1 **Tuesday, 5 May 2026**
2 **(2.20 pm)**
3 **MS HAIDAR:** Thank you, Chair. Please can I call the next
4 witness, Clive Chimbi?
5 **THE CHAIR:** Yes. Thank you.
6 **CLIVE CHIMBI (sworn)**
7 **Questioned by MS HAIDAR**
8 **THE CHAIR:** Yes.
9 **MS HAIDAR:** Mr Chimbi, you have prepared a witness statement
10 for the Inquiry dated 28 November 2025; is that correct?
11 **A.** That's correct.
12 **Q.** Can you confirm the statement is true and accurate for
13 the best of your knowledge?
14 **A.** Yes, I can.
15 **Q.** And for the purposes of the statement the URN for that
16 statement is WITN0154001. Mr Chimbi, you are
17 a Registered Mental Health Nurse, currently at Band 6;
18 is that correct?
19 **A.** Up until about a month ago, yes, I've gone up to
20 clinical lead post.
21 **Q.** So at the time that you were reviewing VC, and at the
22 time that it's relevant to the Inquiry, you were at
23 Band 6.
24 **A.** Yes.
25 **Q.** And is it right that in 2020 you worked as a crisis care

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1 practitioner within the Nottingham City Crisis Team?
2 **A.** Yes.
3 **Q.** And of course, that is a service that's part of the
4 Nottingham Healthcare NHS Foundation Trust.
5 **A.** Yes.
6 **Q.** Mr Chimbi, how many years' experience did you have
7 working as a mental health nurse at the relevant time?
8 **A.** I'd qualified, I believe, in 2011, had worked mostly in
9 acute inpatients, so that's essentially working on -- on
10 the wards. I had worked on the 136 unit as well, the
11 Cassidy Suite, for a period of about two, three years,
12 and at the time when I moved to the Crisis Team, I was
13 actually coming in from the wards, from inpatient acute
14 wards.
15 **Q.** And so you had a significant number of experience if you
16 had qualified for in 2011, that's around 14 years; is
17 that right?
18 **A.** Yes.
19 **Q.** When you changed roles from being an acute general --
20 sorry, from being a nurse within the acute general
21 psychiatric ward to Crisis care, did you undertake any
22 specific training for the Crisis care role?
23 **A.** Not necessarily training but there was a lot of -- there
24 was, I believe, a couple of weeks period of shadowing.
25 Essentially you partnered up when you go out on contacts

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1 with somebody who is a bit more experienced. The
2 viewpoint is that you get to then learn the job role
3 that way.
4 **Q.** Thank you, Mr Chimbi. My questions for you this
5 afternoon will largely focus on your interactions with
6 VC while you were in your role as a crisis care
7 practitioner between 2020 and 2022. And so to begin
8 with, to orientate ourselves in terms of chronology,
9 please can we have on screen NHFT0000168, starting at
10 page 118.
11 Mr Chimbi, you'll be familiar with this document.
12 This the running records, the RiO records for the
13 progress notes --
14 **A.** Yes.
15 **Q.** -- within VC's clinical record.
16 So if we just look at the entry dated 31 July 2020,
17 and that's entered by Jan Oldham. It's just to say that
18 at this point VC had been discharged from his inpatient
19 treatment at Highbury Hospital, and then if we look at
20 the entry dated 1 August 2020 on that same page, that's
21 ended by someone called Lesley Mahachi, and Lesley
22 Mahachi was a member of the Crisis Team; is that right,
23 Mr Chimbi?
24 **A.** Yes, he is, yeah.
25 **Q.** And very briefly that records that the discharge plan

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1 for VC at this point had been agreed on 28 July with the
2 inpatient team during a pre-discharge meeting and, if we
3 look under "Plan" we can very clearly see that one of
4 the aspects for this plan was for the Crisis to offer
5 daily contact to VC to monitor medication concordance
6 and mental health.
7 **A.** Mm.
8 **Q.** So the Crisis Team was brought in so they could provide
9 intensive home treatment for VC; is that right?
10 **A.** Yes, it is right, and more specifically to focus on the
11 medication concordance.
12 **Q.** Could you just tell us very briefly, how does monitoring
13 medication concordance work?
14 **A.** Okay. So essentially a clinician will visit a client in
15 their own home with the view or the aim to support the
16 client in taking their own medication. Ideally what you
17 want to do is actually supervise the client taking the
18 medication, making sure that they're taking the right
19 medication at the right time, and you also want to take
20 that opportunity to assess if there's going to be any
21 potential side effects coming up, you know, assessing
22 their view on compliance and taking medications.
23 **Q.** And can you just help us with this: would the discharge
24 to the Crisis Team have been part of what's known as
25 an early discharge plan at this stage?

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1 A. So my impression of an early discharge would be that if
2 somebody is coming out of hospital and they still remain
3 with some acute symptoms, and possibly a certain level
4 of risk, then Crisis can be involved and at that point
5 it becomes early discharge.
6 Q. And is this what you understood to be the case for VC at
7 that point?
8 A. Yeah.
9 Q. So if we can have on screen, please, Mr Chimbi's witness
10 statement, which is WITN0154001, starting at page 4.
11 Mr Chimbi, at paragraph 18, you've told us that
12 before you engaged with any patient you familiarised
13 yourself with key information, and begin by reviewing
14 why they have come to the Crisis service.
15 A. Mm-hm.
16 Q. I'm going to skip ahead a bit to page 10. So we can
17 have a look at paragraph 50 because you've told us you
18 don't have specific recollection of your understanding
19 of the reasons VC had been discharged from inpatient
20 care to the care of Crisis, which is understandable,
21 given the time that has passed. However, it is
22 important to establish that, as part of your usual
23 practice, you would have reviewed VC's clinical record
24 so we're interested in understanding what documents you
25 may have reviewed at the time.

1 A. Okay.
2 Q. We've already seen the running progress notes, which is
3 the 168 document. Would you have reviewed the referral
4 that was sent by the inpatient team to the Crisis Team
5 at the time?
6 A. Not necessarily. So my practice is usually to look at
7 the core assessment. Ideally, the core assessment is
8 the document. That should have all the bulk of all the
9 relevant information that the next team looking at or
10 supporting the client would need to look at. So I would
11 have looked at that. Now, if there is enough time
12 before I see a client, then yeah, I would delve into
13 a lot more documents, especially if the document that
14 I'm looking at, the core assessment, is not giving me
15 enough information, then, yeah, I can look around at
16 some other bits as well just to get some more
17 information.
18 Q. Just to pause you there, Mr Chimbi. We can pull up the
19 core assessment from VC's second admission, I believe
20 that's NHFT0000187. If we can wait a second until that
21 comes on screen?
22 You'll see here that this core assessment was
23 actually done on 15 July 2020. That is, I believe, the
24 day that VC was admitted or the day after VC was
25 admitted. Just to double check, if we scroll down to

1 the bottom of this document, just to see if it had been
2 updated at any point. So it would be the last page just
3 where it would potentially say if it was updated. So it
4 says "Updated on 15 July", so indeed it wasn't updated
5 throughout VC's stay.
6 A. Yes.
7 Q. So if you had seen that would you have looked at other
8 documents --
9 A. Sorry --
10 Q. Go ahead?
11 A. Sorry to cut you off.
12 Q. No, please, go ahead.
13 A. So my practice is that these are the set of documents
14 that I would tend to look at, core assessment, now the
15 idea being that it should have the bulk of the summary
16 as to who this person is, their history, the chronology
17 of how they have come into the service and what it is
18 they've been supported with during their stay in
19 a particular service.
20 Then I'd look at the risk assessment as well and
21 hopefully it's been up to date, updated with all the
22 information that we need in order to carry out what we
23 need to do within the Crisis Team.
24 I would also look at -- I would filter out -- if
25 somebody is coming from inpatient, I would filter out

1 the MDTs or look at either the last MDT or the last two
2 MDTs, and now, if time allows, then I would look at
3 other things, like the discharge summary. I'd look at
4 other things like the progress notes from that patient's
5 time on the ward. But it's very rare that you actually
6 have enough time to go through all those documents, so
7 you are essentially trying to filter out enough
8 information to inform you as to what you need to carry
9 out during your contact with the client.
10 Q. Okay, that's very helpful. If we can have the 168
11 document back on screen and then this time we'll be
12 starting at page 104. Just to see that that entry made
13 on 28 July 2020, and then over the page to 105, this is
14 a ward review, so one of the types of MDTs?
15 A. Yes.
16 Q. We can see that someone from the Crisis Team had
17 attended this ward review and that's Merima Jordan?
18 A. Yes.
19 Q. Merima Jordan worked with you and was, at the time,
20 a clinical lead. If we just scroll down, would you have
21 reviewed this entry?
22 A. Yes.
23 Q. If we just scroll down to see where it says, "Reason and
24 aims of admission", we can see that it records:
25 "Following recent discharge [VC] returned to his

1 student accommodation, stop making medication, became
2 paranoid about a neighbour and entered his flat. Police
3 called [...] detained under Section 3."
4 So you would at least have been aware that, at this
5 point, VC would have had two recent admissions?
6 **A.** Yeah, if it's on this document then, yeah, I would have
7 been aware of it yes.
8 **Q.** Of course you will have been aware that what led to VC's
9 second admission was that he stopped taking medication?
10 **A.** Yes.
11 **Q.** If we look at the referral document, I know you've said
12 you're not sure whether you reviewed it but this is
13 NHFT0000030. There isn't a huge amount of information
14 within this document but, if we can look at the section
15 which says, "Current Concerns", we see very clearly that
16 one of the things that is documented is that what led to
17 VC's second admission was VC entering his neighbour's
18 flat, and those neighbours restraining him before the
19 police were called.
20 **A.** Mm-hm.
21 **Q.** So this would have been very important information for
22 you to have?
23 **A.** It would have been, yes.
24 **Q.** Were you aware, at the time you interacted with VC in
25 the beginning of August, that there were risks of

1 aggression and violence associated with his relapses?
2 **A.** I can't recall but, if I was, I would have documented
3 that on my initial contact. Usually, I make it a habit
4 of commenting on risk during my contacts so I would have
5 put that in. And just to clarify, so with referral
6 document to the Crisis Team, I generally would not focus
7 on that document personally if I am going out to see
8 somebody. The idea is, if a referral comes through to
9 the Crisis Team, the clinician that's receiving the
10 referral, they filter through the referral, make sure
11 that the client is appropriate for our service, meets
12 all the threshold that needs to be met made for the
13 Crisis Team and that all that work has been done, so by
14 that point that I'm then seeing the patient, that
15 initial screening has been done. So usually we use that
16 referral form for that purpose: to screen if a person is
17 for Crisis Team or not.
18 **Q.** So you've said that you might not have seen the referral
19 but you will have seen the core assessment?
20 **A.** *(The witness nodded)*.
21 **Q.** We've seen that the core assessment has been completed
22 on 15 July --
23 **A.** Yes.
24 **Q.** -- which wasn't particularly up to date. Can you tell
25 us, would you have then reviewed the discharge summary

1 for a more up-to-date document?
2 **A.** Yeah, I possibly would have looked at the discharge
3 summary.
4 **Q.** If I can just pause you there so we can pull it up.
5 Please can we have NHFT0000222, just to assist as we
6 look through what you may have known.
7 So this is the front page of the document. This
8 would have been completed on 31 July which is much
9 closer to his date of discharge. We can see under
10 "Admission Details", under the heading "Reason for
11 Admission":
12 "Increased Risk to Self and/or Others."
13 And then over the page, please, we can see in the
14 summary, very briefly -- I won't read it all in the
15 interests of time -- but it's important to note that
16 what is contained here is that VC was admitted under
17 similar circumstances as his previous admission, posing
18 an increasing risk to both himself and others. He had
19 gone to a neighbour's flat who is staying above him, and
20 the police were called.
21 "During his assessment it was clear that [VC] had
22 decided to stop taking his medication 2 weeks after his
23 discharge from hospital. He believed that he was well,
24 he did not have mental health problems and he would be
25 fine."

1 Just dealing with the last sentence, we can see
2 there that one of the things that led to VC's second
3 admission was issues of insight; do you agree with that?
4 **A.** Yes.
5 **Q.** And of course that when VC was known to be relapsing, he
6 was posing a threat of aggression or violence towards
7 others.
8 **A.** Sorry, can you say that again, please?
9 **Q.** So we can see from the summary, that when VC would be
10 relapsing, when he wasn't taking his medication, he was
11 posing an increased risk of threat to others; is that
12 fair to say?
13 **A.** It is, yes.
14 **Q.** If we look at page 3 under "Risks". Again very briefly,
15 it's important to highlight here that this discharge
16 summary does note that when VC was unwell, after he
17 broke into one of his neighbour's flats, that neighbour
18 had "jumped out of her window as a result of fear and
19 [had] severely injured her back."
20 **A.** Yeah.
21 **Q.** So that's just to set out what you may have known at the
22 time when you --
23 **A.** That's it, yeah.
24 **Q.** -- reviewed VC. And a more general question for you,
25 Mr Chimbi: as part of your practice when you see this

1 type of information about a patient, do you look to
2 obtain any collateral information from other agencies,
3 for example the police, who might have been involved
4 with VC, or do you just rely on the existing records?
5 I know you said there's a lot to read, but just for
6 the information of the Inquiry.
7 **A.** Yes, so I would rely on the existing records. The
8 viewpoint with -- the viewpoint being that within Crisis
9 we work sort of like much more as an MDT. So if there
10 is need for collaboration with sort of like other
11 agencies, the viewpoint is that MDT will sit down and
12 they will have an overall view of the full case.
13 As a clinician that's going in and seeing a patient,
14 I'm going in for a specific piece of work to do, I've
15 got a specific task and I'm sticking to that particular
16 task, and feeding back to the greater, wider team, and
17 if there is need to then develop more knowledge, the
18 team will then -- would then sort of like ask for that
19 to be done.
20 **Q.** Okay, that's helpful.
21 So in the context of patients like VC, who are being
22 discharged to a Crisis Team --
23 **A.** Mm-hm.
24 **Q.** -- are you able to tell us why VC would have been
25 referred to Crisis as opposed to being referred directly

1 to his local mental health EIP team?
2 **A.** Okay. So just from looking through the documents in the
3 discharge summary -- sorry, the last MDT, the request
4 from the ward had been that they needed Crisis Team to
5 step in and offer medication concordance. Within the
6 service structure, that's only offered by the Crisis
7 Team, so automatically that would have been coming to
8 us. There is occasions where, at the point of the
9 discharge, that they will feel that actually this is
10 safe to pass straight on to the Local Mental Health Team
11 and they can do that.
12 But usually, if -- from my experience what I've
13 discovered is that if there is, at the point of
14 discharge, somebody is still presenting with some acute
15 symptoms but they're not significant enough to warrant
16 continued hospital stay, or there is some level of risk,
17 but, you know, it -- that level of risk can be contained
18 in the community, then we usually pass that referral on
19 to the Crisis Team.
20 **Q.** So Crisis Team's involvement effectively is very
21 critical at the point of which there are still concerns
22 around medication concordance, potentially, because
23 Crisis can offer that daily follow-up, can supervise,
24 they have the resources to do that, and potentially
25 where there is still some acute -- or a risk of some

