THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR KHURAM FRAZ MALIK

I, **Dr Khuram Fraz Malik**, will say as follows: -

1. This witness statement is made to assist the Nottingham Inquiry with the matters set out in the Rule 9 Request dated 15 September 2025.

2. I have been asked to submit a written statement addressing matters relevant to my involvement with VC. My involvement with VC is limited to 24 and 25 May 2020.

3. This witness statement was drafted on my behalf by the external solicitors acting for the Nottinghamshire Healthcare NHS Foundation Trust ('NHFT') in respect of the Inquiry, with my oversight and input, following discussions in writing by email and by video conference.

Professional Background and Qualifications

4. I hold a Batchelor of Medicine, Batchelor of Surgery ("MBBS") obtained from Bolan Medical College, Balochistan University (Pakistan) in July 2001. I completed my Post Graduate Diploma in Mental Health Studies from the

University of Nottingham (UK) in December 2011. I then became a Member of the Royal College of Psychiatrists ("MRCPsych") after completing my membership exams in October 2013.

5. Before working in the UK, I worked in Pakistan for two years after completing my MBBS. From August 2001 to September 2002, I worked in Pakistan as a House Officer in General Medicine, Surgery and Urology. From October 2002 to August 2003, I worked in Pakistan as a Medical Officer (Senior House Officer) in Medicine, before coming to the UK to study. During this period, I undertook clinical observation placements and an Honorary SHO position in Medicine.

6. In August 2005, I started the Foundation Programme at East Midlands Deanery. Between August 2005 and August 2007, I rotated through hospital placements in the East Midlands (Derby, Nottingham, Lincoln and Louth). I worked in various specialities including Urology, General Adult Psychiatry, Gastroenterology, General Medicine, Accident and Emergency and General Practice.

7. From August 2007 to August 2008, I worked as a Foundation Year 2 Doctor ('F2') at North Tyneside General Hospital, which involved working in various specialities including Haematology, Palliative care, Accident and Emergency and General Practice.

8. From 2008 to 2012, I worked as a Speciality Registrar in Psychiatry. I started in Grimsby and after the first year, applied for a transfer to East Midlands. I then went on to work in Lincolnshire for a year before working in Nottingham

for two years. During this time, I worked in numerous specialties within psychiatry.

9. From 2012 to 2013, I worked as a Speciality Doctor in General Adult Psychiatry for NHFT.

10. From 2013 to 2014 I worked as a Speciality Doctor in General Adult Psychiatry (Crisis Team) for Derbyshire Healthcare NHS Foundation Trust.

11. I undertook my specialist registrar training in General Adult Psychiatry under the East Midlands Deanery from August 2014 to August 2017. For the first 2 years, I worked in Mansfield as a Specialist Registrar. I then worked as a Specialist Registrar in Nottingham for a year, which included 3 months acting up as Consultant Psychiatrist in Mansfield. I achieved my Certificate of Completion of Training in August 2017. I have since worked as a Consultant Psychiatrist at NHFT in General Adult Psychiatry and remain in this role.

12. At the relevant time, I was involved in conducting Mental Health Act Assessments ("MHAA") and had been working as a Consultant Psychiatrist at NHFT for 3 years.

Role of Registered Medical Practitioner ("RMP")

13. I have significant experience undertaking MHAAs in various settings such as 136 Suites, police stations, Accident & Emergency departments, acute hospitals, mental health hospitals, care homes and in the community. I am approved under Section 12 of the Mental Health Act 1983 (as amended from the Mental Health Act 2007), as having specialist experience in the diagnosis and treatment of mental disorders. In relation to my specific training on

MHAAs, I attended a two-day introductory training course on 21 and 22 November 2012 before receiving my Section 12 approval on 18 June 2013.

14. Since 18 June 2013, I regularly participate in MHAA as part of my day job and when working on call. During my Higher Specialist Trainee ("HST") Training from 2014 to 2017, I was on call frequently and participated in MHAAs on a regular basis. During on call shifts, HSTs are expected to conduct MHAAs in various settings within the catchment area they are covering.

15. The frequency at which I perform MHAAs varies. The Nottingham rota is busy, and on calls are frequent. In one on call shift, I could undertake 3-4 MHAAs. On average, I estimate that I undertake around 6-8 MHAAs a week.

16. My professional background and experience has assisted my ability to perform the functions of a Registered Medical Practitioner ("RMP"). I have been working in Psychiatry since 2008, including as a Speciality Doctor in General Adult Psychiatry for 2 years before completing my HST Training. I was awarded the Certificate of Completion of Training ("CCT") in General Adult Psychiatry on 1 August 2017.

17. Since Completion of Training and the start of my career as a Consultant Psychiatrist, I have continued to work for NHFT as a bank Medic to provide cover for HST shifts by filling gaps on the HST rota.

