

Monday, 11 May 2026

1  
2 (10.00 am)  
3 (Proceedings delayed)  
4 (10.02 am)  
5 **MR WESTON:** Chair, I call Mr Christopher Atherton.  
6 **CHRISTOPHER JAMES ATHERTON (affirmed)**  
7 **Questioned by MR WESTON**  
8 **MR WESTON:** Mr Atherton, you've prepared a statement for  
9 this Inquiry dated 13 November 2025.  
10 **A.** That's correct.  
11 **Q.** Are the contents of that statement true to the best of  
12 your knowledge and belief?  
13 **A.** They are.  
14 **Q.** Mr Atherton, you're employed by Nottingham City Council  
15 as the Strategic Director of Adult Social Care and  
16 Health?  
17 **A.** That's correct.  
18 **Q.** You qualified as a social worker in 2009.  
19 **A.** Yeah.  
20 **Q.** You specialised in adult social care?  
21 **A.** That's true, yeah.  
22 **Q.** You've previously worked at Haringey Council as  
23 a frontline social worker between 2009 and 2015?  
24 **A.** That's correct.  
25 **Q.** Thereafter, in about 2015, you took the role of

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1 exercising a function under this Part in the case of an  
2 individual, is to promote that individual's well-being."  
3 That's the starting point of the Care Act under  
4 Section 1.  
5 If you just go over the page, please, we'll see  
6 that:  
7 "'Well-being', in relation to an individual, means  
8 that individual's well-being so far as relating to any  
9 of the following ... "  
10 And we see that at (b) it refers to "mental health  
11 and emotional well-being".  
12 At (e) it refers to "participation in work,  
13 education, training or recreation".  
14 At (f) "social and economic well-being".  
15 At (g) "domestic, family and personal  
16 relationships".  
17 At (h) "suitability of living accommodation".  
18 If I can take you to the next page, please,  
19 Section 2 of the Care Act:  
20 "A local authority must provide or arrange for the  
21 provision of services, facilities or resources, or take  
22 other steps, which it considers will --  
23 "... contribute towards preventing or delaying the  
24 development by adults in its area ... for care and  
25 support".

3

1 a Principal Social Worker?  
2 **A.** (The witness nodded).  
3 **Q.** From 2018 you became the Head of Quality Assurance and  
4 Development at Haringey.  
5 **A.** That's correct.  
6 **Q.** It's in September 2025, I believe, that you started work  
7 at Nottingham City Council --  
8 **A.** That's correct, June 2025.  
9 **Q.** -- thank you -- as the Strategic Director of Adult  
10 Social Care and Health.  
11 **A.** Yeah.  
12 **Q.** You've produced your statement in response to a Rule 9  
13 Request from the Inquiry, and you say in your statement  
14 that you were considered the best placed person to  
15 assist the Inquiry from the perspective of Nottingham  
16 City Council.  
17 **A.** That's correct.  
18 **Q.** I want to ask you about the role of local authority and  
19 social care in mental health services. Now, if you'll  
20 forgive me, to do that I need to take you through some  
21 of the statute and guidance first, if that's okay?  
22 **A.** Absolutely.  
23 **Q.** So can I please start with the Care Act 2014, so it's  
24 RLIT0000035/001. So Section 1 of the Care Act:  
25 "The general duty of a local authority, in

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1 So there's a focus there on preventing needs before  
2 they arise; is that correct?  
3 **A.** That is correct, yes.  
4 **Q.** The guidance tells us something about that. Can  
5 I please take you to RLIT0000034/022. So this the Care  
6 and Support Statutory Guidance, the Statutory Guidance  
7 that sits behind the Care Act 2014; is that correct,  
8 Mr Atherton?  
9 **A.** That's correct, yes.  
10 **Q.** Paragraph 2.40, states that, at 2.40:  
11 "Prevention should be a consistent for local  
12 authorities in undertaking their care and support  
13 functions".  
14 That's correct, isn't it?  
15 **A.** That's correct.  
16 **Q.** "However, there may be key points in a person's life or  
17 in the care and support process where a preventative  
18 intervention may be particularly appropriate or of  
19 benefit to the person. Approaches to identifying those  
20 people who may benefit from preventative support should  
21 consider how to locate people in such circumstances, for  
22 example ..."  
23 The second bullet point refers to hospital  
24 discharge, doesn't it?  
25 **A.** It does.

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1 Q. So focusing upon hospital discharge there, and also  
 2 requiring the local authority to have in place measures  
 3 to locate people who might be undertaking hospital  
 4 discharge and might need care and support; is that  
 5 correct?  
 6 A. That's correct.  
 7 Q. If I can take you to the next page, please,  
 8 paragraph 2.45, it refers to:  
 9 "Contact with a person who is identified as being  
 10 able to benefit from preventative support may lead to  
 11 the local authority becoming aware that the person  
 12 appears to have needs for either or both care and  
 13 support [or] support in a role as a carer. This  
 14 appearance of need may trigger the requirement to carry  
 15 out a needs assessment..."  
 16 I'm going to come back to needs assessments in  
 17 a moment if I can. It then goes on to say in the next  
 18 sentence:  
 19 "However, where a local authority is not required to  
 20 carry out such an assessment under the Care Act, it  
 21 should nonetheless take steps to establish whether the  
 22 person identified will benefit from the type of  
 23 preventative support proposed."  
 24 So it makes clear that preventable support should be  
 25 considered even where there's no requirement to

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1 a specific individual as regards care and support?  
 2 A. That's correct.  
 3 Q. Can I just take you to the guidance in relation to that,  
 4 please, it's RLIT0000034, page 23. Page 35, please.  
 5 3.26:  
 6 "Local authorities, working with their partners ..."  
 7 That could be health care.  
 8 A. Yes.  
 9 Q. "... must use the wider opportunities to provide  
 10 targeted information and advice at key points in  
 11 people's contact with the care and support, health and  
 12 other local services. These include, but are not  
 13 limited to, known 'trigger points' during a person's  
 14 life such as ..."  
 15 The third bullet point gives an example of hospital  
 16 discharge, once again --  
 17 A. Yes.  
 18 Q. -- it's a trigger point for considering support --  
 19 information and advice.  
 20 Can I take you back, please, to the Care Act, just  
 21 a couple more provisions, if I may. Page 10 of the Care  
 22 Act so RLIT0000035, page 10. This is section 8, which  
 23 sets out the types of care and support provided.  
 24 8(1)(a):  
 25 "Accommodation in a care home or in premises of some

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1 undertake a needs assessment; is that correct?  
 2 A. That is correct, yes.  
 3 Q. Can I take you back to the Care Act itself, so  
 4 RLIT0000035, this is Section 3 of the -- apologies,  
 5 page 0004. Thank you. I'm grateful.  
 6 "A local authority must exercise its functions under  
 7 this Part with a [re]view to ensuring the integration of  
 8 care and support provision with health provision and  
 9 health-related provision where it considers that this  
 10 would:  
 11 "promote the wellbeing of adults in its areas ..."  
 12 So it's looking there at integration with health --  
 13 A. Yeah.  
 14 Q. -- and also once again at the issue of prevention; we  
 15 see that, don't we?  
 16 A. (*The witness nodded*).  
 17 Q. Over the page, please, section 4(1):  
 18 "A local authority must establish and maintain  
 19 a service for providing people in its area with  
 20 information and advice relating to care and support for  
 21 adults and support for carers."  
 22 Now that advice, that information about that can be  
 23 general advice you give to the whole area, can't it?  
 24 A. Absolutely, yes.  
 25 Q. But it can also be targeted advice, advice you give to

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1 other type."  
 2 That could be, for example, supported accommodation  
 3 or something like that of another nature; is that  
 4 correct?  
 5 A. That's correct.  
 6 Q. "Care and support at home or in the community." So it  
 7 could be someone coming into the home or helping someone  
 8 to access the community in some way, that's included  
 9 there?  
 10 A. Yes.  
 11 Q. (c) "counselling and other types of social work; (d)  
 12 goods and facilities; [not relevant here and] (e)  
 13 information, advice and advocacy."  
 14 Which we've just touched upon.  
 15 Then below, section 9 "Assessment of an adult's  
 16 needs for care and support", so we're getting onto the  
 17 assessment part of it now rather than the principles  
 18 we've looked at, it says:  
 19 "Where it appears to a local authority that an adult  
 20 may have needs for care and support, the authority must  
 21 assess whether --  
 22 "... the adult does have needs for care and support,  
 23 and  
 24 "if the adult does, what those needs are."  
 25 It says at (2) that's a needs assessment; do you see

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1 that?

2 **A.** Yes.

3 **Q.** "The duty to carry out a needs assessment applies  
4 regardless of the authority's view of --  
5 "the level of the adult's needs for care and  
6 support, or.  
7 "the level of the adult's financial resources."  
8 The final provision of the Care Act, please,  
9 page 15. This is eligibility criteria. 13(1) sets  
10 outs:  
11 "Where a local authority is satisfied on the basis  
12 of a needs or carer's assessment that an adult has needs  
13 for care and support or that carer has needs for  
14 support, it must determine whether any of the needs meet  
15 the eligibility criteria ..."  
16 So step one: what are the needs?  
17 **A.** Yeah.  
18 **Q.** Step two: are they eligible?  
19 **A.** That's correct.  
20 **Q.** Well, let's have a look at the guidance in relation to  
21 that. If I take you back to that, RLIT0000034, page 88,  
22 please.  
23 Paragraph 6.6 tells us that:  
24 "The assessment and eligibility process provides  
25 a framework to identify any level of need for care and  
9

1 do so."

2 **A.** Correct.

3 **Q.** So needs assessment first of all?

4 **A.** Yeah.

5 **Q.** Then you look if the eligibility criteria is met. If  
6 the eligibility criteria is method, you have to provide  
7 the care and support; is that correct?  
8 **A.** That is correct.  
9 **Q.** If the eligibility criteria is not met, it's  
10 a discretion the local authority has?  
11 **A.** It is, yes.  
12 **Q.** Finally, from the guidance, can I take you to page 117.  
13 6.113:  
14 "Individuals with fluctuating needs may have needs  
15 which are not apparent at the time of the assessment,  
16 but may have arisen in the past and are likely to arise  
17 again in the future. Therefore local authorities must  
18 consider an individual's need over an appropriate period  
19 of time to ensure that all of their needs have been  
20 accounted for when eligibility is being determined."  
21 So if a patient, for example, has, or a person has,  
22 fluctuating mental health needs, it's really important,  
23 when undertaking the assessment of needs and eligibility  
24 to consider what their position is when they're unwell.  
25 **A.** Yeah.

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1 support so that local authorities can consider how to  
2 provide a proportionate response at the right time,  
3 based on the individual's needs. Prevention and early  
4 intervention are placed at the heart of the care and  
5 support system ..."  
6 If I can take you to page 90. This is touching upon  
7 6.13:  
8 "Local authorities must undertake an assessment for  
9 any adult with an appearance of need for care and  
10 support, regardless of whether or not the local  
11 authority thinks the individual has eligible needs or of  
12 their financial situation."  
13 So you need to assess even if you don't think  
14 they're going to have the eligible needs; is that  
15 correct?  
16 **A.** That is correct. So if there is the presentation of  
17 care and support potential needs, then yes, absolutely.  
18 **Q.** Thank you. Can I take you to page 110. Paragraph 6.100  
19 touches upon eligibility:  
20 "The national eligibility criteria set a minimum  
21 threshold for adult care and support needs and carer  
22 support needs which local authorities must meet. All  
23 local authorities must comply with this national  
24 threshold. Authorities can also decide to meet needs  
25 that are not deemed to be eligible if they [choose] to  
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1 **Q.** Now, we've talked about the eligibility criteria. Those  
2 are governed by a set of regulations, aren't they? Can  
3 I take you to that, please, it's RLIT0000037, the Care  
4 and Support (Eligibility Criteria) Regulations 2015.  
5 Section 2:  
6 "An adult's needs meet the exhibit criteria if --  
7 "... the adult's needs arise from or are related to  
8 a physical or mental impairment or illness".  
9 In this particular matter we know that VC had  
10 a mental illness.  
11 **A.** Yes.  
12 **Q.** 2(b):  
13 "as a result of the adult's needs the adult is  
14 unable to achieve two or more of the outcomes specified  
15 in paragraph (2) ..."  
16 I will take you to those in just a moment:  
17 "and.  
18 "... as a consequence there is, or is likely to be,  
19 a significant impact on the adult's well-being."  
20 Just to take you to a couple of those specified  
21 outcomes, can I take you to 2(e):  
22 "being able to make use of the adult's home safely".  
23 It's right that "use of the ... home safely" can  
24 include whether the person can safely access the  
25 property and come and go; is that correct?  
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- 1 A. That is correct.
- 2 Q. The Inquiry has heard evidence of a number of incidents  
3 of aggression and violence involving VC towards those  
4 living in and around his accommodation. Mr Atherton, if  
5 the Chair finds those incidents as a fact, would VC,  
6 under the Regulations, be deemed, when unwell, not to be  
7 able to use his home safely?
- 8 A. So in relation to that, we would look at it from the  
9 perspective of their safety themselves, so their ability  
10 to come in and out of the home, to utilise the  
11 environment itself, and to ensure their own safety. It  
12 wouldn't necessarily apply to the safety of others when  
13 we're assessing the person's safety or managing their  
14 home safely.
- 15 Q. When people get involved in incidents, it's common sense  
16 that they can get injured themselves, can't they, if  
17 they're involved in incidents of violence or aggression?
- 18 A. That's correct, yeah.
- 19 Q. So that can compromise their safety as well as the  
20 safety of others, can't it?
- 21 A. It could, yes.
- 22 Q. In those circumstances, it seems that VC, on that  
23 factual premise that I have put to you, wouldn't have  
24 been able to use his home safely, at least when he was  
25 unwell.

