staff on the suite monitored VC visually at all times and this is what is referred to as by "line of sight". This was the policy of the suite at the time for newly admitted patients and is enabled by the suites CCTV.

89. I was listed as a "responsible clinician" for VC, alongside Dr Manzar (NHFT0000052). As described previously, where no bed is available for patients to be admitted to, myself and the other duty consultants for the crisis team agree to act as RC for patients "*stepped up*" (formally admitted) to the Cassidy Suite place of safety. My role as RC would have passed to the 24 hour consultant on call as soon as my working day finished, which would have been as soon as I left the suite. This is why I took the time to ensure that a plan was in place to manage VC's risk of violence and aggression over the weekend. Dr Manzar would not have been RC for VC.

90. I referred VC to the Psychiatric Intensive Care Unit ("PICU") at around 21:00 on 3 September 2021 (CYGN0000085), with the recorded aim to: "*re- establish Valdo on antipsychotic medication in an environment that is adequately resourced to manage his level of physical aggression and resistance"* (p.2). I identified a PICU environment as necessary due to level of violence and aggression demonstrated during his resistance to travel to the Cassidy Suite and demeanour on arrival there. My view was that VC required treatment with antipsychotic medication to manage his immediate risk of violence and aggression and to attempt to improve his mental state and insight such that he was able to agree to treatment as he had in the past, thus potentially making detention unnecessary.

91. My next interaction with VC was on 10 September 2021, in respect of which the following is recorded on p.188 of the "RiO" medical records, where I noted that: "*Valdo has accepted antipsychotic medication orally which is progress. He has been let out of seclusion with no further incidents of aggression*." Also noted that: "*Valdo remembered me from the execution of the s135. I spoke to him from the doorway with two staff; he did respond politely to my questions but at one point*

stood and appeared to be edging towards me. I asked about the experiences he had described to Claudia. He responded that this was happening, and that the technology used was called 'neural remote imaging' and 'neural remote mapping', which he reported as being able to scan and manipulate his thoughts at a distance. He talked about having researched these technologies on the internet, and that he was quite clear I 'already knew all about this technology' and was involved in its use. We talked about my view that he was experiencing psychosis, that these experiences for him were real, but were not possible or real to those around him. We discussed the limitations of the current level of brain imaging/scanning, and that it was a long way from being able to read or manipulate minds. He countered this saying he experienced these things every day, so how can it not be possible. We discussed his medication. I thanked him for taking the haloperidol orally and screened for side effects, all of which he denied. We asked if there was anything he wished for which he denied." My impression and his current risk were recorded as follows: "*remains unwell with systemetised persecutory delusions driven by first rank symptoms of schizophrenia. He continues to pose a risk of assault to healthcare staff and in my view requires PICU as he did on admission*." The plan I recorded was: i) to continue with haloperidol; ii) transfer to PICU as soon as possible ("*will require secure transport*"); iii) continue to monitor on line-of-sight observation; and iv) ask staff to be on the suite whilst I assess the other patient.

92. I considered that VC still required a referral to PICU for the additional security this provided in terms of environment and staffing compared to a general psychiatric ward. I was aware that the Bed Management Team continued to seek an out of area PICU as our own PICU was full at this point. I note that Dr di Mambro in his patient notes dated on the 7th September 2021 [NHFT0000168 at 7 September

2021 at 10:34] recorded that VC had been declined by 14 PICUs suggesting the team were struggling to find a provider willing to accept VC. I can see that he was successfully transferred to a private provider on the 11th September.

93. It appears that VC spent the 10 days detained to the Cassidy Suite s136 Suite. I cannot recall how I knew that VC had "*accepted antipsychotic medication orally*". I would have received this on handover from the nursing team and/or read it from his medication chart.

94. I believed that accepting anti-psychotic medication would have reduced VC's levels of agitation and fear and led to a reduction in any psychotic symptoms he was experiencing. I was aware that VC had been given IM medication after refusing oral medication from the 4th to the 8th of September; but had later begun accepting oral medication from the 9th of September onwards. VC would have required restraint in the administration of non-oral medication if he physically resisted. This is the case for any patient refusing treatment.

95. I did not consider depot medication as VC was taking oral medication and it was early in the course of treatment. If VC had remained under my care I may have suggested this as his mental state improved in discussion with his regular community team.

96. I said in my record of September 10th that VC "*appeared to be edging towards me*." I cannot recall the details of this beyond what I recorded. It is possible I was hypervigilant given my participation in the s135 assessment. From my memory of the second meeting, I do not recall feeling threatened in the same way. I was able to discuss the nature of psychosis with VC in a way that had been impossible previously.