18. I have undertaken a range of training to support my role as an RMP. As mentioned above, I attended a Section 12 introductory training course in November 2012. I also attended a two-day Approved Clinician Induction Training Course in December 2016. Additionally, my application to be an

Approved Clinician was approved by the Midlands and East of England Mental Health Act, with approval and authority delegated by the Secretary of State for Health. My initial approval was valid from 25th January 2017 until 24th January 2022.

19. Subsequently, I attended an Approved Clinician Refresher Training Course on 13 October 2021. My current notification of Approved Clinician approval started on 25 January 2022 and runs until 24 January 2027.

20. The key document used when carrying out MHAAs is the Code of Practice, to the Mental Health Act 1983. The Code provides guidance to RMPs, and approved clinicians, managers, hospital staff and approved mental health professionals. The guidance sets out how they should proceed when undertaking duties under the Act.

Conduct of MHAAs

21. Once a referral is received, the Approved Mental Health Professional ('AMHP') will co-ordinate and arrange the RMPs which depends on several factors including, expertise required. For example, Child and Adolescent Mental Health Services ('CAMHS'), intellectual disability, General Adult, Mental Health Services for Older People ('MHSOP') and Forensic. The factors also include if a patient is open to NHFT and under a Team, the availability of doctors, patients' communication needs, any previous acquaintance and whether the MHAA is conducted during working hours or out of hours.

22. During working hours, if the patient is known to services and is open to a team, the AMHP will likely contact the Community Consultant or team

involved to be part of the assessment (if available). For out of hours, the AMHP will first contact the on-call HST for the Trust covering the area for the MHAA request.

23. NHFT has a separate out of hours HST rota and there are three HSTs covering three different sites: Nottingham South Rota, Nottingham North Rota, and Blossomwood Rota for Mansfield, Newark and Sherwood. AMHPs will try to arrange to have at least one doctor who is working for NHFT. The AMHPs will have a list of Section 12 doctors, including GPs who they can contact to act as the second doctor. Sometimes when AMHPs are struggling to find a second doctor out of hours, they can request that one of the other HSTs who are covering a different site to be part of the assessment.

24. RMPs and AMHPs work alongside each other to conduct MHAAs. AMHPs co-ordinate the MHAAs. AMHPs require two doctors to conduct the medical assessment. The AMHP will first ask the on-call doctor and then another doctor. The second doctor might be a GP where necessary.

25. Following the MHAA request, AMHPs will have some information from the referral regarding the patient's background, past psychiatric history, substance misuse history, current presentation, historical and current risks. AMHPs will have access to previous AMHP reports, if the person has been assessed under the Act before. AMHPs will usually speak to the family prior to arranging an assessment to get more information and to gather the views and concerns of the family.

26. As part of my role as an RMP, I gather more information ahead of the assessment to ensure it is comprehensive. This information includes past

psychiatric history, past medical history, current medication, forensic history, drug and alcohol history, circumstances leading to the MHAA request, current presentation, concerns raised by the family, any core assessment(s) and previous risk assessment(s) if available. Some of the information may be available in the referral. I will read the patient's electronic notes, speak to the AMHP, Crisis Team or any other relevant person involved prior to conducting the assessment.

27. Depending on where the patient is, I normally speak to the Responsible Clinician for a patient already admitted to a psychiatric ward. If the patient is detained under Section 136, I will speak to the 136 staff. If the patient is in police custody, I will speak to the Liaison & Diversion Team and the Custody Officer. If the patient is in an acute hospital, I will speak to the Liaison Psychiatry team and medical team. These conversations are to obtain the further information listed above at paragraph 26, as well as the patient's current presentation, mental state, risks, concerns and current treatment plan.

28. If a family member is present, RMPs will speak to the family. This will depend on where the assessment is being conducted. For example, family will not be present in a police cell. If the AMHP has managed to talk to the family, they will inform the RMP of this ahead of the assessment.

29. RMPs, AMHPs and Crisis Team staff member will discuss the patient prior to conducting the MHAA and will share information with each other. A Senior Nurse (Band 7) from the Crisis Team will attend the MHAA (if available) for gatekeeping to assess if the patient can be managed safely in the community, or if they require admission.

30. During the assessment, all possible steps are carried out to ensure the assessment proceeds in an appropriate manner. The communication needs of the patient and or the need for an interpreter will be considered, as well as whether the patient is medically fit. The AMHP will normally perform the introduction, explain the purpose of the assessment to the patient and the possible outcomes which includes no intervention, community intervention (Crisis Team referral) and admission to hospital (informal and formal).