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- 1 family relationships of which I'm aware VC was. So, you  
2 know, there is -- there'd be an element there which  
3 would still be being met with the relationship he has  
4 with his family.
- 5 Q. But in terms of personal relationships, if the Inquiry  
6 finds that he was not making relationships with other  
7 students on his course, with housemates around him, then  
8 there were difficulties developing and maintaining  
9 personal relationships, weren't there?
- 10 A. There would be if that was related to his mental health  
11 condition, and if there were challenges with him  
12 engaging in those relationships, yeah, that would be  
13 correct.
- 14 Q. Such isolation meant that VC was difficult to monitor,  
15 he didn't have contact with others, signs of relapse  
16 were not picked up, therefore it appears on that basis  
17 that his isolation significantly impact on his  
18 well-being --
- 19 A. *(The witness nodded)*.
- 20 Q. And that brings us back to 2(c), doesn't it?
- 21 A. Yes.
- 22 Q. Over the page, (2)(i):  
23 "making use of necessary facilities or services in  
24 the local community including public transport, and  
25 recreational facilities or services".

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- 1 A. I'm -- yeah, I think if you're -- the way in which you  
2 can interpret it, it absolutely could be interpreted in  
3 that way, yes.
- 4 Q. Those incidents with the neighbours, significantly  
5 impacted VC's wellbeing, as he had interactions with the  
6 police, health interactions arising from it, and of  
7 course no one wants to be involved in incidents of  
8 aggression and violence, and so therefore it seems 2(c)  
9 is met, doesn't it: it has a "significant impact on the  
10 adult's well-being"?
- 11 A. Yes.
- 12 Q. If I can take you to 2(g), please, "developing and  
13 maintaining family or other personal relationships".  
14 The guidance points to this being engaged where a person  
15 is isolated because of their needs.
- 16 A. *(The witness nodded)*.
- 17 Q. And that can because of the person's mental health  
18 needs, can't it?
- 19 A. It can, yes.
- 20 Q. Now, if the Chair concludes that VC was socially  
21 isolated from the community around him because of his  
22 mental health, including from other university students,  
23 from housemates, that would be a basis for concluding  
24 that (2)(g) was met, wouldn't it?
- 25 A. But it also talks about developing and maintaining

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- 1 We've got evidence before the Inquiry that VC, when  
2 unwell, did not engage with mental health community  
3 services on a number of occasions, so that would be  
4 engaged, wouldn't it?
- 5 A. So a lot of the time how we view that is their ability  
6 of going out and accessing the community more broadly,  
7 so going out and engaging with, you know, the community  
8 provisions, the community services, going to and from  
9 their accommodation, being -- having the opportunity of  
10 being able to engage with that. I suppose you could  
11 look at it through the lens of the engagement with  
12 mental health services.
- 13 Q. I mean, community mental health is a service?
- 14 A. It is a service, yeah.
- 15 Q. It's a very important service in terms of someone's  
16 well-being, isn't it?
- 17 A. Yes, it is.
- 18 Q. If he's not making use of it because of his needs, then  
19 that would be qualified -- then would meet (2)(i)  
20 wouldn't it, there?
- 21 A. *(The witness nodded)*.
- 22 Q. Clearly not engaging with mental health services is  
23 going to be detrimental to someone's well-being.
- 24 A. It would be detrimental to someone's well-being,  
25 absolutely.

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1 Q. Mr Atherton, it follows, therefore, that if the Chair  
2 makes those findings -- I've put those, a matter for the  
3 Chair --  
4 A. Sure.  
5 Q. -- but if the Chair makes those findings, VC not only  
6 had care and support needs, he had needs that met the  
7 eligibility criteria under the Regulations?  
8 A. If it's as put it across, and that's the Chair's view,  
9 then yes.  
10 Q. Then therefore on that basis the local authority was  
11 required to meet his needs.  
12 A. It would be on the basis of the local authority being  
13 made aware of that and undertaking the assessment, yes.  
14 Q. In terms of an assessment, it's right that VC was never  
15 assessed under the Care Act 2014 by the local authority;  
16 is that correct?  
17 A. That is correct.  
18 Q. Therefore, because he wasn't assessed, no needs were  
19 provided under the Care Act.  
20 A. That's correct.  
21 Q. In particular, he wasn't assessed at the point of  
22 discharge, which the guidance we've seen identifies as  
23 a potential trigger point for an individual's needs.  
24 A. That's correct.  
25 Q. Now, aside from the Care Act, the local authority also

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1 Then it goes on to say:  
2 "CCGs and local authorities should interpret the  
3 definition of after-care services broadly. For example,  
4 after-care can encompass healthcare, social care and  
5 employment services, supported accommodation and  
6 services to meet the person's wider social, cultural and  
7 spiritual needs, if these services meet a need that  
8 arises directly from or is related to the particular  
9 patient's mental disorder, and help to reduce the risk  
10 of a deterioration in the patient's mental condition.  
11 "After-care is a vital component in [a] patients'  
12 overall treatment and care. As well as meeting their  
13 immediate needs for health and social care, after-care  
14 should aim to support them in regaining or enhancing  
15 their skills, or learning new skills, in order to cope  
16 with life outside hospital".  
17 A. Yeah.  
18 Q. Mr Atherton, VC was discharged twice, under Section 3:  
19 on 31 July 2020 and on 18 October 2021. However, on  
20 those occasions, the local authority did not assess  
21 whether VC needed Section 117 after-care services; is  
22 that correct?  
23 A. That is correct.  
24 Q. I just want to understand why that was. Can take you to  
25 your statement, please, this WITN0225001, page 8.

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1 has a distinct duty, doesn't it, to provide aftercare in  
2 circumstances where a patient is discharged under  
3 Section 3 of the Mental Health Act?  
4 A. That's correct.  
5 Q. That duty is under Section 117. Let me take you to  
6 that. It's NHSE0000312 and then it's page 355. It's  
7 the guidance in relation to Section 117, please.  
8 First of all, it's right that care services or  
9 after-care services under section 117 have to be  
10 provided free of charge?  
11 A. That's correct.  
12 Q. Without assessment as regards eligibility?  
13 A. That's correct.  
14 Q. Without assessment of finances?  
15 A. Correct.  
16 Q. Turning to this guidance here, 33.3:  
17 "After-care services mean services which have the  
18 purposes of meeting a need arising from or related to  
19 the patient's mental disorder and reducing the risk of  
20 a deterioration of the patient's mental condition (and,  
21 accordingly, reducing the risk of the patient requiring  
22 admission to hospital again for treatment for [the]  
23 mental disorder. Their ultimate aim is to maintain  
24 patients in the community, with as few restrictions as  
25 are necessary, wherever possible."

18

1 Paragraph 26.  
2 "Once released, a care coordinator..."  
3 Once released from detention, you're referring to  
4 there:  
5 A. Yeah.  
6 Q. "... a care coordinator will be identified. That may be  
7 the hospital's Community Psychiatric Nurse ... or an OT  
8 depending in staffing in the Trust. If they identify  
9 social care needs, they can call in the local  
10 authority."  
11 When you're saying "they" you mean the CPN or the  
12 OT.  
13 A. What I meant by that is the clinical team who are --  
14 would be supporting VC in hospital. They would make a  
15 decision on whether there was a requirement under  
16 Section 117 that required adult social care to be part  
17 of that assessment process.  
18 Q. So it could be those assisting in the community; it  
19 could be those before discharge. The whole clinical  
20 team before and after --  
21 A. Absolutely, yeah.  
22 Q. Paragraph 28:  
23 "Overall, however, the local authority is in the  
24 hands of the treating hospital when it comes to  
25 providing information about patients who are coming up

20

1 for discharge or have been released."  
 2 So it appears from your statement, Mr Atherton, that  
 3 whether there's a need to assess under Section 117 under  
 4 the Care Act, was not triggered in VC's case because the  
 5 clinical staff didn't inform the local authority of any  
 6 social care needs.  
 7 **A.** That's correct.  
 8 **Q.** So the decision on whether the local authority has needs  
 9 and has obligations to meet those needs, that decision  
 10 is effectively made by staff from another agency; is  
 11 that correct?  
 12 **A.** That is correct. Obviously we have a number of people  
 13 under the Section 117 arrangements with the mental  
 14 health Trust, so it's a well established process for  
 15 referral into the local authority where they are  
 16 identified potential care and support needs.  
 17 **Q.** We've looked at the Care Act. Some of the needs for  
 18 care and support are more obvious physical needs --  
 19 **A.** Yeah.  
 20 **Q.** -- nutrition and hygiene. Some of them are a bit more  
 21 nuanced, aren't they?  
 22 **A.** They are.  
 23 **Q.** For example, information and advocacy, issues in  
 24 relation to perhaps assistance with accessing the  
 25 community or protecting someone so they're safe in their

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1 mental health staff understood the social care  
 2 legislation and guidance?  
 3 **A.** Again, as I was not here at the time, I'm not aware if  
 4 that took place or not.  
 5 **Q.** Were you aware of any protocols, for example, that would  
 6 assist the mental health services to identify which  
 7 cases they maybe need to pick up the phone and speak to  
 8 a social worker about and say, "What about this case or  
 9 that case?" Some sort of guidance on the ground?  
 10 **A.** Again, I'm not aware of particular guidance at that time  
 11 and what would have been available. I am aware that  
 12 there are good working relationships from a professional  
 13 level, from professional to professional between the  
 14 Mental Health Trust and Adult Social Care, and at that  
 15 time there were. So whether there were informal  
 16 conversations that took place between practitioners and  
 17 clinicians, I -- that may have occurred but I wouldn't  
 18 know for sure.  
 19 **Q.** We still have your statement on the screen. Can I take  
 20 you to paragraph 27:  
 21 "Whilst the division of health and social care needs  
 22 like this makes logical sense, there is a danger that  
 23 vulnerable individuals can slip through the gaps where  
 24 their needs do not fit easily into definitions of health  
 25 or social care."

23

1 home, these sorts of things. As I say, a little more  
 2 nuanced.  
 3 How did the local authority, in the period we're  
 4 concerned with, between 2020 and 2022, satisfy itself  
 5 that the mental health staff understood the social care  
 6 legislation and the guidance that we've been through?  
 7 **A.** That's a difficult question for me to answer, given that  
 8 I wasn't in Nottingham at the time, and didn't have  
 9 engagement with this case. I think the -- like I say,  
 10 the establishment of the working arrangements between  
 11 the mental health Trust, not just in Nottingham but from  
 12 a national perspective of that interplay between adult  
 13 social care and health services and mental health  
 14 services, is obviously very well established.  
 15 The health practitioners and the clinical team will  
 16 have a good understanding of what qualifies as adult  
 17 social care needs and we see that from the amount of  
 18 people we're supporting under Section 117. That is an  
 19 established pathway. But it's difficult for me to talk  
 20 specifically to that time having not been here.  
 21 **Q.** Are you aware of any particular training that was given  
 22 to mental health professionals so they can properly  
 23 understand your processes?  
 24 **A.** I'm not aware, no.  
 25 **Q.** Were there any checks undertaken to check that the

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1 Isn't the point of Section 117 to make sure that  
 2 people don't slip through the gaps between medical and  
 3 social care?  
 4 **A.** It is, yes.  
 5 **Q.** Isn't the way to ensure that no one slips through the  
 6 gaps, to make it necessary as a minimum that mental  
 7 health services notify the local authority when  
 8 a patient is being discharged from hospital and going  
 9 into community mental health services?  
 10 **A.** I think the -- you strengthen that process by having  
 11 teams that sit together and having social work expertise  
 12 that sits within that clinical decision-making team.  
 13 I don't -- I'm not aware that that was what was in place  
 14 at the time. That was certainly strengthened, moving  
 15 forward, ensuring that you had that level of expertise  
 16 sat as part of that ongoing discussion.  
 17 **Q.** But we don't know whether there was social work  
 18 involvement --  
 19 **A.** No.  
 20 **Q.** -- in any particular discharge, and we're talking here  
 21 about safety nets --  
 22 **A.** Yeah.  
 23 **Q.** -- and making sure there's no gaps. Isn't the simple  
 24 way to deal with that to make it a duty or requirement  
 25 for the clinical services to tell the local authority

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1 about what is happening at the point of discharge, given  
2 that it's a trigger point as we've seen in the guidance?  
3 **A.** Yeah, absolutely. I think there is a challenge, and  
4 again, from a national perspective, around the resource  
5 available both between the Trust and the local authority  
6 or local authorities in their engagement, and their  
7 ability for every single patient that goes in to be  
8 informed of the discharge, potentially where isn't  
9 necessarily a requirement for care and support, or  
10 ongoing care and support, from adult social care.

