Witness Name: Dr. Mohammad Omar Manzar
Witness statement no: WITN0350001
Dated: 17/12/2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR. MOHAMMAD OMAR MANZAR

I, **Dr. Mohammad Omar Manzar**, will say as follows:

1. This statement responds to the Rule 9 request dated 14 October 2025. It provides details of my career and role in the Nottinghamshire Healthcare NHS Foundation Trust ("the Trust"), and my interactions with Valdo Calocane ("VC") between July 2020 and January 2022.

2. 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.

3. I confirm that I have not been involved in the care of any other mental health patient who, following discharge or when in the community, killed or seriously injured a member of the public.

Professional Background and Qualifications

Qualifications

4. I am a qualified medical doctor and completed my medical education in 1985. Following my initial house training, I worked in medicine and was working as a

physician abroad. I worked in various branches of medicine before deciding to specialise in psychiatry around 2003.

5. After settling in the UK and completing my Professional and Linguistic Assessments Board ("PLAB") exam, I began working for the NHS. Between 2004 and 2007, I completed my Senior House Officer ("SHO") training post in psychiatry.

6. Around September 2007, I worked in the position of a staff grade doctor for about a year before returning to a training post in Nottingham as well as in Birmingham. After completing that phase of training, I again worked as a staff grade and later as a locum consultant psychiatrist.

7. I obtained a Postgraduate Diploma in Clinical Psychiatry from the Royal College of Physicians of Ireland in 2008, and later a Postgraduate Diploma in General Psychiatry. The latter was obtained from Cardiff University in 2020. I became a Member of the Royal College of Psychiatrists in London in 2014.

8. In 2014, I returned to higher specialist ("SpR") training and successfully completed that training in 2018. Following the completion of my training, I joined the Trust as a part-time Consultant Psychiatrist in Old Age Psychiatry, a post which I continue to hold.

9. I have some supplementary psychiatric qualifications, which include a Certificate in Medical Education obtained from Edge Hill University Lancashire in 2015, and a Certificate in Medical Leadership from Manchester Metropolitan University in 2015. Since 2015, I have been approved as an Educational Supervisor and have been actively involved in teaching and supervising medical students and junior doctors.

10. I achieved my Certificate of Completion of Training ("CCT") in both Old Age Psychiatry and General Adult Psychiatry in 2018, and in the same year, I was approved as a Clinician under the Mental Health Act ("MHA").

11. I am a member of the Royal College of Psychiatrists ("MRCPsych") (my MRCPsych membership number is 814448) and am registered with the General Medical Council ("GMC") (my registration number is 6029038).

Professional appointments

12. My professional relationship with the Trust dates to around 2003, when I first joined the Trust for a short time doing some locum work. Later, when I left the Trust, I worked in different parts of the country, including 7 years in staff grade roles, and locum consultant post apart from my training posts. I returned to the Trust briefly around 2008 for a year and later rejoined in 2018 in my current consultant role. Since then, I have continued to work part-time for the Trust, alongside my independent work as a Section 12 ("s.12") Approved Doctor.

13. I currently work as a part-time Consultant Psychiatrist with the Trust, within the inpatient service. My work pattern is flexible and part-time, reflecting the nature of my current commitments.

Mental Health Act training

14. I was first approved under the MHA s.12 legislation in 2006. Since that time, I have regularly renewed my s.12 approval status. My current s.12 approval status expires on 7 October 2028.

15. I have maintained active involvement in MHA assessment ("MHAA") training work and those activities that fall within the remit of a Responsible Clinician ("RC"). Over the years, I have participated in various conferences, seminars, and other educational activities and events relevant to s.12 approved work.

16. During the period when I began working formally as a consultant and took on responsibilities as an RC, I attended the full mandatory two-day RC training.

This course included structured teaching on the assessment and treatment of individuals detained under the MHA.

17. I completed Mental Capacity Act ("MCA") assessment training last year and have continuously participated in regular training through Continuous Professional Development ("CPD") activities provided by the Royal College of Psychiatrists. I have undertaken mandatory training through the Trust with regards to MHA legislation.

18. As part of my annual revalidation and yearly appraisal, I ensure that my CPD portfolio includes all activities relevant to my role as a RC and s.12 Approved Doctor.

19. Over the years, I have gained experience working as a consultant psychiatrist, as well as during my earlier posts as a staff grade doctor, where I was consistently involved in the assessment and management of detained patients. In addition, I participate in regular peer review and case-based discussions involving detained patients through my CPD peer group, which meets four times a year.

20. My ongoing professional development also includes training and practical experience in preparing medical and legal reports, including documentation for Mental Health Tribunals and court proceedings. This has included attending online courses and participating in seminars and conferences covering important aspects of mental disorders relevant to subjects of detention and treatment of mental disorders.

<u>Specific Roles and Responsibilities pertaining to Mental Health Act Assessments</u>

21. I have been working as an RC consultant for the past few years. I have also been approved under the MHA as an Approved Doctor since around 2006 to carry out such work. I have maintained that approval continuously since then. This accumulation of experience includes my duty to assess, make formulation

of diagnoses, and provide care for patients who are detained under the MHA legislation.

22. These duties and work also include review of those patients detained under Section 2 ("s.2") and Section 3 ("s.3") of the MHA, such as review of detention, the need for continuation of detention, and granting leave to patients under Section 17 ("s.17") leave.

23. In my position as a psychiatrist and with my background of training in this field, I have participated in a number of MHAAs over the years, both in hospital and in community settings. On average, I usually undertake at least two assessments per week. These assessments have usually involved working together with Approved Mental Health Professionals ("AMHPs") and other healthcare professionals, including other doctors.

24. I have gained experience and understanding of different forms of psychopathology and mental illness presentations, including risks attached to patients' mental state and social circumstances. Each assessment has to be considered carefully in terms of fulfilling the detention criteria under the MHA versus accepting the least restrictive principle. This work has been undertaken in both hospital and community settings, which have assisted me in understanding mental illness, risk management, and patient care for those detained under the MHA legislation.

25. My postgraduate qualifications have given me an academic and clinical background to carry out this work safely. I have also worked in various posts over the past few years, from SHO and staff grade doctor to consultant psychiatrist.

26. I have received specific and ongoing training relevant to the roles of RC and Registered Medical Practitioner ("RMP"). I have been approved as a s.12 doctor since 2006, and I attend refresher courses regularly as required for re-approval. I have also completed mandatory MHA and MCA training provided by the Trust.

These are regularly renewed through online training as per the Trust's renewal policy.

27. I have taken part in regular CPD activities, which include participating in conferences, online seminars, and postgraduate activities (provided by the Trust for an hour or two every Wednesday). These activities include completing relevant MHA legislation courses, keeping updated with local and national guidelines, and referring to the MHA Code of Practice for queries and guidance. Our local MHA office and the Trust's lead (for any advice and guidance in relation to such work) are usually in contact with us.

28. The Trust has local policies and procedures for different areas of care. These policies and procedures cover both physical and mental healthcare. The policies and procedures cover areas such as management of aggression and violence, suicidal and self-harming behaviours, management of violent and aggressive patients on inpatient services, review of physical and mental care of those admitted to Psychiatric Intensive Care Unit ("PICU") wards, seclusion policies, and the MHA policy and procedure manual.

29. At the national level, there are guidelines such as the MHA Code of Practice, issued by the Department of Health and Social Care. [**DHSC0000007**] The manual includes statutory guidance for applying MHA legislation and framework. Additionally, there are NICE guidelines in relation to use of MHA legislation, as well as advice on training and standards from the Royal College of Psychiatrists for doctors approved under the MHA and RCs.

30. On occasions when I am asked to become involved in an MHA assessment, I am usually contacted by the AMHP, who provides me with information in relation to the patient's presentation. This includes the circumstances leading up to a request for such an assessment and the reason for such work. The AMHP also provides other relevant history, such as information from second or third parties who have been recently or immediately involved in the patient's care or presentation.

31. When there is a chance and I am near a computer in the Trust, and the patient is registered on their electronic notes, I tend to look at their notes before conducting the MHAA. However, sometimes such information is provided either by the other doctor who works with me, knows the patient well, or has read their notes, or by the staff at the place where the patient has been seen or assessed.

32. The AMHP coordinates the assessment and usually identifies RMPs in conducting the MHAA.

33. The information about the patient's presentation can be shared to facilitate the organisation and the execution of the MHA assessment. There are times when the bulk of the information is either provided by the RMP or the AMHP, or there are instances when information is jointly provided by all practitioners typically involved in the MHAA. The RMP provides their view and input after gathering the necessary information and subsequent mental state examination.

34. The AMHP oversees the entire process, and they finally complete their application if they are happy to proceed with the RMP's recommendation. The agreement can be reached from the outset (in cases when there is an obvious need for either the community option as 'a least restrictive method', informal admission, or detention under a s.of the MHA). The RMPs make sure that the detention criteria are met or otherwise agree with the least restrictive principle.

35. Along with these assessments, there are often Crisis Team members attending as 'gatekeepers' who also provide their views, such as supporting the least restrictive principles for patients when we decide that they can be treated in the community, or at least there can be further scope for a period of community assessment or treatment. The AMHP typically involves the Crisis Resolution and Home Treatment ("CRHT") medical representative as the first doctor in such instances, unless they are not available. The Crisis Team can also send their Band 7 nurse, who is usually an experienced nurse for such an assessment.

Assessment of Risk in Mental Health Assessments

36. In a psychiatry setting, risk applies to the likelihood or possibility of an adverse event occurring. Risk can be multifactorial and can be directly linked to a person's mental state. Behaviour arising out of risk-occurring circumstances may cause harm to self, others, or property. Risk can include the likelihood of an event occurring which may also result in neglect, aggression, violence, sexual offending, assault, exploitation, deterioration in mental or physical state, suicide, self-harm, substance misuse, unsafe living conditions, etc.

37. Risk is dynamic, which means it evolves in the presence or absence of many other factors such as the presence of stressors, medication compliance, life events, and the presence or absence of support both within personal or professional environments.

38. Risk evaluation is an important part of any psychiatric assessment and is part of the Mental State Examination when I conduct an MHAA. As outlined in the Code of Practice in the context of the MHA [**DHSC0000007**], the risk includes risk of a person to their own health and safety and risk to others.

39. When assessing risk of violence to others, I consider many elements including past history of aggression and violence, substance misuse, current mental state such as the presence or absence of psychopathology such as command hallucinations, delusions of persecution or paranoid thinking, impulsivity, and disinhibition. As risk can be dynamic, this can be directly linked to other factors such as environmental or personal stressors, medication adherence, and the presence or absence of personal or professional support.

40. In the context of my work as a s.12 Approved Doctor, I also pay particular attention to whether detention or compulsory treatment is a necessary intervention to manage the risk effectively. In circumstances when the least restrictive principle is considered, I pay attention to whether these risks can be

mitigated with appropriate support in the community and the availability of treatment and service provision. This can be challenging as it carries tension between patient autonomy and public protection.

41. Besides practising as a consultant psychiatrist, I am a Best Interests Assessor ("BIA"), a role I have obtained after attending relevant courses. I have participated in multiple MCA assessments over the years. These experiences include assessing patients both in inpatient service bases as well as in the community.

42. I usually attend regular courses (when the course accreditation expires) on MCA topics, as well as attending compulsory or refresher training courses within our Trust education curriculum. I also attend external courses and seminars, including participating in my regular CPD activities. I also get involved in conversations and decision-making with other colleagues across the Trust and the Trust legal team itself.

43. As a clinician and in line with the MCA, I presume that adults have capacity unless proved otherwise.

44. The test of capacity involves all four aspects of capacity:

    a) Understanding relevant information;
    b) Retaining that information;
    c) Using or weighing that information to come to a decision; and
    d) Communicating that decision.

45. Capacity assessments are decision-specific, involving the legal framework of the MCA. I abide by these rules as outlined in the MCA.

Psychosis-specific considerations

46. In the context of psychosis, the concept of ‘insight’ applies to the term 'awareness', in which the sufferers may or may not understand or be aware that they are suffering from a mental illness. This, however, is not an all-or-nothing awareness process, as it can be partial when the sufferer can understand and be aware that something is wrong with them, but they might not agree with the full extent of their illness, such as the need for care or treatment.

47. This awareness can be multi-dimensional, such as when they may recognise they are ill but feel that they do not need treatment for such an illness. Linked with this, there are other closely related aspects of illness correlated and allied with insight, which also fluctuate as the insight itself does. These include things such as risk and capacity.

48. If a psychotic patient ‘masks’ symptoms, they might hide or camouflage what they feel or think and make a conscious or unconscious attempt to normalise their presentation to others. This can be seen in multiple mental health conditions, including more enduring mental health difficulties such as schizophrenia.