31. After explaining the outcomes, the AMHP can start the assessment or ask a few further questions before handing over to the RMP's. One of the RMP's will take the lead and interview the patient. The second RMP will have the opportunity to ask questions later and clarify anything if required. Towards the end of an assessment the patient is given the opportunity to add anything further or to ask any questions.

32. Following the assessment, a discussion is held amongst the assessors regarding the information and observations that have been gathered as part of the assessment process. Following the discussion, a plan is agreed and implemented. There are a number of possible outcomes which are listed below:

    a. Discharged home without any further involvement of mental health services.

    b. Discharged home and signposted to other agencies (drug & alcohol services, Framework or follow up with GP.

c. Discharged home with a referral to the Local Mental Health Team (LMHT).

d. Discharged home with referral to Crisis Team. A Senior Nurse from the Crisis Team will arrange a further follow up and home visit if the agreed plan is to refer to Crisis Team for home treatment.

e. Admission to psychiatric hospital either informally or by detention.

33. Risk is a core component of MHAA and is an essential part of the criteria for detention under the MHA 1983, as per the Code of Practice Mental Health Act 1983. In line with the criteria for applications, a person can be detained for assessment under Section 2 only if both of the following criteria apply:

a. The person is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment (or for assessment followed by treatment) for at least a limited period;

b. The person ought to be so detained in the interests of their own health or safety or with a view to the protection of others.

34. In addition to the Code, NHFT has its own Risk and Safety Assessment form that is normally completed by the Crisis Team while attending for the gatekeeping assessment.

35. Risk assessment is a structured process to gather all available information. As a general principle, clinicians should try to gather information from as many reliable sources as possible. It is also necessary to obtain a comprehensive

history of the patient, including the patient and carers (where appropriate) in formulating a plan. This is done to enhance safety.

36. Risk is dynamic and can be affected by circumstances that can change over time. Therefore, risk assessments need to include short term perspectives and frequent reviews.

37. Risk assessments mainly include any risk to self, as well as risk of harm to others. Risk of harm to others include psychological as well as physical harm.

38. Risk to others is assessed using a holistic approach, taking into account the factors listed at 3.6 as well as the patient's concordance with treatment, discontinuation or disengagement, previous history of violence or harm to others, forensic history/criminal convictions and cautions, any current thoughts of harming others, including any plans and access or means to harm others. Risk to others includes damage to property.

39. NHFT uses a Risk and Safety Assessment form which includes the following:

    a. To Self (suicide, self-harm, wandering, falls, substance misuse, bereavement, loss);

    b. From Others (all forms of abuse including any domestic violence issues, neglect, exploitation);

    c. To Others (aggression, violence, associated criminality, exploitation, neglect, abuse of others); and

    d. Social factors

Mental Health patients who have killed or seriously injured a member of the public

40. To the best of my knowledge, I have not been involved in the care of any other patient under mental health services who has been treated in the community and subsequently killed or seriously injured a member of the public.

Prior involvement with Valdo Calocane ("VC")

41. I had no knowledge of VC prior to 24 May 2020.

42. I was not involved with VC prior to 24 May 2020 or after 25 May 2020. My only contact with VC was on these two dates.

43. Given the passage of time, I do not have any personal recollections of my interactions with VC on 24 and/or 25 May 2020. Therefore, the contents of this statement are based upon my review of the medical records, including the medical notes completed by the on-call doctors'. I will also make reference to my usual practice.

44. I assessed VC for the purpose of a MHAA and attended the assessment as the second doctor, with the on-call HST. Dr Rahul Gandhi was the on-call doctor on 24 May 2020 and Dr Rosa Sadraei on 25 May 2020). The MHAA documentation and NHFT electronic records ("RIO notes") were completed by the on-call Doctor (Dr Gandhi and Dr Sadraei respectively) as per standard practice. As referenced above, I have no recollection of either of these assessments.

VC's previous arrests

45. Given the passage of time, I am unable to recall the events around VC's arrests, who I spoke to about what happened and anything they might have said to me. Based on the information available in the RIO, I understand that VC was arrested twice, on 23 May 2020 before the first MHAA was undertaken, and on 24 May 2020 shortly after his release from custody for the previous arrest. Based on my usual practice acting as a second doctor, I would have been aware of the patient's background pertaining to the arrest before conducting the MHAA.

46. When I receive a call from an AMHP to conduct MHAA, it's my usual practice to first review the patient notes on the RIO. Based on the notes available, it is recorded that VC was seen by Dominic Lloyd of the Liaison and Diversion Service based at the police station on 24 May 2020, who contacted the Emergency Duty Team ('EDT') to request a MHAA. Based on my review of the medical notes, Dr Gandhi documented that VC was arrested for criminal damage. Specifically, for kicking in a door of another flat. Police were called to a burglary, but they found VC, who resided in the block of flats.