11 So there's some challenge there in being able to do  
12 it in a way that doesn't flood local authorities with  
13 information around potential discharges of patients  
14 where there isn't a requirement for adult social care to  
15 be involved long term. I'm not referring to this case;  
16 I'm talking more broadly.

17 **Q.** Adult social care have an obligation to undertake needs  
18 assessment and to meet needs.

19 **A.** Where there's been a-- where there is -- where that's  
20 been identified, yes, absolutely.

21 **Q.** You're relying upon other professionals to identify the  
22 trigger points for when you might --

23 **A.** Yeah.

24 **Q.** -- meet those needs. You're not aware whether those  
25 individuals have got proper training in relation to the

25

1 perspective it's a challenge, nationally, around having  
2 trained AMHPs in place. We have around 40 that sit  
3 across adult social care teams in Nottingham City, but  
4 it's a challenge with the demand coming through to  
5 ensure assessment, as defined by the legislation, is  
6 carried out.

7 The ongoing involvement would make -- a challenge  
8 would need significantly more AMHPs into the service to  
9 be able to ensure you've got a broader wraparound  
10 provision to be provided if that was something  
11 legislatively that was suggested moving forward.

12 **Q.** The latest Department of Health and Social Care guidance  
13 encourages there to be work on discharge during the  
14 whole period of detention, doesn't it?

15 **A.** That's right.

16 **Q.** The AMHP is there at the point of detention.

17 **A.** Yeah.

18 **Q.** They have some understanding of the case at that  
19 particular point. They can remain involved just in  
20 a sort of focal point at the local authority, and then  
21 can be there to, again, fill that gap, make sure there's  
22 the safety net there at the point of discharge.

23 **A.** I think there -- I think we would welcome the ability of  
24 being able to have a greater level of involvement moving  
25 through. I think anything that connects adult social

27

1 Care Act.

2 **A.** *(The witness nodded).*

3 **Q.** In those circumstances, isn't the only way to avoid  
4 there not being gaps to ensure you're told about these  
5 discharges?

6 **A.** It would ensure a level of oversight. Again, we'll  
7 still be relying on the clinical team to provide  
8 information relating to those individuals, so we'd been  
9 informed of that to make an informed decision, but yes.

10 **Q.** Then you could undertake, for example, a screening  
11 assessment?

12 **A.** Absolutely, yes.

13 **Q.** With all those knowledge and those nuances in the Care  
14 Act that we've looked at, that could then be applied in  
15 that screening assessment couldn't it?

16 **A.** It could be, yes.

17 **Q.** An alternative route to ensure the local authority  
18 remains engaged, and there's no gap in the net, is for  
19 the AMHPs to potentially stay involved, the Approved  
20 Mental Health Professionals; that's an alternative way,  
21 isn't it?

22 **A.** It is an alternative way. It's obviously not stated  
23 that in any of the legislation that we have; it's a very  
24 bespoke role. You know, what I would say in relation to  
25 the AMHP role is that, you know, from a national

26

1 care and health services together in making some of  
2 those decisions would be welcome. But again, I would  
3 point to, you know, the scarcity of our AMHPs to be able  
4 to undertake that role, and also respond to the amount  
5 of Mental Health Act Assessments that they're required  
6 to do.

7 **Q.** Can I take you to document PAGR0000025, please.

8 There is a medical record concerning VC. It's dated  
9 19 October 2021, and I want to take you to the entry  
10 timed at 19:23, and the last paragraph there, second  
11 sentence:

12 "City social work" -- that's probably Nottingham  
13 City Council?

14 **A.** *(The witness nodded).*

15 "... rung this afternoon as they had received  
16 a referral for a NOA."

17 What's an NOA?

18 **A.** I'm not sure. This is a health recording. I'm not sure  
19 what that relates to.

20 **Q.** "CN EP explained this was due to [VC] being NFA [no  
21 further action] however he has not secured accommodation  
22 ..."

23 I think that's probably supposed to say "Now secured  
24 accommodation":

25 "... an[d] therefore does not require further social

28

1 work support."  
 2 Did you see that?  
 3 A. Yes.  
 4 Q. So it appears to be the social worker from Nottingham  
 5 City Council contacting the ward about discharge.  
 6 A. It would appear to be that case, yes.  
 7 Q. And particularly about accommodation.  
 8 A. That's what it states, yes.  
 9 Q. VC was formally discharged from section 3 detention,  
 10 albeit he was still in the hospital, he was formally  
 11 discharged from Section 3 detention the day before.  
 12 Would you expect health and social care to be in touch  
 13 with each other before the discharge and working out  
 14 matters of accommodation?  
 15 A. I would expect that yes, if there was a role for adult  
 16 social care to be involved, particularly if there was an  
 17 issue around accommodation.  
 18 Q. We can see that there was a discussion about  
 19 accommodation, we don't know exactly what the full  
 20 conversation was, but it seems to be quite a short note.  
 21 There is certainly no information here to suggest that  
 22 the social worker was in any way able to assess whether  
 23 VC's accommodation was suitable or not; do you agree  
 24 with that?  
 25 A. I would agree with that.

29

1 A. We have, yes.  
 2 Q. -- if a screening assessment had been undertaken, given  
 3 that we've noted that VC has eligible needs under the  
 4 Care Act, it no doubt would have led to a package of  
 5 support under the Care Act or under Section 117.  
 6 A. I don't think I'd agree that necessarily. I think you  
 7 made the point it was for the Chair to make that  
 8 decision based on the information she had, so that's  
 9 not -- I'm not making that assumption that he was  
 10 eligible. Certainly from the information that we've  
 11 looked at -- and I appreciate obviously the Inquiry has  
 12 much more information certainly than what I've had since  
 13 making the statement -- it doesn't -- it didn't appear  
 14 that the thresholds were met around eligibility. But  
 15 I appreciate the Inquiry has a lot more information than  
 16 I do when I made that witness statement.  
 17 Q. On that basis, on the basis that the Chair makes those  
 18 findings -- and I did frame those questions very much in  
 19 that way -- on the basis that the Chair makes those  
 20 findings, there were -- the eligibility criteria was met  
 21 under the Care Act, wasn't it?  
 22 A. If that's what the Chair deems, yes, absolutely.  
 23 Q. Given that all those criteria were met because of VC's  
 24 mental health, that would have likely mirrored, maybe  
 25 not the same, but would have mirrored the Section 117

31

1 Q. The social worker doesn't seem to be alive to the  
 2 problems that VC had with others in and around his  
 3 accommodation previously?  
 4 A. (*The witness nodded*). Yeah, given the information  
 5 that's on the screen, that wouldn't appear to be the  
 6 case.  
 7 Q. No suggestion the social worker was alive to any of the  
 8 other social care needs that VC may have had that we  
 9 touched upon earlier in terms of socialisation,  
 10 accessing services, those kinds of matters?  
 11 A. That's correct.  
 12 Q. So on 19 October 2021, the local authority were aware of  
 13 a discharge but didn't undertake an assessment of VC's  
 14 needs?  
 15 A. We certainly didn't undertake an assessment of VC's  
 16 needs because there's nothing on our record system.  
 17 Obviously this is a note on a health system that's been  
 18 recorded by a health practitioner. Other than what's  
 19 written on that, there's not much context to that or the  
 20 social worker's involvement, as stated, there wasn't  
 21 anything on our records that talked to any social worker  
 22 involvement other than the AMHP involvement as part of  
 23 that assessment process.  
 24 Q. If, with the result of this information -- we discussed  
 25 a screening assessment before -- (*overspeaking*) --

30

1 aftercare package that could have been put in place?  
 2 A. Yes, on that basis it would do.  
 3 Q. That package would have served as a second set of eyes  
 4 on VC, wouldn't it?  
 5 A. Dependent on what was commissioned as an ongoing level  
 6 of support that would be required, and obviously that  
 7 takes many forms, as you pointed out earlier, in  
 8 relation to the Act of what it deems as the requirement  
 9 for the local authority. It absolutely may well put  
 10 ongoing support around him, that could present extra  
 11 additionality of oversight.  
 12 Q. Could have been perhaps support to take medication?  
 13 A. That is a health function; it's not a Care Act function.  
 14 Q. Reminders, promptings?  
 15 A. Reminders and prompting, if it's incidental and  
 16 ancillary to the other care and support that's being  
 17 provided, then, yes, we could provide prompting around  
 18 the medication if that was -- again, that would be  
 19 arranged -- the broader, wider care and support that  
 20 would need to be in place for him for that prompting to  
 21 take place.  
 22 Q. A social worker could have been encouraging as regards  
 23 information and advice for socialisation or support  
 24 groups or other things in the community potentially that  
 25 weren't clinical interventions?

32

1 **A.** Absolutely. If we're doing the assessment or there is  
 2 identified needs, either under Section 117 or the Care  
 3 Act, we would be looking at VC as holistically as  
 4 possible around what additional support might be put in  
 5 place to support him in achieving his outcomes.  
 6 **Q.** Could be assistance with accommodation?  
 7 **A.** It could be assistance with accommodation if it was  
 8 related to his care and support needs.  
 9 **Q.** Just by having the social worker or the local authority  
 10 involved you would have another set of eyes there to see  
 11 if there's -- he's not taking medication or if there's  
 12 a relapse or any concerns of that nature?  
 13 **A.** Yes, if there is -- on a level of ongoing support that  
 14 is in place, particularly on a daily basis, and I would  
 15 probably, you know, I would state, with the identified  
 16 care and support needs that you have highlighted as  
 17 potentially being eligible under the Care Act, that  
 18 wouldn't necessarily require a day-to-day level of  
 19 support going in and seeing him. A lot of where we look  
 20 at prompting around medication is done so because we've  
 21 got our commission and care support going in place to  
 22 provide support around toileting, washing, dressing,  
 23 those elements obviously which VC didn't have those,  
 24 certainly from the information we have, those identified  
 25 care and support needs.

33

1 **Q.** So that would have been an occasion for the AMHP to say,  
 2 "These nuanced needs that we've looked at, they're there  
 3 and there's a care need and he meets the eligibility  
 4 criteria and Section 117 --  
 5 **A.** Yes.  
 6 **Q.** -- it would have been an opportunity for a package to be  
 7 put in place?  
 8 **A.** Yeah, if the AMHP has gone in -- and obviously our AMHPs  
 9 are qualified social workers -- if they'd gone in and  
 10 been part of that assessment and if they had identified  
 11 that there was ongoing care and support needs, then they  
 12 could have made recommendations at that point, but it  
 13 would obviously be on the basis of those needs being  
 14 identified.  
 15 **Q.** Can I take you to a different duty under the Care Act,  
 16 please, the section 42 safeguarding. Can we go to  
 17 document RLIT0000035, page 44. No doubt, Mr Atherton,  
 18 you'll be very familiar with section 42 --  
 19 **A.** I am.  
 20 **Q.** -- which applies where:  
 21 "... local authority has reasonable cause to suspect  
 22 that an adult in its area ...  
 23 "has needs for care and support (whether or not the  
 24 local authority is meeting those needs),  
 25 "is experiencing, or is at risk of abuse or neglect,

35

1 But yes, while there are support workers going in or  
 2 careworkers going in, there is the opportunity in which  
 3 to -- for them to identify whether medication has been  
 4 taken or prompting the person to take medication. But  
 5 the responsibility around taking medication or the  
 6 medication element does sit with health.  
 7 **Q.** 19 October, we've seen the record, we just touched on  
 8 it, if we could just take that off the screen, please,  
 9 that was a discharge under Section 3. If a Community  
 10 Treatment Order had been in place at that time, would  
 11 the position be any different as regards the local  
 12 authority's engagement, assessment and support at that  
 13 particular time?  
 14 **A.** So if -- because it will be through a Community  
 15 Treatment Order, the AMHP would be back involved in that  
 16 process for whether the Community Treatment Order would  
 17 be appropriate or not.  
 18 Again, whether that potentially, through that  
 19 process, highlights care and support needs via  
 20 Section 117, I'm not sure. But again, once that piece  
 21 of work had been completed, the AMHP would step away  
 22 again and then it would be with the clinical team's  
 23 responsibility to manage the CTO.  
 24 **Q.** So the AMHP would have to be involved at that stage?  
 25 **A.** That's right, yes.