1 acute illness still being present; that's what we
2 understand.
3 **A.** Yes, as I say, as to whether the actual resources are
4 there, that's debatable, but that's what the team is
5 commissioned for.
6 **Q.** I see. So we can now look at your first interaction
7 with VC, so if we could please have NHFT0000168 starting
8 at page 119, please. And while that's being pulled up,
9 Mr Chimbi, can I ask, where VC was referred to the
10 Crisis Team, you -- the team relies on you as a nurse to
11 carry out the medication concordance and the mental
12 health assessment; we don't see that VC is ever seen by
13 the responsible psychiatrist from the Crisis Team, so
14 they don't really do general follow-ups; is that
15 correct?
16 **A.** That's not unusual at all. The viewpoint of the
17 clinician going in is that they should be knowledgeable
18 enough and be confident enough to be able to assess the
19 client's presentation and escalate directly to
20 a consultant if that's needed. But, in addition to that
21 as well, particularly when somebody is coming on to the
22 Crisis Team if they come on to us, it's called a red
23 RAG, they're actually discussed every single day, so
24 there is senior clinical input even if the senior
25 clinicians have not seen the patient themselves

1 directly.
2 **Q.** And that's relevant because VC was actually discharged
3 on a red RAG; is that correct?
4 **A.** Yes.
5 **Q.** And he was to be followed up every day and discussed
6 every day in MDT.
7 **A.** *(The witness nodded)*.
8 **Q.** So if we just have a quick look at your first
9 interaction with VC, if we focus on the third paragraph,
10 you note that, when you had arrived, VC still had not
11 taken his medications:
12 "he agreed to take them in front of us and went to
13 fetch them. After several minutes he came back and said
14 he could not find them."
15 He goes on to say he thinks he may have misplaced
16 them and you explain to him the importance of taking and
17 continuing to be concordant.
18 Just pausing there, Mr Chimbi, we don't have to pull
19 this up but, in your statement at paragraph 44, you said
20 that this did not cause you a huge amount of concern
21 because, although medication concordance was not
22 achieved on this occasion, you would only have concern
23 if it becomes a pattern; is that correct?
24 **A.** Yes, that's true.
25 **Q.** But in order to establish whether this avoidance to take

1 medication was part of a pattern or not, it would have
2 been important to review VC's previous interactions, not
3 only with the Crisis Team but also with other nurses who
4 were involved in his care; do you agree with that?
5 **A.** Yes, that's true but the pattern could also be that, at
6 this point, that we are coming in as a Crisis Team
7 during this period of contact. If there is continued
8 episodes where a person is not taking medications,
9 that's the pattern that I'm more keen to establish.
10 I understand there will be historical patterns in place
11 and those are really, really important and do inform
12 what we do during the current period of care, but I also
13 know that there'd been a piece of work with the wards to
14 try and establish and build up his level of knowledge
15 about the importance of medications and, if that had
16 been successfully achieved, I'm not going to be
17 immediately alarmed during my contacts with him, during
18 this current period of treatment with the Crisis Team.
19 **Q.** Did you know at this stage that VC had previously, after
20 his first discharge, seen the Crisis Team on the 30 June
21 and told them that he was willing to take his
22 medication, and then what, in fact, transpired the next
23 day was that he stopped taking his medication?
24 **A.** I would have been aware that he was coming to us due to
25 non-medication concordance. As to the actual details of

1 that, I may not have been aware as to specifically how
2 that occurred.
3 **Q.** Well, the reason I raise this point in particular,
4 Mr Chimbi, is because the Crisis Team was involved for
5 a very specific reason: it was for medication
6 concordance. On the first occasion, the day after
7 discharge, VC -- medication concordance is not achieved.
8 **A.** *(The witness nodded)*.
9 **Q.** You say that this wouldn't be concerning unless there
10 was a pattern --
11 **A.** Yeah.
12 **Q.** -- and VC's notes do indeed establish that there was
13 a history of VC saying to his clinicians or to the
14 nurses reviewing him, he's happy to take his medication,
15 and then stopping that afterwards. So my question to
16 you is: would it have been prudent to look at the last
17 interaction with Crisis, just to check if there was
18 a pattern at that stage?
19 **A.** Yeah, it would have been prudent to look at the last
20 interaction with the Crisis Team, same as it would have
21 been prudent to go through a whole bunch of notes about
22 his inpatient stay and interactions with other services,
23 but we are dealing with the effect that clinicians
24 within the Crisis Team, they have got very limited time
25 to prep up for their visits, and how much they have to

1 prepare for those visits. So we're looking at
2 a clinician being able to look at all the information
3 that they feel they need to inform them on the actions
4 that they need to carry out. But in an ideal world,
5 yes, I do agree it's really, really important to have as
6 much information and be as well informed about the
7 person that you're going to see.
8 **Q.** I think just to finish that point, the point is that,
9 where there may be a pattern of a patient saying they
10 will do one thing and then doing something else, it
11 would be important to understand the history. And
12 indeed even on the day that VC was reviewed on 14 July,
13 when he was asked by the Street Triage nurse if he was
14 concordant with medication, he did say that he was
15 taking his medication. So this is just in terms of
16 understanding the patterns of VC's behaviour.
17 So that was your first interaction with VC and then,
18 just moving on very quickly to look at the rest of the
19 chronology, the next entry, I believe, after this is by
20 a colleague of yours.
21 **A.** Okay.
22 **Q.** That is on 2 August 2020, still on this page. It's
23 entered by Mr Philip Lavelle. The summary here is that
24 Mr Lavelle doesn't record actually seeing VC taking his
25 medication; would you agree?

1 **A.** Yeah, I don't think he's documented that.
2 **Q.** Then in terms of the next relevant entry in relation to
3 the Crisis Team's involvement, I believe that will be on
4 the 3 August entered by Ms Merima Jordan. Would you
5 have reviewed this note, Mr Chimbi?
6 **A.** Yes, I would have, yeah.
7 **Q.** So this was the plan for Crisis to be involved, and we
8 can see that it says:
9 "Crisis to continue being involved for two to three
10 weeks and then review ..."
11 Again, we can see here that VC was under the red RAG
12 so he requires daily oversight.
13 In the section which says "Plan", it says also "Will
14 require crisis plan". So is that a reference to
15 a Summary & Care Plan that should have been produced by
16 the Crisis Team?
17 **A.** So a crisis plan is a specific piece of document. It
18 essentially sort of like -- it is part of the core
19 assessment risk documents but it's a specific piece that
20 looks at sort of like things like, okay, who is this
21 person; what are they presenting with; what are their
22 risks; what are their symptoms that they've got; their
23 early warning signs and how those can be managed, in the
24 event that, you know, they are relapsing?
25 **Q.** That would have been a nursing document to create?

1 A. That would have been a nursing document to create, yes.
2 Q. But this was never created for VC during this
3 inpatient --
4 A. I don't know if it ever was created.
5 Q. Well, we have not seen a record of it and we've been --
6 we've received all of the care plans for VC, so it seems
7 that one was not created unless you know that there was?
8 A. I'm not aware of one being created based off of this
9 instruction.
10 Q. So if we continue with the chronology, then. You see VC
11 again on 3 August, and we can see that that note starts
12 at the end of page 121. You record again that VC
13 engaged well but he said to you at that point that he
14 had already taken his morning medication --
15 A. Mm-hm.
16 Q. -- and he showed you the evidence of the tablets having
17 been displaced. Just pausing there, you would have
18 explained to VC during your first visit that medication
19 concordance means you need to see him taking his
20 medication?
21 A. Yes, I would have, yeah.
22 Q. VC goes on to say it was a bit excessive of staff to
23 come in and watch him take meds. He prefers to take
24 meds between 8.00 and 9.00, he said he does not want to
25 take it any later and he would not give a valid

1 explanation as to why.
2 A. Mm-hm.
3 Q. So here we are three days after VC had been discharged
4 and he was effectively now refusing medication
5 concordance?
6 A. Yes, he was refusing supervised medication concordance.
7 Q. Supervised medication concordance was part of the
8 treatment plan with Crisis?
9 A. That was part of the treatment plan with Crisis, yes.
10 Q. So, just at the end of this note, you say, under "Plan",
11 if we can just scroll a bit further down, please:
12 "Visit on 4 August 2020. If he refused meds
13 concordance, please explain the risk of relapse and
14 possible hospital admission."
15 This is a note you left for the next nurse who would
16 be undertaking a review of VC. Did you on that day
17 discuss any of the risks related to VC relapsing with
18 him.
19 A. Yes, so the usual practice is, if you're going in for
20 medication concordance and you don't successfully
21 observe the person taking medication for whatever their
22 rationale might be, so usually you kind of like go
23 through, "This is why we need to be doing this and these
24 are the consequences should you not comply with that
25 particular plan".

1 Q. And this is just for your information, we don't need to
2 pull it up, but we have heard evidence from a colleague
3 of yours within the Crisis Team, Dr Ben Lomas, he's one
4 of the psychiatrists. For the record, that is
5 INQT0000065, at pages 4 to 7.
6 Dr Lomas effectively told us that where a patient
7 does not want to take medication, part of the Crisis
8 Team's work is to convince the patient that there are
9 other reasons to take that medication.
10 Now first of all, do you agree that it's part of
11 your work to convince a patient that they should be
12 taking medication?
13 A. Yes, it is, but if I can just clarify that at this point
14 he is saying, "I don't want to be supervised taking
15 medications"; he's not saying, "I don't want to be
16 taking medications". And for us clinicians that carry
17 out medication concordance, there's actually
18 a difference there. So it's not unusual for a person to
19 say, "Look, I'm happy to take my medication," but then
20 object to being supervised, you know, taking the
21 medication. And at that point it comes about trying to
22 establish as to why that is not happening. I think
23 that's why on one of the records I've mentioned
24 something along the lines "Did not give a rationale",
25 because you expect there to be a clear and significant

1 rationale as to why that might be the case.
2 Q. That's understandable, and in order to answer the
3 question as to why VC was not complying with medication
4 concordance monitoring, I would suggest that you could
5 have found the answer within the notes.
6 A. Mm-hm.
7 Q. Because at that point VC had been seen multiple times by
8 the Crisis Team and by other nurses, and had already
9 said to them that he was taking medication when he
10 wasn't.
11 A. Mm-hm.
12 Q. So it seems at this stage that there was evidence that
13 VC was actually unwilling to take medication overall,
14 not just --
15 A. Yeah, I can agree with that, yes.
16 Q. And then just moving on in terms of chronology to the
17 next visit, I know that you didn't undertake all of the
18 visits, Mr Chimbi, but just for the sake of completeness
19 we'll look at the entry on 4 August. Oh sorry, no,
20 before we move on to 4 August if we can just very
21 quickly touch on the MDT meeting which was on 3 August.
22 That's a note made by Dr Mike Skelton. It seems as
23 though Dr Skelton was saying that VC's capacity to
24 consent to medication must be presumed, this was not in
25 question at the time, and in order to assist with

1 concordance, a joint discussion with VC and the
2 Community Team around his relapses and potential lack of
3 insight would help achieve agreement.
4 A. Yes, and this discussion was triggered by myself after
5 I'd seen VC on that second contact, and he is still not
6 taking medication, inasmuch as I've said ordinarily
7 I wouldn't be alarmed, but I thought it very prudent to
8 just take it to our MDT to say, "Look, this is what we
9 are observing at the moment."
10 Now, the thing is as a clinician what you have is
11 only a piece of information at any given time, but when
12 you take it to the MDT that's where there's the fuller
13 picture of everything that's happening, and decisions
14 can be made there.
15 Q. Thank you. If we can have now the next page on screen
16 just to see the entry from the 4 August by Ms Brandi
17 Walters, who is also a crisis care practitioner.
18 Again, VC tells Brandi he had already taken his
19 medication with breakfast. She again explains to him
20 the purpose of medication concordance, and we see that
21 VC at this point agrees to wait for the Crisis staff
22 before taking his medication, but he then says
23 immediately after this:
24 "VC stated he will be a lot happier when the crisis
25 team stop coming."

1 So this was the fourth visit and the fifth time the
2 purpose of the follow-up was explained to VC. Doesn't
3 it seem at this point that although he was not actively
4 resisting the Crisis visits, he was clearly indicating
5 that he was not willing to take his medication?
6 A. I think he was indicating that he was not willing to be
7 observed taking medication.
8 Now, to put it into context, this is not unusual
9 where people go on to medication concordance for the
10 very first time. People -- you know, sometimes we get
11 a clientele group that does not know what it is a Crisis
12 Team does, and for them during those initial contacts it
13 can feel very invasive, having somebody coming in and
14 going like, "Actually, I'm gonna observe you taking
15 medication in your own home, in your environment where
16 you are meant to be the most secure as you can get and
17 I'm going to invade that space."
18 So there is a lot of pushback sometimes from
19 clients. But like I say, because it does happen, it
20 wouldn't ordinarily jump out. That's why there is the
21 need to then take this to our MDT because they have got
22 a fuller picture than what one clinician would have
23 going out on a contact.
24 Q. But it's understandable, Mr Chimbi, that patients often
25 feel that they don't want to be monitored in taking

1 their medication.
2 A. Mm.
3 Q. But as we discussed earlier, the move or the referral
4 from inpatient to Crisis as opposed to a referral
5 directly to the EIP team, was so that Crisis could
6 fulfil the almost transitional role of restrictive
7 follow-up, but in the community. So it was a context in
8 which VC was released to the community so he wouldn't
9 have to continue being an inpatient, but Crisis
10 involvement is to a degree restrictive because of the
11 risks associated with a patient who is referred to you;
12 do you not agree with that?
13 A. To a lesser degree, it is restrictive but I don't think
14 to that full extent of restriction because it still
15 remains that, as a clinician, if you go in to see
16 somebody, you prompt them to take medications. There
17 are occasions when a person will actually say to you
18 "I'm not taking it, I know I agreed to this plan during,
19 say, maybe my assessment, my Mental Health Act
20 Assessment, I agreed to this plan but I no longer wish
21 to do that."
22 Q. Yes.
23 A. So it is restrictive but clinicians are also very
24 limited as to how much we can enforce it, how much we
25 can get the people to comply with the process.