97. The nature of the experiences he described of having his thoughts interfered with and his mind read are not unusual. Nor was the belief that this was possible through advances in secretive technology known to certain groups such as intelligence agencies, the police, the government, foreign government, gangs, certain industries etc. The content of a person's beliefs is often influenced by their cultural and pre-existing beliefs about the world. Other patients might describe telepathy, alien beings, spirits or supernatural entities of one kind or another being responsible. Understanding a patient's beliefs is important because it assists those supporting them to better apprehend possible risks arising from them.

98. I continued to think he posed a threat to staff as he appeared symptomatic and was early in his being reestablished on antipsychotic treatment, which taken in light of the short time he had been out of seclusion indicated a potential ongoing risk that still required a PICU.

99. I have been shown an email sent on 27 January 2022 by PC Abby Pinnock regarding the assault of the police officer of 3 September 2021 about a potential prosecution. This email requested information about VC's mental health condition in order to consider the impact on a decision to prosecute him: (**NGPF0000019**). I believe this was because I had witnessed the assault on the male police officer during the execution of the s135 warrant. I don't recall receiving this email and I can't find it in my inbox. Most of my correspondence with the police around giving a statement was with a PC Matthew Johnson 2511.

100. I did provide a statement, which is dated 27 January 2022 (NGPF0000032). From memory I was interviewed by the officers about what I had observed that evening and relied on my recall as it was at the time. I don't recall making any notes or using the medical records to support giving the statement as this was criminal

matter and sharing VC's information without his consent would have required a justification given his right to expect doctor/patient confidentiality. I can't remember the details of the discussion but from memory, I met with PC Pinnock on this day as I think she was standing in for PC Johnson. I have a meeting with PC Johnson in my diary for 2pm that day but it doesn't contain details of location or other attendees etc.

101. When I wrote in my statement that "*it appeared highly likely CALOCANE was unwell,*" I was referring to the impression of the assessing team at the time. I was not intending to pass comment on VC's capacity or criminal responsibility. Though VC may have been unwell, I believe I was concerned at the seriousness of the assault. I also thought that it was in the interest of the assaulted officer and VC to have this considered by the criminal justice system, given VC's history.

102. I can't recall having any further contact with the police or VC over this matter other than asking VC to consider granting the police permission to access his medical records.

2022

103. I do not recall any involvement with VC prior to 20 January 2022 (other than as touched on above). I acknowledge though, that the records indicate that I held or participated in an MDT on 19 January 2022 that notes as follows: "*MDT Dr Lomas RM. note outcome of mental health act assessment yesterday. previous aggression was in the context of being coerced in to hospital though was significant. there is also a history of forcing entry in to other's property in response to psychotic symptoms. if any suggestion that he does not wish to engage or take*

treatment, would suggest do not press the issue and leave. remain red RAG contact in pairs. low threshold for considering admission." (NHFT0000168, p.205). I cannot recall the exact details of what I knew at this point in time; but as described elsewhere, I would have refreshed my memory of his case as part of the MDT process. Given my awareness of the case, I would have focused on VC's contact with services since our last contact, including his disengagement from mental health services and possible non-concordance. I cannot recall if the MHAA report from the AMHP was available to me

104. I can't recall discussing the MHAA on 19 January 2022, with the AMHP, Roseanna Crane (NOCC0000040). But there was communication about the subsequent MHAA that I eventually undertook on the 22nd January. I have copied that correspondence below for information (NOCC0000067).

Roseanna Crane< **GRO-B**

Lomas Benjamin - Consultant

Okay we will set it up for the original time of 2pm.

Thanks

From: Lomas Benjamin - Consultant

GRO-B >

Sent: 27 January 2022 15:49

To: Roseanna Crane < GRO-B

Subject: Re: Valdo Calocane

Warning: This email is from an external sender and has an attachment or link to the internet, please use caution.

The earliest I can do tomorrow. Mdt til 1030 and then again at 1pm.

Get Outlook for Android

From: Roseanna Crane

GRO-B

Sent: Thursday, January 27, 2022 3:22:56 PM

To: Lomas Benjamin - Consultant

GRO-B

Subject: RE: Valdo Calocane

Thanks. We are of the belief that Valdo is usually up late at night and asleep in the mornings. Is 2pm your earliest?

From: Lomas Benjamin - Consultant

GRO-B

Sent: 27 January 2022 15:21

To: Roseanna Crane < GRO-B

Subject: Re: Valdo Calocane

Warning: This email is from an external sender and has an attachment or link to the internet, please use caution.