34

1 and  
 2 "as a result of those needs is unable to protect  
 3 himself or herself against the abuse or neglect or the  
 4 risk of it."  
 5 At paragraph (2):  
 6 "The local authority must make (or cause to be made)  
 7 whatever enquiries it thinks necessary to enable it to  
 8 decide whether any action should be taken in the adult's  
 9 case [...] and, if so, what and by whom."  
 10 Again, the Inquiry has heard evidence about an  
 11 incident on 25 May 2020. VC was -- well, VC was  
 12 arrested on 25 May 2020 following an occasion there he  
 13 tried to break into a neighbour's apartment --  
 14 **A.** Yes.  
 15 **Q.** -- resulting in the occupant Feven jumping out of the  
 16 window through fear --  
 17 **A.** Yeah.  
 18 **Q.** -- and fracturing her spine.  
 19 Looking at section 42, as a result of the fracture  
 20 of the spine and the physical needs, she had needs for  
 21 care and support at that particular stage.  
 22 **A.** I wouldn't agree with that. I think there is, obviously  
 23 defined by the Act, there was a requirement for medical  
 24 treatment. I'm not aware that that person requires  
 25 ongoing care and support from the local authority, so it

36

1 wouldn't meet that threshold.

2 **Q.** Okay, if they needed a package of support for a matter  
3 of weeks at home following the accident, that would be  
4 a need for care and support?

5 **A.** I guess not -- looking at it, and not to be pedantic,  
6 but looking at where it would be she wouldn't have had  
7 care and support needs at the time when it occurred.

8 **Q.** No, no, indeed. Afterwards. After the incident with  
9 the fractured spine, if they're out of action for  
10 a number of weeks, that's a care and support need under  
11 section 42(1)(a).

12 **A.** I would suggest that's ongoing health treatment for a  
13 short period of time. It wouldn't necessarily  
14 constitute a long-term requirement for adult social  
15 care. So I don't think that threshold is met.

16 **Q.** If the individual had -- and again these are factual  
17 findings from others --

18 **A.** Sure.

19 **Q.** -- but if the individual had problems with toileting,  
20 personal hygiene, maintaining their home for that period  
21 of time, then those are needs for care and support  
22 arising from the injury?

23 **A.** Again, it would be on the basis of us being aware of  
24 those care and support needs at the time, and referral  
25 being made into the service. Obviously, in my

37

1 support being in place and I suppose that's  
2 a question -- you're asking the question, it would be  
3 helpful to clarify: did they have carers going in  
4 providing care and support to them during that period of  
5 time?

6 **Q.** Well, we'll just -- that's a matter of fact for others,  
7 but we'll just leave it there. Then can I take you to  
8 42(1)(b):  
9 "is experiencing, or is at risk of, abuse or neglect  
10 ..."  
11 Now "abuse" has quite a wide definition under the  
12 guidance, doesn't it?

13 **A.** It does.

14 **Q.** It can include threats of violence and harassment, and  
15 someone -- a neighbour trying to break into someone's  
16 property would probably potentially be experiencing  
17 abuse, wouldn't it?

18 **A.** Again, I think it goes to the -- the top bit has care  
19 and support needs and then you go to the bit around "is  
20 experiencing risk or abuse". Again, the carer did not  
21 have care and support needs at the point that that  
22 incident occurred, so ...

23 **Q.** But if there's been an incident and it meets the  
24 definition for abuse and these people are still  
25 neighbours, then is experiencing abuse, there's that

39

1 experience, I don't think I've ever seen anything for  
2 a safeguarding that's been coming for what we would talk  
3 for a short period of reablement. I'm not aware of the  
4 specifics of the case, but what we tend to look at is  
5 what those care and support needs are and those care and  
6 support needs, if we go back to what the Act talks  
7 about, it's about the illness or the impairment and then  
8 the criteria being met and then the significant impacts  
9 on the individual's well-being.

10 So again, because it would be looking at the very  
11 specific incident when it occurred, the person didn't  
12 have care and support needs when that incident occurred.  
13 The idea that they happened afterwards, the safeguarding  
14 becomes redundant on the basis of -- if the individual  
15 has injured themselves post it, and there are care and  
16 support needs at the time when the incident happened  
17 they didn't have care and support needs -- am I making  
18 -- (*overspeaking*) --

19 **Q.** I understand. You're saying they didn't have care and  
20 support needs before the incident, but I want you to  
21 focus on the period after the incident. If they've got  
22 physical needs for support because of a fractured spine,  
23 then albeit that it might not be long term, they've got  
24 needs for care and support, haven't they?

25 **A.** They may have a period of time where their care and

38

1 risk -- then there's an ongoing risk, isn't there?

2 **A.** I guess your point is they're an ongoing risk, again,  
3 dependent on the situation, that there may be.

4 **Q.** At (1)(c):  
5 "As a result of those needs is unable to protect  
6 himself or herself against ... abuse or neglect or the  
7 risk of it."  
8 If someone is out of action because of a fractured  
9 spine, they're going to be quite vulnerable, aren't  
10 they?

11 **A.** They are and I probably just go back to that point.  
12 I can appreciate you're going through each of those  
13 levels. The bits around that they can protect  
14 themselves against the alleged perpetrator and they  
15 should have care and support needs to protect  
16 themselves, so it goes to the incident that happened at  
17 that particular time, the individual did not have care  
18 and support needs at that particular time the incident  
19 occurred, and therefore section 42 wouldn't be  
20 triggered.

21 **Q.** If section 42, on the factual basis that the Chair  
22 reaches, was considered to be triggered, those enquiries  
23 would involve liaison with other agencies, wouldn't it?

24 **A.** There would, yes.

25 **Q.** There would be a need to speak to police and to health

40

1 services?

2 **A.** *(The witness nodded).*

3 **Q.** Risk would then be triangulated, particularly in

4 circumstances of an incident like this where somebody

5 had tried to come into someone else's property, there

6 would be a risk assessment?

7 **A.** Yes, there would be.

8 **Q.** Local authority would lead it --

9 **A.** Yeah.

10 **Q.** -- because it's a duty under section 42, but we would

11 have a multi-agency risk assessment being undertaken at

12 this particular stage; that would be necessary to meet

13 the duty under section 42, wouldn't it?

14 **A.** So again, as a concept of section 42, yes, I would agree

15 with that again. Again, I wouldn't necessarily refer it

16 to the event that occurred, but yes, as a section 42

17 process, if triggered, then the involvement would be to

18 involve other organisations and agencies that may have

19 had contact at that particular time and to make

20 decisions around risk assessment and safety moving

21 forward.

22 **Q.** So you'd be looking to make a safeguarding plan?

23 **A.** Yes.

24 **Q.** That could involve not only social care but also health

25 and potentially the police as well, acting together?

41

1 perpetrator may have care and support needs themselves,

2 then of course there would be more of a broader, wider

3 look at the individuals from both sides and what support

4 could be provided.

5 **Q.** If the best way to safeguard Feven was to reduce the

6 risks from VC, then the package would have a number of

7 measures in it involving VC, wouldn't it? As I've said,

8 medication, social inclusion, potentially accommodation?

9 **A.** Again, the safeguarding itself would primarily look at

10 the victim of the abuse and neglect, the safeguarding

11 process itself would -- perhaps it would trigger another

12 part of the Care Act from an assessment perspective

13 where there is somebody with care and support needs who

14 is the perpetrator for an assessment process. So as

15 part of that broader, wider wrap around, then yes, that

16 would be triggered.

17 **Q.** Even if section 42 hadn't been triggered, even if

18 someone had just turned their mind to whether section 42

19 was triggered, they should have then have been thinking:

20 well, does VC have needs under the Care Act as well,

21 shouldn't they?

22 **A.** I think obviously at the time of the incident and

23 obviously the assessment that was undertaken, that had

24 the involvement of certainly obviously health colleagues

25 and ongoing health support, and therefore you would look

43

1 **A.** Yes, absolutely. It's a multi-agency approach, so

2 again, dependent on what the safeguarding concern that

3 is being raised is, and the section 42 enquiry that

4 takes place, it can involve a range of partners and

5 should do, particularly where those partners have

6 contact with the individual.

7 **Q.** Some of that package may well look like the sort of

8 measures we've already touched upon, medication support,

9 potentially assistance with accommodation, greater

10 social inclusion, these sorts of matters could have been

11 part of that. Towards VC?

12 **A.** Well, and I guess that's the important distinction,

13 isn't it? Here we're talking about VC being the

14 perpetrator at this incident or the incidents being

15 provided and our duty is to safeguard the adult with

16 care and support needs who is the alleged victim of the

17 abuse or neglect that may have occurred to them. So it

18 would be to safeguard the individual.

19 Of course, if the perpetrator in any case -- and

20 again I'm not making reference to this particular

21 incident because I don't think it necessarily mirrors up

22 correctly -- if there is the responsibility for that to

23 be undertaken and there is a person with care and

24 support needs that meets the criteria you've identified,

25 that is at risk of abuse or neglect and also the

42

1 at the expertise of those individuals while working with

2 VC to make a decision as to whether there was an ongoing

3 care and support needs that needs to be referred into

4 adult social care moving forward.

5 **Q.** It would have a social worker looking at VC's situation

6 and then considering whether there's care and support

7 needs there, wouldn't they?

8 **A.** If that's -- again, if that referral had come into the

9 service, then yes, it would be looked at by the social

10 worker who would be picking up the referral being made

11 in by Health at that point.

12 **Q.** When undertaking Section 42 enquiries, the local

13 authority remains very much at the centre of

14 a multi-agency investigation?

15 **A.** That's correct.

16 **Q.** When a Mental Health Act Assessment is undertaken by

17 Approved Mental Health Professionals, again, through the

18 local authority, the local authority is at the centre of

19 multi-agency work there as well, aren't they, working

20 with Health?

21 **A.** Yes, that's correct.

22 **Q.** If this Inquiry is looking at ways to enhance

23 multi-agency cooperation for patients with mental health

24 needs, the local authority is uniquely placed to be

25 a focal point or coordinator for that sort of protocol

44

1 or multi-agency working?

2 **A.** I think we already are, not in this specific example  
3 that you're giving, but certainly around where we look  
4 at other risk management frameworks that we operate  
5 within. So MAPPA and MARAC. We've got a SERAC, so  
6 a Slavery and Exploitation Risk Assessment Conference,  
7 we've got a Complex Persons Panel, we have a Hoarding  
8 Panel. So there's lots of things we either lead on or  
9 are part of as part of ongoing risk assessments for  
10 identified individuals. We would expect obviously to be  
11 involved in anything relating to a level of complexity  
12 where we could bring something of value to those  
13 conversations.

14 **Q.** I want to touch upon AMHP services, please. I'm not  
15 going to ask you to give indirect evidence about the  
16 actual assessments that were undertaken with VC. I want  
17 to look at some higher level issues with you, if I may.

18 **A.** Sure.

19 **Q.** Can I start with information gathering guidance. Can  
20 I take you to a document, please: WITN0114004. This is  
21 the first page of a Nottingham City Council operational  
22 policy for approved mental health professional services.  
23 Do you recognise this?

24 **A.** I do, yes.

25 **Q.** It was extant at the time we're concerned with, 2020 to

45

1 **A.** That's correct.

2 **Q.** There's no mention here about getting any information  
3 from the police.

4 **A.** No, there isn't.

5 **Q.** Would you expect an AMHP to do that if they're  
6 considering a risk of violence in relation to  
7 an individual they're assessing?

8 **A.** I would, yes. I would expect the AMHPs to be in contact  
9 with the police and potentially the police may already  
10 have some involvement, depending on the Mental Health  
11 Act Assessment that's taking place, but yes, I would  
12 agree that police would be an important partner in which  
13 to have the conversations with.

14 **Q.** As an operational policy that this is, would it not be  
15 helpful to put that into the policy to assist AMHPs?

16 **A.** It would do, yes.

17 **Q.** There's no mention either of housing or education?

18 **A.** No, there's not.

19 **Q.** Again, in the right circumstances, where it's  
20 relevant --

21 **A.** *(The witness nodded).*

22 **Q.** -- particularly if there's been incidents at someone's  
23 accommodation --

24 **A.** *(The witness nodded).*

25 **Q.** -- and they're a university student, that could be very

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1 2022; is that correct?

2 **A.** That's correct.

3 **Q.** Can I take you to page 8, please. Apologies, page 4.  
4 Section there on "Information and communication". I'm  
5 not going to read it out, it's quite lengthy, but you're  
6 familiar with it, no doubt, Mr Atherton?

7 **A.** Yes, through the information that's been provided I am  
8 aware of it. Obviously again, at the time I wasn't in  
9 Nottingham but I am aware of the document, yes.

10 **Q.** It continues over the page, please, touching upon  
11 further matters, including giving information after  
12 a Mental Health Act Assessment.

13 Now, it touches -- does touch upon this operational  
14 policy, it does touch -- and perhaps if you can go back  
15 to the previous page, please. It does touch upon  
16 gathering information from CareFirst and Castle.  
17 CareFirst is a local authority resource?