47. Soon after he was released from custody on 24 May 2024, VC was further arrested as he had been kicking the front door of a neighbour's property and had caused the occupant to flee the address by jumping out of a window.

48. I am unable to personally recall who I spoke to about the events or what I was told.

49. Apart from speaking to the AMHP, when assessing a patient in the police station it is my usual practice where possible to ensure that I am aware of the family views and concerns. I also liaise with the Liaison and Diversion staff

based at the police station, as well as the Custody Sergeant regarding the circumstances that led to the arrest, any charges against the patient and their presentation since being detained.

50. Based on my review of the notes on 24 May 2020 [NHFT0000168 pp 1-2], Dr Gandhi recorded that VC's mother denied VC having mental health issues in the past. VC's mother denied any history of him posing a risk to himself or others. Based on this entry, it is evident that either Dr Gandhi or the AMHP contacted VC's mother to obtain this information.

51. I am unable to recall any specific concerns about VC being aggressive or violent. Having reviewed the medical records, I note that VC was seen for the MHAA in a medical room in the police station. Generally, if there are concerns around aggression or safety, we assess the person in a police cell in presence of a police officer.

52. Having reviewed the electronic notes and the entry made by Dr Gandhi on 24 May 2020, I am unable to see anything that suggest VC was aggressive or violent at the time of the MHAA. In respect of the circumstances leading to his arrest, it is recorded that VC told the assessing team that he had heard someone screaming and he had gone to investigate.

53. VC was arrested again on 24 May 2020. Based on the medical notes it is recorded that VC was unable to tell us what happened after he was released from custody on 24th May 2020. However, I am unable to recall this conversation personally.

54. The MHAA entry by Dr Ghandi on 24 May 2020 records that he questioned VC about the incident on 23 May 2020 [NHFT0000168 p2]. An extract of the note is below:

> "VC initially was confused but then told assessing team that he heard someone screaming and he went to investigate. Upon further questioning VC revealed he heard his mother screaming, and people were screaming telling him that his mother was being raped, and she was in pain. VC stated that earlier in that evening his mother had texted him and told him she wanted to visit him, but VC had told her not to travel".

55. In Dr Sadraei's MHAA notes written on 25 May 2020, it is documented that it was difficult to engage VC in a conversation [NHFT0000168 pp 4-5]. He was not able to tell the assessing team about what happened after he was released from Police custody on 24 May 2020 before being detained again. The record states:

> "VC said that he heard a screaming woman at the time of the incident and went to the neighbour's door and broke the door".

Information available for the purposes of conducting the MHAAs

56. Given the passage of time, I am unable to recall what specific information I accessed to conduct these MHAAs.

57. I cannot recall deviating from my usual practice, which is to ask the AMHP for the available information and to review the electronic records before conducting the MHAA. Where possible, I would talk to the Custody Sergeant,

the Liaison and Diversion Service, the Crisis Team and the family. The AMHP receives the referral and collects all the relevant information before the MHAA is conducted. It is the responsibility of the AMHP to organise the MHAA. The AMHP organises the MHAA by contacting the on call HST covering the relevant site, and requests that the second doctor attends at the agreed time. This is the process for MHAA undertaken out of hours. It is usual practice that the RMPs, AMHP and the Crisis Team representative discuss the patient and share relevant information with each other before conducting the assessment.

Information that was not accessed for the MHAA

58. Given the passage of time, I am unable to recall any issues accessing specific information. I am unable to recall any information that I could have accessed but did not.

59. I do not recall deviating from my usual practice which is set out above at paragraph 57.

Previous Acquaintance

60. This was VC's first contact with Mental Health Services. We were not aware that he had previously been assessed under the Mental Health Act or seen by Mental Health Services. It is the responsibility of the AMHP to organise the MHAA. The AMHP organises the MHAA by contacting the on call HST covering for the relevant site and requesting that the second doctor attends.

61. The process for conducting an MHAA is the same, whether or not the patient is a previous acquaintance of the assessing doctors. If a patient has a previous or existing relationship with the mental health service, for any

subsequent assessments the AMHP would normally attempt to contact the RMP for the upcoming assessment. This is because it may be beneficial to have the input from a doctor who has seen the patient previously, to be able to compare the patients' change in presentation between the two encounters.

62. Whilst conducting MHAAs out of hours, I do come across some patients who are not known to NHFT and have never been assessed under the MHA or seen before. In these circumstances both the first and second doctor conducting the MHAA will not be previously acquainted.

63. As, to my knowledge, VC had not had any previous contact with NHFT, it would not have been possible to identify an RMP who was a previous acquaintance, although this would be the responsibility of the AMHP to identify in any event. Irrespective of whether an RMP is a previous acquaintance of a patient, the process of the MHAA is the same and in my usual practice, does not influence my decision making.