2pm please

Get Outlook for Android

From: Roseanna Crane

GRO-B

Sent: Thursday, January 27, 2022 2:22:08 PM

To: Benjamin.Lomas GRO-B

GRO-B

Subject: FW: Valdo Calocane

Hello Ben,

Scratch that. Dr Skelton feels this one does need a warrant, on the balance, therefore I will be getting that first. There is a high chance this will take place tomorrow. I see you have one at 11 already. What time would you be free for this, if at all?

KR

Rosie

From: Roseanna Crane

Sent: 27 January 2022 14:00

To: Benjamin.Lomas GRO-B

Subject: Valdo Calocane

Hello Ben,

I am aware you are not the duty consultant today, however a MHAA request for Valdo Calocane has come through from Crisis. Mike is in an MDT, then MHAA after. There are significant risks to others with this patient. He lives in Student halls. Me and Mike

assessed him last week and the community plan isn't working. Are you able to support na assessment this afternoon? Around 3?

I'll understand if not.

Kind Regards,

Rosie Crane

Social Worker/ AMHP

Mental Health Social Care Team South

Stonebridge Centre -Cardiff Street

Nottingham, NG3 2FH

Office: GRO-B

Direct Landline 0115 969 1300 extn GRO-B

Mobile GRO-B

Email: GRO-B

105. I came to be involved in the MDT on 20 January 2022 because I was the duty consultant for the crisis team that day. Also in attendance was Rachel Masterson B7 Crisis Care Practitioner. I cannot recall what information I had available to me at the time for the purpose of the MDT and from whom, but the normal process is to review the patient record as described above and to receive a hand over from the B7 practitioner or shift lead that day.

106. I do recall saying that VC was to "*remain red RAG contact in pairs".* This means that daily contact was to continue, as well as daily MDT. Contact in pairs means visits should be with two staff and this was in light of his previous Mental Health Act assessment and initial period of detention when unwell, as well as the report of an assault on a flat mate triggering the assessment undertaken on the 19th January. The purpose was to offer some mitigation of the risk of assault on staff.

107. I also recall saying: "*if any suggestion that he does not wish to engage or take treatment, would suggest do not press the issue and leave*". I wanted to flag that if staff attempted to be persuasive or firm in their recommendation that he take the medication (as we may often be with patients with psychosis) he might react angrily and possibly assault them. With some patients we are able to be firm in our recommendations for taking treatment, with others this may only antagonise them. For this latter group, emphasising their agency in taking medication may make them more likely to accept treatment. I had not personally assessed VC at this point so would not have been able to comment specifically on capacity.

108. I also said that there was a "*low threshold for considering admission*". We generally recommend this for patients where home treatment may not be successful or does not sufficiently mitigate risks in the management of the patient. This was recommended given the circumstances of his previous admission and his initial referral to the service. I wanted to be clear that the risks were such that less restrictive alternatives to hospital had less leeway than may be the case with other patients. Behaviours such as reluctance to engage, missed visits, or evidence of non-concordance of treatment should result in consideration of the need for admission sooner than in other cases.

109. I was non-duty consultant on the 25th and 27th January. The crisis team at the time was full complement of 3 whole time equivalent consultants, meaning that as well as the duty day input to the team, between the 3 consultants we provided two half day clinics each week to offer urgent reviews of complex and high-risk cases which were determined through the MDT. Though I don't think I was involved in formal discussions about VC's care such as MDT, I believe I had discussed the case with Dr Skelton who was the duty consultant but I can't recall the details of what was said. It was not unusual to discuss cases in this way, in fact, we set aside time specifically for us to discuss our impression of cases under the teams as part of trying to ensure continuity of care and approach with a team held caseload.

110. I have seen a record of an MDT on 28 January 2022, which notes as follows: "*MDT Dr Lomas VG MHA called today. to take place at 2pm today. remain red RAG until outcome clear.*" (NHFT0000168, p.213. I can confirm that I was the duty consultant for that day. For the period between 20 January and 28 January 2022, I was aware that VC had missed certain appointments with the team and had been observed to put something from his mouth to the bin, raising the possibility this had been medication. I was aware that the team were uncertain as to whether he was taking his medication.

111. I had been asked to attend the MHAA on 28 January at 14:00 by Roseanna Crane AMHP. Victoria Green, a B7 crisis care practitioner, also attended. I would have had the handover from the team and the content of the record as detailed in the background section of my record of the Mental Health Act Assessment.