18 **A.** That's correct, yes. At the time that's what was being  
19 used, I believe.

20 **Q.** And Castle?

21 **A.** I'm afraid I don't know what Castle is.

22 **Q.** It also discusses getting information from healthcare?

23 **A.** Yeah.

24 **Q.** Also advises the AMHP to speak with the nearest relative  
25 as is required under the Act?

46

1 useful as well, couldn't it?

2 **A.** It could do, yes.

3 **Q.** Again, useful to have that in the policy, wouldn't it?

4 **A.** Indeed.

5 **Q.** Medical intervention is mentioned. We've heard quite  
6 a lot about the RiO health systems record. At the  
7 relevant times, so we're talking 2020 to 2022, there was  
8 no formal arrangement in place for social workers to  
9 have access to RiO; is that correct?

10 **A.** That's correct.

11 **Q.** Series of *ad hoc* approaches need to be made by AMHPs  
12 towards healthcare colleagues to try to look at RiO if  
13 possible?

14 **A.** Yeah, and I'm aware that some AMHPs have access, those  
15 probably who are embedded in the mental health teams and  
16 aligned much more closely to mental health colleagues.  
17 Obviously our AMHPs are placed in other teams as well,  
18 and I'm aware that the access is not the same for all of  
19 the AMHPs and there are ongoing issues with gaining  
20 access to the RiO notes.

21 **Q.** This lack of a formal arrangement, have any steps been  
22 taken to remedy that since the relevant period?

23 **A.** I'm not aware that any formal additional steps have been  
24 taken. It's sort of a by-person request that goes in to  
25 the Trust and the Trust makes the decision as to whether

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1 we've got -- that individual can have access to the  
 2 records.  
 3 **Q.** AMHPs cannot make entries on to RiO themselves, can  
 4 they?  
 5 **A.** That's my understanding, yeah.  
 6 **Q.** And so they can't update or correct the facts, they  
 7 can't add their Mental Health Act Assessments to RiO?  
 8 **A.** *(The witness nodded).*  
 9 **Q.** They have to send it and then it has to be added by  
 10 someone else, doesn't it?  
 11 **A.** That's correct.  
 12 **Q.** Has that been remedied?  
 13 **A.** No.  
 14 **Q.** Do healthcare have access to the local authority  
 15 records?  
 16 **A.** There is some read across through the systems that we  
 17 have, our care records system, where there is -- health  
 18 colleagues can see some information. Mostly it's from  
 19 a local authority perspective, we can see information on  
 20 healthcare records. At present they cannot see  
 21 information on our records but there is work that's  
 22 being undertaken to ensure that they have similar  
 23 access, not to all the information, but to some agreed  
 24 information on the system that they'll be able to  
 25 identify and utilise as part of their ongoing assessment

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1 have the information to hand of what that includes as  
 2 part of that process. So I couldn't comment  
 3 specifically on that particular element that you've  
 4 highlighted.  
 5 **Q.** Where in the guidance or policies that Nottingham City  
 6 Council has are they advised as to the regards to the  
 7 importance of protecting the public in the work that  
 8 they do?  
 9 **A.** So again, the documentation, the policy documentation  
 10 that we have that talks to the AMHP function of the role  
 11 which obviously you've highlighted is the documentation  
 12 that we have. If there isn't -- if it's not referenced  
 13 within that, then it's not referenced elsewhere.  
 14 **Q.** Can we go to document NHSE0000312, page 24, please.  
 15 This touches upon the least restrictive option,  
 16 "maximising independence", paragraph 1.2:  
 17 "Where it is possible to treat a patient safely and  
 18 lawfully without detaining them under the Act, the  
 19 patient should not be detained".  
 20 So the guidance there refers to detaining where  
 21 patients cannot be safely treated in the community. So  
 22 when we're talking about the least restrictive option,  
 23 it's the least restrictive safe option; do you agree?  
 24 **A.** Yes, that's how I'd read it also, yes.  
 25 **Q.** Therefore it's an over-simplification to refer, as you

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1 of individuals. But at this current time, they don't  
 2 have access.  
 3 **Q.** The operational policy also touches upon information  
 4 that should be given by the AMHP after the assessment.  
 5 Again, it mentions informing the nearest relative; it  
 6 mentions informing healthcare. But there's no mention  
 7 of passing on potentially risk information to the  
 8 police, housing or education. That should be in there,  
 9 shouldn't it?  
 10 **A.** It should be in there, yes.  
 11 **Q.** If you could take that off the screen, please.  
 12 When undertaking a Mental Health Act Assessment, an  
 13 AMHP is required, under Section 2 and Section 3, to  
 14 assess whether a patient requires detention with a view  
 15 to protection of others.  
 16 **A.** That's correct.  
 17 **Q.** One of the things that they need to look at is whether  
 18 there's a risk of that patient posing a risk of violence  
 19 to family, to friends or to people in the community.  
 20 What training does Nottingham City Council provide  
 21 to its AMHPs as regards assessing the risk of violence  
 22 to others?  
 23 **A.** I couldn't specifically talk to that. I know that our  
 24 AMHPs, as part of their re-warranting, have to undertake  
 25 a certain amount of training to be re-warranted. I don't

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1 do in your statement to detention being a last resort;  
 2 do you agree?  
 3 **A.** I would agree, yes.  
 4 **Q.** Are AMHPs given any guidance or training as to regards  
 5 to this nuance that we've just touched upon?  
 6 **A.** I'm not aware, no.  
 7 **Q.** Since VC's attack in -- attacks in June of 2023 there's  
 8 been a rapid review that's been undertaken by Adult  
 9 Social Care at Nottingham City Council, hasn't there?  
 10 **A.** That was undertaken in the summer of last year, so July  
 11 2025, I believe.  
 12 **Q.** Can I take you to that document please, it's  
 13 NOCC0000192. It's dated July 2025. Your statement is  
 14 dated 13 November 2025, but you say in your statement  
 15 that the report was not yet available. Could you  
 16 explain why you said that?  
 17 **A.** Yeah, I think the first draft of that statement that --  
 18 when the Rule 9 came in, I think I'd been in post for  
 19 about a month at that point, so that initial statement  
 20 had been drafted was accurate. Obviously when it was  
 21 submitted in its final form of November, that should  
 22 have been amended, so apologies.  
 23 **Q.** Since the events of June 2023, has there been any  
 24 updated guidance or training given by Nottingham City  
 25 Council to AMHPs as regards information sharing,

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1 information communication after Mental Health Act  
 2 Assessments, or on how to do a risk assessment?  
 3 **A.** I couldn't answer that having not been there at the  
 4 time. I can only probably talk to obviously the last  
 5 11 months where I've been in post.  
 6 **Q.** But you've said in your statement you're the person that  
 7 was nominated as best person to give evidence --  
 8 *(overspeaking)* --  
 9 **A.** That's correct.  
 10 **Q.** If there had been any new policies or protocols, you  
 11 should be able to tell us that, shouldn't you?  
 12 **A.** I can tell you from the period of myself coming in at  
 13 that time, and I'm not aware of anything from my time of  
 14 coming in to the role in June 2025 of new policy  
 15 documents or guidance that's been provided to our AMHPs  
 16 since then.  
 17 **Q.** One final document, please. It's PHSO000010. This is  
 18 statutory guidance that's been issued by the Department  
 19 of Health and Social Care since the attacks. It's dated  
 20 26 January 2024. Can I take you to page 18, please.  
 21 "Principle 6":  
 22 "information should be shared effectively across  
 23 relevant health and [social] care teams and  
 24 organisations across the system to support the best  
 25 outcomes for the person."

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1 wider system for a lot of the work that it is  
 2 undertaking. There isn't one that specifically looks at  
 3 discharge, but discharge is included as some of those  
 4 wider, broader, strategic conversations that take place.  
 5 **Q.** Any particular timescale for when those conversations  
 6 might lead to new protocols, new information, new  
 7 training, something tangible?  
 8 **A.** I couldn't give a timeframe that would -- that would be  
 9 an informed one at this time.  
 10 **Q.** Can I take you over the page to page 21, please.  
 11 Two pages further forward, Principle 8:  
 12 "Funding mechanisms for discharge should be agreed  
 13 to achieve the best outcomes for people and their chosen  
 14 carers and should align with existing statutory duties.  
 15 "NHS bodies and local authorities should ensure that  
 16 funding mechanisms for discharge are agreed by all  
 17 partners and should align with existing duties including  
 18 those under the Care Act ... [the] Mental Health Act ...  
 19 [the] Children Act 1989 ... 2004 and the Children's and  
 20 Families Act ..."  
 21 Have those funding mechanisms been put in place  
 22 between the local authority and NHS bodies in the area  
 23 that you work?  
 24 **A.** So we have a Section 117 policy that's been developed  
 25 between Nottinghamshire County Council, the ICB and

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1 It goes on to say:  
 2 "NHS bodies and local authorities should have  
 3 information sharing protocols in place to ensure there  
 4 is a clear process and that information is shared  
 5 between organisations across the health and care system  
 6 in a secure and timely way".  
 7 Has Nottingham City Council put in those information  
 8 sharing protocols?  
 9 **A.** I'm not aware that they've been implemented, no.  
 10 **Q.** Can I take you over the page, please, to "Principle 7":  
 11 "local areas should build an infrastructure that  
 12 supports safe and timely discharge, ensuring the right  
 13 individualised support can be provided post-direction.  
 14 "NHS bodies and local authorities should ensure  
 15 there is senior strategic leadership and oversight of  
 16 the discharge process to reduce unnecessary delays and  
 17 to make sure that discharge protocols are being  
 18 followed."  
 19 Are there any new discharge protocols since this  
 20 policy has come out or since June of 2023?  
 21 **A.** I'm not aware of them, no.  
 22 **Q.** Is there senior strategic leadership and oversight of  
 23 this issue?  
 24 **A.** There is a lot of engagement strategically between  
 25 mental health and adult social care services, and the

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1 Adult Social Care. So that's being worked on over a  
 2 number of months now. I believe it is at the point of  
 3 sign-off.  
 4 **Q.** Is that going to lead to joint funding mechanisms?  
 5 **A.** There are already joint funding mechanisms in place,  
 6 when we talk about Section 117, obviously there wasn't  
 7 in the case of VC, but we have hundreds of other people  
 8 that are supported through Section 117.  
 9 **MR WESTON:** Yes, thank you. I don't have any further  
 10 questions, but if you stay there, others might.  
 11 **THE WITNESS:** Thank you.  
 12 **MR MOLONEY:** *(Off microphone - inaudible).*  
 13 **THE CHAIR:** Yes.  
 14 **Questioned by MS CARTWRIGHT**  
 15 **MS CARTWRIGHT:** Good morning. I ask questions on behalf of  
 16 the survivors. Can I just briefly go back to the review  
 17 that was commissioned that you were taken to by  
 18 Mr Weston, NOCC0000192, please.  
 19 Thank you. This obviously was commissioned after  
 20 you came into post in the June. Can I ask you, just  
 21 first of all, before we move to the section I want to  
 22 look at on page 20 regarding Section 117 aftercare, can  
 23 you help us in terms of VC? We know that you've got  
 24 Mental Health Social Care Team North and South, which  
 25 are very differently configured.