1 Q. But in that circumstance, and this is actually what
2 happens with VC, if we go to the next entry which is
3 5 August, and I believe that starts the end of this
4 page. We see the entry by Dr Ben Lomas, and Dr Ben
5 Lomas again, he would have been writing this in the
6 context of an MDT.
7 So if we scroll to the next page, it's very brief.
8 Dr Lomas does say:
9 "has stopped medication, though seemingly appears
10 symptom free from last visit."
11 Do you understand from that note that it was the
12 view of the MDT that actually VC had stopped medication
13 at this point?
14 A. I would have seen the document, yes.
15 Q. So it was the MDT's view that VC had stopped taking
16 medication, which was quite different to VC simply
17 refusing medication monitoring concordance.
18 A. Yes, I can --
19 Q. And potentially in line with that, Dr Lomas had written:
20 "remain red RAG for concordance."
21 And: "further assessment."
22 So on 5 August, Dr Lomas is saying: because VC is
23 potentially not engaging, because he's potentially not
24 taking his medication, he should remain on red RAG.
25 A. Uh-huh.

1 **Q.** Then the next entry in the records is by Kelly Barber on
2 5 August. She is also a colleague from Crisis; is that
3 correct?
4 **A.** She was at the time, yes.
5 **Q.** Yes. And for the purposes of time, the most important
6 aspect of this record at the moment is VC actually is
7 recorded for the first time to take his medication in
8 front of this clinician. I believe that's -- if we want
9 to highlight it, it's -- exactly -- under "Medications",
10 and this is actually the one and only time during VC's
11 care under the Crisis Team in this period that he is
12 seen taking his medication.
13 **A.** Yes.
14 **Q.** So then if we go further down to page 124, we get to the
15 6 August. Again, this is a note by you, Mr Chimbi. On
16 this occasion, you attended a joint visit to VC's home
17 with the LMHT team and you noted that:
18 "VC appears stable with no overt signs of
19 psychosis."
20 He says to you he is happy to continue with his
21 medication regime. You discuss the importance of being
22 compliant. Did you discuss with VC that, if he stopped
23 taking his medication, he would actually be at risk of
24 becoming aggressive and causing harm to others or was
25 that not part of the discussion?

1 **A.** So the usual practice is to highlight to the patient
2 what would potentially happen should they stop taking
3 medications. As to whether I went into that detail with
4 him, I can't recall but, like I say, usually you want to
5 say to people, "Look, if you don't take your medication,
6 you're going to relapse and, when you relapse, these are
7 the things that happen and when that happens this is
8 what services we may have to do".
9 So, essentially, you're trying to explain to the
10 patient that things can become a bit more difficult not
11 only for yourself but for the people around you in that
12 the actions from services may be a lot more restrictive.
13 **Q.** Then if we just scroll down where it says "Comment",
14 you've written:
15 "Since discharge [VC] has engaged with the Crisis
16 Team."
17 Strictly speaking, he has engaged but has he
18 complied with the requirements of the Crisis Team at
19 this point?
20 **A.** Yes, no, he hasn't. I can see how it looks from the
21 outside but, within the service, we know that when we
22 say "he has engaged", it's reference to the client is
23 willing to meet with the service provider, is willing to
24 engage with some of the invasive process we're doing.
25 We're going in and saying to him like some of the more

1 difficult things that he's experiencing, we are digging
2 into it and asking him questions about his symptoms and
3 symptomology and, you know, these are things that can be
4 quite difficult for people to engage with. So to that
5 level, he is engaging with the process but he's not
6 fully compliant with the actual plan.
7 **Q.** At this stage, we see, under where it says, "RAG" you
8 note:
9 "This has been changed to green, in line with the
10 above plan."
11 Now, we had seen that the day before, Dr Lomas had
12 put VC on a red RAG, to monitor medication concordance,
13 but the next day it was changed to a green RAG. Can you
14 help us understand, Mr Chimbi, the basis on which this
15 was changed?
16 **A.** Okay. So there is several discussions, before we got to
17 this particular contact and, during those discussions,
18 that's when it was initiated that we would need to start
19 the discharge planning. I believe there had been two
20 senior caseload reviews that had indicated the timeline
21 that we were going to follow, right from the point of
22 discharge within the hospital.
23 **Q.** Can I just pause you there, so you were working
24 according to a plan which had been set at the point of
25 discharge from hospital?

1 **A.** Starting at the point of discharge from hospital, and
2 then reviewed. I believe, there was a senior clinician
3 that did a caseload review and, based off that caseload
4 review, had then suggested that we need to start the --
5 to review the RAG, which translates to, "Let's start
6 that discharge planning process."
7 **Q.** Wouldn't that discharge plan have been updated when
8 Dr Lomas said, "Keep the red RAG" the day before?
9 **A.** Yeah, it would have been. So I can only imagine that
10 I might have missed that particular MDT and focused on
11 the previous other MDTs where these plans had been put
12 in place.
13 **Q.** So it might have been an error to change it so quickly
14 from a red RAG to a green RAG at that point?
15 **A.** It might have been an error at this point based off that
16 entry from Dr Lomas but, thinking about it, I think
17 I probably focused on those plans that had been put in
18 by the senior nurses when they had done their caseload
19 reviews.
20 **Q.** Then just trying to complete this period of care, VC is
21 reviewed again by Patrick Crolla on 8 August. I believe
22 that record is on page 126. Again, just to summarise
23 and you speak to this in your statement, Mr Chimbi,
24 Mr Crolla does not record that he sees VC taking
25 medication, so again VC is just not seen taking

1 medication at this point. You visited VC for a final
2 time to discharge him from the Crisis Team on 15 August
3 and that record starts at page 129. Sorry, I know we're
4 going through the records quite quickly, just in the
5 interests of time.
6 So that starts 15 August, 1.36 pm; originator,
7 that's yourself, Mr Clive Chimbi. Then we can go over
8 the page.
9 This was your last visit with VC on this date and we
10 can see that you note -- this is the last sentence of
11 the -- it would be the second paragraph:
12 "Objectively, I found him to have a masked
13 expression and euthymic in mood."
14 Now, just pausing there, what did you mean by
15 "masked expression"?
16 **A.** So a masked expression is essentially where a person --
17 when you look at a person's face, there is a lack of
18 emotion there, there is a lack of -- it is almost blank,
19 you can't tell if they're happy or sad or in between.
20 They're lacking emotion. It's sometimes associated with
21 mental health conditions such as depression and
22 schizophrenia.
23 **Q.** So it could be a sign of potential deterioration at this
24 point?
25 **A.** It could be a sign of potential deterioration at this

1 point or it could be -- it could be indicative of
2 a person who was released early from hospital and
3 therefore, by definition, would still have retained some
4 symptoms of the condition that they was initially
5 admitted for. So, again, Crisis is about working with
6 people who are acutely unwell. It does not necessarily
7 mean that symptoms have gone. Symptoms can, you know,
8 remain during the person's journey with Crisis.
9 **Q.** But did you enter any information about his final
10 presentation anywhere within VC's -- potentially his
11 risk assessment or his care plan at this point?
12 **A.** If --
13 **Q.** So he potentially might still be exhibiting some
14 symptoms?
15 **A.** So this particular document is to sort of like say this
16 is his current presentation, as I'm seeing him now.
17 A risk assessment, you'd usually update a risk
18 assessment if you've got enough information to convince
19 yourself as a clinician that risks have now changed.
20 But, like I say, at this particular point, my impression
21 is this is somebody that is acutely unwell, working with
22 a service that sees people that are acutely unwell,
23 being passed over to a service that supports people with
24 a specific condition and they are specialist to this
25 particular condition. So, in my opinion, it would

1 have -- this is in line with what I am expecting from
2 somebody who I'm going to be passing over to their
3 specialist service.
4 **Q.** Mr Chimbi, those are my questions in relation to the
5 first period that you were reviewing VC.
6 I have a couple of questions in relation to your
7 review of VC in January 2022, that was a very brief
8 interaction. So if we could please go to page 210
9 within the running records, this is an entry by you,
10 Mr Chimbi, on 24 January 2022 and, at this point, again,
11 just to orient ourselves, VC had been referred to the
12 Crisis Team again for a medication concordance
13 monitoring --
14 **A.** Yeah.
15 **Q.** -- because it was felt by his Community Team that he was
16 non-concordant and that he was potentially relapsing.
17 Did you review VC's clinical record in the lead-up to
18 this review?
19 **A.** Yes, so what my practice would have been, so it would
20 have been definitely looking at the core assessment,
21 definitely looking at the risk assessment, looking at
22 the last few MDTs from the service that had referred him
23 into our service and, if time allows, any other
24 additional information.
25 **Q.** Just to note under "Risk" at that point you noted,

1 "Risk":
2 "... approaching neighbours due to persecutory
3 ideas/auditory hallucinations (neighbour needing to jump
4 from window to leave on one occasion), verbal
5 hostility."
6 The Inquiry is very aware at this point that by
7 24 January 2022, there had actually been two further
8 serious incidents of violence that occurred while VC was
9 relapsing: one in which he seriously assaulted a police
10 officer, and the one that led to this involvement with
11 Crisis where he was accused of assaulting his housemate.
12 We don't note that within this risk assessment. Is
13 it because -- could you give us a reason why?
14 **A.** Yeah, so this is a ... this is not the static risk
15 assessment. So that information should be contained
16 within the static risk assessment. This is more
17 a dynamic risk assessment to say, "On this occasion that
18 I'm interacting with this particular person, these are
19 the things that I'm observing" on this, you know, on
20 this particular occasion, in this timeframe, these are
21 the things that I've identified.
22 Now if I pick out any information from that contact,
23 that needs me to update the risk assessment, yes,
24 I will. And the expectation is whoever is reviewing
25 this particular set of notes would be aware that, should

1 they want the more comprehensive risk assessment, there
2 is a clear document so named "risk assessment" where
3 they could actually go and find that particular
4 information.
5 **Q.** Mr Chimbi, I think the point of having an accurate risk
6 assessment within this review is that at this point VC
7 was considered to be at risk of relapsing, at risk of
8 being non-concordant and, if that were to be the case,
9 if you had observed him to not be taking his medication,
10 the risks associated with him relapsing would have been
11 more serious than what's written here.
12 **A.** Yes.
13 **Q.** And so there would have been a lower threshold to report
14 back about potential non-concordance; do you agree with
15 that?
16 **A.** Sorry, you've lost me. How do you mean: a lower
17 threshold?
18 **Q.** So if the accurate risks were recorded here, if you had
19 recorded that VC is at risk of relapsing and potentially
20 assaulting members of the public, it would impact your
21 view as to the seriousness of him not taking his
22 medication, would it not?
23 **A.** Yes, so definitely it would impact the team's view, but
24 I still maintain that, as a clinician going in, and you
25 comment about the risk, the expectation you are

1 commenting about the risk, that the more dynamic risk at
2 that particular time. Yes, you can start to go a bit
3 more comprehensive and look at all the potentials that
4 may be there, but ideally, all those really should be
5 captured within the more static risk assessment. This
6 particular comment is not to be taken in isolation and
7 should be used in conjunction with the actual risk
8 assessment.
9 And any clinician who has got access to these
10 particular notes, because this is the concern, the
11 intended consumer for these notes will know that this is
12 not to be used in isolation and you will need to look at
13 the complete risk assessment. When you marry the two
14 together, you can then start to work out actually,
15 there's non-concordance, and non-concordance, from the
16 clinician that's seen the patient, will then lead on to
17 other things happening such as an increase in risk in
18 aggression, and that information is then captured from
19 the actual risk assessment.
20 **Q.** So your evidence is that clinicians need to be looking
21 at multiple documents to properly assess the risk.
22 **A.** Yes.
23 **Q.** Then my final question for you, in terms of risk
24 assessments and the types of documentation, nursing
25 documentation, that the Crisis Team potentially should

1 have filled out and didn't while VC was under their care
2 is, was there an audit system in place to ensure that
3 these documents were being completed at the time?
4 **A.** So at the time, I'm not too sure, but I know that by the
5 point I've left the Crisis Team there's definitely a lot
6 of auditing and anything that's outstanding, clinicians
7 are then prompted to complete whatever is outstanding.
8 **MS HAIDAR:** Thank you.
9 Chair, those are my questions for Mr Chimbi.
10 **THE CHAIR:** Yes, thank you.
11 Any questions?
12 **Questioned by MR BEGGS**
13 **MR BEGGS:** Mr Chimbi, just three very short points.
14 Can you look, please, at paragraph 91 *(sic)* of your
15 statement, which is WITN0154001, page 21. Do you see --
16 forgive me, page 17. That's my fault.
17 Do you see in the second line of your record you say
18 VC was not a risk to people. That's 15 August 2020.
19 Yes? I'm just drawing it your attention --
20 **A.** Sorry, which particular bit on the --
21 **Q.** Do you see in the second --
22 **A.** Okay, and --
23 **Q.** "He's not a risk to people", in the second line. It's
24 just been highlighted for you.
25 **A.** And which interaction was this with him, what date was

1 this interaction?
2 **Q.** 15 August 2020.
3 **A.** Sorry, I didn't catch that.
4 **Q.** 15 August.
5 **A.** Yes, 2020, yes.
6 **Q.** You've recorded VC is not a risk to people; do you see
7 that?
8 **A.** Uh-huh.
9 **Q.** Then if you turn over, if the operator would turn over
10 the page to the paragraph 96, I think what you record
11 there is:
12 "Based on my involvement with VC and having reviewed
13 the medical records, I considered that ..."
14 Should it say "he would continue to take his
15 medication"?
16 **A.** Yes, it should be "he would", yes.
17 **Q.** Then you say:
18 "I had not seen him take his medication, however, he
19 had said all the right things ..."
20 **A.** Mm-hm.
21 **Q.** Do you see that?
22 Looking at those two paragraphs in combination,
23 wasn't it tolerably obvious by August 2020, that VC was
24 at risk of psychosis without his medication?
25 **A.** So any client that's not taking their medication, they

1 are at risk of relapsing but, as to what that relapse
2 would then lead on to, you -- you know, I would --
3 I would be too -- I'd be afraid to comment at this
4 particular stage. When I said he's not at risk to
5 others, like I said earlier on, this is more of
6 a dynamic view that in this moment. Now, what informs
7 the pathways within Crisis is that, if I am saying that
8 if he is a risk to others at this particular point, what
9 I'm essentially saying is there is significant harm that
10 would come to the public imminently. That's what that
11 would imply.
12 And that would be different to looking at it and
13 going, actually, in the more wider view and in the more
14 aesthetic view of risk, yes, there is a risk that any
15 particular person with a particular condition, should
16 they relapse, they can present with symptoms of their
17 condition which can have associated risks with that.
18 **Q.** But you did know that there'd been two troubling
19 incidents on 24 May and another troubling incident on
20 13 July, and this is only 15 August?
21 **A.** Yeah, and I still maintain that this is more a dynamic
22 view of the significance of -- or rather the imminence
23 of risk at this particular point.
24 **Q.** Yes. Can you look, please, at page 22 of your
25 statement, paragraph 115, where, if we zone in on it, do

1 you see you're referring there -- this now January 2022,
2 you're referring to previous incidents including the one
3 that we're calling Feven jumping out of a window. Can
4 you see that, towards the end of that paragraph, third
5 line?
6 **A.** Yes.
7 **Q.** "One incident", yes, it's been helpfully highlighted for
8 you; do you see that?
9 **A.** Yes.
10 **Q.** You don't mention the incident in September 2021, where
11 he repeatedly punched and headbutted a police officer?
12 **A.** Okay. And can I just understand, this is off my
13 statement -- is that right -- or is it off a RiO note
14 that I put in?
15 **Q.** I'm looking at what you have recorded --
16 **A.** Okay.
17 **Q.** -- and I just wonder why you didn't make reference
18 expressly to the assault on the police officer as part
19 of your overall assessment?
20 **A.** So I believe at the time I wrote this assessment,
21 I would have looked at some documents. As to how much
22 of the documents I would have looked at, I'm not too
23 sure but this was after my period where I actually
24 delivered care to him, so I'm looking at the records
25 available at that particular point.