49. The patient’s aim may be multifactorial; it can be in the context of delusions or paranoid thinking, so behaviour and conduct appear socially or medically acceptable. It may be aimed at avoiding care or treatment.

50. Masking symptoms can make clinical assessment and judgement harder, as the overall picture of illness can become under-represented compared to the true level of underlying psychopathology.

51. Working on a ‘need-led basis’ means the service response is largely led by the patient's needs, rather than driven by a routine or fixed service output such as service convenience, appointments, or regular follow-ups. It is more based and centred around individual patient's actual needs or requirements. There are multiple examples of these, such as frequency of contacts, needs for frequent assessment for risk management, medication review, and other aspects of

needs such as social care needs, more intense follow-up, flexible appointments, etc., designed to be tailored to improve outcomes.

52. Whilst the formulation of risk can be based on various factors, a combination of objective as well as subjective factors can assist in assessing the level of risks and degree of insight. These can include information such as assessment of mental state, collateral information (from family and keyworkers), and other clinical and historical factors. Other factors such as past forensic history, substance misuse, compliance with care and treatment, self-harm or suicidal attempts, past history of violence and aggression, along with other dynamic factors such as social, personal, and environmental factors, can play a part in formulating such risks.

53. Similar factors can be applied to determine the level of insight, and these factors include awareness of a person suffering from a mental illness, making connections between their symptoms and a mental disorder, and accepting care and treatment.

54. Psychiatric patients can consciously or unconsciously mask their symptoms. Features can include avoidance of treatment, hospitalisation, and avoidance of being labelled as being mentally unwell. Those perceived factors can be conscious (e.g., for secondary gain) or unconscious (related to factors such as reaction or denial).

55. The information accessed by clinicians before the decisions around assessments are made include the patient's notes. As a s.12 Approved Doctor, it would also include information from the AMHP or the crisis doctor who attends the MHAA with me.

56. I have not been involved in the care of any other mental health patient who, following discharge or when in the community, killed or seriously injured a member of the public.

<u>Your involvement with and knowledge of VC in 2020</u>

57. I have been asked to comment on a series of records which indicate that I participated in several MHAAs of VC between 2020 and 2022. These assessments, and the records pertaining to them, as follows:

a) The 14 July 2020 recommendation

A MHAA with Geoff Culpin, the AMHP, and Dr Faizal Seedat ("the 14 July 2020 MHAA") following which VC was admitted to hospital under s.3. This assessment was recorded in an "AMHP Report Referral and Assessment" [NOCC0000046] ("the 14 July 2020 AMHP report"), completed by Geoff Culpin. My recommendation was recorded in Form A8 [NHFT0000037].

b) The 3 September 2021 recommendation

A MHAA with Amie Staples, the AMHP, and Dr Ben Lomas ("the 3 September 2021 MHAA") following which VC was admitted to hospital under s.2. This assessment was recorded in an "AMHP Report Referral and Assessment" [NOCC0000050] ("the 3 September 2021 AMHP report"), completed by Amie Staples. My recommendation was recorded in Form A4 [PAGR0000153].

c) The 19 January 2022 AMHP report

A MHAA with Roseanna Crane and Dr Mike Skelton ("the 19 January 2022 MHAA") following which no application to admit VC to hospital was made. This assessment was recorded in an "AMHP Report Referral and Assessment" [NOCC0000040] and completed by Roseanna Crane.

d) The 28 January 2022 recommendation

A MHAA with Fiona Parker, the AMHP, and Dr Ben Lomas ("the 28 January 2022 MHAA") following which VC was admitted to hospital under s.2. This assessment was recorded in an "AMHP Report Referral and Assessment" [NOCC0000043] ("the 28 January 2022 AMHP report"), completed by Fiona Parker. My recommendation was recorded in Form A4 [NHFT0000070].

58. I saw VC on the 14th of July 2020. This was the first time I had been involved in a MHAA with him. I attended this assessment in the capacity of a s.12 Approved Doctor.

59. I spoke with the AMHP preceding the assessment. The relevant information was provided by the AMHP and the staff at the Cassidy Suite. I also had access to his RIO notes (the Trust's electronic records) from which I obtained relevant background information.

60. I learnt that he had a diagnosis of schizophrenia and had a recent admission to hospital for a first episode of psychotic illness. I was made aware that he had been discharged not long before this assessment from an inpatient service. I believe at the time of his discharge he was prescribed Aripiprazole. My understanding was that his compliance with treatment was poor.

61. From the available information at the time, I became aware that there had been an incident in which he had forced entry into a flat in his accommodation block. He had reportedly been banging on a neighbour's door, and when the occupant opened the door, he made a forced entry inside the flat. He was then restrained by a resident who called for help. Later on, police became involved. On his arrival at the Cassidy Suite, we were informed that he had been brought in by police and had accepted food and fluids. He showed poor insight into the relapse of his mental illness.

62. The AMHP informed us that he had been becoming unwell for the past two weeks prior to his presentation at the time. His mother had also expressed

concerns, stating that he had been vague when asked whether he was compliant with his medication. I believe she reported that he was becoming mentally unwell.

63. Dr Seedat also attended this assessment as part of this MHAA. As far as I remember, Dr Seedat provided me with some relevant information about his recent presentation and history over the telephone. It was quite clear and evident from the background information that his presentation was in keeping with a relapse of his psychotic illness.

64. During my assessment of him, he presented with clear psychotic symptoms, including paranoia and persecutory delusions. His understanding of his illness was poor, and he lacked capacity to make informed decisions about his care and treatment.

65. From my assessment, it became quite clear to me that he was relapsing into his illness and his relapse was highly likely in line with his medication non-compliance.

66. My overall impression was that he was presenting with a relapse of his illness, he displayed very poor insight, and he lacked capacity to make decisions about his care. I therefore concluded that he needed a further period of hospital admission for treatment of his mental disorder.

67. I briefly spoke to Dr Seedat over the phone, who had previous involvement with VC's care. I was also briefed by the AMHP before the assessment. I had been provided with an overview of his presentation, care and treatment history, including being prescribed Aripiprazole. My understanding was that he responded to previous treatment when he was an inpatient in the hospital. I have also reviewed his electronic records prior to seeing him. As far as I can recall, he was discharged on Aripiprazole.

VC's previous treatment and detention

68. The records indicate that VC had been released from Highbury Hospital, where he had been detained under s.2, on 17 June 2020 [NHFT0000223], following the 14 July 2020 AMHP report.

69. The records indicate that VC had been detained under S.136 ("s.136") of the MHA on 13 July 2020, the evening prior to the MHAA which I conducted. He had been detained after attempting to force entry into a neighbour's apartment [NHFT0000261]. This information came from the AMHP prior seeing him.

70. I was made aware of VC's behaviour and presentation by the AMHP. The information included details of his aggressive and intimidating behaviour towards neighbours in the adjacent flats where he was living.

71. As far as I can remember (given there is a long lapse of time), I did not speak with anyone regarding his s.136 detention, as at the time of our attendance the police were no longer present at the Cassidy Suite. The primary sources of information were, the AMHP, the staff at the Cassidy Suite, and information from Dr Seedat, who provided me with some information about his past history over the phone.

72. My understanding was that VC had become aggressive and violent due to the relapsing of his mental disorder and a re-emergence of his psychotic symptoms. These symptoms were characterised by auditory hallucinations where he believed his neighbours were discussing him or talking about him.

73. As far as I can remember, during the assessment, he demonstrated poor insight, although he did acknowledge feeling paranoid, staying mostly indoors, and not going out much. He tended to minimise the impact of his behaviour on others and did not fully acknowledge the risks he was posing to those around him.

Mental Health Act Assessment on 14 July 2020

Events recorded

74. From my memory, I recall that during the assessment on 14 July 2020, VC was calm and did not present as particularly agitated or aggressive. I did not feel intimidated by him at the time of his presentation.

75. He communicated reasonably well throughout the assessment, and as far as I remember, there was no indication that he was becoming violent or aggressive during our interaction. His communication was appropriate, and he was generally engaged in conversation, responding to questions when asked. I did not feel threatened or intimidated by his behaviour at any point.

76. He acknowledged that he was feeling paranoid and demonstrated some limited insight into his mental health difficulties. However, overall, he did not show a good level of insight into the nature of his illness or understand why hospital admission was required for assessment and treatment of his mental disorder.

77. In the s.136 documentation [NHFT0000261], it was recorded that when assessed by the Street Triage team, VC: "*did answer questions but he was subdued and the nurse felt that there may be underlying issues that he was trying to mask*".

78. I did not discuss this directly with the Street Triage team. I was able to access his records electronically, which had given me insight into his presentation.

79. I am unable to comment on whether I agree that there may have been an '*underlying issue that he was masking*'. This is because, my recollection is limited and, I appreciate that impressions between clinicians can differ. If the Street Triage clinician felt that way, that would be their professional opinion.

80. From my assessment, all I can remember is that there was a degree of guardedness, though otherwise he was open to other areas of discussion. My

subsequent impression, or overall impression, was that he was unwell and he needed to be admitted to hospital for a period of treatment.

Record of events

81. I note that there is a typed version of my handwritten note in the 14 July 2020 Recommendation [NHFT0000037, p.4] which has been transcribed correctly. It reads as follows:

> *"This 28 years old gentleman is known to mental health service with diagnosis of psychotic disorder & he had recent inpatient admission. He has been also known to EIP service. Presently he is detained under s.136 of MHA after he forced his way to a neighbour flat. He believed that someone was at danger & he wanted help. He appeared very preoccupied, with a fixed gaze & he was not making much sense. He is reporting hearing voices "inside his head" discussing him in third person & making comment on what he is doing. His mood, affect & presentation fluctuate & he is not compliant with his medication. Associated presentation includes poor sleep, excess anxiety, & loss of function. He is a 3rd year university student, appeared not to be using any illicit substances & his presentation appears to be in line with a relapse of his psychotic disorder possibly a schizophrenia in nature. He seems to be lacking capacity to make an informed decision about his care. His Insight varies & his presentation can change drastically. Community treatment is not safe or practical option. He is refusing an informal admission. He is needing a period of inpatient treatment under s.3 of MHA. Current treatment plan includes optimisation of his psychotropic medication, then offer of OT & psychological therapy"*

82. Reflecting on my medical recommendation, although it met the detention criteria in terms of both nature and degree (as highlighted in the medical recommendation), I would ideally have included more detailed information

regarding the circumstances leading to detention and the direct risks he was posing to the public. Whilst I did tick the box indicating that detention was necessary for the protection of others, in hindsight, I would have added further clarification on this aspect.

83. Similarly, thinking retrospectively, I would have elaborated more on his degree of medication compliance, potential need for depot antipsychotic treatment, consideration of a Community Treatment Order ("CTO"), psychology involvement, and the optimisation of psychotropic medication for adjustment or possible change of antipsychotic medication. It would have been desirable to do so to have achieved as detailed an assessment as possible.

84. However, as a s.12 Approved Doctor, it is not often possible to write a more specific treatment plan without being the patient's RC. Nevertheless, it covered the essential criteria for the purpose of detention under s.3.

Factors considered

85. I would have taken a number of factors into consideration during the assessment, including his presentation.

86. VC was guarded, although he described feeling that someone was in danger. He denied hearing anyone in distress, which in my opinion at the time suggested that he was minimising his symptoms and appeared guarded.

87. I also noted from the records that his responses during the assessment were limited. Although he stated that he was taking medication, this did not appear to be the case. In response to the question of whether I would have agreed at the time that he was attempting to mask symptoms; my impression was that he was rather guarded than masking symptoms. Based on this I have formed my opinion that he was mentally unwell, experiencing psychotic symptoms hence I have agreed detention under the mental health act.

88. Within the 14 July 2020 Recommendation [NHFT0000037 p 4], I described VC as being very preoccupied. I noted that he appeared preoccupied, and I felt this was due to him experiencing hallucinatory experiences and hearing voices, and it was probable that he was ruminating on this in his mind. I cannot remember in detail what questions I asked him that elicited those answers, as there is a long lapse of time since that particular MHAA but looking at my medical recommendation and what I remember, he discussed his hallucinations on several occasions.

89. From what I can remember, his intense look towards me made me think that he was either becoming agitated internally or was preoccupied in his mind, possibly listening to his auditory hallucinations.

90. When I used the term "*not making much sense*", this was not in reference to his speech but rather to the content of his psychotic symptoms, particularly his auditory hallucinations. I was concerned by this because these symptoms were indicative of an underlying psychotic disorder.

91. Due to the time lapse, I cannot recall the exact wording of my questions or the full details of his responses. However, I have some recollection of when he stated that he was hearing voices of people discussing him. These voices were distressing and intrusive. I thought they were concerning as they seemed to be having a negative impact on his mental state and his behaviour, and they were influencing his actions.