112. In the MHAA, I wrote that VC was to "*remain red RAG until outcome clear*". There is nothing to be decided from the MDT at that point as the decision had been made to request a formal assessment under the MHA. The team is essentially

stating that we don't feel community treatment is sufficient and that admission is necessary. The outcome of an assessment depends upon the examination and assessment undertaken by the assessing team. On some occasions the outcome of the assessment is that further assessment and treatment in the community is felt to be appropriate, hence we keep the patient on red RAG rating until the outcome of the assessment is known so we are prompted to implement care plans as a safety net in these cases. Likewise, the outcome of an assessment may be that admission is agreed formally or informally but a bed is awaited, and there continues to be a need for the crisis team to visit regularly to offer what support and input we can whilst a bed is located.

113. The records indicate that I was involved in the MHAA which took place on 28 January 2022 ("the 28 January 2022 MHAA"), with Fiona Parker (AMHP) and Dr Manzar. My note in respect of this is recorded on pp.214-215 of the "RiO" records (NHFT0000168). Under "background", I referenced a "*recent incident where he held his flatmates hostage, though the details of this are not clear.*". I considered the details surrounding this unclear because the description in the notes comment that a flat mate was taken hostage and assaulted, but that the police attended with no action being taken. It would be highly unusual for an incident of such seriousness to result in the individual being left in the property with the victim. The email in the record from the student reports that they prevented an assault by restraining VC. There was likewise no clear description of the drivers for the incident in the student email and VC's account in the AMPH report from the 19th described an argument over cleaning escalating to a "scuffle". I had not spoken to any individual in particular about the assessment. I was reliant on the records which

contained information from the victim and any further information provided at the assessment itself.

114. In the incident, VC reported in the MHAA report from Roseanna Crane that this was an argument about a cleaning rota that escalated into a brief scuffle. The student email reports an attempt to assault them and that they had had to restrain VC to prevent harm coming to themselves. Other entries mention hostage taking and assault. The incident was obviously alarming enough for the police to be called, but VC was not arrested or removed from the property.

115. For completeness I should reiterate that ahead of the assessment, I would have reviewed the clinical record for recent events. I would also have discussed VC's presentation with the team and with staff who had been on visits with him. In addition, I would have had a handover of other information gathered by the AMHP in the course of arranging the assessment too.

116. It would have been good to have access to the detailed police report of their attendance at the incident and to have spoken with VC's regular consultant and care coordinator. The other clinical demands on my time this day were considerable. I undertook three other Mental Health Act assessments, an urgent assessment for a complex patient under the care of the crisis team and a review of a patient informally admitted to the Cassidy Suite. One of the MHAAs required the organisation of an urgent community re-titration of clozapine which requires considerable planning and coordination with pharmacy and the crisis team. This would presumably have been alongside the MDTs undertaken in the morning and at lunchtime, whilst offering supervision to the wider clinical team over any other cases they wished to discuss with me as a consultant. This would have limited my ability to undertake further information gathering. The staff I could have spoken to

may also have had other commitments, or been less than full time and not at work etc. I do not recall speaking to any of VC's family members for the purpose of conducting the MHAA and would normally rely on the AMHP to liaise with the nearest relative.

117. The "RiO" notes that whilst another warrant was obtained on this occasion, it did not have to be executed because VC "*was compliant with the request he travel to the Cassidy suite for a further assessment*" and he "*travelled willingly with the ambulance.*" (NHFT0000168, p.215). However, it is noted that VC was "*unhappy that services had reneged on the agreement he made with the assessors at the last assessment*". From VC's point of view he was complying with the plan from the earlier MHAA and he did not feel it was proportionate or fair that he again be assessed under the Mental Health Act. I cannot recall exactly what was said, but from my records it seems he would have expressed displeasure at being asked to travel to Highbury Hospital again, though he did not offer any resistance to doing so.

118. With respect to the background to this MHAA and the prior input from clinicians in the community, I recorded that "*on at least one occasion he [VC] was believed to be witnessed spitting the medication from his mouth and putting it in the bin. He has refused to drink fluid on most occasions and staff are unclear as to whether he has been taking the medication.*" (NHFT0000168, p.215). It was documented in the record of one of the nursing visits by Sarah Wiecek and Nathalie McPherson on the 21st of January: "*As he walked away we watched him walking towards his accommodation and as he was passing a bin he put his hand to his mouth - then threw something in the bin which appeared to be the medication we had just given him*". This, alongside the historical risks, and the brief nature of most of the contacts

with VC with the team indicated to me that we could not be confident that VC was taking the antipsychotic medication which would be a key requirement of continuing with less restrictive alternatives to hospital in managing his psychosis.