1 **Q.** The final point, if we go just to the top of the next
2 page, 118, so to remind you, this is January 2022, you
3 say:
4 "... while VC was not actively posing a risk at the
5 time of contact, his history and the potential
6 consequences of non-compliance warranted close
7 monitoring and intensive support to mitigate the risk of
8 harm to himself or others."
9 Do you see that?
10 **A.** Yes, I do.
11 **Q.** You don't mention there the possibility of you or your
12 colleagues briefing the local police about this risk of
13 harm, do you?
14 **A.** Yeah, can I just clarify, though, this is my statement
15 for this Inquiry?
16 **Q.** Yes.
17 **A.** So, in that, I'm reflecting on the pathway of care
18 within the service. So if I'm in a position where I can
19 then say -- where I'm saying this is the potential
20 risks, at that particular point, if there is need to
21 alert the authorities, yeah, I would have. I would
22 have. But this statement, when I created the statement,
23 this is a retrospective statement of the care that he
24 had received.
25 **Q.** That's why I was asking you, and just inviting your

1 comment. Wouldn't a sensible approach be to include the
2 police in your considerations, given the risk that
3 you've identified in paragraph 118?
4 **A.** Yeah, so the way the service is structured is if there
5 is an identified risk and if it is felt that alerting
6 the authorities would somehow mitigate that risk, yes,
7 there is potential that we could alert the authorities.
8 But having said that, we are also acutely aware, as
9 clinicians, as to at what point you might need to alert
10 the police and what questions the police might have for
11 yourselves, and it sometimes influences when and how you
12 actually alert the police.
13 So in the absence of clear evidence that somebody is
14 an imminent risk to a member of the public, there is
15 very minimal information to go on as to why you might
16 need to alert the police. We work with a client group
17 that are continually halfway through their treatment
18 plans, are posing a risk not only to themselves but
19 sometimes to other people. So if that's then the
20 criteria to inform the police, a significant proportion
21 of the clientele group that we work with would be
22 reported to the police.
23 **MR BEGGS:** Thank you, Mr Chimbi.
24 **THE CHAIR:** Mr Beer? Thank you.
25 **Questioned by THE CHAIR**

1 **THE CHAIR:** I just wanted to ask you one question,
2 Mr Chimbi, and that's in relation to when you said that
3 when you were looking for information, you said about
4 the records, you would look for the core assessment, the
5 risk assessment, and you said you would also filter out
6 the last MDTs, possibly the last two. By "filter out",
7 are you talking about a search capacity within RiO?
8 **A.** Yes, it's a search capacity where you can go to --
9 usually if you filter out the medic information you can
10 usually find the MDT. So I would either filter out for
11 the medic entries or specify MDT entries, because they
12 tend to be the one point where everybody are sat
13 together, considered everything that needs to be
14 considered, put in action plans that need to be put in,
15 and possibly instructions for me to carry out --
16 *(overspeaking)* --
17 **THE CHAIR:** So you can just search for MDT entries in RiO?
18 **A.** So you can just type in "MDT". You would need to sort
19 of live maybe play around with the wording because it
20 only searches as how you put that terminology in. So if
21 I put in "MDT" and maybe a particular MDT has not been
22 labelled, "MDT" has been labelled "Multi-Disciplinary
23 Team meeting", that won't come up. All the ones that
24 will come up would be the ones that have been
25 abbreviated to MDT.

1 **THE CHAIR:** And if you wanted to look up your own entries or
2 somebody else's entries, you could do that as well,
3 could you?
4 **A.** Yeah, with your own entries it gives you an option to
5 just click on your name, then it brings up your own
6 specific entries. With another person, I don't think
7 I've done that but it is potentially you could put
8 a person's name in and it would bring up all the entries
9 that they have made.
10 **THE CHAIR:** Yes, thank you.
11 I have no further questions.
12 We'll start again, we'll take a break now, at 20 to,
13 please.
14 **(3.23 pm)**
15 **(A short break)**
16 **(3.40 pm)**
17 **THE CHAIR:** Yes?
18 **MR JONES:** Thank you, Chair. Can we please call Amie
19 Staples?
20 **AMIE STAPLES (affirmed)**
21 **Questioned by MR JONES**
22 **MR JONES:** Thank you, Ms Staples. You've prepared a witness
23 statement for the Inquiry dated 13 November 2025; is
24 that right?
25 **A.** Yes, that's correct.

1 **Q.** And can you confirm that it's contents are true to the
2 best of your knowledge and belief?
3 **A.** Yes.
4 **Q.** And for the purpose of the transcript, the witness
5 statement number is WITN0117001. You are an Approved
6 Mental Health Professional; is that right?
7 **A.** That's right.
8 **Q.** Or an AMHP, as they are abbreviated. The Inquiry has
9 already heard from several AMHPs already, so I won't ask
10 you to repeat the ins and outs of the role, but we know
11 from previous evidence that AMHPs are responsible for
12 arranging Mental Health Act Assessments; is that right?
13 **A.** Yes.
14 **Q.** For conducting them with two Section 12 doctors?
15 **A.** Yes.
16 **Q.** And then for making an application for detention in
17 hospital if appropriate; is that right?
18 **A.** Yes.
19 **Q.** And we'll come on to the detail of your involvement, but
20 in brief, you conducted a Mental Health Act Assessment
21 on VC on 3 September 2021; is that right?
22 **A.** Yes.
23 **Q.** With Drs Manzar and Lomas; is that right?
24 **A.** Yes, that's correct.
25 **Q.** And we've already heard evidence from both of those as

1 well.
2 You'll have known at the time that this was VC's
3 fourth Mental Health Act Assessment since 2020; is that
4 right?
5 **A.** Yes, yeah.
6 **Q.** He'd had two previous in May and one in June, both 2020;
7 is that right?
8 **A.** Yes.
9 **Q.** And we'll come on to the detail, but in terms of the
10 outcome of your assessment, it was that VC was detained
11 to hospital under Section 2 of the Mental Health Act; is
12 that right?
13 **A.** That's right.
14 **Q.** And you may need to speak up just a little bit and sit
15 a bit closer to the microphones if you can.
16 Now in terms of your background, you've worked in
17 social care since 2005; is that right?
18 **A.** That's correct.
19 **Q.** And you've been an AMHP since 2009.
20 **A.** Yes.
21 **Q.** In your witness statement you say you're a senior AMHP.
22 What does that entail, what does the senior part entail?
23 **A.** So within the team we have social workers, AMHPs,
24 community care officers, and then two senior roles, and
25 then a team manager. So we sit below the team manager,

1 we provide supervision to the social workers and also
2 perform a function as doing senior cover for the Mental
3 Health Act rota. So on any given sort of working day
4 you have one senior AMHP who would screen and assess all
5 of the referrals in for a Mental Health Act Assessment,
6 and then allocate them out to the AMHPs on duty.
7 **Q.** And by the time we get to September 2021, you'd
8 obviously been an AMHP for some time.
9 **A.** Yeah.
10 **Q.** I imagine it's difficult to put a number on but you must
11 have done well over 100 -- how many Mental Health Act
12 Assessments, do you think?
13 **A.** I would guess around 600, 700, probably.
14 **Q.** So per week, per month? What would you say per week in
15 your typical workload at that time?
16 **A.** So when I was a full-time member of staff I'd be on duty
17 twice a week on average and I guess you might do one or
18 two assessments on each of those days. Obviously some
19 days you don't get an assessment, but yeah, on average,
20 I would think.
21 **Q.** So it's fair to say very experienced at doing Mental
22 Health Act Assessments by the time you see VC.
23 **A.** Yeah.
24 **Q.** And in terms of, just to give a rough overview, roughly
25 how many of those involved patients who had psychosis?

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1 **A.** I don't know. I mean I guess ... I would have thought
2 perhaps half of that number. I guess we see quite a lot
3 of people with personality disorder-type diagnosis and
4 obviously people with mood disorders, but I would think
5 psychosis would form quite a large proportion of the
6 people that we see in a Mental Health Act Assessment.
7 **Q.** Quite a significant amount.
8 **A.** *(The witness nodded)*.
9 **Q.** So it certainly wouldn't be usual *(sic)* to be conducting
10 a Mental Health Act Assessment on somebody with
11 psychosis, as far as you are concerned?
12 **A.** It wouldn't be unusual, no.
13 **Q.** Turning, then, to the referral that came in for VC,
14 which led to your involvement, it's right, isn't it,
15 that the referral was made on 31 August 2021, so a few
16 days before you --
17 **A.** I believe so, yes.
18 **Q.** -- picked it up. We'll turn to the text of the referral
19 in a moment but it was a few days before it made its way
20 to you; is that right?
21 **A.** Yes.
22 **Q.** And you picked it up on 3 September.
23 **A.** Yes.
24 **Q.** And it was initially processed within the AMHP team by
25 somebody else, the person who picked up the referral; is

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1 that right?
2 **A.** Yes.
3 **Q.** And initially allocated to a different AMHP by the name
4 of Jen Shaw --
5 **A.** Yes.
6 **Q.** -- is that right? She made attempts to carry out other
7 Mental Health Act Assessment the day before --
8 **A.** Yes.
9 **Q.** -- on 2 September. What do you know about what happened
10 on 2 September?
11 **A.** I believe, from the notes, that she made three attempts
12 to see VC on 2 September at different times during the
13 day, trying to work out whether or not he was out,
14 whether or not he was sort of refusing to answer the
15 door and that's what they weren't sure about, really.
16 **Q.** And incidentally we can obviously see from the records
17 that whilst the referral came in on the 31st, that the
18 assessment wasn't attempted, it seems, until
19 2 September.
20 **A.** *(The witness nodded)*.
21 **Q.** Do you know why that is?
22 **A.** I don't know, I wasn't involved in that decision.
23 **Q.** So if we could have on screen, please, paragraph 33 of
24 your witness statement, which is on page 12. You can
25 see there the text of the referral that came in, which

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1 you've reproduced in your witness statement and, as you
2 can see there from the third line down, it's recorded on
3 the contact form generated by Beverley Shepherd that VC:
4 "has history of psychosis. Became unwell after
5 episode in May 2020 and was in hospital. Has had 2
6 episodes since then but has been fairly settled last
7 year. During the last few months Claudia ..."
8 That's Claudia Birtles; is that right?
9 **A.** Yes.
10 **Q.** "... has noticed a difference in presentation. She has
11 been to see him today and he is very unwell. Struggling
12 with delusional beliefs and feels there is a conspiracy
13 with police and hospital who have created technology
14 which creates voices. He has stop taking his meds. He
15 is not willing to discuss anything. He is very
16 suspicious, paranoid and confrontational. He was
17 accusatory and belligerent and told Claudia that she had
18 been mocking him. He has no insight and has said
19 categorically that he doesn't want support. He doesn't
20 trust them. Claudia believes he has never been fully
21 better but he has never acknowledged his psychosis."
22 So it's right that this referral came in by
23 telephone, Claudia ringing it in to the AMHP service --
24 is that you're understanding?
25 **A.** Yes, that's what it says on here, yes.

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1 **Q.** So this then would be Beverley Shepherd's note of what
2 was reported to her by Claudia?
3 **A.** Yes.
4 **Q.** By the time this comes to you, what did you make of that
5 information about VC when the referral made its way to
6 you?
7 **A.** I guess the kind of crucial bits for me would be
8 evidence that he appeared to be unwell and likely in
9 need of a Mental Health Act Assessment, which is
10 evidenced by her talking about his delusional beliefs,
11 the conspiracies, the paranoia, the fact that he seems
12 more kind of agitated, the paranoia and confrontational
13 comments and also, crucially, that he's saying he
14 doesn't want to support, won't trust services. So we
15 always have to kind of consider whether or not a Mental
16 Health Act Assessment is necessary or whether other
17 things should be tried first. But I think Claudia's
18 information was quite clear that he wasn't willing to
19 engage at that point. That's what he'd indicated to
20 her. So that's what I'd kind of take from that.
21 **Q.** Would you have also placed any emphasis on the fact that
22 there's a history of psychosis?
23 **A.** Yes, as part of the evidence of his mental disorder.
24 **Q.** Would it have suggested to you there's an underlying
25 diagnosis, that stretches back some time, of psychosis?