92. I considered that his mood and his insight into his presentation could be fluctuating at the time of my assessment. On the basis of the available information and despite his psychotic symptom experiences, there were periods when he was able to function relatively well. These were reasonable levels of functioning, such as being able to attend his university course and study.

93. In my view, these periods of relative stability interchanged with phases of deterioration in mental state, during which his mood and presentation were markedly affected by the psychotic experiences. These fluctuations of mental state seemed to interfere with his ability to maintain his normal routines and functioning. The same applied to his insight.

94. This presentation, in my opinion, was varying, as I believed that it was in the context of his medication compliance leading up to relapses. When he was adherent to his medications, he was well and able to function well.

95. I referred to loss of functioning as a reduced ability to study or to attend his university course. During the period when he relapsed, my understanding from speaking with him was that he had become increasingly anxious and preoccupied with his psychotic experiences, had reduced concentration and academic performance. The relapse of his symptoms appeared to have had a negative impact on his ability to study or function effectively on a day-to-day basis.

96. I believed VC's more general symptoms (poor sleep, excess anxiety) to be related to his underlying psychotic symptoms. These symptoms were not isolated but rather part of the wider picture of his deteriorating mental state. At the time of my assessment, I believed that his level of anxiety was undue and excessive, and that this was affecting multiple domains of his functioning, such as his sleep pattern. I regarded these features as clinically significant and relevant to my overall impression of his presentation.

97. In summary, these factors were important in my decision-making, as such elements were contributory factors in view of his relapses and, secondly, it assisted me to make my decision in light of these that he was unwell; hence I concluded that he needed admission to hospital under a s.3 of the MHA.

Medication concordance and substance misuse

98. I became aware that he was not compliant with his medication. I remember asking him directly about this and specifically enquired why he was not taking his prescribed medication. He did not offer a clear reason for his non-compliance but did show some regret about having stopped his medication. I cannot recall his exact wording, but he confirmed to me that he had discontinued his medication.

99. VC did not appear to be using illicit substances. I would have come to this conclusion based on the absence of any available collateral information (from him and other sources). I recall asking him directly whether he was using any illicit substances. His reply to this question was, *'no'*. I had no reason at that point to doubt his answer.

100. If I had been suspicious or believed that he was using illicit substances, I would have considered the possibility of a drug-induced psychosis. The presence of a drug-induced psychosis would have influenced my diagnostic formulation and risk formulation. The absence of such evidence supported my impression that his presentation was more consistent with a primary psychotic disorder.

Diagnosis and capacity

101. I considered VC's presentation to be a relapse of his illness, possibly schizophrenic in nature. I used the term "*possibly schizophrenic*" to reflect my clinical impression at the time. This was based on the nature of the symptoms he exhibited during our assessment.

102. Although I was not his RC or directly involved in his ongoing care, his presentation was characteristic of someone suffering from schizophrenia. These symptoms were characterised by prominent auditory hallucinations, paranoid thinking, persecutory beliefs, poor insight, and functional decline. Based on this, I believed that his presentation represented a relapse of an underlying psychotic illness. The risks attached to this were the possibility of him acting on his delusional beliefs. I therefore concluded that he needed to be

detained in hospital for treatment of his mental disorder and containment of risks.

103. I considered that VC lacked the capacity to make an informed decision about his care based on the fact that he was unable to fully understand the nature of his presentation (suffering from a mental disorder of a nature and degree). He also displayed a lack of belief that he was mentally unwell, he failed to understand the need for treatment of his mental disorder, and he failed to weigh up the risk he was posing to himself and others.

104. I can see from the records that the AMHP, Geoff Culpin, spoke to VC's mother by telephone. I did not speak to VC's mother, or any other family member.

Risks identified in the AMHP Report

105. From what I can gather, the risk that was indicated in the AMHP Report [NOCC0000046, p.4], related primarily to the risk of aggression from VC towards neighbours, as well as a risk of further deterioration in his mental health, including self-neglect and lack of sleep. The AMHP Report assessed these risks as being of high or severely high likelihood.

106. The assessment of risk documented in the AMHP Report was undertaken by the AMHP, not the s.12 Approved Doctor. However, as a medical practitioner, I also made my own clinical judgement regarding the risks. This judgement was based on VC's presentation at the time. The role of the AMHP involves not only overseeing the overall MHA processes but also having a responsibility to balance the assessment of risk against the potential for the least restrictive option, such as care and treatment in the community.

107. This duty extends to considering how the act of depriving someone of their liberty may serve to protect both the individual and others who may be at risk of harm. An AMHP has to strike the right balance for safeguarding the person's

rights, health, and wellbeing, whilst also considering any potential risks to the public.

108. I believe that questions relating specifically to the AMHP's reasoning would be best answered by the AMHP himself. However, in my capacity as a s.12 Approved Doctor, I carefully weighed these risks in the context of my assessment at the time of the assessment. These would include consideration of the severity of his symptoms and the level of risk. Based on this, I made a medical recommendation that he required detention in a hospital setting for his own health and safety and for the protection of others.

109. In the AMHP Report, there was a specific reference to the risk of aggression towards neighbours, which had been marked as high or severely high, and this was indeed evident from VC's presentation. His behaviour had already resulted in his admission to a place of safety, indicating the seriousness of the situation.

110. These risks appeared to have arisen directly from his psychotic symptoms, which were driving his behaviour towards others. At the time of presentation, VC's aggressive behaviour appeared to be bordering on, or escalating towards, actual violence.

111. My understanding of the term aggression is that it is distinct from violence: violence is an act of ferocity or viciousness referred to as an 'intention to cause physical harm'. This could result in serious injury or harm to a person and can result in injuries, permanent physical harm, or death. An act of violence can also cause property damage or cruelty to man or animals.

112. Aggression, however, refers to threatening, hostile, or intimidating acts driven by behaviour which may or may not result in harm. There are many examples of aggression, which include verbal or physical nature.

113. Both aggression and violent acts can be linked to mental health problems, as these can happen in the context of psychiatric presentation and symptom manifestation.

Treatment recommendations

114. Following my assessment of VC, I had a telephone conversation with Dr Seedat. This discussion was around the circumstances of his admission and detention under s.136.

115. As far as I can recall, Dr Seedat gave me a brief history of his past presentation and his previous involvement with VC in the inpatient service. Given the diagnosis at the time, together with VC receiving treatment in the community following discharge from hospital, detention under s.3 was agreed to be deemed an appropriate course of action.

116. I also held a separate discussion with the AMHP. As far as I can remember, there was no difference in opinion but a shared consensus in reaching such a decision for detention under s.3. I believe this was necessary, appropriate, and proportionate in relation to VC's presentation at the time.

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

118. I had no further involvement with VC's care, assessment, or treatment when he was admitted to hospital at this time.

Your involvement with and knowledge of VC in 2021

Attempted Mental Health Act Assessment on 2 September 2021

119. On 2 September 2021, I attempted to conduct a MHAA, but VC did not answer the door. I cannot recall the events, but if they are recorded in the records, I have no reason not to believe they are correct.

120. This is recorded in an entry by Jen Shaw in the Nottingham Adult Social Care Teams 'case notes' [NOCC0000034, p.10], and in any entry by Dr Ben Lomas on RIO [NHFT0000168, p.164]. These records are as follows:

Nottingham Adult Social Care Teams 'case notes', 2 September 2021, 18:06

"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."

RIO medical records, 2 September 2021, 20:58

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.

121. I did not see or interact with VC directly on 2 September 2021.

122. I became aware from the feedback Dr Lomas provided when we initially attended the MHAA. VC appeared to be unwell and was not engaging with his Community Mental Health Team ("CMHT"). He stopped taking his antipsychotic medications.

123. Based on the information available to me at the time, regarding the events that led to the referral for this MHAA, I was also informed that, when seen a few days prior to the assessment by his care coordinator, VC presented as disgruntled and unwilling to take medication or engage with care and treatment in the community.

124. It was also reported that the CMHT felt uncomfortable during their visit. I believe this was due to VC's demeanour and uncooperative behaviour, which resulted in a subsequent MHAA.

125. I recall having a brief discussion with Dr Lomas. We both agreed that a re-attempt at the MHAA was necessary, as earlier attempts had been unsuccessful. I did not have any direct contact with VC's mother or any other family members.

126. I am unable to comment on why it was considered that VC might have left his property in anticipation of being assessed. As an independent s.12 Approved Doctor, I had no further interaction or any involvement with him or with any other individuals in relation to this matter. No additional information was provided to me.

Re-attended Mental Health Act Assessment on 3 September 2021

127. On 3 September 2021, I re-attended VC's accommodation in order to carry out the MHAA. The records indicate that prior to the 3 September 2021 MHAA, a warrant had been obtained [NOCC0000048], following an application by Amie Staples [NOCC0000049]. I became aware that a warrant had been obtained before the assessment, when the AMHP called me to inform me of this.

128. Specifically, with regard to the execution of the warrant, the following is recorded in the 3 September 2021 AMHP Report, by Amie Staples [NOCC0000050, pp. 2-3] :

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.

129. Further, the following was recorded by Dr Lomas in the RIO notes: [NHFT0000168 pp.167]

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 MHAA. 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.

130. I believe that this note provides an accurate account of what took place on that day.

131. When I first encountered VC, we were standing outside his flat. A short while after, a car pulled over beside us. At that point, we were not clear who the driver was, but he lowered the window, appeared to be someone of African origin, calm and collected, and said something along the lines of, "*why we were there or how we had come to be there*". I cannot recall the exact words.

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

133. I did not have any concerns prior to the arrival of the police, that VC might become aggressive or violent. My main concern was that he might not engage in the assessment. He was quite clear from the outset and stated that, "*the assessment was not going to take place*". He was calm and collected at that point. We felt that pressing the matter further could risk escalating the situation. However, I did not anticipate that he would become violent or aggressive at that point.

134. I cannot recall exactly what was discussed with VC before the police arrived. I do not have access to contemporary notes from that time, as I usually delete or shred my confidential notes after a certain period. My recollection is that we explained to him that the assessment was being carried out under a warrant and that we needed to proceed with it. He was offered options as to whether the assessment could take place in his flat or at a place of safety.

135. I note that Dr Lomas's account was that VC seriously assaulted a police officer. I remember that there was a great deal of commotion at that point. I was standing towards the back of the group, near the end of the corridor, and did not witness the full sequence of events. However, from what I could hear and partly observe, it did appear that he had seriously assaulted a police officer. From the corner of my eye, I saw him raising his arm high and striking an officer. I recall that he had one hand either already cuffed or partially cuffed, but he appeared to have broken free from one of the restraints, either by force or by seizing a cuff from another officer. I cannot state with certainty which occurred, but it was clear that a serious assault had taken place.

136. I also began coughing heavily during the incident. This was during the COVID outbreak, and I felt bad coughing so violently, so started retreating back towards the exit. I later realised that the police had discharged CS gas in order to subdue him.

137. I do not recall seeing any medication in his flat. By that point, I had already retreated due to the effects of the CS gas.

138. I recall that the condition of VC's flat and living environment appeared to be in good order. There was no evidence of clutter, neglect, or poor hygiene. I did not accompany him on the journey from his flat to the hospital.

139. I am unable to comment on Dr Lomas's observation that VC was normally a gentle and law-abiding young man. I have not had the same level of involvement or familiarity with him as perhaps Dr Lomas and his Crisis Team had, and therefore it would be inappropriate for me to comment on this point. I have had no interaction with VC during any period when he was not psychotic. My only involvement was during MHAAs. Therefore, it would be inappropriate for me to comment.

140. With respect to Dr Lomas' observation that his eye contact was intended as a challenge, I believe that is accurate. His gaze at that point was fixed and unyielding. Given the events that had occurred an hour earlier, it did indeed feel unnerving and somewhat alarming.

<u>Phone calls made to the Cassidy Suite</u>

141. The records note that I made two telephone calls on 3 September 2021:

<u>To the police</u>

03/09/21 7:22pm – Cassidy Suite S.135 – T/C from Dr Manzar who had gone to execute S.135. Valdo refused entry and police were called. Four

officers attended but Valdo was aggressive and officers called for further support. Valdo continued to be aggressive and was tasered twice to no avail and then sprayed. Valdo taken to ED for medical assessment and will be transferred to Cassidy when deemed medically fit. [CPSE0000025, p.26]

To Sophia Mutonono (a nurse)

T/C from Dr Manzar who had gone to execute S.135 at Valdo's house. Valdo has been reported to be settled at first and was responding well to the assessing team however he refused them entry to his house and they had to call the police officers. Four officers attended and Valdo was aggressive towards them, they had to call for more support and several officers attended however he continued to be aggressive. He was tasered twice but to no avail. Police had to use paper spray. Valdo was then taken to ED for medical assessment and will be transferred to Cassidy when he is deemed to be medically fit. Two more extra staffs have been put out for support. Dr Manzar recommended PICU referral and Bed Management was informed. [NHFT00168, p.164]

142. I believe these records are reasonably accurate of the events.

143. The purpose of these calls was primarily to alert the Cassidy Suite at the Highbury Hospital about the expected arrival of VC, as I did not want the staff to be unprepared, particularly since there are occasions when staffing levels at the place of safety are limited. That was the main purpose of this call.