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- 1 A. They are.
- 2 Q. Has the local authority done a piece of work to  
3 identify, across the addresses that VC lived at between  
4 2020 through to 2023, where that accommodation engaged  
5 whether it was the North Team or the South Team?
- 6 A. I'm not aware that they have, no.
- 7 Q. All right. But would you agree that essentially,  
8 particularly the North Team, it works in a less  
9 integrated way than the team in the south?
- 10 A. Yes, I would agree with that, yes.
- 11 Q. Thank you. Then can I take you to page 20, please. And  
12 just picking up on Mr Weston's theme of what the  
13 authority had done since the incident, it's right, isn't  
14 it, that this review found some significant systemic  
15 failings in respect of how the local authority  
16 discharged the Section 117 aftercare duty; would you  
17 agree?
- 18 A. I think the report highlights almost the  
19 over-prescription of Section 117 aftercare, whereas  
20 other mechanisms could be utilised to provide support to  
21 individuals, particularly around continuing healthcare  
22 and funding through the Care Act. So it has highlighted  
23 the -- that there is a lack of consistency, as it stands  
24 at this time around section 117.
- 25 Q. Well, let's -- before we deal with the bottom paragraph

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- 1 social care now have bespoke singular Section 117  
2 aftercare documents for assessments of those entitled?
- 3 A. So the work we've been doing with Section 117 with the  
4 ICB and our county colleagues, that policy will then  
5 support the changes that are required to be made around  
6 section 117 documentation moving forward. So no, it  
7 hasn't been done at this time, but it will be done in  
8 the coming months as we move through our improvement  
9 plan within adult social care services.
- 10 This rapid review was commissioned on the basis that  
11 we identify that there are areas for improvement, it  
12 also happened at the same time we did a peer review, so  
13 we are inviting external challenging(?) because we  
14 recognise there is areas we absolutely need to improve  
15 on. That will form part of our further development  
16 around our new target operating model.
- 17 Q. Okay, but you'd agree, wouldn't you, that this review  
18 found that the continued use of inappropriate templates  
19 may result in individuals being wrongly assessed, denied  
20 access to their entitlements or directed into  
21 alternative service routes that are not appropriate?  
22 This introduced risks not only of unmet need, but also  
23 of legal challenge, financial liability, and  
24 reputational damage for the local authority.
- 25 A. So I would agree that there's certainly a risk there,

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- 1 and go over the page, it's right, isn't it, that the  
2 review from the local authority has not identified any  
3 occasion during the period of time when VC became  
4 entitled to essentially unfunded packages of care after  
5 he'd had his Section 3 detention. There's no evidence  
6 whatsoever, would you agree, that anyone from the AMHPs  
7 or from the local authority talked to VC or referenced  
8 Section 117 aftercare and VC's entitlement to it in the  
9 records?
- 10 A. I don't see any reference to that from the reports that  
11 have been provided.
- 12 Q. Thank you. One of the things that this review picked up  
13 on, would you agree, that if we go over the page, that  
14 the assessment documentation, the top paragraph, please,  
15 thank you, that essentially the authority didn't have  
16 specific templates for Section 117 and so this review  
17 essentially identified that people were almost using the  
18 Care Act framework rather than having a dedicated  
19 Section 117 aftercare framework which would meet and  
20 discharge the distinct statutory duty that the local  
21 authority has for free of charge without eligibility  
22 criteria or assessment?
- 23 A. That's correct, yes.
- 24 Q. So just picking up on Mr Weston's questions, has that  
25 now been rectified and does the local authority, adult

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- 1 yes.
- 2 Q. Certainly in terms of the Care Act Framework being an  
3 inappropriate template for Section 117, would you agree  
4 that not only was there no evidence of VC under  
5 Section 117, as has already been identified, no evidence  
6 at any point, that anyone considered the Care Act  
7 Framework for VC either?
- 8 A. I would agree with that, absolutely. What I would say,  
9 though, is this was done in a period of time sort of  
10 three years post our involvement with VC. So it's  
11 difficult to talk to whether this was what was in place  
12 three years ago. I can talk to this is what's obviously  
13 the rapid review found in the summer of last year. I'm  
14 not sure how -- whether this relates to the period of  
15 time in which the team worked with VC.
- 16 Q. Thank you. I think also, just finally, it's right, as  
17 well as not having appropriate templates, the review  
18 also identified -- I don't know whether it's on this  
19 page, if it could just be expanded. Thank you. If we  
20 could go over the page, please, I think it also  
21 identified that the local authority, there was an  
22 absence of a Section 117 register. So even for those  
23 that qualified, there's not a register. Has that been  
24 rectified? Does there now exist a Section 117 register?
- 25 A. We have a list of our Section 117, but it's not

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1 a register in its current format, but it will be moving  
2 forward.

3 **Q.** Will that then mean that immediately on being aware that  
4 someone in the locality has been detained under  
5 Section 3 that they are automatically added to that  
6 Section 117 register?

7 **A.** It wouldn't, no, because it would be dependent on  
8 whether Section 117 duty would be triggered on the basis  
9 of there being identified care and support needs.

10 **Q.** But Section 117 aftercare is triggered automatically  
11 when someone has had Section 3, so would you agree that  
12 at least someone should be continually reviewing or  
13 assessing whether there is that need?

14 **A.** So the next 117 register, from our perspective, would be  
15 those individuals we're providing ongoing funding for  
16 because the threshold for care and support has been met  
17 under 117. It wouldn't be for anybody who was -- had  
18 a treatment order under the Mental Health Act, would be  
19 ultimately put onto that, it would be the register of  
20 the ones we have an ongoing supporting responsibility  
21 to.

22 **Q.** It's right, isn't it, for mental health individuals who  
23 have been repeatedly detained under Section 3, that also  
24 engages the need for specialist accommodation to be  
25 commissioned by the local authority?

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1 readmission seemed to be for his non-concordance with  
2 his medication at the time, which sits obviously from  
3 a health perspective. But obviously if somebody in that  
4 position is well and treated and has ongoing support  
5 around their medication, then there may not necessarily  
6 be any involvement for adult social care.

7 **Q.** I understand. I appreciate it doesn't fit with the  
8 facts here, but theoretically in the event that someone  
9 is treated successfully and they are discharged from  
10 hospital even if they're detained under Section 3, it  
11 wouldn't automatically mean --

12 **A.** No.

13 **Q.** -- that there would be a need for the provision of  
14 aftercare.

15 **A.** No, that is correct.

16 **Q.** Working backwards through the questions, you responded  
17 in relation to, I think, Mr Weston's questions in  
18 particular about multi-agency involvement and you made  
19 reference to various agencies such as MAPPA and the  
20 like.

21 **A.** *(The witness nodded).*

22 **Q.** Building on that, what happens in the event that  
23 somebody isn't already, for example, known to the  
24 criminal justice system? What would you do in those  
25 circumstances?

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1 **A.** Again, it would -- it's absolutely dependent on the  
2 individual at the time and the assessment what their  
3 current support needs are assessed as and what would be  
4 most appropriate. I couldn't say for VC's case what  
5 would be most appropriate for him.

6 **MS CARTWRIGHT:** Thank you.

7 **THE WITNESS:** Thank you very much.

8 **THE CHAIR:** Thank you.

9 Yes, Mr Straw.

10 Anyone from the council? Mr McNamara.

11 **Questioned by MR MCNAMARA**

12 **MR MCNAMARA:** Mr Atherton, one of the last questions you  
13 were asked by Ms Cartwright on behalf of the survivors  
14 was in relation to section 117. If a person is  
15 successfully treated in hospital, would you expect to be  
16 involved in the provision of aftercare?

17 **A.** That would depend on the identified care and support  
18 needs for the individual coming out, and whether there  
19 was an ongoing requirement for support to be in place.  
20 It will vary from individual to individual, depending on  
21 their ongoing presenting needs, or also whether there is  
22 something additional than just their mental health need  
23 they need support with.

24 Obviously having looked at some of the information  
25 related to VC, the requirement for admission or

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1 **A.** Can you give a bit more context to the question, please?

2 **Q.** Yes, forgive me, MAPPA obviously depends on we're  
3 talking about --

4 **A.** Yeah.

5 **Q.** -- about public protection in the event that somebody  
6 already has a criminal record?

7 **A.** Yes, that's correct.

8 **Q.** Or they've been discharged from, for example, hospital  
9 order with various provisions put in place by the MoJ.  
10 If you were confronted by somebody with whom there was  
11 nothing like that by way of history, so here on the face  
12 of it there's no established criminal record, what  
13 provision would you put in place for multi-agency  
14 involvement?

15 **A.** It would depend on the presenting need of the  
16 individual, it would depend on what other organisations,  
17 agencies were involved. We would -- what we would look  
18 to do is bring together agencies for discussions in  
19 relation to that particular individual and that  
20 particular presentation.

21 So the ability to have multi-agency meetings isn't  
22 defined just by the sort of formal ones we have in  
23 place; they should be accessed by the professionals  
24 involved, working with the individuals to provide the  
25 best possible care for that person moving forward.

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1 Q. Thank you. You've been asked a number of questions  
2 about care needs and in particular when section 42 is  
3 triggered, and it was suggested, for example, that in  
4 relation to Feven, the young woman who was injured when  
5 she leaped to safety, clearly she had to have hospital  
6 treatment and quite serious care and treatment as a  
7 result of that. But she was also the victim of a crime.  
8 Does the local authority investigate the care needs of  
9 all victims of violent crime who sustain physical  
10 injury?  
11 A. We do not, no.  
12 Q. Are you customarily told about the needs of all victims  
13 of violent crime who sustain physical injury?  
14 A. We are not, no.  
15 Q. Absent some sort of surveillance of the healthcare  
16 system or the criminal justice system, how would you  
17 discover that somebody required the input of the local  
18 authority for the purposes of section 42?  
19 A. We would -- if that -- if something had occurred, there  
20 would be the referral process that would need to come  
21 into Adult Social Care from -- well, that's a  
22 safeguarding concern can be raised by any number of  
23 partners or public.  
24 MR McNAMARA: Thank you very much. Those are all my  
25 questions.

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1 responding to Ellie saying he could not return to his  
2 accommodation.  
3 Q. Okay, so it's essentially a firmer position than here.  
4 It wasn't at risk, he couldn't return to it.  
5 A. Yeah, Ellie had said the placement was at risk prior to  
6 the assessment.  
7 Q. Right. Subject to that correction, can you confirm the  
8 contents of your statement are true to the best of your  
9 knowledge and belief?  
10 A. Yes, I can.  
11 Q. Briefly by way of background, you are a social worker by  
12 training; is that right?  
13 A. I have social worker training, yeah.  
14 Q. Then you qualified as an Approved Mental Health  
15 Professional in October 2021?  
16 A. That is correct.  
17 Q. It was in that role you participated in a Mental Health  
18 Act Assessment of VC on 19 January 2022?  
19 A. That is correct.  
20 Q. You've therefore only been in the role for some three or  
21 four months by that point; is that right?  
22 A. Yes.  
23 Q. I think you say you'd done no more than 20 or so  
24 assessments?  
25 A. That's what I suspect it to have been around, yes.

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1 THE CHAIR: Thank you.  
2 Right, I have no questions. So we'll break now and  
3 we'll take the morning break and we'll come back at  
4 11.30. Thank you.  
5 ( 11.20 am)  
6 (A short break)  
7 (11.30 am)  
8 MR BAYNHAM: Chair, may I please call Roseanna Crane.  
9 ROSEANNA TIFFANY CRANE (affirmed)  
10 Questioned by MR BAYNHAM  
11 THE CHAIR: Yes.  
12 MR BAYNHAM: Ms Crane, you have provided a witness statement  
13 to the Inquiry dated 13 November 2025.  
14 A. Yes, I have.  
15 Q. I understand there's a correction you'd like to make to  
16 that statement; is that correct?  
17 A. That's correct.  
18 Q. What is the correction?  
19 A. The correction is in paragraph 91, it's referencing the  
20 telephone call I have with Ellie from the University  
21 after the assessment, and in the statement it says:  
22 "Ellie stated VC's accommodation was at risk".  
23 And that should say: "Ellie had said that he could  
24 not return to his accommodation."  
25 So my response to everything after then is

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1 Q. Given your limited practical experience, do you feel  
2 your training as an AMHP had sufficiently equipped you  
3 for the assessment on 19 January?  
4 A. Yes, I was qualified as an AMHP on 19th January.  
5 Q. The Inquiry has already hearing evidence from Dr Manzar  
6 and Dr Skelton, who were the two doctors attending the  
7 assessment, and they've addressed a lot of the  
8 decision-making, the rationale, et cetera, already. So  
9 I'm not going to go through every issue with you, I just  
10 have a few short topics to ask you about.  
11 If we can, firstly, turn to the referral, which is  
12 NOCC0000062. We can see there the referral assessment  
13 was made by Ms Abi Parsonage, who we've heard evidence  
14 from, on 18 January 2022?  
15 A. Yes.  
16 Q. And you say your colleague Ms Bagtas had already done  
17 some of the work on the referral on that day, including  
18 obtaining the warrant.  
19 A. That's correct.  
20 Q. And so you then picked up the referral on the  
21 19 January?  
22 A. Correct, when a place of safety was available.  
23 Q. If we just see there the reason for contact:  
24 "[Mental Health Act Assessment] ... request. Flat  
25 tenants have contacted the [mental health] ... team due

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1 to having concerns as an incident happened last night  
 2 resulting in [VC] assaulting one of them. All other  
 3 tenants have been removed from himself as hostile and  
 4 has missed five appointments."  
 5 So it's clear there that the incident is being  
 6 described in the referral as an assault.  
 7 **A.** Yes, that is correct.  
 8 **Q.** VC has been described as hostile, and it also says there  
 9 that he's missed five appointments.  
 10 **A.** Yes.  
 11 **Q.** Is that right?  
 12 **A.** Yes, that is correct.  
 13 **Q.** If we then turn to the Nottingham City Council case  
 14 notes, NOCC0000034, and page 7. Would you have reviewed  
 15 these notes before or when you became involved and  
 16 picked up the referral on the 19th?  
 17 **A.** Yes, I would have.  
 18 **Q.** We can see there a note at the top of the page entered  
 19 by your colleague, Ms Bagtas, which provides some  
 20 further information which is that:  
 21 "... [VC is] showing relapse of Psychosis, increased  
 22 aggression, disengagement ... [and there is an] Incident  
 23 occurred where he assaulted his flatmates and trapped  
 24 them in the room. Police [were] called but no further  
 25 action as no injuries sustained."