119. I did also record that VC was "*adamant that he was taking his medication*" and that he denied that he still held his prior conspiratorial symptoms (NHFT0000168, p.215). With regards to the medication, I was unsure. He appeared genuine in his assertion and from memory offered a plausible alternative for the incident where he was observed to put something from his mouth to the bin. With regards to whether or not he was actively experiencing psychotic symptoms, I note that in the AMHP report from Fiona Parker, she suggests Dr Manzar and I felt he was masking symptoms; but in terms of his mental state at this assessment, I document that he was not overtly psychotic and in my medical recommendation, I document that he is "*possibly experiencing psychosis*". From memory, my honest impression was that he was probably not acutely psychotic at that time, but that it remained possible and the historical risks justified coercive intervention based on this possibility.

120. This was my second MHAA of VC (following that of 3 September 2021). Compared with the previous assessment I could not detect the subtle signs of psychosis that were present before. His eye contact was normal and his affect was not blunted. His body language was not threatening at any point, and there was no violence as had occurred previously. From memory, his communication was normal. He was frustrated at being brought to hospital and at the prospect of having his studies interrupted but this was understandable. I don't recall his exact movements during the assessment. Fiona Parker's AMHP report suggests we spoke to him from the office door on the Cassidy Suite, in my memory we were stood by the door with VC stood in the middle of the shared area of the suite.

121. I cannot recall the exact conversation we had about "*remote neural mapping*". But I would have spent time asking directly about experiences like those he had described to me previously, as well as exploring other common psychotic experiences in general conversation in an attempt to elicit evidence of these as described above. I felt safer in his presence than when I had met him last but was wary given his history. I diagnosed that VC was "*not overtly psychotic*" but that his presentation was "*entirely consistent with his previous relapse where after several days of treatment he did discuss his psychopathology more openly and clearly*." By previous relapse I was referring to my previous assessment with him. The reason for my impression being that VC was not overtly psychotic was that at no point during the execution of the warrant or during the subsequent assessment was I able to detect clear evidence of active hallucinations, delusions, or thought disorder either through conversation with VC or in observation of his body language, facial expression. This does not rule out psychosis however, and clearly he had had a history of psychosis. Hence, I don't state that he appears in remission, but equally I am unable to state with certainty that he is actively psychotic at that point.

122. It is recorded that I discussed depot medication with VC during this MHAA: *"I suggested to Valdo that he have a long acting injection if he was happy to take the medication – I explained that patients we work with secrete or palm mediations frequently, or will not take them orally, and that this assures clinicians that there are no issues with concordance. He flatly refused to accept this saying there was no need as he was taking the medication*" (NHFT0000168, p.215). The reason for the Mental Health Act being called had been because we were unable to be certain of his concordance in the community and were having brief appointments only which did not enable a full assessment of his mental state and potential risk. Depot

antipsychotic medication would have removed the need for daily visits and allowed less frequent but longer and more in-depth reviews with qualified staff that would address the concerns about the current approach and permit continued less restrictive alternatives to hospital admission.

123. I was aware of the NICE guidance around the treatment of schizophrenia on Long-Acting Injections (LAI) and the British Association of Psychopharmacology guidelines on the treatment of schizophrenia at the time of the assessment; as well as local policies addressing the administration of depot medication, managing missed doses and so on. [NHFT0003138]. For a patient admitted under section 2, regardless of capacity, if the conclusion of the inpatient team and RC following further assessment is that depot medication against the person's will is justified, there are no barriers to prevent treatment being instigated. The patient may subsequently require a further MHAA to consider detention under section 3 if the person continues to refuse the necessary treatment in order to establish the person on a therapeutic dose of depot antipsychotic. The Mental Health Act Code of Practice is clear that all patients liable to be detained except those on short-term holding powers/restricted patients/certain forensic patients can be treated under the Mental Health Act.

124. When the subject of depot was brought up, I can't recall any more detail than what is documented in the record. VC flatly refused, saying it was unnecessary as he was concordant with oral treatment. I don't remember any anger or agitation on his part.

125. In my medical recommendation advising admission to hospital under section 2 of the MHA 1983, I recorded the following: "*Valdo presents as possibly experiencing psychosis. He behaved threateningly to his flatmates, is guarded or*

superficial in his interaction with healthcare workers, and does not agree there are any grounds for worry about him. Attempts at further assessment have been unsuccessful in the community, He has a significant history of risk to others and the recent indicant with his flat mates suggest this has returned. He requires admission for further assessment and treatment including 24-hour nursing observation and care. This is not possible without the act." (NHFT0000070, pp.9-10). I was unsure as to whether VC was actively experiencing psychotic symptoms, or whether he was as he asserted in some degree of remission. I was well aware of his history of psychosis and the attendant risks.

126. Dr Manzar's medical recommendation appears to state that VC's illness was "*one of psychotic disorder*" (NHFT0000070, p.8). VC clearly had a history of psychosis. I am afraid I cannot read Dr Manzar's medical recommendation but was in agreement on balance that admission under section 2 was appropriate.