144. I cannot recall whether I contacted the police directly, but the telephone call I made was specifically to alert the Cassidy Suite. During this call, I discussed the nature of his presentation, that he had been aggressive and agitated. I also provided an overview of the events that had occurred during the execution of the warrant.

145. The PICU referral was made based on the severity of his presentation at the time.

146. No other decision was made in my capacity as a s.12 Approved Doctor. The call was more of a courtesy call rather than a direct management plan or expectation of outcome.

Dr Lomas: a 'previous acquaintance'

147. The information available to me for the purposes of conducting the MHAA was primarily provided by the AMHP at the time of referral. In addition, the Crisis Team doctor, Dr Lomas provided information. I was satisfied that the details provided were sufficient to inform the rationale and purpose of the MHAA, which was undertaken due to VC's disengagement from community services and the absence of any viable alternative to assessment under the MHA legislation.

148. I do not believe it is accurate to state that Dr Lomas had no previous acquaintance with VC prior to this assessment. Upon reviewing the records, it is evident that VC had been discussed in multidisciplinary team ("MDT") meetings both in June and August 2020. Whilst the full details of those meetings are not known to me, the documentation suggests that Dr Lomas had prior familiarity with the case.

149. In this context, 'previous acquaintance' should be understood as including both direct and indirect knowledge of the person, whether through reading clinical notes, participation in discussions about the case, or prior involvement in their care. From what I can see, Dr Lomas did, in fact, have such previous acquaintance. Therefore, I do not believe this aspect of the record is entirely accurate.

150. Furthermore, during the assessment, it was apparent that Dr Lomas knew VC considerably better than I did. As a sound and good clinician, he was very much on board with his presentation. It was quite clear that both of us had a shared

understanding of VC's presentation and mental state at the time. Considering that presentation, we jointly decided that detention under s.2 was necessary and proportionate.

151. The AMHP Report notes that the MHAA took place in the Cassidy Suite at around 20:00 [NOCC0050, p.3]. It is noted that, "*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*."

VC's presentation

152. I cannot recall VC's presentation during the subsequent MHAA on 3 September 2021. I cannot recall with accuracy the details of his presentation. In order to compare this with the previous assessment undertaken in July 2020, my reflections are primarily based on the information documented in his electronic clinical records. Any memory inevitably retains only certain distinct or striking details rather than the full nuance of an earlier assessment.

153. From what I can recall, VC's overall presentation had returned to a similar state as before the scuffle with the police. His language remained assertive, and he appeared resolute in his conviction that he neither required hospitalisation, nor any form of medication. He was guarded and reluctant to engage, offering little in the way of meaningful dialogue about his symptoms or mental state. This aligns with the concurrent documentation by Dr Lomas on the 3rd of September 2021 at 22:35 hours.

154. VC's presentation during the assessment appeared calm in manner and showed no overt signs of physical aggression, in contrast to his earlier behaviour at his flat. He spoke softly, and whilst his content reflected fixed beliefs, there was no immediate sense of hostility or threat. Nonetheless, given the events that had occurred in the preceding hours, particularly his aggression towards police officers, I did not feel entirely at ease in his presence.

155. It is inherently challenging to draw a precise and meaningful comparison between the assessments of July 2020 and September 2021. My recollection is limited and supplemented by the available records, but it is evident that his presentation continued to reflect poor insight, guardedness, and a firm rejection of medical intervention.

Risks identified

156. I note that Dr Lomas appears to have recorded a number of risks in the records: [NHFT0000168, p.167]

> *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." Equally, 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").*

157. In my view, Dr Lomas's notes were accurate. The identified risks were indeed real and significant, though they were primarily associated with periods of acute relapse into psychosis. I believe that during times when VC was stable and

functioning well, the level of risk he posed was considerably lower. My observations are made in the context of my role as a s.12 Approved Doctor, drawing upon my own impressions formed during a brief but focused MHAA, as well as upon the information available to me at the time.

158. During the assessment, it was evident that VC had disengaged from the CMHT and had become increasingly irritable and resistant to intervention. His demeanour reflected a sense of resentment towards the team's attempts to engage him in care or to reintroduce medication. His perception of the situation appeared markedly distorted by his psychotic state, which likely exacerbated his hostility and reduced his capacity for cooperation or insight.

159. Regarding Dr Lomas' observation that he was "*highly likely to deteriorate in the community with subsequent social harm and self-neglect*," my view is that this was a fair clinical judgement based on the information available at that time. Whilst I cannot independently verify every detail, I recognise that VC's past stability under treatment - including his ability to pursue university studies - demonstrates that when adequately supported and medicated, he was capable of functioning at a reasonable level. However, when unwell, his relapse was accompanied by considerable risks, both to himself and to others.

160. As for the risk formulation recorded by Amy Staples, the AMHP, who assessed the risk to self as "*moderate*", I would note that risk assessments inevitably reflect individual clinical perspectives and professional weighting of available information. In my view, VC's risk to others was more prominent, particularly at the height of his psychotic symptoms, when he was aggressive and unpredictable.

161. The identification of these risks was based primarily on his immediate presentation, his recent history of disengagement from services, and the deterioration in his behaviour as documented by community teams. These risks were principally characterised by aggression and the potential for violent outbursts.

162. The recognition of these risks directly influenced my clinical decision-making. I concluded that his presentation at that time could not be safely managed within the community setting and that compulsory admission under the MHA was necessary to ensure both his own safety and that of others.

Treatment recommendations

163. The records include a note that I wrote on 3 September 2021 which included the following recommendation:

> *Valdo is known to mental health service with diagnosis of psychotic disorder. He had previous detention & admission under the Mental Health Act. Valdo is open to LMHT & the CRHT at the moment. He is relapsing & he is disengaging from the Mental Health Service. Valdo is very guarded, suspicious, paranoid & experienced auditory hallucination. Valdo believes that there are conspiracy against him & the voice he hears are a result of technology & a conspiracy from the Highbury Hospital & he is the victim. He thinks the mental health workers are working with the judicial system. Valdo has assaulted 4 police officers today who tried to support us for the s.135 warrant. The assault was unpredictable & he had to CS gased & tasered. In past relapses he had entered a neighbours house & she had to throw herself out of the window. Valdo is currently paranoid about his neighbours. He is needing to be seen & mental health professionals were not able to see him until today when a s.135 has been executed. He is not taking his prescribed medication. He has poor insight & he is lacking capacity to make decisions about his care. He is refusing an informal admission. Community assessment is not viable or safe option. He is meeting the detention criteria (for both nature & degree) under the MHA s.2 (1983).*

164. With the benefit of hindsight, my medical recommendation could have been supported by including an additional risk formulation, the nature of VC's

psychopathology linked to violent behaviour, and a more in-depth purpose of hospitalisation, proposal for depot initiation, and referral to specialised services (forensic).

165. Dr Lomas's note [NHFT0000168, pp. 167-168] appears to reference an assault on one police officer in particular, whereas in my recommendation, I noted that VC assaulted "*4 police officers*". This description reflected my observation that he was physically engaged in a scuffle with multiple officers, which, in my professional view, constituted assault. Although it was clear that one officer in particular was assaulted more seriously, his behaviour included pushing, striking, and attempting to evade restraint; actions that, in their totality, met the threshold of assault. From my vantage point at a distance, it appeared that he was involved in a broader physical altercation rather than an isolated act.

166. The assault was, in my view, entirely unpredictable. There was no provocation or external stimulus to justify his sudden escalation. Both the police officers and mental health professionals present were courteous and professional in their approach, and the outburst occurred abruptly, without warning or any particular trigger. This sudden and disproportionate aggression highlighted the volatility of his presentation and the degree to which his actions were dominated by psychotic processes rather than rational control.

167. My note conveyed that VC was "*open to LMHT & the CRHT*", by which I meant he would be cared for by the Local Mental Health Team ("LMHT") and the CRHT. In retrospect, the term "*open*" may have been imprecise, but my understanding was that he continued to be an active case known to both services.

<u>*VC's presentation and behaviours*</u>

168. I described VC's behaviours in my medical recommendation using the terms "*guardedness*", "*suspiciousness*", and "*paranoia*". [PAGR0000153] These were direct observations. He was notably reserved, offering limited elaboration on

his thoughts, but his manner and demeanour were unmistakably suspicious. His body language and tone conveyed clear mistrust towards the assessment team. These features aligned closely with previously documented accounts of his persecutory delusions and ongoing psychotic symptoms, confirming that his presentation represented a relapse of established illness.

169. My observations included that VC believed that there was a "*conspiracy against him & the voice he hears are a result of technology & a conspiracy from the Highbury Hospital & he is the victim*" and that he believed mental health workers to be "*working with the judicial system*". I cannot definitively compare whether these were identical to those I witnessed during the earlier assessment in July 2020. The time gap between the two assessments was substantial, and while the overall pattern of paranoid ideation was similar, I cannot accurately recall the exact nature or content of his delusions on that earlier occasion.

170. When VC expressed the belief that he was a victim, my understanding was that he felt persecuted and unfairly targeted by mental health professionals. He did not believe he was unwell or in need of medication and viewed the team's attempts to engage with him as harassment. His conviction that mental health workers were "*working with the judicial system*" appeared to reflect a fixed persecutory belief that his care was part of a coordinated effort to control or punish him.

171. I believed VC's persistent symptoms (more than a year after my previous assessment) were a continuation of his psychotic illness. While I cannot confirm that the symptoms persisted continuously throughout that period, it appeared likely that they fluctuated in intensity connected to his treatment compliances, with intermittent periods of relative stability followed by significant relapses.

172. I cannot recall whether VC was paranoid about any particular neighbour when I recorded that he was "*paranoid about his neighbours*". I cannot recall what VC specifically said about his neighbours.

173. My reference to him being paranoid about his neighbours was informed by the clinical record and by the context of his auditory hallucinations. He appeared to believe that his neighbours were discussing or monitoring him, which fuelled his persecutory fears. Whilst he did not explicitly express hostility towards his neighbours during this particular assessment, historical information indicated that he had previously acted on such beliefs, including incidents where he had forced entry into a neighbour's property and caused alarm.

Diagnosis and capacity

174. I concluded that VC lacked insight into his condition and had no capacity to make informed decisions about his care. He denied being mentally unwell, rejected any need for treatment, and refused to engage with services. When comparing this presentation with my earlier assessment in July 2020, no specific new features immediately stood out; rather, this appeared to be a repetition of his established pattern of relapse. Once again, he had lost insight, disengaged from treatment, and experienced a re-emergence of florid psychotic symptoms associated with aggression and risk to others.

175. At the time, given the severity of his presentation and the circumstances immediately preceding the assessment, I judged community treatment to be neither viable nor safe. His behaviour and expressed refusal of care placed him at a level of risk that exceeded what could reasonably be managed in the community. In those circumstances, an inpatient approach was necessary to stabilise his mental state and reduce risk to himself and others.

176. With respect to whether community treatment might have been possible at some point in the future, I consider that it was potentially achievable. Historically, he had shown a favourable clinical response to antipsychotic medication and demonstrated a period of stability following a brief hospital admission during which he accepted sponsored treatment, regained insight, and was subsequently discharged with improved functioning. Those episodes

indicated that, under the right circumstances, a community pathway would have been possible.

177. Before community care could safely be contemplated in the future, several preconditions would have been required. Those considerations would have been a close inpatient and liaising MDT approach communicating with the local mental health service in collaboration with relevant stakeholders.

178. Those essentials would include: a clearly documented, robust discharge and relapse-prevention plan; reliable community follow-up (including assertive engagement by the local mental health team and a named care coordinator); an agreed medication plan with contingencies for non-adherence (and consideration of depot therapy where appropriate); confirmation of sufficient social supports and accommodation stability (risk management); rapid access to crisis resources/criminal justice system approach; and explicit risk-management arrangements shared across services and carers. I was involved in his care in the position of a s.12 Approved Doctor, so some of these reflections are retrospective, following the very sad and disturbing circumstances which followed.

Medication concordance

179. I must note that VC was not engaging meaningfully in the assessment process. He was guarded, dismissive, and unwilling to participate in any detailed discussion about his treatment. Given his presentation at the time, it was extremely difficult to explore issues such as medication adherence or long-term treatment planning with him. His responses were minimal and non-committal, and he declined to engage in dialogue about mental health input or pharmacological treatment.

180. The immediate clinical priority, therefore, was to ensure his safe admission to hospital, as the situation carried a degree of urgency due to escalating risk and lack of cooperation.