1 **A.** Well, that's what the notes say, doesn't he -- he has
2 a history of psychosis and he first presented in May
3 2020. So I would have taken that on board.
4 **Q.** Did you then speak to Claudia Birtles?
5 **A.** I really struggle to recollect if I spoke to her or not.
6 I would have tried to, that's what routinely we would do
7 but, obviously, it's such a long time ago I can't --
8 I don't have a clear recollection of it.
9 **Q.** There's no record of a conversation between you and
10 Claudia, is there?
11 **A.** No.
12 **Q.** Would you ordinarily keep one if you had called the
13 person who had made the referral?
14 **A.** Normally I would include that in my AMHP report. I am
15 mindful that I wrote this AMHP report very late in the
16 evening after a very long assessment and it's not as
17 detailed as I would have wished to or would ordinarily
18 have included.
19 **Q.** So if there isn't a note, is it more likely that it
20 didn't take place, the conversation with Claudia, or can
21 you just not remember?
22 **A.** I don't remember, I'm sorry. I think -- well, in my
23 handwritten note, I talk about him taking aripiprazole,
24 don't I, I think, and I wonder whether that was from
25 speaking with Claudia but I can't say I definitely did

1 because it was a long time ago and I can't exactly
2 recollect.
3 **Q.** It would be quite an important conversation to have,
4 wouldn't it, with the care coordinator; is that fair?
5 **A.** Yes, yeah, and I would always try and speak to the care
6 coordinator wherever possible. I know in Claudia's
7 notes she makes reference to intending to speak to me,
8 I think to pass on the family's concerns. So I think
9 it's quite possible that we did speak and, I'm sorry,
10 I didn't record that at the time.
11 **Q.** In terms of what records you then accessed, you would
12 have started with the Liquidlogic case notes; is that
13 right? They're the in-house Nottingham City Council
14 notes; is that right?
15 **A.** Yes, yeah.
16 **Q.** You also tell us in your witness statement that you have
17 read-only access to the RiO records?
18 **A.** That's correct.
19 **Q.** I'm sure it's an obvious question but it simply means
20 that you can read what's on there --
21 **A.** *(The witness nodded)*.
22 **Q.** -- but you can't make any entries; is that right?
23 **A.** Yes.
24 **Q.** Is that true of all AMHPs?
25 **A.** No, some AMHPs don't have access to RiO. It's partly,

1 I think, because I've -- I'm co-located with the health
2 teams at the moment so not all the AMHPs are based
3 within the LMHT bases, and it's -- so it's been a kind
4 of slightly scattergun, I suppose, effect in terms of
5 who has access and who doesn't. It depends how closely
6 you work with them. But within our team it --
7 generally, people are expected to have access to RiO.
8 **Q.** Can you recall what you would have picked up from the
9 RiO records; what you would have identified of
10 significance from reading back through?
11 **A.** I would have read through the recent notes, so I would
12 have read through Claudia's information and the
13 preceding attempts to see VC. I guess I would have
14 picked up on the fact that I think there was a sense
15 that he'd been reluctant to see staff in the recent
16 period leading up to my assessment, and that partly
17 would have informed my decision to apply for a warrant
18 because, obviously, I think the team that went out the
19 day before me weren't certain if he was at home or not,
20 but I think, combined with the fact that they've tried
21 at three different times of the day to try and catch him
22 at different times and combined with the fact that he
23 had indicated very clearly to Claudia that he didn't
24 want to be seen and didn't see a role for contact with
25 mental health services, that was kind of the evidence

1 for suggesting that perhaps we should get a warrant
2 because it seemed more likely than not that he was
3 evading kind of contact with the services at the time or
4 not wanting it, at least.
5 **Q.** So that was the information that informed the decision
6 to apply for the warrant, which we'll come on to. Had
7 you picked up from the RiO records that VC had
8 a diagnosis of paranoid schizophrenia?
9 **A.** So he was under EIP and I think I would have known that
10 he had a diagnosis of psychosis. I don't recall if that
11 had been formalised as paranoid schizophrenia at that
12 point. I can't remember. If I put it in my report then
13 I would have read that at the time, I can't ...
14 **Q.** Well, we see in your report reference to psychosis and
15 that appears in the referral as well. But you can't
16 recall now, looking back, whether you were aware of
17 a diagnosis specifically of paranoid schizophrenia?
18 **A.** No.
19 **Q.** Is it your experience that there's any stigma around the
20 term "paranoid schizophrenia"?
21 **A.** I think a lot of people probably would find the term
22 "paranoid schizophrenia" stigmatising and, certainly,
23 people do experience discrimination in that context but
24 I -- it is a term that I use where I know that that's
25 what the formal diagnosis has been because that's the

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1 formal diagnosis.
2 **Q.** So had you picked that up from the records, you would
3 have been comfortable using it in your report and in any
4 conversations with VC and other health professionals?
5 **A.** I suppose in conversations with a patient, you might use
6 that language if it was appropriate and relevant at the
7 time but you also might not because you're trying to
8 understand their perspective and understanding of
9 something. So, yes, I would -- if that's someone's
10 formal diagnosis, that's what I'd put in my report, if
11 that's what I'm aware of, yes.
12 **Q.** So when mightn't it be appropriate, in your view, to
13 discuss it with the patient themselves?
14 **A.** I suppose I don't enter into a discussion with a patient
15 in the assessment with a "I hear you've got a diagnosis
16 of paranoid schizophrenia". I'd start off with, "Can
17 you tell me a little bit about your experiences, about
18 your understanding of what's happening?" And I suppose
19 whether it's relevant at that point to say, "This is the
20 label that services have given you". It would very much
21 depend on the person's circumstances and what we were
22 hoping to achieve in that conversation.
23 But I don't think I was in any way trying not to use
24 that label, if that's what he'd been given. I think
25 I probably didn't know that was the case, if it was.

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1 **Q.** Right. So you told us a moment ago that you went on to
2 apply for a warrant and that was under Section 135 of
3 the Mental Health Act it?
4 **A.** *(The witness nodded)*.
5 **Q.** Very briefly can you just explain what that is?
6 **A.** So Section 135, Part 1 is a warrant to search for and
7 remove a patient to a place of safety in order to
8 complete an assessment of their mental health and, if
9 necessary, to make other provisions for their care and
10 treatment.
11 **Q.** So you've explained that the reason you applied for one
12 on this occasion was because you hadn't been able to
13 locate VC; is that right?
14 **A.** Yeah, primarily because we felt there was a need to
15 force entry into his property, in order to check if he
16 was there and then to convey him to a place of safety
17 for assessment.
18 **Q.** We know that that was granted on the same day -- is that
19 right?
20 **A.** That's correct.
21 **Q.** -- by a magistrate, and you then spoke with
22 Nottinghamshire Police by phone; is that right?
23 **A.** That's correct. Yes, I --
24 **Q.** What was the purpose of that? Was that to make
25 arrangements for them to attend as well?

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1 **A.** Yes.
2 **Q.** Can you recall if you discussed anything else with the
3 police?
4 **A.** The police have like a standard form that they go
5 through when you ring to arrange for a warrant, so
6 they'll ask questions about the person -- why you've
7 obtained the warrant, a little bit about the person's
8 situation, I guess, whether there's any risk history
9 known in relation to the person. So they have a kind of
10 standard format that they go through.
11 **Q.** So when you refer to "risk history", that's information
12 that the police might give to you to inform you of any
13 risks arising from the patient; is that right?
14 **A.** Not usually. It's more us giving that information to
15 the police of what information we have available because
16 lots of people won't be known to the police. Obviously,
17 they will do their own searches but they won't
18 necessarily share that with us at that point.
19 **Q.** So can you recall if you were given any information by
20 the police during that call?
21 **A.** I don't recollect.
22 **Q.** Do you know if you asked for any about VC, about whether
23 there was any history, or ...?
24 **A.** I don't recollect that, no.
25 **Q.** You then tell us that you also spoke with VC's mother,

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1 Celeste; is that right?
2 **A.** Yes, I believe so.
3 **Q.** By telephone. Do you know if that was before or after
4 applying for the warrant?
5 **A.** No, I -- unless it says in my notes, I don't remember if
6 it was before or after.
7 **Q.** You tell us --
8 **A.** I think it probably would have been before, actually,
9 but I'm not certain.
10 **Q.** Before?
11 **A.** Yes.
12 **Q.** All right. You say it was about a 15, 20-minute
13 conversation in your witness statement; is that --
14 **A.** I think so, yeah.
15 **Q.** Around about that?
16 **A.** *(The witness nodded)*.
17 **Q.** So quite a detailed conversation.
18 **A.** Yes. I think I was just trying to understand the
19 background, the family's concerns and sort of any
20 information that they were kind of happy to give me
21 about that, and yeah.
22 **Q.** And what was your impression after that phone call? How
23 did that add to your understanding of the patient you
24 were about to see?
25 **A.** My impression was that the family were concerned for him

1 and felt that there'd been a bit of a change in
2 behaviour. As I understand it, my impression was that
3 he'd withdrawn from them a little bit and that usually
4 they'd have quite close telephone contact, but that
5 actually he'd been sort of reluctant to engage in that
6 with them, and I suppose that I also interpreted that as
7 a possible sign that he was deteriorating and perhaps
8 feeling more paranoid, or ...
9 **Q.** And what about medication? Did you learn anything about
10 whether VC was taking or not taking his medication from
11 his mum?
12 **A.** I don't recollect.
13 **Q.** You say in your witness statement that you learnt during
14 that conversation that VC was at university in
15 Nottingham; is that right?
16 **A.** That's correct.
17 **Q.** And also that he was going to be going back to
18 university having deferred for a year in October, so the
19 month after you were seeing him; is that right?
20 **A.** That's correct.
21 **Q.** And you also say just briefly that you learnt that VC's
22 mother thought that he'd been at a course that day or
23 the day before. Do you know anything about that? Did
24 you learn anything about what that course was?
25 **A.** I don't remember, I'm sorry. Yeah.

1 **Q.** Coming, then, to your attendance at VC's property on the
2 3rd. When you first got there, you were just with Drs
3 Lomas and Manzar; is that right?
4 **A.** Yes.
5 **Q.** Tell us what you recall from when you arrived at the
6 property first?
7 **A.** We were waiting on the -- on the street, kind of
8 a little bit down from VC's address. The three of us
9 were there waiting for the police to arrive, and the
10 ambulance, so that we could then go and knock on his
11 door, and then a car pulled up, and a guy got out and
12 came over to us, and asked us why we were there, and
13 asked -- seemed to recognise Dr Manzar, and asked if we
14 were from the hospital. So we established it was VC,
15 and explained why we were there. And he agreed that we
16 could go over to the flat, which is what we did
17 initially.
18 **Q.** And one of the things you say in your statement, is that
19 VC appeared, and these are your words, "understandably
20 a little reticent". What do you mean by that?
21 **A.** Did I use the word "reticent?" I think he --
22 **Q.** We can take you to your statement. So paragraph 59 of
23 your statement on page 20.
24 **A.** 59.
25 **Q.** You see it about --

1 **A.** Oh right, yes. I think -- so yeah, he asked if we were
2 from the hospital because he'd recognised Dr Manzar, and
3 so we were saying, "Are you VC?" And he seemed a little
4 bit reluctant to confirm that either way but then did
5 say he was, and at that point we explained kind of why
6 we were there.
7 **Q.** And what did you make of that?
8 **A.** Um, I mean I suppose lots of people would be a little
9 bit reluctant to confirm their identity to three
10 strangers on the street, wouldn't they? I think it
11 could have been a sign that he was maybe a bit paranoid
12 but I wouldn't necessarily just from that interaction
13 draw that conclusion. I think it could --
14 **Q.** So it didn't set any alarm bells ringing at that time?
15 **A.** No, I think that would be quite average for how people
16 are when you approach them kind of in the context of the
17 work we do.
18 **Q.** And so after that interaction, what happened then?
19 **A.** So he agreed to us walking over to his flat, so we kind
20 of walked over with him, and we were talking to him. He
21 unlocked the door and we started to go into the flat and
22 Dr Lomas was walking in in front of me, and then I, it
23 just -- his kind of sense of willingness to let us in,
24 I sensed that he wasn't then happy for us to actually
25 continue with going into the flat and doing the

1 assessment, at that point. So I, I think I indicated to
2 Dr Lomas that we should probably go because I think he
3 was saying, "Oh actually, I'm not happy now for you to
4 come in."
5 **Q.** Just pausing there, we can see on the screen there the
6 top line, you said you had the "sudden impression that
7 VC had changed his mind." Hopefully you can see it on
8 the screen there just at the top of the page.
9 **A.** Oh yeah, mm-hm.
10 **Q.** So it was quite a quick change of mood.
11 **A.** Yeah, because we were kind of on our way into the flat
12 and then he sort of seemed to change his mind.
13 **Q.** You then go on to describe the interaction that happened
14 after that. And you say, further down the page, that VC
15 at this point "did not seem particularly agitated or
16 angry"; is that your recollection?
17 **A.** He was very polite with us throughout the interaction.
18 I didn't have a sense that he was -- no, angry in any
19 way. He just didn't seemingly accept what we were
20 saying about the need to do the assessment.
21 **Q.** And further on, you used the word "scared". You say
22 that "I distinctly gained the impression that he was
23 scared about the whole process."
24 In the context, and that's at paragraph 62, for
25 those following along -- in the context of what you'd

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1 been told about paranoid beliefs, psychosis, and the
2 sudden change, what did you make of that? What did you
3 understand by the fact you thought VC was scared? How
4 did you interpret that?
5 **A.** I think I had the impression that he was frightened by
6 what we were intending to do with him, that he didn't
7 believe that we were really taking him for
8 an assessment. That's what I wondered, in terms of how
9 just his kind of demeanour towards us. It didn't seem
10 aggressive at that point; it seemed more worried about
11 what we were trying to achieve, I suppose.
12 **Q.** And so you then say that you left the property and
13 essentially waited outside until the police came; is
14 that right?
15 **A.** Yeah, we explained that to him, that we would -- and he
16 said, "Let them -- let the police come."
17 **Q.** Now the Inquiry has already heard evidence about what
18 happened next, heard about the attack on PC Pritchard
19 from a number of witnesses, and we've seen the footage.
20 Can I just check, have you seen that footage since the
21 incident?
22 **A.** No, not really.
23 **Q.** In terms of your impressions of what happened and the
24 attack on PC Pritchard, was it your view that it was
25 a violent assault?