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1 information on what had happened from the police?  
 2 **A.** I believe more information about anything relating to VC  
 3 history and leading up to the assessment is helpful.  
 4 **Q.** Why didn't you seek that information from the police?  
 5 **A.** I was working with headline information from this  
 6 document and the warrant application. I didn't seek the  
 7 information specifically, and ordinarily I don't have  
 8 high confidence it would have been available. However,  
 9 I didn't explore that myself.  
 10 **Q.** Why do you say you wouldn't have had confidence that  
 11 wouldn't have been available?  
 12 **A.** Within the timeframes that I was working towards to go  
 13 from being allocated the assessment and completing the  
 14 assessment.  
 15 **Q.** Okay, so simply practically the amount of time you had?  
 16 **A.** The time limitation.  
 17 **Q.** Would there have been any other barriers to you  
 18 obtaining further information or seeking further  
 19 information from the police?  
 20 **A.** Largely I feel that the time limitation would be the  
 21 barrier in getting the information from the people that  
 22 had it within the police.  
 23 **Q.** And so is it essentially the case that, in the  
 24 circumstances, you felt you had sufficient information  
 25 to conduct the assessment?

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1 Can you see that?  
 2 **A.** Yes, I can see that.  
 3 **Q.** Was there any doubt, therefore, in your mind, that the  
 4 incident triggering this assessment was a serious  
 5 assault?  
 6 **A.** There was no doubt this was a serious assault --  
 7 assault, a serious incident.  
 8 **Q.** Nonetheless, did you consider contacting the police to  
 9 get more information on the assault?  
 10 **A.** I had --  
 11 **Q.** -- (*overspeaking*) --  
 12 **A.** So I had these case notes and I had the information used  
 13 for the warrant application. I didn't contact the  
 14 police when I was arranging the warrant about the  
 15 assault. We had some conversations, prior to execution,  
 16 about their notes and risk history but we didn't discuss  
 17 this assault.  
 18 **Q.** Okay, so you had conversations with officers when  
 19 executing the warrant.  
 20 **A.** Just prior.  
 21 **Q.** Just prior to executing the warrant. But not about the  
 22 incident immediately precipitating the assessment.  
 23 **A.** Not more detail than what I had in these notes and the  
 24 warrant application about the assault.  
 25 **Q.** Would it have been helpful to try and find some further

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1 **A.** It's usual to use headline information. We have  
 2 a summary of the assault, the police attendance and the  
 3 outcome, and that was the information we used for the  
 4 assessment.  
 5 **Q.** If we turn to your report, which is NOCC0000040, and  
 6 you'll see the front page. So if we just go to the  
 7 front page just to familiarise yourself, we can see the  
 8 date of the referral, the date of the assessment, and  
 9 your name as the AMHP there; can you see that?  
 10 **A.** Yes, I can see that.  
 11 **Q.** If we turn to page 4, we have a note of your telephone  
 12 call with Celeste, VC's mother. And it says there that:  
 13 "Celeste advised that she was not aware of any  
 14 issues with [VC's] mental health."  
 15 That's not a positive statement that there were no  
 16 issues, is it?  
 17 **A.** What I'm trying to say with this sentence was that VC's  
 18 mother was not communicating concerns about VC's mental  
 19 health at around the time of when she reports of  
 20 speaking to him. I do believe she's aware that he has  
 21 mental health difficulties.  
 22 **Q.** Forgive me, so what I'm asking is, did you interpret  
 23 this as her saying that VC was well, or as her saying  
 24 that she wasn't aware of any reason -- not aware of any  
 25 issues with his health at that point?

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- 1 A. I believe I talk about this in my statement that at this  
2 time VC's mother was not raising any concerns about  
3 things that she had heard or spoken to him about  
4 recently about relapsing with his mental health. That  
5 didn't mean, to me, that they couldn't be there.  
6 I think in my statement I say that they don't live in  
7 the same property, so it may be easier for the picture  
8 of how she understands it to maybe be different from how  
9 it actually is.
- 10 Q. As well as them not living together, you understood that  
11 VC had withdrawn his consent for her to be kept involved  
12 and updated as to his care; is that right?
- 13 A. Yes, I did.
- 14 Q. I think you also say in your statement you suspected  
15 that VC may not have been fully open with her.
- 16 A. Yes, I put that in my statement.
- 17 Q. And you note here that Celeste was frustrated about not  
18 being more involved in VC's care; is that right?
- 19 A. Yes, I've put that there.
- 20 Q. Ultimately, her view was that she had no objection to  
21 admission if that's what the professionals thought was  
22 required.
- 23 A. That's correct, and that would have been relevant if we  
24 were pursuing a Section 3 detention.
- 25 Q. Thank you. If we then look just further down the page

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- 1 A. It would be usual for such a salient point, within the  
2 context of me being an AMHP, to do a Mental Health Act  
3 Assessment, and I do -- I'm not sure if Ellie worked  
4 with the AMHP service or she knew the AMHP service, but  
5 I have a sense that she knows our team, and I can't tell  
6 you exactly how I know that so I'm sorry if that feels  
7 speculative. But I think she believes she understood  
8 what I was there to do, so something so salient like  
9 that, when we're talking about the plan, would usually  
10 be furnished to me quite immediately.
- 11 Q. So you relied on her to say that, rather than asking  
12 about whether there were any accommodation issues  
13 yourself?
- 14 A. She's saying that the placement is at risk. She's  
15 worried about him being there. But we're not talking  
16 about an instance of he can't be there.
- 17 Q. Okay. Turning to the execution of the warrants, I think  
18 you say in your statement that when you arrived VC was  
19 sleepy, perhaps a little surprised, but there was  
20 nothing particularly unusual you felt about his  
21 presentation; is that right?
- 22 A. That's what I wrote down at the time.
- 23 Q. And you say VC co-operated in being taken to the Cassidy  
24 Suite.
- 25 A. He went with police and EMAS staff, yes.

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- 1 we can see your -- the note of your call with -- that's  
2 Ellie Turner at Nottingham University. What does she  
3 tell you?
- 4 A. Ellie advised me that VC -- I'm just reading the note  
5 here, so I don't know if I'm -- (*overspeaking*) --
- 6 Q. Take your time to read your --
- 7 A. -- meant to say something in addition, but in large, it  
8 was that there had been the incident of assault at the  
9 property and that police were called, and that students  
10 were temporarily relocated out of the flat.
- 11 Ellie had concerns about VC's mental health as being  
12 a risk indicator of aggression and how that could impact  
13 the other students, and I advised Ellie when  
14 I introduced myself that I was the AMHP that was going  
15 to be doing a Mental Health Act Assessment on that day.
- 16 Q. I think you say that you were not told during that  
17 conversation that VC was going to be unable to return to  
18 his accommodation or that that was a possibility; is  
19 that right?
- 20 A. No, I wasn't. My working knowledge at that time was  
21 that there was temporary safeguards in place and that  
22 there was still a sense of worry about risk, but it  
23 wasn't that he could not be there or that day, or after  
24 the assessment.
- 25 Q. Did you not ask that question proactively yourself?

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- 1 Q. If we can turn to your witness statement, WITN0177001,  
2 page 20, and it's paragraph 62 I want to look at first.  
3 You say that VC did respond to questions. If we can  
4 just display paragraphs 62 and 63. Thank you. You say  
5 VC did engage in a two-way dialogue. However, his  
6 answers were "just about" -- to the bottom of that  
7 paragraph -- "just about on topic but evasive and  
8 superficial."
- 9 Can you see that?
- 10 A. Yes, I can see that.
- 11 Q. And then paragraph 63: "... his delivery monotonal and  
12 flat."
- 13 And then you say you got the impression -- last  
14 sentence of that paragraph, that "he knew what to say  
15 and what not to say."
- 16 What do you mean by that?
- 17 A. What I mean is that it felt that we were leading the  
18 questions and then he would consider his answer and to  
19 say something back, so it didn't feel like he was  
20 offering up lots of information. So that impression  
21 gives me he's saying the minimal amount of information  
22 needed to progress the assessment. And I also felt that  
23 when we got to topics of medication concordance, risk,  
24 and hospital admission, he would steer his answers  
25 towards what he felt was the right thing to say to

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1 minimise or present those things as less risky.

2 **Q.** Is what you're describing there VC knowing what to say  
3 in order to avoid being detained?

4 **A.** I did get the impression that he did not want to be  
5 detained to hospital during that assessment.

6 **Q.** It sounds like you're describing a capacity or  
7 propensity to manipulate; is that fair?

8 **A.** I'm describing somebody who doesn't want to go to  
9 hospital, and is filtering the information that he's  
10 sharing. I understand why you're using the word  
11 "manipulate" but it's not the word I'm using. It might  
12 be "persuasion" or "selective information".

13 **Q.** Were you concerned by that?

14 **A.** Yes, when you're not completely confident in the  
15 information that you're getting, it will increase  
16 uncertainty in the decision-making and the information  
17 that you've got to support the decision-making.

18 **Q.** Did you make those concerns that you had clear to  
19 Dr Skelton and Dr Manzar?

20 **A.** Yes, and I believe this was a mutual feeling within the  
21 assessment, and when there were opportunities to present  
22 other evidence to VC in the interview, myself,  
23 Dr Skelton, Dr Manzar, were doing that in the moment as  
24 well.

25 **Q.** If we just go back to your AMHP report NOCC0000040, and

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1 **Q.** And I think you say in your statement that you also  
2 considered it to be an incident that related to VC's  
3 mental health.

4 **A.** Yes, and thank you, you've just sort of re-found me on  
5 what I was trying to say. It was about his response not  
6 being proportionate; that we could anchor ourselves into  
7 being confident and being able to put that forward,  
8 because, regardless of what he may discuss as the cause,  
9 that's not a proportionate response to what he was  
10 describing.

11 **Q.** It had also been reported to you that VC had disengaged  
12 from his Community Mental Health Team; is that right?

13 **A.** Yes, that's correct.

14 **Q.** And we can see on page 4 of your report the note of your  
15 call with Ms Parsonage that VC had missed five  
16 appointments, and last collected his medication on  
17 17 December 2021.

18 You note on page 5 of your report that VC said that  
19 he was taking his medication as prescribed but that he'd  
20 essentially misunderstood the doses; is that right?

21 **A.** Correct.

22 **Q.** Did you consider that to be a likely explanation?

23 **A.** It wasn't possible to be correct, and we did not  
24 consider it to be likely, and it was helpful that we had  
25 been provided with -- and we could work out that he

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1 page 5, in the big chunk of text we see in the middle of  
2 the page there, you note that VC "described the events  
3 with the flatmate as being an altercation between  
4 housemates regarding the rotor [sic] for the bathroom  
5 cleaning."

6 Can you see that?

7 **A.** Yes, I can see that.

8 **Q.** And if we go to page 7, this is where you're setting out  
9 the rationale for the decision, you note again that:  
10 "[VC] stated ... the altercation with the flatmate  
11 was a normal interaction between peers over household  
12 tasks."

13 Was it your view that this was a normal interaction  
14 between peers over household tasks?

15 **A.** No, this is just putting what his account was regarding  
16 how he had explained the incident of assault.

17 **Q.** Was it concerning that VC was describing a serious  
18 assault as a normal interaction?

19 **A.** Yes, it is concerning and it felt for myself, and  
20 I believe for the assessing team, that he was minimising  
21 the incident of assault, and that ... one sec, I'll just  
22 leave the sentence there because it's gone.

23 **Q.** Okay. So your view is this was obviously a serious  
24 assault?

25 **A.** Yes.

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1 would have ran out because we were able to put that  
2 forward to him that he would have run out if he was  
3 taking his medication, which was the first account that  
4 he gave, and then changed the account after being told  
5 he would have run out.

6 **Q.** So it was clear that he wasn't concordant at this point.

7 **A.** I don't know if it was clear; what was clear was that he  
8 hadn't been taking it as prescribed.

9 **Q.** Is that not the same thing? Forgive me.

10 **A.** Yes, I suppose where I've understood it differently is  
11 if he'd taken any, that's what I was trying to  
12 respond to.

13 **Q.** Okay, so it's a question of total non-concordance or  
14 partial concordance, but not full concordance.

15 **A.** It could not be full concordance.

16 **Q.** I asked you questions earlier about whether you thought  
17 VC was manipulating or attempting to manipulate. Did  
18 you therefore think that VC wasn't being truthful about  
19 this point?

20 **A.** It was a probability that he could be not being honest  
21 about his medication concordance in the assessment.

22 **Q.** And again, did you make your view on that clear to  
23 Dr Skelton and Mr Manzar?

24 **A.** I believe that this was a working knowledge between us  
25 and we had discussed prior and after about the risk

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1 around medication non-concordance.

2 **Q.** Turning to the decision itself, why was VC not detained?

3 **A.** VC, the assessment itself, it was difficult to discuss

4 in terms of the legal criteria for detention, that the

5 outcome of least restrictive option was a hospital

6 detention under the Mental Health Act. Therefore we

7 couldn't detain him, and for my decision as an

8 independent decision with no medical recommendations,

9 I was then not making an application for detention.

10 **Q.** If I can just turn to a couple of paragraphs in your

11 witness statements, first of all paragraph 88 on

12 page 28. You say there:

13 "I remember Dr Skelton was clear in his view that VC

14 could be discharged to the community and supported by

15 the Crisis Team."