181. Dr Lomas recorded the following plan further to the MHAA: [NHFT0000168, p.168]

> *1. Detain under s.2*
> *2. After reviewing his records, and finding that he generally in good health, and considering the degree of violence and aggression I have prescribed haloperidol 5mg bd, with advice the medication be given IM if he refuses oral.*
> *3. I have also prescribed lorazepam 2mg PO PRN for agitation, and IM for if he is refusing oral lorazepam.*
> *4. Having discussed with the nursing restraint team, we agreed to nurse him in seclusion for the protection of nursing staff and potentially other patients on the unit.*
> *5. He will be monitored by line of sight as per unit policy.*
> *6. He will require a full clerking, physical, bloods and ECG, but this should only be undertaken with support of numerous members of staff, and only if safe to do so.*
> *7. I have completed a PICU referral and informed senior cover Lauren re seclusion - she will go and check seclusion review policy followed etc.*

182. Dr Lomas was acting in his capacity as the crisis consultant at that time, and VC remained under the care of the Crisis Team while still held at the place of safety. Until an appropriate bed became available, it was entirely reasonable and clinically justified for the Crisis Team to retain responsibility for his ongoing care and risk management.

183. With the benefit of hindsight, the interventions recorded were proportionate and appropriate to the clinical circumstances and needs. The use of pro re nata ("PRN") medication was necessary to contain acute behavioural disturbance and mitigate immediate risks to both staff and to himself. The subsequent management plan; as documented by Dr Lomas, appropriately included the

option of seclusion for the protection of staff and other patients, regular monitoring of physical health parameters, and referral to a psychiatric intensive care unit in light of his presentation. These steps were consistent with good clinical practice and the duty to maintain safety while ensuring that VC received care within the least restrictive environment possible.

<u>VC's admission under s.2 Mental Health Act</u>

184. It has been some considerable time since this MHAA took place on 3 September 2021. [PAGR0000153] I cannot recall every detail of the discussion that took place at the time. However, the records indicate that we had the routine discussion amongst all three of the MHAA attendees after the completion of the MHAA.

185. My clear recollection is that the immediate clinical priority was to secure an urgent hospital admission under the MHA, as the situation necessitated swift containment and assessment. From my recollection, the detention was primarily intended to facilitate assessment and short-term treatment under s.2. This approach was supported by the historical pattern of responding well to treatment within a short period, with previous admissions being brief and often resulting in relatively rapid stabilisation and discharge.

186. Furthermore, within the MHA Code of Practice, there is emphasis on the principle of least restrictive alternative consistent with the patient's clinical needs and the protection of others. In that context, we considered that a s.2 detention was the most proportionate and appropriate option.

187. At that stage, it was not entirely clear to me how a longer-term treatment framework under s.3 could have been formulated, as the treatment plan had not yet been clearly established. I acknowledge that a Community Treatment Order ("CTO") might have been an appropriate consideration following any subsequent s.3 detention. At the time of assessment, my focus as a s.12

Approved Doctor, was on meeting the immediate statutory criteria for hospital admission. These criteria, in my professional judgement, were fully met under s.2 for the purposes of further assessment and treatment. In addition, I did not have a complete or definitive understanding of VC's psychopathology. Whilst information provided by the AMHP and Dr Lomas was informative, there remained a degree of uncertainty about the full clinical picture, including the precise nature and causes of his mental disturbances.

188. In light of the above, detention under s.2 was the most appropriate, legally sound, and clinically justified course of action.

189. At the time of the MHAA, Dr Lomas, Amy Staples (the AMHP), and I made the decision to recommend detention under s.2. VC presented as significantly unwell, displaying florid psychotic symptoms and marked aggression. This observation was based on the given available history at the time and his s.135 encounter. VC was not engaging in any meaningful dialogue at the time of our assessment, and his guarded and hostile manner made it difficult to obtain a clear understanding of his psychopathology or to formulate a comprehensive treatment plan.

190. Given this limited diagnostic clarity, my professional view was that detention for assessment and treatment under s.2 best met the statutory criteria and adhered to the least-restrictive principle outlined in the Code of Practice [DHSC0000007].

191. With the benefit of hindsight - and in light of how events subsequently evolved I can now see that a detention under s.3 might have been a more reasonable course of action. However, that conclusion is based on retrospective knowledge that was not available at the time. My contemporaneous decision to use s.2 was, in my professional judgement, both proportionate and lawful, reflecting the information, risks, and uncertainties present during the assessment. It remains my view that the decision was made appropriately and in good faith, in line with both clinical and legal standards.

192. I note that I have been listed as the RC, alongside Dr Lomas, following VC's admission to hospital on 3 September 2021 [NHFT0000052]. This record is not correct. I attended these assessments in my capacity as a s.12 Approved Doctor. I cannot comment on the position of Dr Lomas at the time, but I knew he attended the assessment in his capacity as a crisis consultant.

193. I was not aware of the subsequent referral that Dr Lomas appears to have made for VC to be moved to the PICU [CYGN0000085]. After the completion of the MHAA, I was no longer involved in VC's care.

Your involvement with and knowledge of VC in 2022

Mental Health Act Assessment on 19 January 2022

194. The records suggest that Clarisse Bagtas, an AMHP, had applied for a warrant under s.135(1) of the MHA [NOCC0000051] in order to search and remove VC ahead of the MHAA. This was granted the same day [NOCC0000041]. This was at 15:45 on 18 January 2022.

195. The records note that I participated in an MHAA of VC on 19 January 2022 with Roseanna Crane, the AMHP, and Dr Skelton. I cannot recall having any discussion with Clarisse Bagtas about her obtaining the warrant. However, on the day of the MHAA, Roseanna Crane had phoned and briefed me about VC's presentation. From what I can recall, this was in relation to the warrant she obtained from the Court to remove VC to a place of safety. I cannot recall the full details of the conversation.

196. I cannot recall the full details of the conversation and rely on the document [NOCC0000051] that VC assaulted his housemates in the flat the night before, trapping them inside the flat, which resulted in police involvement. No charges were made against him by the police.

197. VC missed five appointments with the CMHT and when he collected his medications, he presented as hostile. [NOCC0000051]

198. The information available to me at the time had been briefly relayed over the telephone by the AMHP. I am unable to recall the full details of that conversation. However, from what I remember, it was a concise account indicating that the VC had been involved in an incident the previous night at his accommodation, during which he reportedly assaulted his housemate and confined him within the flat, an episode that involved police attendance.

199. My impression of VC, based on what the AMHP told me, was that he had displayed aggression and had assaulted his flatmate, although I was informed that no criminal charges had subsequently been brought by the police. Beyond this, I do not recall any further details from that initial discussion.

200. I had no direct contact with VC at that stage and he did not tell me anything about the incident. When I attended to execute the warrant alongside the AMHP and the police, there was no opportunity for me to speak with him at any length. The reason for my attendance was the execution of the warrant, as it requires the presence of one doctor, an AMHP and the police.

201. I was present at VC's accommodation with Roseanna Crane when she attended to execute the warrant. My recollection is that, upon arrival and prior to entering the property, we held a brief discussion with the police officers. The AMHP provided them with an update explaining the reasons the warrant had been sought from the Court and gave a summary of the events that had taken place the previous evening, as well as a description of VC. I recall this particularly well due to the setting at the university where the incident occurred and the sequence of events as the police arrived, which assists my memory.

202. The police entered the flat, and initially the AMHP spoke with him, outlining the concerns and explaining that he would need to be removed to a place of safety. From what I can remember, there was a brief conversation with VC himself at

the scene. He was in bed, he was calm, cooperative and not agitated or aggressive. We explained to him the reason for attendance and told him that he needed to undergo a MHAA. He accepted this.

203. As far as my memory serves, there were no instances of violence or aggression from him towards the police or any third party at that time, and he was conveyed to the place of safety.

Assessment at the Cassidy Suite

204. The records note that VC was subsequently taken to the Cassidy Suite at Highbury Hospital in order for the MHAA to be carried out. The following was recorded by Roseanna Crane in the 19 January 2022 AMHP Report [NOCC0000040, p.5]:

> *Dr Manzar's raised that he felt uncomfortable undertaking the MHAA without police presence. Dr Manzar and I had a discussion with Valdo about his willingness to engage in the MHAA. Valdo stated he would comply, however Dr Manzer stated that Valdo was highly unpredictable as he had assessed Valdo previously in the past. It was concluded that two police officers would stay.*

205. This account is correct. I exercised caution because of VC's previous presentation, when we had assessed him under a s.135 warrant and he became aggressive towards the attending police officers. In contrast, on this occasion he appeared compliant and stated that he was willing to engage. Nevertheless, I felt it prudent to remain vigilant to ensure that no professional would be exposed to any potential or unpredictable harm. For that reason, I considered it advisable to conduct the interview in the presence of police officers.

206. My recollection is that there was a general consensus between the attending medics that it was a sensible and appropriate precaution, given the circumstances of his previous presentation.

207. I considered that VC was "*highly unpredictable*", based entirely on my prior experiences when I attended the previous s.135 warrant. My opinion was formed through those earlier interactions, during which VC had displayed sudden and unpredictable changes in behaviour. My involvement with him was limited to those assessments, in my capacity as a s.12 Approved Doctor. Apart from those occasions, I have not been involved in his care.

Information accessed and discussions between medics

208. The information available to me at the time was provided primarily by the AMHP. In addition, I briefly reviewed VC's electronic clinical notes, which indicated that he had not been taking his prescribed medication in the period leading up to the assessment and had also been disengaging from services.

209. My knowledge of VC's care, treatment, and presentation between my previous involvement and this assessment, I can confirm that my understanding was limited to what I gathered from the electronic notes and the AMHP's briefing. From these sources, I learned that, following his earlier assessment, he had been admitted to hospital and had been under the care of the local mental health team.

210. The following was recorded by Roseanna Crane in the 19 January 2022 AMHP Report [NOCC0000040]:

> *The professionals discussion was short due to Dr Manzer having another commitment elsewhere, and the assessment initially being delayed by the discussion with police. All professionals agreed that Valdo could benefit from a hospital admission. Dr Manzer and Dr Skelton advised that they felt the community plan was most suitable based on the interview, balanced*

also with Valdo being in the middle of his exam period. Rosie could see the balance of the argument of for and against however as it was mutually felt that a community plan is least restrictive and Valdo's presentation does not present to the degree it has previously, Dr Manzar and Dr Skelton both having previous acquaintance. It was agreed that Valdo would be offered a community plan with the crisis team. This would be daily visits for medication concordance.

211. From my recollection, I spent a considerable amount of time involved in the process. This was from the execution of the initial s.135 warrant through to his conveyance to the place of safety. There were some delays during the assessment, partly due to our discussions with the police.

212. Initially, there was general agreement amongst the professionals that hospital admission was necessary. The team included Roseanna Crane (the AMHP), Dr Skelton (the Crisis consultant), Dr Skelton led the assessment and the subsequent detailed plan regarding intensive Crisis Team inputs and escalation matters if VC disengaged. However, as the assessment progressed and we had the opportunity to engage more fully with VC, our view evolved. His presentation appeared more stable than anticipated, and his engagement with us was reassuring. On balance, we felt that a community-based treatment plan, supported by intensive input from the CRHT Team, would be appropriate and consistent with the least restrictive principle under the Mental Health Act.

213. We also took into account VC's personal circumstances. In particular, that he was in the middle of his university examinations at the time, and his expressed willingness to cooperate with treatment. These factors, together with his demonstrated capacity to engage and his prior positive response to medication when compliant, led us to conclude that community treatment represented the least restrictive and most proportionate course of action at the time.

214. The main part of the discussion about the treatment plan was led by Dr Skelton who had also had prior involvement with VC. Nevertheless, as the s.12

Approved Doctor, I contributed to the clinical deliberations and supported the view that a community management plan was reasonable in this instance.

215. Although I cannot fully recall having had any commitments elsewhere, but for sure I can say that the process was comprehensive and accurately reflected the depth of assessment and multidisciplinary discussion that took place. In fact, much of the discussion around VC's medication adherence and the proposed treatment plan took place directly with VC during the assessment itself. By the time the formal deliberation concluded, the plan was already well formed, with a clear consensus emerging amongst the professionals present. Consequently, the post-assessment discussion was more concise in nature because the key decisions had already been made.

216. Our initial consideration of hospitalisation was based on the information available prior to the assessment, particularly VC's previous presentation and the circumstances surrounding the execution of the s.135 warrant, which suggested a higher degree of risk and instability. However, as the assessment progressed, his presentation appeared more settled, calm, and cooperative. He provided consistent reassurance that he would engage with treatment, and his mental state did not suggest the same level of disturbance or risk as previously observed.

217. On balance, whilst hospital admission remained an option, we collectively agreed that the least restrictive principle could appropriately be applied. Given his willingness to engage with the CRHT Team and resume medication, alongside his relatively stable presentation, it was considered that his needs could safely be managed in the community under close professional supervision.