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1 **A.** Yes, he was certainly very violent towards PC Pritchard.
2 **Q.** And did you consider that it was provoked, unprovoked?
3 **A.** I think -- well, I think from his perspective he was
4 fighting against being removed from his home, so it was
5 within a context of that, and I suppose reacting to
6 that.
7 **Q.** So indeed at paragraph 67 of your witness statement,
8 I don't know if we can just have it back on screen, you
9 say:
10 "... it seemed more an act of violent resistance
11 than a desire to harm anyone else."
12 **A.** Yeah.
13 **Q.** Is that your view?
14 **A.** Yes. That was my impression. That he didn't actually
15 want to harm anyone. In that -- you know, in that
16 discussion he'd told us that he didn't want to go with
17 us, and then he'd asked the male officer to step forward
18 because he'd kind of implied "If it was anyone, it's got
19 to be you," but we'd interpreted that I think that he
20 was going to come out with us and get in the ambulance
21 but obviously that wasn't what happened.
22 **Q.** So that was your interpretation of why he asked that
23 from the outset --
24 **A.** Yeah.
25 **Q.** -- but looking back afterwards, I mean certainly the

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1 Inquiry has seen the footage, it seems to go on for
2 quite a long time, looks like quite a violent incident.
3 Do you stand by saying that you don't think there was
4 a desire to harm anyone?
5 **A.** I can't speculate on -- well, I suppose you're asking me
6 to speculate on his intention, but my sense was he --
7 you know, we'd come there to him. I don't think he was
8 wanting to attack anyone, I think he wanted to stay in
9 his home and he felt -- my impression was that he felt
10 he had no option.
11 **Q.** All right. And you don't think that underplays the
12 level of violence that was seen during the incident?
13 **A.** I don't think I'm underplaying the level of violence.
14 It was a really serious attack and it was obviously very
15 distressing for the police involved and caused them
16 significant harm. I'm sure it was also very traumatic
17 for VC. It was -- I have -- you know, it's one of the
18 most distressing Mental Health Act Assessments I've ever
19 witnessed. So I'm not underplaying that in any way.
20 **Q.** All right. And you weren't able to complete the Mental
21 Health Act Assessment in the flat as originally planned;
22 is that right?
23 **A.** That's correct.
24 **Q.** And VC was taken to Highbury Hospital to the Cassidy
25 Suite that evening. Before leaving the property, you

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1 say that you found some unused medication in VC's flat;
2 is that right?
3 **A.** That's correct.
4 **Q.** And you tell us that it dated back -- this is at
5 paragraph 68, you can see it on screen there -- to
6 February 2021. Tell us about that. What did you find?
7 **A.** As far as I recollect, it was a bag of medication. Some
8 of the boxes dated back to February, but we didn't go
9 through all of the empty boxes at that point to check
10 exactly what had been taken and what hadn't been, but it
11 was clearly quite a lot of it hadn't been. That was our
12 impression.
13 **Q.** So you said "boxes".
14 **A.** Mm.
15 **Q.** Sounds like quite a few. Can you give us a ballpark
16 figure, how much medication you found?
17 **A.** I wouldn't like to speculate because it was a number of
18 boxes in a bag.
19 **Q.** When you say "dating back to February --"
20 **A.** Yes.
21 **Q.** -- are we to understand that that meant there was
22 medication from February, March, April, May, all the way
23 up to September that hadn't been used?
24 **A.** I don't know. I didn't do a kind of -- *(overspeaking)*
25 --

1 **Q.** Can you recall what kind of medication it was?
2 **A.** I assume it was the aripiprazole because that's what he
3 was prescribed at the time. But I can't definitely
4 confirm that, because it was a long time ago.
5 **Q.** I assume, then, you can't recall what doses --
6 **A.** No.
7 **Q.** -- the medication was? Did you ask VC about that?
8 **A.** So I don't recollect if we tried to ask him that when we
9 were in the Cassidy Suite. I think we probably would
10 have done; it would be like a routine question, but he
11 wasn't really willing to speak to us at that point. So
12 I don't think we got any answer to that.
13 **Q.** And what about with the other healthcare professionals,
14 Drs Lomas, Manzar? Did you discuss what you'd found
15 together? What were your impressions? What did you
16 make of it?
17 **A.** Yes, Dr Lom -- well, we all discussed it because we
18 discussed it again in the Cassidy Suite, but Dr Lomas
19 and I found the medication together as we were sort of
20 locking up the place.
21 **Q.** And so in terms of what that meant, was it your
22 understanding that he hadn't taken any medication since
23 February?
24 **A.** My impression was that he clearly wasn't compliant with
25 his treatment at that time. I don't know exactly when

1 he'd stopped it or whether -- because I think sometimes
2 there can be an overlap of what medication is given at
3 different times but certainly it seemed like a lot of
4 medication to have left if you were being compliant with
5 your treatment. So I interpreted that that he wasn't
6 compliant.
7 **Q.** So it's quite a big clue that he wasn't taking a lot of
8 the medication --
9 **A.** Yes.
10 **Q.** -- that he'd been given.
11 Potentially quite a serious issue, isn't it, with
12 a psychotic patient who is not taking their medication
13 and who is now exhibiting symptoms? Is that how you
14 interpreted it?
15 **A.** Yes.
16 **Q.** You -- I'm not sure whether you set out in your
17 statement whether you discussed this explicitly with
18 anyone in the Trust, so Claudia Birtles, for instance,
19 the care coordinator or the responsible clinician. Did
20 you have a conversation with either of those people
21 about the medication specifically?
22 **A.** After I'd found the stockpile of medication?
23 **Q.** Yes.
24 **A.** So I would have provided my AMHP report to Claudia's
25 team and to the admitting hospital, so they would have

1 had copies of all of that information in the stuff that
2 we'd found, and I know it was in the RiO notes as well,
3 I think. I don't -- I can't tell you if I had
4 a conversation with Claudia about it afterwards.
5 **Q.** But would it not be fair to say that it's something you
6 would want to talk about with the care coordinator?
7 It's quite a significant finding, isn't it?
8 **A.** I think it's -- so I don't routinely, after every Mental
9 Health Act Assessment, speak to the care coordinator and
10 I don't think most AMHPs do because obviously you are --
11 you're doing a standalone assessment. Your involvement
12 is quite a discrete episode. I would want them to know
13 that information, and that's why I provide it in an AMHP
14 report and make sure that's delivered to all of the
15 relevant parties but we don't always have the
16 opportunity to, you know, meet with care coordinators
17 after every assessment. And it's quite common that
18 people we're bringing into hospital have been
19 non-compliant with their treatment. That's often a key
20 factor.
21 **Q.** You said a moment ago -- I think the word you used was
22 this was one of the most traumatic Mental Health Act
23 Assessments you'd been involved in since starting in
24 2009.
25 **A.** *(The witness nodded)*.

1 **Q.** In those circumstances, did you not think it was
2 important to have a conversation with Claudia Birtles
3 afterwards?
4 **A.** I can't recollect if I did or if I didn't have that
5 conversation. I think it would be my expectation
6 that -- well, the information was really clear in terms
7 of his record and his history -- the notes that we'd
8 provided about what happened in the assessment. So
9 I would expect that the care coordinator would read
10 that. That's what you would do, as a care coordinator.
11 So, yeah.
12 **Q.** Right. Now, in terms of the Mental Health Act
13 Assessment itself, in the Cassidy Suite, your
14 interactions with VC, what you discussed, what can you
15 tell us about that?
16 **A.** I don't have such a strong recollection of the
17 discussion in the Cassidy Suite, but I think we tried to
18 talk to him about the concerns Claudia had raised, about
19 his mental health, about willingness to have treatment,
20 and he wouldn't really speak to us, is what I recollect.
21 **Q.** All right. Now the decision ultimately was to admit
22 under Section 2; is that right?
23 **A.** That's correct.
24 **Q.** You've mentioned a couple of times, and we'll bring it
25 up, it's your AMHP report which is NOCC0000050. If we

1 could turn to page 4, please. The box at the top, this
2 is your recording of the decision to admit under
3 section 2; is that right?
4 **A.** Yes.
5 **Q.** So it's your explanation as to why you and the other
6 clinicians have decided to admit under Section 2. We
7 can see you've written there that:
8 "[VC] seems to be suffering from a relapse of
9 psychosis, characterised by conspiratorial delusions and
10 auditory hallucinations. He appears suspicious,
11 paranoid of others. He is refusing treatment ...
12 presents a risk to others when feeling under threat.
13 All agreed that detention under [Section 2] is
14 necessary."
15 How much consideration did you give to admitting
16 under Section 3 instead of Section 2?
17 **A.** Well, I think we always give consideration to admitting
18 under section -- which section we're going to admit
19 under. I think in VC's case, he'd had one previous
20 episode of psychosis, which had led to two admissions
21 quite close together, and he wasn't someone who'd had
22 a long-established history, where there'd been concerns
23 for a while. We had the information from Claudia about
24 her discussion with him, which described the kind of
25 conspiratorial delusions and his hallucinations. But he

1 wouldn't give us any of that information on our
2 assessment with him, and so it's difficult to kind of
3 draw out what symptoms he was experiencing in terms of
4 his current presentation around his mental disorder at
5 that point.
6 So although we had a kind of potential diagnosis of
7 psychosis, and I don't think I was aware if he had been
8 given a diagnosis of paranoid schizophrenia because
9 I think I would have put it in the report, we didn't
10 know in terms of the immediate current nature of it,
11 because he wouldn't speak to us, and that warranted
12 a further period of assessment in hospital, in our view.
13 I guess the other factors that impact on that are
14 there wasn't necessarily a clear treatment plan.
15 I think he had been on the aripiprazole. For whatever
16 reason he didn't seem to have been compliant with that,
17 whether that wasn't working, whether he was having side
18 effects. It wasn't clear to us what the ongoing
19 treatment plan would be. Both myself and Dr Lomas
20 didn't know him before the assessment, so it was
21 difficult to say that we were part of the ongoing -- you
22 know, in terms of what the ongoing treatment was,
23 I don't think that was wholly clear to us.
24 Also, I think, in terms of considering Section 3,
25 you have to be able to say where available treatment is

1 and we didn't know where that was at that point. It was
2 actually quite a few days later that the admission was
3 agreed to a hospital in Darlington, I believe. So in
4 terms of saying where appropriate treatment was, I don't
5 think we were clear about that at that point.
6 So I think from our perspective, there were grounds
7 for having a further period of assessment of his mental
8 disorder, to see what the symptoms were, to see how he
9 presented over a period of time, and to also consider
10 whether or not, as with all patients, you have to
11 consider whether or not within the timeframe they're
12 likely to respond to some treatment and be able to
13 consent to informal admission. So all of those things,
14 which the Code of Practice tells us to consider in terms
15 of Section 2 and Section 3.
16 **Q.** Looking back now, we can see that you knew of the
17 history of psychosis --
18 **A.** Yeah.
19 **Q.** -- identified a relapse of symptoms, had found the
20 unused medication --
21 **A.** *(The witness nodded)*.
22 **Q.** -- and appeared to have a good understanding that
23 medication non-concordance was contributing to the
24 symptoms. Do you think Section 3 would have been more
25 appropriate, in hindsight?

1 **A.** I think it's hard to judge. I think, in terms of my
2 background training, we're always asked to consider
3 whether or not there are things that need to be
4 assessed, as part of someone's admission to hospital.
5 And where someone has been out of hospital for a year,
6 seemingly functioning okay, and then concerns have
7 started to arise and it's not clear why they've
8 stopped -- they may or may not have stopped their
9 treatment, it's not clear whether or not that treatment
10 has worked or not, it's not clear what the future plan
11 is, I think there were things to assess at that point
12 and, in terms of, you know, the -- I suppose AMHPs often
13 come to the question of Section 2 or Section 3 from
14 a position of wanting to consider Section 2, and --
15 **Q.** Is that because of -- sorry to interrupt. Is that
16 because of a sense that Section 2 is less restrictive?
17 **A.** I think it's a combination of different things. I think
18 it's the importance of fully assessing people's
19 presentation because people's presentation changes over
20 time, so I -- I've worked for 20 years with a whole
21 range of different people with mental disorders and it's
22 really common that people's diagnosis will change over
23 the years. So you might have someone who starts off
24 with first episode psychosis, it might then be
25 considered drug-induced psychosis, it might then be

1 paranoid schizophrenia or you might get, you know,
2 personality disorder elements. So it's actually really
3 common that you have people with four or five different
4 diagnoses, where they're someone who comes in and out of
5 hospital quite a lot.
6 So I think it is quite common that people would be
7 readmitted for a further period of assessment and they
8 have the option for treatment, if that's required.
9 **Q.** In terms of what happened after, we touched on earlier
10 and you explained -- well, you confirmed that you knew
11 that VC was going to be going back to university the
12 following month in October?
13 **A.** That was his plan, yeah.
14 **Q.** That was his plan and you knew he was at university in
15 Nottingham?
16 **A.** Yes.
17 **Q.** The evidence we've heard so far is that the University
18 weren't aware either of the incident involving VC and
19 PC Pritchard, the attack on PC Pritchard, or the fact
20 that he was then sectioned. Does it follow that you
21 didn't contact the University after the assessment on
22 3 September?
23 **A.** I didn't contact the University.
24 **Q.** Do you think that's something you should have done?
25 **A.** So, obviously, I've reflected on this. I think it's

1 complicated because, if I hadn't have -- when I don't
2 admit someone and they're involved with the University
3 health services, I would communicate with the University
4 afterwards in terms of the plan or, if we had any risk
5 concerns, then it would be really important to share
6 that with the University at that point.
7 I think where someone's admitted -- and bearing in
8 mind the AMHPs role is very much for that assessment, so
9 you don't have any ongoing involvement in their care and
10 treatment -- I think, from my perspective, it made sense
11 that the ward would make decisions about what
12 information needed to be shared at the point of
13 discharge because, in terms of protecting people's
14 confidentiality, it may be that it's necessary to share
15 that confidential information but I didn't know at that
16 point whether or not he would be returning to
17 university, whether or not that was still his plan and,
18 in terms of the immediate risk, that's contained within
19 his admission, isn't it?
20 So there was no immediate risk to others at that
21 point.
22 **Q.** So as far as you're concerned, responsibility lay more
23 with the discharging hospital staff?
24 **A.** The ongoing clinical team. Yeah, I think they would
25 assess and make a decision about what information needed

1 to be shared.
2 **Q.** We know VC was never placed on a CTO, Community
3 Treatment Order.
4 **A.** *(The witness nodded)*.
5 **Q.** Looking back with what you know, with what you've read
6 of the records, do you think -- well, firstly can you
7 just very briefly explain what role AMHPs play in CTOs?
8 **A.** So we're involved in Community Treatment Orders in terms
9 of, so the responsible clinician is the kind of
10 applicant, if you like, but we have to be consulted and
11 agree to the Community Treatment Order. So we'd
12 interview the patient and be part of that discussion in
13 terms of planning their discharge and agreeing both
14 whether or not it's right for them to be on a Community
15 Treatment Order and what the nature of the conditions
16 should be.
17 **Q.** And do you have experience of patients with psychosis,
18 with paranoid schizophrenia, being on Community
19 Treatment Orders?
20 **A.** Yes.
21 **Q.** And can they be effective, in your experience?
22 **A.** Yes, they can be very effective for some people.
23 **Q.** Does it surprise you that one wasn't used in VC's case
24 with your experience as an AMHP?
25 **A.** I think -- so I used to work in Assertive Outreach,

1 which was when we were in integrated health teams, and
2 there we'd work with people, I'd be -- I was a care
3 coordinator in that role and I would work with people
4 over a period of months or years where they were really
5 acutely unwell, and had a cycle of repeated admission to
6 hospital. And so quite a few of those people would end
7 up on a Community Treatment Order and that could often
8 be really helpful to sort of establish that engagement
9 and that consistent treatment.
10 I think with VC it's more difficult. We are --
11 I think it's less common to use a CTO where someone is
12 only on their second episode of psychosis. It tends to
13 be reserved for people who've had more frequent
14 admissions, I guess.
15 **Q.** So possibly at some point later down the line?
16 **A.** Yeah. But I don't know, it would have been an option
17 that the ward at Cygnet, I believe it was, could have
18 considered, certainly.
19 **Q.** All right. Final topic from me. It's right, isn't it,
20 that you were approached by the police in 2021 later,
21 after the September --
22 **A.** *(The witness nodded)*.
23 **Q.** -- Mental Health Act Assessment, and you were asked to
24 provide a statement with regard to the criminal
25 proceedings being investigated against VC for the

1 assault on PC Pritchard; is that right?
2 **A.** That's correct, yes.
3 **Q.** You didn't in the end provide a statement, did you?
4 **A.** I said I would but they didn't want me to, I don't
5 think.
6 **Q.** All right. Could we have on screen NGPF0000017. This
7 is a document, an MG6 form, signed by -- we don't need
8 to go to it, but by PC Myers of Nottinghamshire Police
9 in April 2022. And if we could scroll down to page 53,
10 please. See that this is a written dialogue essentially
11 between the police and CPS with regard to the evidence
12 held about the assault on PC Pritchard. Have you seen
13 this document?
14 **A.** I have just today, but I think --
15 **Q.** Well, we'll just first of all have a look at what it
16 says under "Additional information". I don't know if we
17 can expand the bit at the bottom. It's the bottom box.
18 You can see there "Additional information":
19 ".. [is] there ... any other relevant information in
20 this case ..."
21 And then:
22 "All Key Witness Statements".
23 You can see that CPS ask:
24 "Is there any reason why the AMHPs who were present
25 at the time of the assault have not provided statements?