VC's lack of recorded previous mental health history

64. I note it is recorded in the respective AMHP reports dated 24 May [NOCC0000044] and 25 May 2020 [NOCC0000045] that VC had no previous mental or physical health issues and that his first presentation was on 24 May 2024. It is also recorded that he: "never experienced any mental health difficulties in the past" (p.2 of both reports).

65. I did not write either of these reports and cannot personally recall what the source of this information was.

66. Based on my usual practice, the process of obtaining this information would have been to check the RIO electronic records (the electronic recording system used by NHFT). Upon review of the records, I can see that there was an entry made by Dominic Lloyd from the Liaison and Diversion Service on 24 May 2020 prior to the first MHAA [NHFT0000168 p1] which documented that he had assessed VC and had noted there was no previous police or mental health history.

67. It is also documented in Dr Gandhi's MHAA entry dated 24 May 2020 [NHFT0000168 pp 1-2] that VC told the assessing team during the MHAA that he has no past history of mental health difficulties. Dr Gandhi also noted that VC's mother denied him having mental health issues in the past and that he did not have any history of harming others or himself.

68. The only records available to us during the MHAA were the patients records held at NHFT and anything the patient, police or family told us.

VC's behaviour and presentation during each of the assessments

69. Given the passage of time, I am unable to independently recall VC's behaviour or presentation during the 24 and 25 May 2020 MHAAs.

The first MHAA (24th May 2020)

70. Given the passage of time, I am unable to recall if VC reacted in a defensive manner as documented in the AMHP Report [NOCC0000044].

71. I am unable to recall whether VC appeared “guarded and suspicious”. However, based on the MHAA notes recorded by Dr Gandhi, it appears that VC was guarded and suspicious.

72. I do not recall how the above matters were factored into the assessment and the decision-making around this. I have reviewed Dr Gandhi’s notes and base my explanation on these notes. Dr Gandhi’s notes concluded that VC was experiencing his first episode of psychosis.

73. It is clear in the notes that VC was presenting with psychotic symptoms and in my experience, patients can present as “guarded and suspicious” when having a psychotic episode. Normally, when completing a MHAA all factors are taken into consideration when making decisions as detailed at paragraph 26, above.

74. Following the assessment, a discussion is usually held with all practitioners involved, including the AMHP and the Crisis Team, before a final decision is made.

75. Based on my review of Dr Gandhi’s notes [NHFT0000168 pp 1-2] it appears that although VC was guarded and suspicious during the first assessment, he did engage and even talked about some of his difficulties. Although inpatient admission was considered, following discussion amongst the assessors, it was agreed that considering the least restrictive principle of MHA Code of Practice, community treatment by the Crisis Team should be offered first. VC agreed that he was unwell and needed help. VC consented to seeing the Crisis Team for home treatment and agreed to take Olanzapine (antipsychotic medication). It was also documented that the Crisis Team would undertake a

further assessment of VC's psychopathology and risk and would refer him to the Early Intervention in Psychosis ("EIP") Team.

76. Annette Palmer, Senior Nurse from the Crisis Team who attended for gatekeeping was part of this assessment and discussion, agreed to provide home treatment including twice daily home visits by Crisis Team and observe VC taking medication.

Observations in the 24th May AMHP Report and impact on decision-making

77. Given the passage of time, I am unable to personally recall the following observations which have been recorded in the 24 May AMHP report [NOCC0000044 pp 2-3]:

> "Valdo seemed to struggle to follow the thread of conversation – it would often take him a number of seconds to respond to a question. He often also at times didn't register the question that was asked and so it would have to be repeated."
>
> "Valdo stated that he has not slept for seven days and that he feels confused and tired."
>
> "He said that he could hear screaming and that he could hear voices telling him that it was his mother, and she was being raped. This is why he broke into the flat."

78. On the basis of Dr Gandhi's notes, it appeared that VC was very distracted. VC struggled with his attention and Dr Gandhi had to repeat his questions a

number of times. He also noted that VC reportedly had not slept for a week and he had heard screaming as well as other voices telling him that it was his mother and she was being raped. I am unable to specifically recall how these comments or observations influenced decision making.

How the conclusion was reached that VC was experiencing a psychotic episode

79. The medical notes written by Dr Gandhi on 24 May 2020, and Dr Sadraei on 25 May 2020, suggest that VC was presenting with psychotic symptoms which included experiencing auditory hallucinations, being guarded and suspicious, expressing paranoid ideas, appearing distracted, and thought disordered. These symptoms would have informed the conclusion that he was experiencing a psychotic episode and. this diagnosis would have informed the treatment plan.