VC's presentation

218. VC's body language and the manner in which he communicated, both in tone and content, during this assessment was calm and cooperative. His body

language was relaxed and non-threatening. His tone of voice was calm, and the content was appropriate.

219. During the assessment, from what I recall, VC remained seated on his bed throughout. This recollection is supported by the AMHP Report, which similarly described him as calm and cooperative.

220. As the interview progressed and our conversation developed, I increasingly felt reassured in VC's presence. He appeared markedly different on this occasion compared with my previous experiences of him, particularly the earlier assessment conducted under a s.135 warrant.

221. I noted that VC was considerably calmer and more composed, compared with the previous occasions when I had assessed him in July 2020 and September 2021. He appeared settled, cooperative, and engaged appropriately throughout the discussion. Unlike in earlier encounters, there were no subtle signs of sudden agitation, hostility, or tension in his demeanour; none of the restlessness or guardedness that can often be apparent in an individual's eyes or posture. Instead, he came across as relaxed, approachable, and more at ease, which collectively suggested a more stable presentation at that time.

222. I considered that VC's presentation differed from previous episodes. I would note that his overall demeanour was markedly calmer and more cooperative. Although there remained a degree of guardedness, consistent with his longitudinal presentation and partial mistrust of services, his behaviour was controlled, and he did not display the agitation or hostility previously observed. His engagement during the interview demonstrated a more settled mental state, with no overt signs of psychotic agitation or behavioural disturbance, supporting our conclusion that community management was a safe and proportionate approach.

223. It is also worth noting that, when discussing the incident, VC's own account suggested that the disagreement with his flatmate arose primarily from

domestic issues, specifically, a dispute about shared cleaning responsibilities and a rota system within the accommodation. Whilst it was not possible to determine the full accuracy of this account, it appeared that some elements of the reported incident may have stemmed from an interpersonal disagreement rather than overt aggression.

224. I cannot remember the full details of these interactions. During a Mental Health Act assessment, in relation to gathering detailed information, I believe it is important to acknowledge the practical limitations inherent in these situations. I cannot fully recall whether anyone spoke with the flatmate. My understanding at the time was that the flatmate had been moved elsewhere.

225. In urgent mental health assessment situations, it can be very difficult to obtain collateral information. The circumstances are often such that decisions must be made rapidly, based on the information available at the time. The Approved Mental Health Practitioner (AMHP) usually takes the lead in contacting the nearest relative, friends, or other relevant acquaintances.

226. While, in principle, obtaining comprehensive and detailed information about the risks leading to a person's presentation would be ideal, this is often very challenging in real time. Mental Health Act assessments typically occur under pressured circumstances, sometimes shortly after an incident, and the full details of events may not yet be available. Information can be fragmented, evolving, or reliant on third parties who may not be immediately contactable.

227. At the time of this assessment, we were satisfied with the explanations provided directly by the patient regarding the circumstances of the incident, including the disagreement that occurred and the subsequent involvement of the police. In addition, the collateral information available from the Approved Mental Health Professional (AMHP) supported a coherent and consistent account of events, which helped us to form a reasonable understanding of the risks involved at that time.

228. In hindsight, and as part of good clinical practice, gathering more detailed background information would always be beneficial. However, MHA assessments often require timely decision-making based on the best evidence reasonably available. In this case, the information obtained from both the patient and the AMHP was sufficient to inform our risk formulation and decision-making during the assessment.

229. Furthermore, my understanding at the time was that the incident had been investigated by the police and that no criminal charges were brought against him. This would suggest that, whilst there had indeed been a disagreement, his reaction was likely disproportionate rather than overtly violent, and this response could reasonably be understood in the context of his medication non-concordance during that period.

230. That said, it remained difficult at the time to establish a clear and objective understanding of what had occurred. There were likely multiple contributing factors influencing his presentation, including situational stressors. As noted in Dr Skelton's contemporaneous record from the MHAA, he was experiencing academic pressures related to his university examinations (though the significance of this factor was unclear), which were thought to be exacerbating his mental state. This stress, alongside an underlying degree of psychotic symptomatology, may have contributed to the deterioration in his overall presentation during that period.

VC's circumstances and treatment plans

231. We were informed that VC was in the midst of his university examination period. This factor was taken into account during the decision-making process, although it was by no means the sole consideration. We did acknowledge that the academic pressures and associated stress may have contributed to his overall presentation and possibly exacerbated his mental state.

232. From the information available, it appeared that he had been non-compliant with his prescribed medication for some time. It was therefore uncertain to what extent the stress of examinations alone had intensified his psychotic symptoms. It is well recognised that stress can precipitate or worsen psychotic phenomena, particularly in individuals with an underlying mental disorder, and it was reasonable to consider that such stressors may have been a contributing factor in this case.

233. However, I do not believe that the examination stress was, in itself, a determining factor in our decision to recommend community treatment. Rather, it was one of several elements discussed during the assessment.

234. The decision to pursue a community-based plan was made after considering a range of factors: including VC's mental state at the time, his engagement and willingness to cooperate, his past response to medication, and the principle of least restriction under the MHA. In addition, we ensured that he would receive intensive community support through the CRHT Team. A clear contingency plan was also agreed: should he fail to engage with the proposed treatment or if his mental state were to deteriorate, he would be recalled for reassessment with a view to hospital admission. This structured approach provided an appropriate balance between supporting him in the community and safeguarding against potential relapse or risk.

235. My recollection, refreshed by reviewing the actual electronic notes recorded by Dr Skelton, is that the agreed plan included treatment with oral Aripiprazole, alongside intensive monitoring and support from the CRHT Team. The CRHT Team was tasked with overseeing his adherence to medication and providing close observation of his mental state and risk.

236. We were informed that the students who had been living with VC in the same flat had been temporarily relocated elsewhere. My understanding, again refreshed by the notes, was that the AMHP had discussed the situation with a university support officer, who had been informed of the outcome of the

assessment and the plan for community management. It was also my understanding that the university had begun proceedings to terminate his tenancy, meaning he would not be returning to live with the same flatmates involved in the incident. We considered this a positive step in reducing the immediate interpersonal risks that had preceded the assessment.

237. However, this was not the only risk factor considered. As emphasised by Dr Skelton, the primary ongoing concern related to his adherence to treatment and the potential for deterioration in his mental state. The plan therefore included close clinical monitoring by the CRHT Team, with a clear contingency arrangement: if there were signs of further non-engagement, or increased risk, a further MHAA would be arranged with a view to hospital admission. This was explicitly documented in his clinical notes.

238. My recollection about the extent to which I discussed the option of informal hospital admission and VC's views, though inevitably limited given the passage of time, is that the option of voluntary admission was explored with him during the assessment. He was, however, not agreeable to this. From reviewing the records, I can see that the AMHP subsequently revisited this discussion with him after consulting with the university support staff, and that he again declined an informal admission.

239. I do not recall any significant disagreement between myself, the AMHP, and Dr Skelton in relation to the final decision. Our initial position at the outset of the assessment was that hospital admission might be required. However, as the interview progressed and we observed a more settled presentation, improved engagement, and reduced immediate risk, the consensus naturally shifted towards supporting a community-based plan. This decision was reached collaboratively and reflected a shared professional judgment that community treatment, supported by intensive CRHTT input and robust contingency planning, was the most appropriate and least restrictive course of action at that time.

240. My understanding of VC's compliance with medication at that point was that it was clear from both the documentation and our discussions that he had not been compliant with his prescribed treatment for some time. This non-adherence was considered a central issue contributing to his relapse and reinforced the importance of CRHT Team oversight within the community management plan.

241. My recollection about whether I discussed any specific aspects of his care and treatment plan directly with VC is very limited. I have only a vague memory of the precise details of our discussion. The assessment was predominantly led by Dr Skelton and the principal elements of the treatment plan were formulated by him. As a s.12 Approved Doctor, my primary role was to provide an independent medical opinion on the statutory criteria under the MHA rather than to lead on the operational aspects of the treatment plan.

242. I had not previously worked within a CRHT Team. Dr Skelton had attended the assessment in the capacity of the CRHT consultant. I was not entirely familiar with the CRHT Team internal processes at that time or how they work in conjunction with the LMHT when they take a patient on board. Whether they work in collaboration is difficult for me to answer. Nevertheless, I felt that Dr Skelton's articulation of the proposed plan was appropriate and proportionate in the circumstances, and I agreed with it.

243. The decision was taken not to admit VC into hospital on this occasion because the circumstances at this assessment were notably different from his previous presentations. He was more cooperative, better engaged, and not overtly dismissive as he had been in the past. Although he continued to display certain psychotic features, these were not accompanied by a level of behavioural disturbance or risk that would have justified compulsory admission at that time. On balance, we considered that treatment in the community was both viable and clinically justified, in line with the least restrictive principle embodied in the Mental Health Act. The plan therefore aimed to provide necessary treatment

and risk management within the community whilst safeguarding his rights and autonomy.

Professionals involved with the Mental Health Act Assessments

244. I note that Dr Skelton made the following entry in the RIO notes regarding the 19 January 2022 MHAA, [NHFT0000168, p.205]

> *MHAA. Cassidy Suite. Present: myself; Dr Manzar, Rosie AMHP*
> *Summary*
> *Not detained*
> *For CRHT Red RAG, daily meds concordance of aripiprazole 20mg od. Next visit tomorrow (he may want this at a café/away from his home; for morning visits for meds concordance; he's been given aripiprazole 20mg on Cassidy following the Assessment).*
> *Overall picture of poor engagement with team, being guarded and recent altercation at his home (police attended, did not arrest) suggest he is relapsing, but currently CRHT intervention is appropriate – made clear if he does not accept meds concordance then hospital would be next step. He agreed to the plan.*
> *There are some stresses which may be exacerbating things - Uni exams. He seems to have not been well concordant with meds; did say he'd taken aripiprazole 10mg since start of Jan as he'd run out. He was unwilling to countenance my suggestion that we might look at an alternative antipsychotic medication – he said he'd had side effects on others.*
> *He denied any sx of psychosis; his insight overall into his condition and risk of relapse given the admission earlier in the year is relatively low in my view.*
> *CRHT can monitor - if it becomes clear he is not engaging or further risks become apparent, we will look at admission.*

Presently he was calm - no imminent risks to self or others but there is a past hx of aggression when unwell and in recent days his flat mate was worried about him.

245. I am unable to provide further detail due to the considerable time elapsed since that assessment. I do not recall the full specifics of the case and therefore cannot expand upon what has already been documented. However, having reviewed Dr Skelton's entry, I consider his note to be reasonable, accurate, and reflective of the overall nature of the encounter, even if concise in its summary.

246. The records suggest that on 21 January 2022, Dr Skelton attended an MDT meeting at which a plan was formed to discuss VC with myself, in the event that VC was not compliant with medication. [NHFT0000168, p.206]:

CRHT MDT MS AP
Valdo missed meds concordance yesterday, despite reasonable attempts by CRHT to rearrange and they explained they were late etc. If Valdo misses meds concordance today, then I will be completing a medical recommendation for admission to hospital under the MHAA and will liaise with AMHP and Dr Manzar from the assessment this week

247. My involvement at that stage was limited solely to my role as a s.12 Approved Doctor. I had no ongoing clinical responsibility for VC beyond my participation in the MHAA. To the best of my knowledge, no one has contacted me with regard to the above documentation. There were therefore no discussions between myself and the crisis team or the AMHP during that interim period.

248. I was booked to attend a MHAA on the 28th of January 2022. Prior to this, I received a telephone call from Judith Modern. I cannot recall the exact details of this conversation; however, I believe it was a brief discussion regarding the arrangement of time and attendance for the assessment, as I had previous

acquaintance with the patient. Beyond this, my recollection is limited. There is a record of this at [NOCC0000034, p.4].

249. I can confirm that I had not spoken with anyone other than Fiona Parker, the AMHP, on 28 January 2022, about what I knew regarding the events leading up to the assessment, who I had spoken with, and who contacted me to arrange the timing. My understanding of the circumstances prompting the assessment would have been based on the usual information provided by the AMHP prior to undertaking such assessments. I partially recall the conversation over the phone with the subsequent AMHP, who gave me the reason for the MHA.

250. Given my prior involvement with VC in the preceding assessment, any discussion at that time would likely have focused on how he had been presenting recently and the reasons a further MHAA was required. I would have read his RIO notes briefly either at the place of safety or been satisfied with the information shared with the CRHT consultant, Dr Lomas, prior to the MHAA.

251. From what I can recall, the information available to me at that point suggested that VC had become non-compliant with his prescribed medication. I may also have briefly reviewed the clinical notes before attending the assessment.