127. I described how staff from the crisis team found him at their appointments, indicating a limited ability to explore his current mental state. This is recorded to justify not persisting with less restrictive alternatives to hospital despite VC's agreement with, preference for, and engagement with the care plan agreed at the recent MHAA where he was not detained. I did not know if VC was masking his symptoms but felt he required close observation beyond what was available in the community. I documented this in the record and recommended detention as a result. He could have been masking his symptoms, or equally he could have been in a degree of remission: for example symptom free and lacking insight, or symptom-free, insightful, and embarrassed and wishing to downplay his history. I can't recall discussing this specifically with others.

128. I considered that VC again required *"24 hour nursing observation and care"* because our attempts as a crisis team to support and monitor VC in the community were not eliciting sufficient detail or assurance about his mental state or concordance with treatment. Further assessment of his current mental state was required in hospital including the provision of 24-hour oversight that is provided by a patient being in a hospital setting.

129. I concluded that admission under section 2 was preferable to section 3, as to which I recorded as follows: "*Section III was discussed, but the balance of the assessors felt that further assessment was required given the lack of clear psychopathology currently. We agreed to recommend detention under section II"* (NHFT0000168, p.215). This was the second occasion that Dr Manzar and I had jointly assessed VC under the Act. We were both wary given our previous experience of attempting to assess him under the Act, but on this occasion VC was calm, cooperative, and offered no resistance. We were also assessing him in the context of a recent MHAA team finding that he did not require detention and less restrictive alternatives to hospital were appropriate. He had also broadly complied with the plan agreed from that assessment, as opposed to previously where he stated in no uncertain terms that he would not see mental health services, take medication, or be admitted to hospital.

130. On assessing VC's mental state on this occasion, he would engage with conversation with us, and denied experiencing symptoms of psychosis like those he had previously. I also could not detect signs of psychosis that could be observed in his behaviour or general demeanour as there had been at the previous assessment. He was also clear that he would cooperate with whatever input was felt to be necessary in the community including continuing to take treatment on our

recommendation, to see the nursing team regularly, and to work with services going forward.

131. The lack of clear psychopathology was relevant because of the degree or current manifestation of his disorder. He could be taking the medication and it was being effective; he could be as he asserted in remission from his psychotic symptoms, and his annoyance about being monitored in taking his medication by multiple different health professionals was frustrating him as it interfered with his routine and studies in a way he saw as unnecessary. If this was the case then the risks could be assumed to be adequately mitigated to allow community input as a less restrictive alternative to hospital, as we are required to consider by the Mental Health Act Code of Practice, whereby any intervention should be delivered in the least restrictive environment for the shortest time possible and include consideration of the patient's views and wishes.

132. I also considered the possibility that VC was still symptomatic and was simply able to deny his experiences and control his responses to them such that they were not observable to us in the course of his assessment. In that case, the risks would not be adequately mitigated such that less restrictive approaches were not safe and appropriate. If he was still symptomatic, then this could be because he was not concordant with treatment and that depot aripiprazole would be an appropriate intervention. Or, it could be that he was concordant with treatment and that aripiprazole was simply ineffective or only partially effective and that a switch to an alternative oral antipsychotic would be appropriate.

133. We suggested alternatives to detention, including informal admission to permit closer monitoring of his mental state. This would afford greater assurance of concordance than was possible in the community in order to support a deeper

understanding of his current presentation. One other possibility was a depot antipsychotic and continued community treatment, which would reduce the need for daily contact and possibly enable less frequent, but more in-depth assessment of his current mental state and risks. Acceptance of either of these may have resulted in detention or even admission being deemed unnecessary.

134. A patient may be detained on the nature of their illness. In VC's case, this was a recurrent psychotic illness which had previously been associated with risk to others and a pattern of non-concordance and disengagement. It is also important to note there had also been one period with EIP where VC sought treatment and appeared to improve. He was managed without crisis involvement or consideration of admission being necessary when seeing Dr Burri in late 2020/early 2021. There had been a recent incident where the police had to be called, but this did not result in arrest or charges being brought. The seriousness of this incident, in comparison with previous ones, was not clear. It was also not clear if it related to VC's mental disorder.

135. My thought on his case was that awareness of his historical risks suggested caution about pursuing less restrictive alternatives to hospital was necessary, but equally our assessment did not reveal a clear and obvious treatment plan. We were aware a depot antipsychotic could be necessary, though this depended on the eventual understanding of his current presentation as laid out above. It could also be that he was simply not responding to aripiprazole and that an alternative oral antipsychotic would be required, including possibly clozapine for which there is no LAI in any case.