1 They could have evidenced his background and covered the
2 points in relation to his diagnosis and detention ..."
3 We can see the police reply below that:
4 "The AMHP who were present have been spoken to and
5 haver stated ... they are not willing to provide
6 statements due to the fact that they have to continue to
7 work with the defendant [VC] and if they were seen to
8 'take sides' with the Police on this matter then it
9 could make their job of caring for the defendant more
10 difficult in the future."
11 It's right, isn't it, that you were the only AMHP
12 there on 3 September?
13 **A.** I think this is a mistake, because when you look at the
14 next page in the information I was given, it says that
15 they did speak to me and I did agree to give
16 a statement. I wonder if they're talking about the
17 CPNs, because I didn't have any ongoing involvement with
18 him so it wouldn't make sense for me to say any of those
19 things, so --
20 **Q.** Well, I'm sure it can be picked up with others. The
21 other document you're referring to is December; this one
22 is from slightly later on in April 2022.
23 Looking at this, does that reflect your
24 understanding of what happened? Did you refuse to give
25 a statement for those reasons?

1 **A.** No, I've said I was happy to give a statement. They
2 then asked for details of his medical condition and his
3 ongoing treatment, and I said I wasn't best placed to do
4 that because I'm not a medical professional. But I was
5 happy to give a statement to kind of what had happened
6 and the sort of my involvement in the situation. But
7 I think this must relate to somebody else. I don't know
8 if it relates to the CPNs because they would have had
9 ongoing involvement. I don't know.
10 **Q.** So you don't know who this refers to, and you think --
11 **A.** No, but in the subsequent page it talks about speaking
12 to me and that I've agreed to give a statement and then
13 I direct them to Dr Lomas if they need to know more
14 about his medical condition, that that would be a more
15 appropriate person to ask.
16 **Q.** All right. So is it your evidence that had they come
17 back to you, asked you for a statement --
18 **A.** Yes.
19 **Q.** -- you would have given it as far as you felt was in
20 your --
21 **A.** Yes, I mean I couldn't give his history of medical
22 treatment or his sort of future treatment because I'm
23 not involved in that, but --
24 **Q.** All right.
25 Chair, those are my questions.

1 **THE CHAIR:** Yes, I'm just going to ask, do we have the
2 second page of this? You think this is the same
3 document --
4 **MR JONES:** Yes, it's a slightly different document which
5 I can give you --
6 **A.** Yeah --
7 **Q.** -- the reference for.
8 **THE CHAIR:** There's nothing further on this document, is
9 there?
10 **MR JONES:** It's NGPF0000027, page 18.
11 **THE CHAIR:** Yes. I wonder if we could just get that up,
12 just before anybody else asks any questions, so we could
13 just deal with that point.
14 **MR JONES:** You see there box 24, about two thirds of the way
15 down the page:
16 "Spoken with attending AMHP Amie STAPLES. She is
17 willing to provide a statement ..."
18 **THE CHAIR:** Yes, thank you.
19 **MR JONES:** So we can see there this is obviously in
20 December 2021 and the previous document we were looking
21 at was a bit later down the line in April '22, but your
22 evidence is you don't know what's happened there; it
23 wasn't you who said -- *(overspeaking)* --
24 **A.** No, I mean they also refer to Dr Lomas as an AMHP as
25 well, so I think perhaps there's just some confusion

1 about what that title is.
2 **THE CHAIR:** Yes, thank you.
3 **MR JONES:** Chair, I think Mr Moloney has some questions.
4 **THE CHAIR:** Yes, Mr Moloney. Thank you.
5 **Questioned by MR MOLONEY**
6 **MR MOLONEY:** Good afternoon, Ms Staples. I've just two
7 topics to ask you about, if I may, please. Firstly,
8 your contact with VC's mother prior to the 3 September
9 assessment and the events at VC's flat on 3 September.
10 So just in terms of the first topic, contact with VC's
11 mother, I just want to check a few more details by
12 reference to your statement, if I may, and that
13 statement is WITN0117001. If I could take you
14 straightaway to page 18 of that and paragraph 49, there
15 we are, so "Prior to executing the warrant", which of
16 course confirms any uncertainty you had about when it
17 was, that's it:
18 "[You] spoke with VC's mum Celeste. She had spoken
19 with VC around 8 pm the previous night and spent about
20 an hour on the phone to him. He seemed preoccupied with
21 'government conspiracies' and was 'not making sense'
22 which I understood she interpreted as signs that he was
23 relapsing and she stated that she was very concerned
24 about VC. She told me that she didn't think he was
25 taking his medication; which was consistent with his own

1 disclosure to Claudia Birtles on 31 August."
2 Then if we go far to paragraph 52, please, we see
3 that halfway down -- yes, there, so the first line --
4 that:
5 "... not in such regular contact as usual ... This,
6 combined with the apparent persecutory ideas, increased
7 her concern. I had a sense, having spoken to mother
8 that she was worried VC was not telling her everything."
9 Then finally at 55, we see there on the next page --
10 oh no, it's there:
11 "I recorded that VC was withdrawing from family
12 involvement and I understood this to be out of
13 character. I do not now recall whether Celeste
14 specified he was reducing contact just with her or with
15 all of the family. However I noted on my AMHP report
16 that he had reduced telephone calls to 'every week or
17 two', which I understood to be a substantial reduction."
18 You made a note of that at the time. So that was
19 something that was essentially said to you, which you
20 were able to note at that time?
21 **A.** Yes.
22 **Q.** Can I just ask to clarify those details of reduced
23 contact, if I could describe it in that way, that
24 whether or not you got any sense of when Celeste had
25 last physically seen VC?

1 **A.** No, I don't think I -- I mean, obviously it's a long
2 time ago but I didn't have the sense that she'd seen him
3 recently. But I could be wrong about that. That's my
4 recollection.
5 **Q.** So I just want to clarify. Did you get any sense of
6 whether, given she was very concerned about him, she'd
7 recently visited him in Nottingham?
8 **A.** I don't think she told me that but she may have done.
9 Yeah, it's a long time ago.
10 **Q.** Okay.
11 **A.** Obviously, she lives a great distance from Nottingham,
12 so I was mindful it was difficult for the family to
13 travel and see.
14 **Q.** Sure. Sorry, I couldn't catch that last bit?
15 **A.** I was mindful that it was difficult for the family to
16 come and visit.
17 **Q.** Right, okay.
18 3 September, please. You got the impression he
19 didn't want to hurt or harm anybody. I just want to ask
20 about what you witnessed that day. Did you see VC take
21 off his glasses before any officer even stepped towards
22 him?
23 **A.** I don't recollect that.
24 **Q.** Did you hear VC prior to the start of the violence say
25 that he had no history of hitting women but he was

1 prepared to go out with PC Pritchard?
2 **A.** I remember him say -- sorry, I remember him saying
3 something about it should be the male officer but
4 I don't remember it being about violence -- not being
5 violent to women. But I may not have heard that because
6 I was on the edge of the room.
7 **Q.** Did you then see VC punch PC Pritchard as he stepped
8 forward?
9 **A.** Yes.
10 **Q.** And then repeatedly punch him?
11 **A.** I didn't watch the assault because, obviously, when
12 you're in that --
13 **Q.** You didn't watch it?
14 **A.** -- in that situation the police sort of are in control
15 of that sort of situation, so I moved backwards just
16 because I didn't want to be in the way --
17 **Q.** You moved back?
18 **A.** Yes.
19 **Q.** Did you move back away from the flat door and out of
20 view of the assault?
21 **A.** I was kind of line with the doorway but I went back to
22 stand with the ambulance crew.
23 **Q.** Right. So you didn't see VC trying to headbutt
24 PC Pritchard?
25 **A.** No, I didn't.

1 **Q.** You didn't see him take handcuffs and use them as
2 a weapon against the officers?
3 **A.** I'm not certain if I saw that or not.
4 **Q.** I won't ask you if you saw the officers hit VC, but did
5 you hear him saying, because you weren't watching, but
6 did you hear him saying to PC Pritchard that he'd done
7 well not to go down?
8 **A.** No, I didn't hear that.
9 **Q.** Right. Okay. On that day, you didn't check how much
10 medication exactly was still in the flat but it went
11 back as far as February?
12 **A.** Yes, the box says from February.
13 **Q.** Would it not have been very relevant to assessing the
14 degree of non-concordance in the community to establish
15 how many tablets were there, that you could do an audit
16 of what he'd received and what he hadn't taken?
17 **A.** I suppose I potentially would. I mean, as an AMHP and
18 part of Adult Social Care, we don't tend to get that
19 involved with the actual medication itself. So that
20 would more be a kind of health aspect. So I wouldn't
21 routinely go through people's medication. But we'd ask
22 about it and, obviously, as part of the assessment, but
23 yes, perhaps it would have been better to have collected
24 it up and -- but I would have returned it to the 136
25 suite. I wouldn't have personally counted it because --

1 **Q.** Well, somebody -- whether it's you or not -- somebody,
2 would have been able to establish the degree of
3 non-concordance, wouldn't they?
4 **A.** I guess so. We had a sense that he was non-concordant
5 and --
6 **Q.** But the degree of non-concordance would have been very
7 relevant to the Mental Health Act Assessment, wouldn't
8 it?
9 **A.** I think whether or not he was compliant or not was
10 certainly relevant and we took that into account in the
11 assessment. I suppose the exact date that he'd stopped
12 it, I don't think would have massively impacted on the
13 decision but, yes, it was relevant that he had stopped
14 his treatment.
15 **MR MOLONEY:** Thank you very much, Ms Staples.
16 **THE CHAIR:** Yes.
17 Ms Cartwright?
18 **Questioned by MS CARTWRIGHT**
19 **MS CARTWRIGHT:** Good afternoon, Ms Staples. I ask questions
20 on behalf of the survivors.
21 Can I just clarify, you obviously were discharging
22 the role of the AMHP on 3 September but your statement
23 tells us that, essentially, when not doing AMHP duties,
24 you are a senior practitioner in the Mental Health
25 Social Care Team South, and that you, in that team,

1 provide Care Act assessments, you commission social care
2 packages and undertake adult safeguarding duties; is
3 that correct?
4 **A.** Yes, that's correct.
5 **Q.** So that's essentially the majority of the time of your
6 duties; would you agree?
7 **A.** Well, it's part of my duties. I'm part time, so
8 predominantly my duties were more around the Mental
9 Health Act work and the supervising staff but I do hold
10 a very small caseload of people as well.
11 **Q.** Thank you. Can I ask as part of that team, you'd also
12 have a role for those that you were supporting of
13 continuing aftercare under Section 117, would you agree,
14 for those who had been detained under Section 3?
15 **A.** So, yes, if people have Section 117 entitlement, that is
16 covered by the City Council.
17 **Q.** Now the issue I want to explore with you is, you saw VC
18 driving and you've not accommodated that in your risk
19 assessment or neither have you escalated that serious
20 concern of a psychotic, unwell man, who -- you are on
21 the street when you see him drive up. So, first of all,
22 is there a reason why you didn't take down the name, the
23 make of the vehicle or the registration number?
24 **A.** No, that wouldn't have occurred to me to do that in that
25 context when he was being admitted to hospital but

1 perhaps you're right.
2 **Q.** Let's pause there for a minute. Let's contextualise
3 this. Let's look at what you said about the warrant
4 about VC, it's NOCC0000049.
5 So you have applied to the court to get the
6 Section 135 that VC has a diagnosis of psychosis, two
7 previous admissions under the Mental Health Act at that
8 time.
9 **A.** Mm-hm.
10 **Q.** "... saw [a] CPN three days ago and expressed psychotic
11 delusions pertaining to her, mental health staff and the
12 criminal justice system conspiring to persecute him. He
13 believes that they are using technology to manufacture
14 his psychotic symptoms. He is refusing treatment and
15 refusing to see mental health staff again. Three
16 attempts to visit yesterday were all failed as VC did
17 not answer the door. In the past police have had to
18 attend when he was unwell after he broke into
19 neighbours' flats believing his mother was held inside."
20 So that's the context of the concerns that got the
21 warrant. So would you agree, a patient with that
22 presentation should absolutely not be behind the wheel
23 of a car?
24 **A.** I think our primary concern in doing this assessment was
25 to safeguard him and everybody around him and obviously

1 the outcome of it was that we admitted him to hospital.
2 I think it's really difficult to comment on his fitness
3 to drive, but yes, I don't think he was safe to be in
4 the community in general at that point; that's why we
5 detained him in hospital. So I don't think driving
6 would be safe for him at that time.
7 **Q.** Would you be aware as well there's DVLA obligations of
8 someone who has had an admission of psychosis, that they
9 should be told not drive in any event?
10 **A.** And that's something the ward would go through with him.
11 That's something they routinely do, to discuss --
12 **Q.** Well, you say that, so that's an assumption. But you as
13 a practitioner saw VC driving.
14 Let's just look, please, at your assessment,
15 NOCC0000050. Thank you. And if we go to page 2, we see
16 the description of you being there:
17 "Planned for 6 pm."
18 We see that.
19 "Whilst we were waiting for the police to arrive,
20 a man pulled up in a car and got and approached us."
21 And essentially your evidence on what follows
22 effectively shows that it's VC.
23 So what I want to understand is bearing in mind the
24 risk, why that didn't immediately flag something from
25 a safeguarding perspective, bearing in mind this is