252. No other information was given to me apart from what was shared by both the AMHP and the Crisis consultant, Dr Ben Lomas. As a matter of routine and from what I remember, I also reviewed his clinical records prior to the assessment. I can say that I was satisfied with the given information in assisting me with the assessment.

253. I can confirm that I did not spoke with any of VC's family members. Such discussions are typically conducted by the AMHP, who ordinarily liaises with the patient's relatives as part of the assessment process.

254. The RIO records demonstrate 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*".

255. The only agreement that was reached at that time was that VC would take his prescribed medication and remain engaged with the Crisis Team for monitoring and support. Beyond that, I cannot recall any other specific agreement which might have been broken, or which could explain his feelings of disappointment or mistrust. Therefore, it is difficult for me to speculate on the significance of this matter in relation to his mental state or associated risks.

256. As documented in his notes, Dr Lomas noted that VC was "*unhappy that services had reneged on the agreement he made with the assessors at the last assessment*". I believe this was a misinterpretation of information given to him regarding the community treatment we had discussed with him in the prior MHAA. I believe the only significance of this would be as a highlight of his symptoms at that time, consistent with delusional misinterpretation and misconstruing of the information, with confabulatory features.

257. VC may have felt hopeless and thought that he needed to be admitted to hospital. He may also have felt resentful towards the service for him to willingly travel to the place of safety. However, this is speculation.

258. The records demonstrate that Dr Lomas 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].

259. I only became aware of this just prior seeing VC for the MHA assessment on the day the MHA was conducted. I believe this would only say that he was not fully complaint with his medications.

260. With respect to Dr Lomas's note that VC was "*adamant he had been taking his medication*" [NHFT0000168, p.215] and denied holding any continuing conspiratorial beliefs, I recall that he indeed insisted he was compliant with treatment. However, based on my recollection and subsequent reflection on the records, I did not believe that he was taking his medication consistently. My understanding, both from Dr Lomas's account and the clinical presentation at the time, was that he had likely taken medication only partially, occasionally spitting doses out or omitting them altogether.

261. In terms of the clinical significance, VC's poor compliance was clearly an important factor. It contributed to the view that community-based treatment was no longer a viable option, as he was unwilling or unable to adhere to his treatment plan and continued to lack insight into his condition and remained guarded.

VC's behaviour and presentation during the 28 January 2022

262. VC's manner of communication in tone and content during the assessment was generally appropriate and without any concerning features. His tone was calm and subdued, and his speech was coherent and goal-directed. The main focus of his discussion centred on his medication, with him repeatedly asserting that he was fully compliant. He also expressed disappointment and a degree of frustration at being asked to attend hospital for the assessment. There were no signs of agitation, hostility, or irritability. His overall presentation was calm, cooperative, and emotionally contained.

263. I do not recall that VC was doing anything remarkable. He remained seated at the table throughout and participated appropriately in the discussion. His behaviour was organised and without any overt psychomotor disturbance.

264. I did not feel threatened or unsafe at any point during his last MHAA. His demeanour was non-confrontational, and there was no behaviour suggestive of potential aggression.

265. As to the comparison with his previous assessments, specifically those conducted in July 2020, September 2021, and January 2022, although there was a considerable gap between these encounters, my recollection is supported by contemporaneous documentation. Again, these encounters were short-term and in the context of MHAA.

266. All I can say is that in my last two encounters with him, he was cooperative and amenable to engaging in assessment despite his ongoing psychotic symptoms.

267. The records demonstrate that Dr Lomas recorded that VC was not presenting as "*overtly psychotic*" during this MHAA, 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*". [NHFT0000168, p.215]

268. Dr Lomas knew the patient better than I did, as he had been involved in his care longitudinally and had regular contact with the Crisis Team, receiving feedback from the MDT and nursing staff involved in his ongoing management. He may also have discussed the case with his consultant colleagues, which may have informed his impression from those encounters.

269. From my own perspective, during the assessment, he did not present as floridly psychotic. He did not articulate any fixed delusional beliefs, nor did he report hearing voices or describe any other hallucinatory experiences. However, there was a degree of guardedness, and he was reluctant to elaborate on his internal experiences, which suggested the presence of underlying psychotic processes. His level of insight appeared limited.

270. It is possible that Dr Lomas had access to more detailed or ongoing information about his mental state, including observations from staff suggesting that he had shown more overt psychotic features previously or subsequently. Following admission, he appeared more forthcoming and elaborated further on his psychotic symptoms, which supported the view that his presentation during the assessment had only been a partial reflection of his psychopathology, and I agree with this view.

271. In hindsight, this would be consistent with the view we formed at the time, that the assessment setting itself did not allow full exploration of his symptoms. We felt that he required a period of inpatient assessment and treatment in a more structured and contained environment, where he might develop greater trust in staff and feel able to disclose more of his experiences to the inpatient multidisciplinary team. With regard to the extent to which this was significant, I believe this informed our view in favour of detention under s.2.

272. *Depot medication*

273. The records demonstrate that depot medication was discussed 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]

274. As far as the records of the MHAA are concerned, Dr Lomas had clearly documented that the issue of depot medication was discussed with the patient. I reiterate that my role during these assessments was as a s.12 Approved Doctor. The lead clinician responsible for the patient's ongoing management was Dr Lomas, who had been involved with him longitudinally as the Crisis

Consultant and had oversight of the MTD's input, including feedback from nursing staff and community professionals.

275. My role was to assist in determining whether the statutory criteria for detention under the MHA were met, rather than to make decisions about his long-term treatment plan or the initiation of depot antipsychotic medication. It was therefore appropriate that discussions regarding medication strategy, including the consideration of depot treatment, were led by Dr Lomas as part of his broader and continuing clinical involvement.

276. As a psychiatrist, I am familiar with both local and national guidelines relating to the use of depot antipsychotic medication, particularly in individuals who lack capacity or refuse oral treatment. These frameworks emphasise that any such intervention must be clinically justified, proportionate, and compliant with the principles of the MHA and the MCA, including assessment of the person's capacity and consideration of their best interests.

277. From my perspective, exploring his views about medication during the assessment formed part of evaluating his insight and capacity to understand the need for treatment. It was evident that he lacked the capacity to make informed decisions in this regard. Specifically, he did not demonstrate understanding that he was mentally unwell, that he required treatment for his condition, or that medication was necessary to address his mental health difficulties.

278. With respect to barriers to the administration of depot antipsychotic medication in such circumstances, these commonly include the patient's refusal or non-engagement, the need to ensure compliance with legal safeguards under the MHA, the ethical implications of administering treatment without consent, and the practical difficulties of safe administration in the presence of potential resistance or agitation.

279. A patient who lacks capacity to consent to treatment under the MCA can, if detained under the MHA, receive necessary treatment for mental disorder without consent, provided it meets the legal criteria and is authorised under s.63 of the Act. In this particular case, the assessment demonstrated a clear lack of capacity, as he was unable to understand or retain the relevant information about his illness, treatment, or the likely consequences of refusal.

280. The treatment frameworks differ between patients detained under s.2 and s.3. A s.3 detention provides a clearer and more sustained platform for implementing a comprehensive treatment plan, including the consideration of depot medication and structured rehabilitation. By contrast, s.2 detention is intended for assessment purposes and typically precedes a more detailed formulation of treatment.

281. The decision to detain VC under s.2 rather than s.3 at that stage reflected the fact that his psychopathology had not yet been fully clear from our assessment as documented by Dr Lomas, and a further period of assessment was required.

282. Although VC was diagnosed with a psychotic disorder, likely schizophrenia, there was uncertainty at the time regarding the exact nature of his symptoms. As documented by Dr Lomas, the symptom cluster was not clearly defined. There were no recognised features o such as paranoid thinking, fixed delusional beliefs, or auditory hallucinations or other first rank symptoms. As a result, it was uncertain to what extent his presentation could be attributed to a relapse of schizophrenia-type illness.

283. We also understood that he had been non-compliant with his medication, and as noted by Dr Lomas, he appeared to be denying elements of his psychotic experiences. This pattern was consistent with his previous relapses, during which he often became more open and clearer about his psychopathology only after several days of treatment.

284. Because the psychopathology was not yet clear, we felt that detention under Section 2 was more appropriate than Section 3. Section 2 allows a period of further assessment, during which the clinical picture could become clearer and, consequently, a more definitive treatment plan could be formed. Previously following admission to hospital and over the subsequent days, VC's symptoms became clearer, which allowed for better diagnostic clarification. Given this diagnostic uncertainty at the time, detention under Section 2 was agreed, with the intention that further observation and assessment would allow his mental state to settle and enable him to articulate any psychotic symptoms more clearly, should these be present.

285. In relation to whether such diagnostic uncertainty would normally be expected to appear explicitly in the written medical recommendations, this is not necessarily the case. Mental Health Act assessments are often concise, focused procedures. The key objective is to establish mental disorder, risk, determine the need for detention under a legal framework, and justify the grounds for admission. Although Section 3 might have been appropriate in a broader sense, the specific circumstances at that point; namely the unclear psychopathology and limited clarity about symptom patterns, made Section 2 the more suitable option. Section 2 also provides a legitimate platform for stepping up to Section 3 if required, once further assessment has clarified the clinical picture.

286. I agreed that a more structured and explicit treatment plan could appropriately follow under s.3, once VC's clinical presentation had been explored in greater depth. In hindsight, had the assessing team not been so focused on the uncertainty surrounding the lack of overt psychopathology at the time, we might have considered detention under s.3 of the MHA as a more appropriate framework. Such an approach would have provided greater scope for ongoing treatment and continuity of care, including the option of initiating depot medication and facilitating a structured community treatment plan.

287. At the time, however, the decision to proceed under s.2 was influenced and driven by the absence of clear psychopathological features during the assessment. It was felt that an inpatient admission under s.2 would allow further observation and assessment, particularly given VC's historical pattern of disclosing symptoms more openly once he had settled in hospital. This approach was therefore taken with the view that his underlying psychopathology might become clearer over time, enabling a more informed and robust treatment plan to be developed subsequently.

288. It was clear that VC was not happy with administration of medication, as documented by Dr Lomas.

My record of VC's symptoms and presentation

289. I wrote the following recommendation on 28 January 2022: [NHFT0000070]

> *Valdo is known to mental health service with having had previous admission to hospital. He was previously detained under S.135 of the MHA & subsequently under s.2 of the MHA. The nature of his illness is one of psychotic disorder & it is remitting & relapsing condition. He has a recent s.135 detention following a growing concern in vis to his deterioration mental health. He had taken hostage in his university accommodation & he assaulted a fellow flat mate. On his subsequent assessment he was offered CRHT support but he only superficially engaged with them. Out of many CRHT visits he had only taken few tablets of antipsychotic medication but on the rest he either thrown them away or spit them & he refused to talk with to ensure it had been swallowed. Valdo continued to present very suspicious & paranoid. He feels mental health professionals are mocking him & they interfere with his thoughts & beliefs via "neuro distant mapping" which he thinks is a technology designed to deliberately annoy & upset him. Valdo thinks he is targeted & persecuted by people. The impact of his mental health difficulties now takes a toll on him as he is failing his courses & the university are threatening to terminate his course & also planning to*

evict him from his accommodation. Vlado remains with very poor insight, he is irritates by professionals visits to his accommodation as he can't see any needs for these inputs. Valdo is refusing an informal admission. He is posing a significant risk to others. In his past 135 warrant he had seriously assaulted multiple police officers & recently (few days ago) he had taken his flat mate as hostage. He is lacking capacity to make decisions about his care. Valdo is meeting detention criteria under s.2 of the MHA (1983) for a period of input & assessment. Community assessment or treatment are no longer viable or safe options. Valdo is meeting the detention criteria under the above act for both nature & degree.

290. I would add a clarification that some of the symptoms recorded may have reflected historical or previously reported experiences, rather than symptoms that were clearly evident or expressed during this particular assessment.

291. The historical symptoms I documented in my previous Mental Health Act assessment included auditory hallucinations, paranoid preoccupations, poor sleep, mood fluctuations, heightened anxiety, paranoid beliefs, and experiences such as "neuro-distant mapping." These formed part of his earlier presentation.

292. However, at the time of this assessment he presented mainly as suspicious and paranoid, with a clear lack of insight and capacity.

293. When assessing a patient under the Mental Health Act, we do not routinely record all historical symptoms. The focus is on the current presentation. Historical symptoms may be included when the patient offers very limited information, or when past presentations help demonstrate the nature and chronicity of the mental disorder, supporting the need for admission.

294. In summary, it is not always necessary to include all historical symptoms. However, when a patient is particularly guarded or suspicious, it can be appropriate to reference relevant past symptoms that help clarify the clinical

picture. In this case, although I documented some historical features, his current presentation was predominantly characterised by paranoia and suspicion, and this was accurately reflected in the medical recommendation.