80. As part of immediate treatment plan, VC was referred to Crisis Team on 24 May 2020 for further assessment and treatment. Given that it was VC's first presentation, it was recommended that VC be referred by the Crisis Team to the EIP Team for further assessment and treatment.

AMHP Report on 24th May 2020

81. Following an MHAA, a discussion is held amongst all the assessors (RMPs, AMHP and the Crisis Team member), taking into account the patient's history and presentation, past psychiatric history, previous risks, history of substance misuse, any charges or conviction they might have, mental state, possible

risks and possible outcomes, all of which are relevant to the consideration of risk. Following this discussion, a plan is agreed and implemented.

82. Risks would have been considered as part of the assessment of VC, and I would have been part of the post-assessment discussion where risk would have been discussed. I have reviewed the medical records, and it is documented in Dr Gandhi's notes that VC did not have any thoughts to harm himself or others. In addition, he has recorded that VC's mother denied VC having mental health issues in the past and denied any history of risk to self or others, which is also relevant information taken into account when assessing risk.

83. Given the passage of time, I am unable to recall the following observations/risks contained within the 24 May AMHP report [NOCC0000044]:

    a. "What was unclear was what the risk factors were." (p.3)

    b. "further MH deterioration", (p.5)

    c. "Aggression towards neighbours – broke into neighbour's flat" (p.5), and

    d. "Disruption to studies" (p.5)

84. It is not my usual practice to categorise risk in the same manner as within the AMHP report. As I did not formulate or document these specific risks, I am unable to comment on whether I agreed with the above statements, how those risks were identified or the significance of those risks.

85. I am unable to comment upon what the AMHP meant by “aggression” and whether this is distinct from a risk of “violence” in their assessment.

86. I believe the AMHP is the best person to comment on the content of the report because the AMHP is the author. Usually, RMPs do not complete this report, and AMHPs do not usually send us a copy following the assessment. The AMHP report was written after MHAA was completed. To the best of my knowledge, I did not receive a copy of AMHP report and did not have sight of this prior to providing this statement.

87. It is standard practice for the on-call HST to record the entries on the patient notes following the assessment, rather than the second doctor. I therefore did not record my own notes on this occasion documenting my personal assessment of risk and am unable to recall anything in addition to what has been recorded by Dr Ghandi on 24 May 2020.

Capacity in the first AMHP Report

88. Given the passage of time, I am unable to recall the following observations as recorded in the first AMHP report [NOCC0000044]:

    a. “Valdo found it difficult to understand and retain information. It is felt that he lacked capacity to consent to treatment, however, he was agreeable to taking medication and accepting of CRHT input stating that he did want help” (p.5)

    b. “Valdo could not understand information given to him regards possible care a [sic] treatment. He lacked insight into his mental health issues,

believing them to be real. However, it is in Valdo's best interest to pursue home treatment at this time." (p.7).

89. I attended the MHAA as the second doctor, with Dr Gandhi who was the on-call HST. I have checked the medical entry by Dr Gandhi which clearly states that VC had limited insight, and that he lacked capacity to consent to treatment [NHFT0000168 p2]. However, VC acknowledged that he was unwell and needed help. Dr Gandhi documented that VC consented to home treatment.

90. I am unable to comment on why the AMHP ticked next to the question, "Does the citizen have capacity to make this decision?" The AMHP would be better placed to address this.

91. I cannot recall my assessment of whether VC had capacity. I have checked the electronic records and in the MHAA entry, Dr Gandhi documented that VC lacked capacity to consent to treatment.

92. I am unable to recall whether VC lacked "insight". On the basis of Dr Gandhi's notes, he clearly documented that VC had limited insight. VC acknowledged that he had not slept for a week. He described being stressed due to coursework and an upcoming exam. He stated that he had not been eating well as he was busy with his coursework.

93. Given the passage of time, I am unable to recall the discussion around VC's capacity and how this impacted the decision-making at the time. However, after reviewing the medical notes, it is clear that both options of inpatient care

and community treatment were considered. A Crisis Team band 7 Nurse was part of the MHAA who offered twice daily visits with monitoring of medication.

94. Based on the medical entry by Dr Gandhi, following the discussion amongst the assessors, including the Crisis Team, it was agreed that considering the least restrictive principle of the MHA Code of Practice, community intervention by the Crisis Team would be offered first prior to considering admission to hospital. VC consented to home treatment and Olanzapine.

Dr Ghandi prescribed Olanzapine to VC

95. Prescribing medication as part of the MHAA process is something that does not happen very often. There could be several possible outcomes following a MHAA, including no intervention, community intervention (LMHT or a Crisis Team referral), or admission to hospital.