1 a man that's psychotic and unwell and, would you agree,
2 a risk of impulsive unpredictable behaviour, why you
3 were not then raising that specifically to the police as
4 to first of all who -- what's the vehicle? Does he have
5 insurance? Where's he been driving? Would you agree,
6 and that's something --
7 **A.** Yes.
8 **Q.** -- that you should have done?
9 **A.** So perhaps it is something that we should consider,
10 going forward. I don't think that's something that
11 routinely an AMHP would consider, where somebody is
12 admitted to hospital.
13 Obviously we have assessments where people are
14 assessed and aren't detained and they're driving and
15 then that would be a really crucial discussion: we would
16 do things like alert the police, we'd agree who's going
17 to do that.
18 But I suppose where people are admitted we don't
19 tend to do that, and perhaps that's an oversight on my
20 part so --
21 **Q.** So I'm going to suggest it's an oversight also in the
22 risk assessment because this is a risk of harm to
23 others, and you'll understand why in particular I'm
24 anxious about the driving aspect and the failure of
25 individuals to make it absolutely clear to VC that he

1 mustn't get behind a wheel.
2 If we look in the same document, please, in the risk
3 assessment, which is on page 4, I think. Thank you.
4 There. So risk, the "Risk Summary":
5 "Risk to Others".
6 The only risk to others you reference there is:
7 "Serious risk of physical harm to police officers in
8 the context of a [Mental Health Act] ... assessment."
9 Would you agree it should have included in there:
10 "Risk to members of the public: VC was seen driving
11 a vehicle at the time when he was mentally unwell."
12 And that should have been a risk to others due to
13 his driving; would you agree?
14 **A.** Perhaps so, yeah.
15 **Q.** Just perhaps so?
16 **A.** Yes, I guess, if he -- yes.
17 **Q.** But because, in the Liquidlogic notes as well it had
18 been identified, and I'm not going to take the time of
19 taking you to that, but the day before it had been
20 identified that VC was working in a warehouse, and
21 equally you'd ascertained from Celeste Calocane that VC
22 had been on a course all day.
23 Again, part of the professional curiosity of putting
24 the bits of jigsaw together: what's this man doing in
25 the community? Would you agree it was essential to find

1 out where this warehouse was that VC was working at
2 night and how he was getting there? Because again if he
3 was driving, that again poses a risk to members of the
4 public.
5 **A.** I think at the point at which I was detaining him in
6 hospital, those risks were contained, and I think in
7 terms of the discharge planning, that's where you
8 consider all the risks kind of going forward, you'd have
9 the discussions around whether or not it's safe or
10 appropriate to drive. That's when routinely you'd do
11 that.
12 I think in terms of the AMHP role, trying to find
13 out where people work when they're not -- they're being
14 admitted, I think that's a bit complicated. He wouldn't
15 actually speak to us about any of his circumstances so
16 it was difficult to get that information.
17 **Q.** I'm going to suggest this is something wider, that with
18 your occasions where you can raise issues and under the
19 duty of confidentiality, if someone is psychotic and
20 unwell, driving a vehicle, that creates a risk of
21 serious injury or death, and so that you had
22 an obligation, I'm going to suggest, that you should
23 have been making sure with the police: "He's just turned
24 up in a vehicle. Can you do checks? Does he have
25 insurance? What's going on here? What's he been told

1 about his not being able to drive?"
2 And I'm going to suggest that's something you should
3 have, at the time of considering risk, even in the
4 knowledge now that it is a place of safety and then
5 detained, it's highly relevant as to what VC is doing in
6 the community; would you agree?
7 **A.** I accept that view, yeah.
8 **Q.** Because I'm going to suggest that had you done that, it
9 would have enabled the multi-agency partners doing their
10 multi-agency risk assessment to identify where the
11 warehouse was that VC was working; that if you'd asked
12 the police about that, it would have identified that VC
13 had been caught speeding on 22 February 2021, 27
14 April 2021, 5 May 2021, 8 May 2021, 15 May 2021, and
15 18 August 2021.
16 Again, all highly relevant information that would
17 suggest that VC is also, when driving, exceeding the
18 speed limit, again relevant to the risk to members of
19 the public.
20 **A.** Okay.
21 **Q.** Would you agree?
22 **A.** Yes.
23 **MS CARTWRIGHT:** Thank you.
24 **THE CHAIR:** Thank you.
25 Yes, Mr Straw.

1 **Questioned by MR STRAW**
2 **MR STRAW:** Ms Staples, good afternoon. I represent VC's
3 family.
4 Could we go back, please, to Ms Staples's witness
5 statement: WITN0117001, page 18. This is a passage that
6 Mr Moloney has already taken you to; it's about the
7 phone call that you had with Celeste Calocane on
8 3 September. Just a couple of supplementary questions.
9 You note there that Celeste said:
10 "... [VC] seemed preoccupied ..."
11 So this is Celeste now, on 3 September, talking
12 about a call she had with VC the night before, at 8 pm:
13 "[VC] seemed preoccupied with 'government
14 conspiracies' ... was 'not making sense' which
15 I understood she interpreted as signs that he was
16 relapsing ..."
17 Now, did you understand this to be a continuation of
18 what Ms Birtles had described on 31 August 2021, when VC
19 had been saying similar things about government
20 conspiracies, persecutory ideations, and so on?
21 **A.** I interpreted it as additional information that he was
22 unwell and paranoid about these things.
23 **Q.** Was it your impression that he was in a state of
24 psychosis, which had been ongoing, both on 31 August and
25 on 2 September when he spoke to his mum?

1 **A.** Um, yes.
2 **Q.** On 3 September 2021 when you spoke to him, he refused to
3 speak about his delusional ideas. Do you understand
4 why?
5 **A.** No, because he wouldn't speak to us about what his kind
6 of thoughts and feelings were about it, but obviously
7 he'd had, you know, had been a very distressing event,
8 hadn't it, leading up to him being on the Cassidy Suite,
9 and I had the sense that he was angry about that,
10 understandably, I guess.
11 **Q.** And did you take account that these entries, both from
12 Ms Birtles and from his mum, indicating that he had
13 paranoid delusions or he was preoccupied with government
14 conspiracies?
15 **A.** Yes.
16 **Q.** Could we go forward, please, to the next page, to
17 page 19. And the bottom of that page, please,
18 paragraphs 54 to 55. Again, you've already seen this.
19 You described the calls as helpful. You say at the
20 bottom of 54:
21 "It was my impression that the family were caring
22 and concerned for VC and keen for him to engage and
23 access support and treatment from mental health
24 services".
25 And 55:

1 "I recorded that VC was withdrawing from family
2 involvement and I understood this to be out of
3 character."
4 Now when you were asked about that earlier you
5 indicated that he was perhaps feeling more paranoid. Do
6 you remember saying that?
7 **A.** I wondered if that was a motivation of him withdrawing
8 the contact with the family.
9 **Q.** Why?
10 **A.** Because in the context, my recollection is that Celeste
11 was saying normally they had like very regular contact
12 over the phone and that that had been a change in his
13 presentation, and I guess combined with the conversation
14 with Claudia where he'd disclosed all of those paranoid
15 thoughts that people were acting against him, trying to
16 manufacture mental health symptoms, those kind of
17 things, and combined with the concerns that his mother
18 had raised, that -- those conspiracy theories, it seemed
19 possible that perhaps that also impacted on his
20 relationship with family, but I don't know. That was
21 a speculation.
22 **Q.** It was a speculation but it was based on concrete
23 evidence of his mental state on other occasions, isn't
24 it?
25 **A.** Yes.

1 **Q.** Okay. Can we go forward, please, to page 25. And then
2 this is moving on to the violent incident on
3 3 September. Paragraph 73 at the bottom there, please.
4 And you say there:
5 "... it was evident that [VC] was paranoid about our
6 intentions in bringing him to the hospital for
7 assessment, as he had expressed delusional beliefs that
8 services were conspiring to make him think he was
9 unwell. The level of aggression to officers clearly
10 showed his reasoning was impaired, which appeared likely
11 to be associated with his mental disorder ..."
12 So was it your impression that his mental disorder
13 was at the root of the aggression that day?
14 **A.** That's how I interpreted it because of the things he'd
15 said about thinking mental health services were
16 conspiring against him and then his very extreme
17 reaction to us trying to take him into hospital to
18 assess him. I interpreted that to be a sign that he was
19 unwell.
20 **Q.** Thank you. Then the last topic -- sorry, two very quick
21 more topics. The first one is the medication that was
22 found dating back to February 2021. You indicated that
23 quite a lot hadn't been taken. Can you help us: had he
24 taken some or had he taken none from between February
25 to --

1 **A.** I'm sorry, I don't recollect.
2 **Q.** Okay, thank you. Then, finally, you mentioned earlier
3 when asked about a CTO, you said that this was only his
4 second episode of psychosis. Were you aware that there
5 was evidence that he was expressing psychotic symptoms
6 from as early as March 2020 to the end of 2020?
7 **A.** Yes, I suppose I interpreted that as kind of the first
8 episode and it seemed that things had resolved a little
9 bit and he was -- there weren't so many concerns in the
10 community and then, obviously, that he'd re-presented in
11 a more acute state. So that's how I interpreted it.
12 **Q.** But you're not suggesting that this was just a short
13 initial period of psychosis. It was actually a very
14 extended period, wasn't it?
15 **A.** No. Well, yes, certainly he had two admissions in that
16 first period of psychosis, didn't he?
17 **MR STRAW:** Okay. Thank you very much.
18 **THE CHAIR:** Yes, thank you.
19 Mr McNamara.
20 **Questioned by MR McNAMARA**
21 **MR McNAMARA:** Ms Staples, could I ask you a few questions,
22 please.
23 Could I ask to have two documents displayed
24 simultaneously, if possible, please, so NGPF0000017 and
25 it should be page 53, and could I also have on screen,

1 please, NGPF0000027, page 18. Ms Staples, you were
2 asked some questions about essentially only the first
3 document on the left of the screen. Where it is the
4 heading, "All key witnesses", do you see there where it
5 says:
6 "The AMHP who were present had been spoken to and
7 have stated that they are not willing to provide
8 statements due to the fact that they have to continue to
9 work with the defendant and if they were seen to 'take
10 sides' with the Police on this matter then it could make
11 their job of caring for the defendant more difficult in
12 the future."
13 Does that reflect your accurate recollection of what
14 occurred?
15 **THE CHAIR:** I think she has already told us this, hasn't
16 she?
17 **A.** No.
18 **MR McNAMARA:** Very well. Well, can we compare then, please,
19 the other document at line 24, where it says:
20 "Spoken with the attended AMHP Amie Staples. She is
21 willing to provide a statement ..."
22 Is that an accurate version of what happened?
23 **A.** Yes.
24 **Q.** Thank you. Do you have access to the Police National
25 Computer when you undertake assessments?

1 **A.** No.
2 **Q.** So you wouldn't have access, for example, to things like
3 driving offences?
4 **A.** No.
5 **Q.** Where did VC go after you had affected the warrant and
6 after he'd been to the Queens Medical Centre, that is,
7 for the physical check?
8 **A.** He was conveyed directly to the Cassidy Suite at
9 Highbury Hospital and he remained there following us
10 detaining him, and then was admitted, I believe, to
11 Cygnet, I think, Darlington.
12 **Q.** Thank you. Are you aware as to what happened in terms
13 of his treatment over the next few weeks and whether he
14 remained, for example, detained pursuant to Section 2?
15 **A.** I know he was subsequently placed under Section 3 by one
16 of our AMHPs but I didn't know the details of his
17 treatment. I wouldn't have any ongoing involvement with
18 this case.
19 **Q.** I think that's your colleague Alison Jacques; is that
20 right?
21 **A.** That's correct.
22 **Q.** For your reference, Chair, her witness statement is
23 WITN0114001 on page 7 and at paragraph 29. There's also
24 her AMHP report as well, which is the NOCC0000038
25 document.

1 In fact, his detention was converted to Section 3
2 whilst he was detained by Cygnet at the private
3 hospital; is that right?
4 **A.** That's correct.
5 **Q.** How obvious was it that he needed to be detained on
6 3 September 2021?
7 **A.** I think we were unanimously of the view that he needed
8 to be detained in hospital, given the level of distress
9 and violence towards the police officers.
10 **MR McNAMARA:** Thank you very much, I have no more questions.
11 Thank you, Chair.
12 **Questioned by THE CHAIR**
13 **THE CHAIR:** Can I just ask you, if we can just get the AMHP
14 report up, which is NOCC0000050, page 4.
15 I hope that's going to come up, so you can see it.
16 Yes. Just looking at the risk to self, risk to others,
17 the risk you put to himself are "Risk of reprisals for
18 his behaviour", and to him being "unable to engage with
19 his university studies" and then under "Risk to Others",
20 only the "Serious risk of physical harm to police
21 officers".
22 **A.** Yes.
23 **THE CHAIR:** On the previous page, you've set out, and we
24 don't need to go to it, saying about the incident which
25 we know as Feven jumping out of the window, you said he

1 was arrested and detained in hospital:
2 "His neighbour was so distressed by his behaviour on
3 entering her home that she leapt out of the window."
4 Did you know then that she suffered serious injury?
5 **A.** No, I didn't.
6 **THE CHAIR:** But you knew she'd jumped out of the window.
7 **A.** Yes.
8 **THE CHAIR:** Why did you not put "Risk to Others" or anything
9 of that kind?
10 **A.** Yes, I should have put that he was at risk of obviously
11 the incidents when he'd broken into the other flats or
12 in the neighbouring property. I mean, they weren't --
13 there was no indication at the time that I assessed him
14 that that was in his thoughts at all. He hadn't
15 expressed any paranoid thoughts about the neighbours but
16 certainly it was a risk that was relevant, so I should
17 have recorded that.
18 **THE CHAIR:** It was quite recent, wasn't it?
19 **A.** It was the year before, yes.
20 **THE CHAIR:** Yes, all right. Thank you.
21 Just finally, just in relation to the medication: do
22 you know where it went? Who took control of that
23 medication that he hadn't used?
24 **A.** I didn't have it. I don't know if it would have gone
25 with the ambulance crew or with Dr Lomas. I can't

1 remember.
2 **THE CHAIR:** Was there ever any suggestion that anybody might
3 look at it and see what he had been taking and what he
4 hadn't?
5 **A.** I don't know if Dr Lomas did. As I say, as a local
6 authority employee, we don't tend to get involved with
7 the kind of physical handling of medication.
8 **THE CHAIR:** But in this case, I mean, do you see that it
9 would have been quite useful to know what he was and
10 wasn't taking, and maybe in other cases too?
11 **A.** I think -- I suppose we felt that it was sufficient to
12 know that he wasn't compliant with his treatment and
13 that kind of the detail of that, with -- well, we
14 already had -- the decision was quite clear. I don't
15 think it was a kind of borderline decision about whether
16 or not to detain him. So it was sufficient to know this
17 is a person who hasn't been taking their medication as
18 prescribed.
19 **THE CHAIR:** Yes, thank you.
20 Right, well, we'll finish there for today and start
21 again tomorrow morning at 10.00, please.
22 **(4.56 pm)**
23 **(Hearing adjourned until 10.00 am the following day)**
24
25

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