295. On reflection, I should have elaborated further on the chronic nature of his psychotic symptoms and explicitly linked these to his history of violence and aggression. This would have strengthened the risk formulation and supported a more robust inpatient management and safeguarding plan, clearly outlining the risks arising from his persecutory beliefs in the context of his previous violent incidents.

296. I described the presentation as a psychotic disorder, which I used as a broad descriptive term encompassing schizophrenia and related psychotic illnesses. The term psychotic disorder can appropriately include schizophrenia within its scope.

297. Superficial engagement with the crisis team indicated that VC was in an acute phase requiring close community input for stabilisation and risk management. However, such engagement did not necessarily imply adherence to treatment, acceptance of medication, or insight into illness. It therefore reflected limited cooperation rather than meaningful therapeutic engagement.

298. On reflection, some of the beliefs I mentioned in the January 2022 assessment, such as being mocked or targeted through "*neuro-distance mapping*" were more accurately historical, reflecting his earlier presentations rather than active symptoms at that time. These references were based on recollections and previous reports rather than contemporaneous statements made during this assessment.

299. I regarded these persecutory-type beliefs as clinically significant, as such fixed ideas can lead to distress, anger, and a risk of retaliatory or aggressive behaviour toward those perceived as persecutors. At time of our assessment,

VC did not elaborate on any of his symptoms, such as who he believed to be targeting him.

300. I recorded that VC's insight was poor and on this occasion, I described it as very poor. On reflection, I believe that the difference in wording does not reflect a substantial clinical change but rather the language I used at the time. Both terms were intended to convey that his level of insight remained significantly impaired.

301. In retrospect, I could have simply stated that his insight continued to be poor, as the degree of impairment was consistent with his relapse. I used the term very poor interchangeably to emphasise the same finding. Namely, that he was guarded, did not acknowledge having a mental health disorder, and refused medication and treatment.

302. Given VC's historical and current presentation, the persistently poor insight indicated a pattern of relapse and ongoing deterioration in his mental health. This, in turn, informed my opinion that continued assessment and treatment under the MHA were necessary for both his own safety and the protection of others.

303. I considered VC posed a significant risk to others because, in his previous presentation, he had acted on his delusional beliefs. For example, entering a neighbour's house believing he was being persecuted, and on previous occasions being aggressive and agitated towards the police during relapse.

304. As the s.12 Approved Doctor attending the assessment, I concluded that short-term inpatient detention under s.2 was necessary to mitigate these risks and anticipated that the admitting MDT would consider further measures to reduce long-term risks.

Decision making around s.2 and s.3

305. In my previous assessments, VC had variably demonstrated some capacity. On one occasion he acknowledged needing help, accepted some support in the community, and participated in his care. In the current assessment, however, he was guarded, actively refused medication and hospitalisation, denied suffering from a mental disorder, and did not understand the need for care or treatment. I therefore judged that he lacked capacity to make informed decisions about his admission and treatment. He failed to understand and weigh the relevant information: that he was unwell, that he required medication or hospitalisation, and that refusal would carry risks. This lack of capacity was significant because it removed the option of relying solely on voluntary treatment and supported the need for detention under the MHA.

306. In this assessment I judged that community treatment was not viable or safe at this time, due to VC's history of relapse when untreated, current refusal of treatment, and escalating risk behaviours. Previously, there were times when he functioned in the community (such as when attending university, etc.), showing the remitting–relapsing nature of his illness. However, given this presentation, the unpredictability of relapse and risk escalation made future community treatment unsafe. Hence, we concluded that detention under s.2 of the MHA was necessary and anticipate that the inpatient service will work on stabilisation of his mental state and future risk management.

307. It was agreed that admission under s.2, rather than s.3, was preferable, as recorded by Dr Lomas [NHFT0000168, pp. 168]. The decision to detain him under s.2 rather reflected the fact that his psychopathology had not yet been fully clarified from our assessment as documented by Dr Lomas, and a further period of assessment was required.

308. I agreed that a more structured and explicit treatment plan could appropriately follow under s.3, once his clinical presentation had been explored in greater depth. In hindsight, had the assessing team not been so focused on the uncertainty surrounding the lack of overt psychopathology at the time, or other factors such as the treatment plan, we might have considered detention under

s.3 of the MHA as a more appropriate framework. Such an approach would have provided greater scope for ongoing treatment and continuity of care, including the option of initiating depot medication and facilitating a structured community treatment plan.

309. At the time, however, the decision to proceed under s.2 was influenced and driven by the absence of clear psychopathological features during the assessment. It was felt that an inpatient admission under s.2 would allow further observation and assessment, particularly given his historical pattern of disclosing symptoms more openly once he had settled in hospital. This approach was therefore taken with the view that his underlying psychopathology might become clearer over time, enabling a more informed and robust treatment plan to be developed subsequently.

310. Dr Lomas and I discussed the option of depot medication with VC during his admission. However, he expressed a clear refusal to consider or accept this form of treatment. I cannot recall in greater detail the extent of this discussion.

311. I recall that there was a shared professional consensus between myself, Amy Staple, the AMHP and Dr Lomas in terms of decision-making. We were all in agreement with the assessment outcome and the decision for detention.

312. In retrospect, although we agreed for detention under s.2 of the MHA and at the time considered it to be the correct decision, on reflection I believe that s.3 may have been a more appropriate framework. This would have provided a more robust legal and clinical basis for treatment, particularly given the chronicity of his psychotic illness and the need for sustained intervention.

313. Dr Lomas recorded the following "Risk" observations [NHFT0000168, p.215]:

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.

314. Although Dr Lomas appropriately outlined the risk factors relating to VC's potential harm to himself and referenced his historical risks in the context of psychosis and relapse, I believe the risk assessment could have more explicitly emphasised the significant risk he posed to others. This would have been better linked to his presentation in terms of violence, aggression, and the potential for serious harm. The remainder of the risk formulation, as documented, largely captured the key features and general outline of the risks present at the time of our assessment.

315. I would describe VC's risk profile as fluctuating but persistent. Whilst at certain times he appeared less overtly aggressive or confrontational, and this appeared to be outside his relapsing illness, the underlying risk remained significant, particularly when he relapsed or when he was acting on persecutory beliefs.

316. The risks were identified through a combination of historical review, collateral information, and contemporaneous observation. This included reference to previous incidents of aggression, documented episodes of violence linked to psychotic symptoms, and discussions with the AMHP and the crisis team.

317. The significance of these risks was determined in light of VC's history of acting on delusional beliefs, which had previously resulted in harm to others, including force entry to others flat and aggressive and violent behaviour towards police and a fight or alleged hostage taking by preventing his flat mates leaving their accommodation.

318. The identified risks and their persistence over time directly influenced my clinical judgment that hospital detention was necessary under s.2 for assessment and treatment in a safe environment. Given VC's limited insight,

lack of engagement, and history of violence associated with psychosis, community-based alternatives were not considered viable at the reference to those times when he was detained under the MHA.

319. The records note that Dr Lomas advised, "*continuing aripiprazole 20mg od for now, and explore depot prior to discharge*." [NHFT0000168, p.216]. Dr Lomas's opinion reflected his professional judgement at the time of the MHAA. As the attending crisis consultant, Dr Lomas and his team had been directly involved in VC's care with ongoing community care and medication management, giving him a more comprehensive understanding of the overall treatment context. Dr Lomas recommended the use of depot antipsychotic medication, to which I agreed, as he was in the best position to formulate this treatment plan.

320. From my perspective, depot antipsychotic treatment, irrespective of the specific agent, would have been an essential component of his discharge and relapse prevention plan/strategy. However, I am unable to comment further on how this might have been implemented following his hospital admission, including the choice of medication, dosing, or clinical response, as I was not involved in his ongoing care beyond the MHAA.

321. The records erroneously state that following VC's admission to hospital on 28 January 2022, I was VC's "*CRHT Clinician*" [NHFT0000212]. This is not correct. I was not involved in VC's his care outside of those MHAAs, either directly or indirectly.

322. My view is that a CTO would have been an appropriate course of action at any point. VC had previously been detained under s.3 of the MHA, and although I cannot comment on whether a CTO was formally considered at that time, on reflection, such a measure would have been suitable. Given his pattern of engagement with both community and inpatient mental health services, a CTO could have provided a structured framework to support adherence to treatment whilst ensuring ongoing monitoring and risk management.

323. As far as my recollection goes, there was no discussion during this Mental Health Act assessment regarding the consideration of a Community Treatment Order (CTO). This was because the agreed outcome was detention under Section 2 of the Mental Health Act. I agree that, had detention been sought under Section 3, the possibility of a CTO on discharge could have been considered.

324. A patient can indeed be admitted under Section 3 without necessarily being discharged on a CTO. The use of a CTO depends on the clinical judgement of the inpatient professionals involved in the patient's care, who must determine whether such a framework would be appropriate and beneficial. While a Section 3 detention provides the legal platform for a CTO, it does not automatically lead to one.

325. At the point of admission, this assessment was clearly for Section 2, and to the best of my memory, no further discussion took place regarding the use of a CTO.

Input into other investigations

326. I am aware of an email I sent to Dr Anna Hiley on 8 October 2024 [NHFT0004797], from which she responded stating I had a meeting booked with Dr Jason Read on 9 October 2024 in order to provide my response to questions sent by the families of VC's victims. The record states that I attended this interview, which I did. However, I cannot recall the full discussion that took place. I believe this was in relation to providing a joint response to the relatives of the victims in relation to their queries.

327. To the best of my knowledge, I have not had any input into or involvement with any other investigations or reviews pertaining to VC.

Recommendations

328. I have been asked to provide any recommendations I have in respect of structural issues relating to the MHA process, local procedures or policies, training, or information sharing. From my perspective as a s.12 Approved Doctor, there are few challenges whenever a MHAA are completed:

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

b) For detention under s.3 of the MHA, the AMHP needs to name a bed in any psychiatric hospital, and this can result in a logistical problem, making detention under s.3 difficult.

c) There is a need for a broader collaborative working between the police and mental health services in managing very ill service users. Particularly where the service users are very aggressive and violent, it is imperative that they are supported in a timely manner. A decisive police and forensic service involvement in such instances are crucial to minimise risk of harm to public. We often see less use of police action in diverting such patients through criminal justice system.

d) The current high forensic psychiatric service threshold for referring aggressive and violent patients means that many potential 'low or high forensic secure unit patients' are left to be managed by general psychiatric services. General psychiatric services do not have the means, the appropriately trained staff, or appropriate facilities for manging high-risk patients. The forensic service needs to review their current threshold for accepting referrals for those patients who have the potential for severe aggression or violent behaviour before committing serious offences. Their service should be flexible in accepting 'urgent assessment or review' and

accepting such patients to their service before the patients commit a serious index offence.

e) There is an urgent need for reinstating or strengthening specialist psychiatric services such outreach services. These services deal with less compliant, elusive and difficult service users. Specifically, those with enduring mental illness or high-risk patients who are also chronically unwell. Their care and treatment are challenging for ordinary LMHT and specialist services are necessary to treat these patients.

f) There is a need for a greater use of CTOs. This is a legal framework which is intended be used where patients have demonstrated a clear pattern of relapse, poor engagement, or escalating risks.

329. Overall, while systemic pressures and resource limitations inevitably influence decision-making and patient care, enhanced inter-agency collaboration, improved resource allocation, and more consistent application of structured legal frameworks could meaningfully strengthen both patient safety and public protection and help prevent similar attacks in the future.

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.

Signed:

GRO-B

Dated: 17/12/25

<u>**Index to First Witness Statement of Dr Manzar**</u>

No.	Inquiry URN	Document Description
1	DHSC0000007	Mental Health Act 1983: Code of Practice (Updated 2015)
2	NOCC0000046	14 July 2020 AMHP Report
3	NHFT0000037	14 July 2020 Recommendation
4	NHFT0000223	16 June 2020 Discharge Summary
5	NHFT0000261	MHA Comms and Monitoring Information Form
6	NOCC0000034	Nottingham City Council Adult Social Care Records
7	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary
8	NOCC0000048	3 September 2021 Warrant
9	NOCC0000049	3 September 2021 Application for Warrant
10	NOCC0000050	3 September 2021 AMHP report
11	CPSE0000025	Officer Report
12	PAGR0000153	3 September 2021 Recommendation
13	NHFT0000052	Seclusion Documentation Pathway
14	NOCC0000051	18 January 2022 Application for Warrant
15	NOCC0000041	18 January 2022 Warrant
16	CYGN0000085	PICU Gatekeeping Referral Form
17	NOCC0000040	19 January 2022 AMHP report
18	NHFT0000070	28 January 2022 Recommendation
19	NHFT0000212	Bed Management Form
20	NOCC0000043	28 January 2022 AMHP Report
21	NHFT0004797	Emails between Dr Omar Manzar and Dr Anna Hiley on 8 October 2024