96. Prescribing medication will depend on the circumstances, the patient's presentation and the urgency of the situation. Sometimes the on-call HST will initiate the treatment after the MHAA, following a discussion with the Crisis Team, if deemed necessary. On-call doctors do not carry a prescription pad with them: medication is instead supplied by the Crisis Team if they agree with the plan.

97. I understand that Dr Gandhi was the on-call doctor when the assessment of VC was undertaken out of hours on Sunday 24 May 2020. Specifically, he was an on-call locum HST for the NHFT, covering the Nottingham South rota/shift. It was Dr Gandhi's clinical decision to initiate Olanzapine in conjunction with the Crisis Team. In my opinion, this is likely to have been to

avoid further delay in starting treatment, treat his symptoms and avoid further deterioration. Prior to the first MHAA, VC had already been to the Emergency Department where he underwent blood tests and was deemed medically fit.

98. However, on the basis of the medical records, VC was presenting with a psychotic episode that needed to be treated with an antipsychotic medication. Olanzapine is an antipsychotic medication, which is commonly prescribed as a treatment for psychosis. Based on my review of the notes, it appears that the prescription of Olanzapine was a reasonable course of action at this time.

99. I am unable to recall VC being prescribed with Olanzapine when he was seen at police station for MHAA. Having reviewed the medical notes, it appears that VC was not given the Olanzapine medication at police station while he was in my presence. Antipsychotic medications are not stocked or available in the police station. I am unable to recall if I had any reason to believe that he was not willing to take the medication at the time.

100. Based on the medical notes available, VC was referred to Crisis Team, the plan was for the duty doctor covering for the Crisis Team based at Highbury Hospital, Bulwell to complete a community medication card for Olanzapine. The Crisis Team would then deliver the medication to VC's home address later in the evening and would observe him taking medication. However, I note that VC was arrested soon after his release and before the Crisis Team could deliver his medication on 24 May 2020.

101. I am unable to recall whether there were any concerns about VC's lack of insight or capacity impacting his ability to take medication in the community. However, if there were any concerns these ought to have been documented.

The second MHAA (25th May 2020)

102. I understand that I was the only RMP who was involved in both of the MHAAs on 24 and 25 May 2020. I am unable to personally recall the two MHAAs given the passage of time.

103. The medical records state that during the second MHAA on 25 May 2020, a Senior Nurse (Band 7) from the Crisis Team did not attend, as the Crisis Team were of the view that, based on the last 24 hours, home treatment was not feasible [NHFT0000168 p4].

104. The second MHAA was done with AMHP, Eleanor Cullen, and on-call HST, Dr Rosa Sadraei. I understand that neither had met VC before [NHFT0000168 pp 4-5]. Eleanor Cullen contacted me to attend the assessment with Dr Rosa Sadraei, who was covering for Nottingham South rota and Bridewell Custody on 25 May 2020.

105. During the second MHAA, VC was seen in the police cell, it is noted that VC was difficult to engage in a conversation.

106. I cannot recall to what extent I observed a change in VC's presentation and behaviour between the two assessments, nor how this influenced our decision-making process given the passage of time since the assessment

107. Having reviewed the notes written by Dr Sadraei and medical recommendation, it appears that during the second MHAA on 25 May 2020, VC seemed perplexed. In addition, he took a very long time to answer any questions being asked. VC appeared very distracted. VC was guarded, suspicious of his surroundings and there were very long pauses. VC

appeared thought disordered; He was unable to tell us what happened after he was released from custody the day before. He continued to hear voices and was acting in response to these. VC was deemed to lack insight. His parents described his behaviour as completely out of character for him.

108. Having reviewed the notes, it appears that there was a further decline in VC's presentation and mental health from the baseline set at the MHAA on 24 May 2020, and there was a further serious incident with the police within a short period of time involving VC damaging the door of a female neighbour, who was reported to be fearful for her safety and jumped from a first-floor window as a result.

109. The medical notes indicate there was a marked deterioration in his presentation, lack of engagement during assessment and lack of insight and capacity. It is noted that there was a further serious incident in a short period of time, and a previous trial of home treatment. These factors and taking into account VC's mother's preference that he goes into hospital as he was a risk to others in his current mental state, would have likely influenced the decision making that VC required admission to hospital, as the least restrictive option (home treatment) had already been considered and failed.

110. Having reviewed the medical records, it appears that VC clearly lacked insight when seen at the second MHAA. He also lacked capacity to consent to an informal hospital admission.

Prescription of Olanzapine that had been made the previous day by Dr Ghandi.

111. Given the passage of time, I am unable to recall whether I asked VC if he had taken Olanzapine following the MHAA on 24 May 2020. However, after reviewing notes it appears that VC was not issued a prescription by Dr Gandhi at Bridewell on 24 May 2020. As explained above, the plan had been for the Crisis Team to undertake a home visit during the evening of 24 May 2020 and to deliver the medication.