136. Regardless of what the potential treatment requirements may have been in the long term, VC was refusing depot antipsychotic whilst agreeing to oral medication.

To override a patient's wishes when they were taking effective evidence-based treatment, which would potentially include having to physically restrain VC to administer the depot unless he could be persuaded to accept it would be restrictive practice which requires careful consideration as stated in the Mental Health Act Code of Practice.

137. As a result, section 3 was considered, but the assessors agreed that on balance section 2 was more appropriate as the full extent of the nature and degree of the patient's illness was not clear; and there was a need to carry out a new inpatient assessment to re-formulate a treatment plan. The use of section 2 did not preclude VC being placed on a section 3 if necessary, if the outcome of the inpatient assessment was that depot medication, administered against VC's wishes for the foreseeable future, was necessary and proportionate to the nature of his illness.

138. There was consideration of the fact that an admission under section 3 (rather than section 2) could result in VC being subsequently released from hospital on a CTO. I was aware that a patient detained on a section 2 was not eligible for a CTO, but a patient detained on a section 2 who is deemed after assessment to require admission for treatment can be assessed for and subsequently detained on a section 3 if required. They would then be eligible for a CTO. I was not called on to consider the possibility of administering depot medication to VC in hospital subsequent to an admission. VC was transferred to Redwood 1 ward the Sunday after the assessment. I was not involved in his care during admission.

139. The AMHP for this assessment was Fiona Parker. As with the previous assessment, I do not recall any dissent in terms of the outcome we arrived at. I do remember the decision being a challenging one because of the unexpectedly

compliant nature of VC's engagement with us and his willingness to accept treatment and to work with services.

140. For the reasons stated before, the decision of section 2 detention was in accordance with the Mental Health Act Code of Practice, that ensured adequate containment of the risks identified in VC's case at that point. It facilitated the opportunity to consider what approach to treatment was required going forward. Knowledge of the future was unavailable to the assessors at the time. Based on our assessment and my understanding of the MHA CoP, the decision appears clinically appropriate.

141. Under the heading "Risk", I recorded the following in the "RiO" records: "*To self: the risk of deliberate self-harm appears low currently, though requires further assessment in light of his reaction to being detained. To others: male, psychosis, hx of significant assault on police and ongoing risk to staff following last admission. Currently he is presenting as calm and cooperative, though is clearly unhappy at the prospect of being detained. He presented similarly calm prior to the previous incident of significant violence*." (NHFT0000168, p.215). The risk to others did not appear as acute or pressing as it did at his previous assessment, but the long-term risk around possible aggression in future episodes of illness appeared to remain. Hence he did not at that time require nursing in a PICU environment, rapid tranquilisation, or nursing in seclusion but could be safely managed in a general adult psychiatric ward.

142. Considering VC's "*reaction to being detained*" I thought that the risk to himself required further assessment. There was a decidedly different reaction to his detention under the s135 in 2021 compared to his reaction to the decision to detain him under section 2 at this assessment. I feared that if he was symptom-free as he

asserted, he could become distressed at the prospect of the disruption to his life and studies that detention to hospital represented. This could lead to thoughts of suicide.

143. I advised: "*continuing aripiprazole 20mg od for now, and explore depot prior to discharge*." (NHFT0000168, p.216). He reported he had been concordant. My reasoning was that if he continued to take it but evidence accrued of his being unwell, then we could conclude that it was ineffective. If he appeared well, it may be that this would support the efficacy of aripiprazole and its choice as a long-acting injection if VC could be persuaded to accept this, or if he could not, it was concluded that forcible administration was justified.

144. I cannot comment on VC's response after admission, that is, whether he took his medication; and if so, what effect it had. I was not involved in management after the assessment. I don't recall any further involvement in discussions about prescribing depot medication, either with VC or with clinical staff. I was not involved in VC's management once he was detained, so I am unable to say whether he was ever prescribed depot medication; or whether it was administered to him. I was not aware of the details of his care, treatment and subsequent presentation after admission on 28 January 2020. My work is generally wholly community based and his inpatient management was overseen by the team on Redwood 1.

145. I spoke to VC on 21 February 2022 to seek his permission to disclose his mental health to the police (NHFT0000168, p.255). This was in an effort to support the police in pursuing the charges relating to assault on the officer as they had requested me to do so. VC was pleasant and polite. There is nothing that stands out from the interaction as significant from memory. He asked to consult the information that came with the consent form and said he would discuss it with a

solicitor before signing anything. I did not have input into VC's care or treatment after 21 February 2022.