112. I am unable to recall if medication was discussed with the VC at the second MHAA, or whether there was an indication that he would be unwilling to take his medication during the second MHAA.

First MHAA resulted in treatment in the community and second MHAA resulted in admission under section 2

113. Having reviewed the medical notes, it appears that following VC's release on 24 May 2020, VC was further arrested a few hours later, following a serious incident involving VC damaging the door of a female neighbour, who was reported to be fearful for her safety and jumped from a first-floor window as a result. She required ambulance attendance, and she was subsequently taken to hospital.

114. It appears that when the second MHAA was conducted on 25 May 2020, the Crisis Team were of the view that based on the last 24 hours, home treatment was not feasible and were therefore not in attendance.

115. VC's medical record indicates that his mother voiced that she would prefer that her son goes into hospital as he is a risk to others in his current mental state. As well as taking the previous failed home treatment trial into account,

it was clear from the recorded presentation during the second MHAA, his lack of engagement, lack of insight and lack of capacity to consent to informal admission that VC required admission to hospital, hence why detention under the Act was deemed necessary. Following a discussion between myself, Ms Cullen and Dr Sadraei, there was a consensus between the assessors to admit VC under Section 2 of the Mental Health Act 1983.

116. Admission into hospital would provide for a period of further assessment and treatment.

Medical recommendation of 25 May 2020 that: "Community is not an appropriate option due to the risks he is posing to others".

117. Given the passage of time, I am unable to recall how I reached the above conclusion on 25 May 2020 that "Community is not an appropriate option due to the risks he is posing to others" [NHFT0000004 p4].

118. Based on the available medical notes, it appears that when VC was assessed on 24 May 2020, this was his first contact with Nottinghamshire Mental Health Services. He had no past psychiatric history, no previous contact with the police, no forensic history and no previous history of posing a risk towards others.

119. Although VC was arrested for alleged criminal damage, VC denied any thoughts of harming himself or others. As explained above, following discussion amongst the assessors and the Senior Nurse from the Crisis Team, it was decided that VC would be offered home treatment by the Crisis Team on 24 May 2020. This was in consideration of the least restrictive

principle of MHA Code of Practice. Based on the records I believe that this was an appropriate course of action at the time.

120. However, within hours of his release from the Bridewell police custody on 24 May 2020, VC was arrested for criminal damage following a further incident involving VC damaging the door of a female neighbour, who was reported to be fearful for her safety and jumped from a first-floor window as a result.

121. VC's medical record indicates that concerns were raised by his mother who voiced that she would prefer that her son goes into hospital as he is a risk to others in his current mental state. There appears to have been a further decline in VC's mental health as compared to when seen initially on 24 May 2020, as noted above.

122. I am unable to recall what potential risks to others were considered at the time.

123. I cannot recall recording the following comment given the passage of time: VC was "not eating properly" [NHFT0000004 p8].

124. However, on review of the records, this information is within the RIO records, in the MHAA entry by Dr Gandhi. Dr Gandhi noted that VC had not been eating well [NHFT0000168 p3] which could possibly lead to weight loss and affect physical health

Discussions with VC's relatives

125. I cannot recall if I was part of any discussions with VC's relatives, however, I believe I would have been aware of the information provided by VC's mother

on both occasions she was spoken to as this has been documented in the notes.

126. It is my usual practice to take a family's views and concerns into account when formulating opinions and making decisions, as well as considering my own observations and assessments.

Decisions taken on 24th May 2020 and on 25th May 2020

127. Given the passage of time, I am unable to recall to what extent there was agreement between myself, Benjamin Williams, Dr Gandhi, and Ms Palmer about the decisions taken on 24 May 2020. Nor can I remember to what extent there was agreement between myself Ms Cullen and Dr Sadraei about the decisions taken on 25 May 2020. Based on my review of the medical records for this statement, and in the absence of any recorded disagreement, I consider that it is likely that there was a general consensus between the assessors that the actions taken and treatment provided at both MHAAs were appropriate at the time.

128. Following the second MHAA, both Dr Sadraei and I completed the individual medical recommendation which was agreed by the AMHP and the application for Section 2 admission was completed.

Recommendations

129. I do not have any recommendations for the Inquiry, as I only had very limited involvement with VC.

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 11 Dec 2025

Index to First Witness Statement of Dr Khuram Fraz Malik

No.	Inquiry URN	Document Description
1	NHFT0000168	RIO records
2	NOCC0000044	AMHP report, dated 24 May 2020
3	NOCC0000045	AMHP report, dated 25 May 2020
4	NHFT0000004	Forms H3, A4, A2, and A4 of Valdo Calocane, dated 25 May 2020