INPUT INTO OTHER INVESTIGATIONS

146. I am aware that a selection of questions was sent to the Nottinghamshire Healthcare NHS Foundation Trust by the families of VC's victims and that these were passed to me specifically (NHFT0004861). I did not respond formally in writing. I was interviewed by Anna Hiley and an external consultant psychiatrist whose name I cannot recall and gave verbal responses to the questions asked. I did make notes to support my responses to these questions which I will provide to the inquiry [WITN0316005] I was also booked to be interviewed as part of the investigation (NHFT0004831). As before, I will provide my personal notes. I do not have copies of the notes that were produced as a result of the interview or the final response to the questions.

REFLECTIONS AND RECOMMENDATIONS

147. I do not have any overarching points for reflection at this time, though I do hope that the manner in which I have responded to the inquiry's questions has included elements of reflectiveness.

148. Similarly, I cannot think of any recommendations that I would like to make at this time.

NOTE

149. This witness statement was drafted on my behalf by the external solicitors acting for the Trust in respect of the Inquiry, with my oversight and input, following discussions in writing by email and by video conference. I also sought advice from my Medical Defence Union.

Statement of Truth

I believe the content of this statement to be true. I understand that proceedings 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 of its truth.

Signature: GRO-B .....

Dated: 2nd December 2025.....

Index to First Witness Statement of Dr Benjamin Lomas

No.	Inquiry URN	Document Description
1	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary
2	NHFT0002229	Guidance re: Staying safe from suicide
3	WITN0316002	Core Assessment Final Draft
4	WITN0316003	Risk Assessment Final Draft
5	WITN0316004	Formulation And Care Plan
6	NHFT0003138	Guidance on Managing Missed and Delayed Doses of Antipsychotic Depot Injections
7	WITN0316005	Questions for Dr Ben Lomas CRHT
8	WITN0163046	Email from Faizal Seedat [NHFT] to Alison Harrison [NHFT], Ben Di-Mambro [NHFT] and Matt Callaghan [NHFT], Re: Crisis team visiting Valdo
9	NHFT0007087	Report compiled by Sarah Taylor and Beth Rogers, Re: AMH Key Themes from QIPs Working Groups Risk assessments and care planning Highlight Summary Report
10	NHFT0000222	Medical Records of VC dated 31/07/2020, NHFT, Re: Discharge summary - Version 2.2
11	NOCC0000034	Report compiled by Nottingham City Council Re: Nottingham Adult Social Care Teams
12	NOCC0000050	AMHP Report Referral and Assessment Form of VC
13	NOCC0000048	Warrant to search and remove patient VC under Mental Health Act 1983, S.123 (1) dated 03/09/2021
14	NOCC0000049	Information in support of application for warrant to search for and remove patient VC dated 03/09/2021 by Amie Staples
15	NOCC0000044	Report dated 24/05/2020, compiled by Dominic Lloyd, Re: AMHP Report Referral and Assessment of VC
16	NOCC0000045	Medical Report of AMHP dated 25/05/2020, Re: AMHP Report Referral and Assessment for VC

17	PAGR0000153	Forms H3 (Record of detention in hospital), A4 (Medical recommendation for admission for assessment), A2 (Application by an approved mental health professional for admission for assessment) and AMHP report referral and assessment of VC
18	NHFT0000047	Medical Records of VC dated from 03/09/2021, Re: drug prescription and administration record
19	NHFT0000052	Medical form for VC dated 03/09/2021, Re: AMH Seclusion and Long-term segregation procedure
20	CYGN0000085	PICU Gatekeeping Referral Form for VC
21	**NGPF0000019**	Email from Abigail Pinnock to Abigail Pinnock, Re: Suspects mental health condition
22	NGPF0000032	Witness Statement of Dr Benjamin Lomas, dated 27/01/2022
23	NOCC0000040	Report dated 19/01/2022, compiled by Roseanna Crane, Re: AMHP Report Referral and Assessment of VC
24	NOCC0000067	Email from Roseanna Crane [NOCC] to Benjamin Lomas [NHFT], Re: VC
25	NHFT0000070	Form H3 - Regulation 4(4) and (5) Mental Health Act 1983, Sections 2, 3 and 4 - Record of detention in hospital of VC
26	NHFT0004861	List of questions for Dr Ben Lomas CRHT from Letter of concern / complaint received by VC's victim's families
27	NHFT0004831	Email from Benjamin Lomas [NHFT] to Samantha Cobb [NHFT] and Anna Hiley [NHFT], re: Booking of interview - Request to participate in Trust process
28	NHFT0015099	Guidance, Re: Assessment and management of risk to others, Royal College of Psychiatrists
29	WITN0058002	Report dated May 2017, compiled by Royal College of Psychiatrists, Re: Rethinking risk to others in mental health services