16 And that he then started "writing up prescriptions

17 ... as soon as the discussion was over."

18 Paragraph 90 at the bottom of that page, you say:

19 "Dr Skelton was comfortable to own the risks

20 associated with this [ie, the community treatment plan]

21 from the perspective of the Crisis Team."

22 Then over the page, if we just go down a little, in

23 the middle of that paragraph there, you say:

24 "Dr Skelton had an influential perspective, and

25 I trusted the judgement of the doctors. It was after

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1 this was an appropriate plan?

2 **A.** It's not "persuaded" because I wasn't saying that it

3 wasn't and he was saying that it is.

4 Dr Skelton's input is to inform me about the

5 appropriateness of this plan. If I had something that

6 was -- felt quite stark, I could challenge that, but I'm

7 not leading the appropriateness of that plan within that

8 team. So "persuaded" is a difficult word, but he is

9 influential because he is able to put that plan forward

10 and to own that plan. So I am influenced by that

11 position, but I wasn't persuaded.

12 **Q.** Okay, but you went into the conversation thinking it was

13 quite a high chance that VC was going to be detained

14 until Dr Skelton gave further information on what the

15 community treatment plan could look like?

16 **A.** No, I mean I went into the Mental Health Act Assessment

17 with that feeling --

18 **Q.** Okay.

19 **A.** -- not the professionals' discussion. Then I believe

20 I used wording of it was feeling balanced.

21 **Q.** Right.

22 **A.** So ...

23 **Q.** Just briefly, if we can look at paragraph 84 in your

24 statement, you say -- sorry, page 27, paragraph 84. You

25 say:

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1 our professionals' discussion that I held the view that

2 I was comfortable in applying the least restrictive

3 option Community treatment."

4 You say you were comfortable with that plan after

5 the discussion. What was your view going into the

6 discussion?

7 **A.** So I hadn't made a decision or an assessment within that

8 assessment around the treatment in the community because

9 it's not something that is my focus from a Crisis Team

10 perspective, and I feel that before going into the

11 assessment it felt quite high that he would be detained,

12 just generally looking backwards at the history.

13 **Q.** So you don't know the details of the Crisis Team and

14 what they can provide because that's not your role?

15 **A.** To this detail, and that's not what I was focused on in

16 the assessment, that is what I would be deferring for

17 the input from. If it wasn't from Dr Skelton on this

18 occasion it would likely be another practitioner from

19 the Crisis Team. I don't confidently say they

20 definitely can do this particular treatment plan.

21 **Q.** And you repeat again at -- we don't need to turn to

22 it -- at paragraph 96, you repeat twice more that

23 Dr Skelton was comfortable to own the risk or take

24 ownership of the risk of that plan.

25 Were you persuaded by Dr Skelton, effectively, that

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1 "It is important that the plan was about treatment.

2 This was not an [assessment] ... for the purpose of

3 assessing his condition, this was about treatment

4 because we already knew what his diagnosis was."

5 By that, do you mean that this was really a choice

6 between no detention or Section 3?

7 **A.** It felt that this assessment -- we didn't, because we

8 weren't detaining, we didn't get into the conversation

9 as a group around Section 3. My view was looking at

10 a recent discharge, and I'd spoken to Mum to make sure

11 that if we were looking at Section 3, which felt very

12 much on the table, for want of a better phrase. That

13 was a possibility, so it was about treatment.

14 **Q.** Yes, so you're faced with what seems to be a relapse of

15 a known condition, recent admission, it's a question of

16 whether admission is necessary to treat that condition;

17 as you say here, it's not about assessing the condition.

18 **A.** So we didn't go into that conversation --

19 **Q.** Didn't get to that stage -- (*overspeaking*) --

20 **A.** -- as an assessing team around what's happened between

21 discharge to now? What's typical? Is there anything

22 that feels different? So that would have come

23 afterwards, but it was very much on the table,

24 a Section 3 assessment.

25 **Q.** You have some administrative involvement in the

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1 assessment a week later, just over a week later, on  
 2 28 January. Are you able to say from that involvement  
 3 whether it's likely the assessment there would have been  
 4 the same choice, ie, looking really at Section 3 or no  
 5 detention, or are you not able to comment on that?  
 6 **A.** We didn't discuss it in the assessment that I was a part  
 7 of and I wouldn't want to speculate.  
 8 **Q.** If we can go back to your AMHP report, I just briefly  
 9 want to look at the risk summary. It is page 7 of the  
 10 report NOCC0000040. You assessed the risk to others as  
 11 medium likelihood. Why was that? Can you see that in  
 12 the page now?  
 13 **A.** Yes, I can see this. So this risk assessment has  
 14 identified a risk to others. This is looking at the  
 15 historical information and then the incident of assault  
 16 and the severity of that is that it's highly severe for  
 17 that risk to occur.  
 18 The medium likelihood rating is given after the  
 19 assessment and this is considering the safeguards in  
 20 place, agreed between the University accommodation, Uni  
 21 and police at the time. The closer supervision in the  
 22 community from the Crisis Team and supervised medication  
 23 concordance which links VC being treated and well to be  
 24 reducing this risk, but I'm not saying that VC is  
 25 treated and well at that time, but it's about having

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1 **Q.** The flatmates may have been moved, but wherever he is,  
 2 he's going to have neighbours, he's going to have other  
 3 people in close proximity, isn't he?  
 4 **A.** Yes, that's correct.  
 5 **Q.** So that mitigation measure only addresses the risk to  
 6 a certain number of individuals; it doesn't address the  
 7 risk to others in proximity with VC or indeed the wider  
 8 public?  
 9 **A.** Correct, and I do understand the point that you're  
 10 making. So we've got the incident of assault that has  
 11 taken place and the safeguards for that immediate  
 12 environment inside of the flat. There's a bit of time  
 13 that passes with -- from the incident to executing the  
 14 warrant, where we don't see further, and it's not to say  
 15 that that means everything's resolved, and then we've  
 16 got the closer monitoring. So it's not eliminated. A  
 17 risk assessment, it is difficult and it's not -- you  
 18 can't fully predict, but it was looking at the -- those  
 19 things together, and seeing if that felt proportionate,  
 20 and it can be dynamic and respond to further  
 21 information, further evidence.  
 22 **Q.** Forgive me. So part of the reason for the medium  
 23 likelihood is the fact that the flatmates have been  
 24 moved, which addresses the risk to them but not to  
 25 others; is that right?

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1 that plan in place.  
 2 **Q.** Yes.  
 3 **A.** -- (*overspeaking*) --  
 4 **Q.** So if he was treated and well, the risk would be medium?  
 5 **A.** So at that time I've put it as medium because that plan  
 6 is in place. So it's -- my thinking at the time was  
 7 that those measures or that plan that was in place had  
 8 reduced the risk around safeguarding and increased  
 9 supervision and supervised treatment as a plan.  
 10 **Q.** When you talk about mitigations and provisions, are you  
 11 talking about VC's flatmates being relocated?  
 12 **A.** Yes, the -- (*overspeaking*) --  
 13 **Q.** If they hadn't been relocated, would the risk be high?  
 14 **A.** Like -- possibly, but I think there'd have to be more  
 15 exploring with VC, with the flatmates, about how they  
 16 felt, and that wasn't something that I had done at the  
 17 time to see if that was going to be high. It's --  
 18 I didn't do that.  
 19 **Q.** Did you understand the risk to be uniquely posed to  
 20 those that VC lived with?  
 21 **A.** Yes, or lived around.  
 22 **Q.** Well, quite, because here it says there's a risk,  
 23 particularly those who live in close proximity such as  
 24 neighbours and flatmates.  
 25 **A.** Yes.

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1 **A.** In part that -- (*overspeaking*) --  
 2 **Q.** Forgive me, the other aspect of the plan is the  
 3 treatment plan that's been put in place, closer  
 4 supervision; is that right?  
 5 **A.** Supervision and supervised treatment.  
 6 **Q.** Yes. But that of course relies on that plan working, VC  
 7 complying with it; yes?  
 8 **A.** Yes.  
 9 **Q.** Also, it's not going to immediately reduce the risk  
 10 because there would be time for that treatment to take  
 11 effect?  
 12 **A.** That's correct.  
 13 **Q.** Bearing those points in mind and his history of violence  
 14 and aggression, on reflection do you think that risk  
 15 should have been assessed as high?  
 16 **A.** It's high, it can have high, and the reasons that I've  
 17 put, I'd put medium. The severity absolutely is high,  
 18 and it was the likelihood that was felt to be a medium  
 19 because of those things that had been put in place.  
 20 **Q.** Just on reflection, going through those issues, do you  
 21 think the likelihood should also have been high?  
 22 **A.** So in this particular incident with the flatmates, it  
 23 was with the flatmates, and we didn't have anything to  
 24 indicate further delusions, that would be a bit more  
 25 generalised. I do understand that the cause was more

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1 interpersonal within that flat rather than something  
 2 that linked VC's aggression to the public at large for  
 3 this particular incident.  
 4 So I do understand what you're saying. However,  
 5 this is how I'd understood it at the time, to be medium.  
 6 **Q.** Okay. Just moving on to after the assessments, you then  
 7 speak again with Ms Turner; is that right?  
 8 **A.** Yes.  
 9 **Q.** From the university?  
 10 **A.** Yes, that's correct.  
 11 **Q.** It's that conversation that -- well, tell us what she  
 12 says about VC's accommodation in that conversation?  
 13 **A.** Ellie shares that he can't return back to the placement.  
 14 That was the sentence, maybe not word for word, but to  
 15 that effect.  
 16 **Q.** You say that information felt to you like a tipping  
 17 point; is that right?  
 18 **A.** It felt in that moment, yes, as a tipping point. If  
 19 there's no accommodation for a community treatment plan,  
 20 it would undermine the successfulness, and then thus  
 21 increase the risk more widely, including risk to the  
 22 public at large.  
 23 **Q.** Yes, but at that point Dr Manzar had already left,  
 24 I think; is that right?  
 25 **A.** That's correct.

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1 **A.** So we had concluded that assessment prior to speaking to  
 2 Ellie ... VC has been discharged so what I could do it  
 3 would be starting a new process. So when I've gone back  
 4 to the Cassidy Suite, I'm informed the placement, he can  
 5 return to the placement. The placement is at risk,  
 6 which is as I had understood it to be at the beginning  
 7 of the assessment.  
 8 **Q.** Right. Just finally, you set out a number of  
 9 reflections and recommendations at the end of your  
 10 statement. The first is that an Assertive Outreach  
 11 capability would be of benefit in cases such as VC's  
 12 and, in particular, you say that might have the effect  
 13 of reducing the need for Mental Health Act Assessments.  
 14 Can you just expand briefly on that?  
 15 **A.** So I understand that there used to be Assertive Outreach  
 16 functions in this Trust where I work. I don't work --  
 17 I work alongside, and they have more resource and  
 18 smaller caseloads to work with more challenging people  
 19 to engage.  
 20 **Q.** I'm not talking about just specifically what benefit the  
 21 team might have been for VC's treatment, but the  
 22 specific points on the interrelation between that and  
 23 demand on the AMHP service. You say that an Assertive  
 24 Outreach Team or function, you think, might reduce the  
 25 need for Mental Health Act Assessments; is that right?

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1 **Q.** But you spoke to Dr Skelton?  
 2 **A.** Yes, we were --  
 3 **Q.** What was his response?  
 4 **A.** So we agreed that I would provide this additional  
 5 information to VC because we hadn't shared that in the  
 6 assessment, and that might impact his decision around  
 7 informal admission, and then I passed the telephone to  
 8 Dr Skelton because I didn't want to -- Ellie's phone  
 9 call to be terminated. It wasn't finished at that  
 10 point, but I didn't want to miss the opportunity to  
 11 speak to VC.  
 12 **Q.** So VC then reviewed an informal admission that you put  
 13 to him?  
 14 **A.** That's correct.  
 15 **Q.** So the decision was made to carry on with the plan that  
 16 had already been discussed before this information came  
 17 to light?  
 18 **A.** So the decision was already made prior to the  
 19 conversation with VC and VC declined informal admission  
 20 again, even in light of the new information.  
 21 **Q.** But there was nothing you could do to revisit your  
 22 decision, one, because you require supported medical  
 23 opinion which wasn't available to you, Dr Manzar had  
 24 left, and Dr Skelton, it didn't cause him to revisit his  
 25 view on the appropriateness of the plan, did it?

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1 **A.** Um -- can I see it?  
 2 **Q.** We can turn to it if we need to.  
 3 **A.** Can I see it?  
 4 **Q.** Yes, it's the final page of your witness statement.  
 5 Page 34.  
 6 **A.** Yes, okay. Thank you.  
 7 **Q.** At the end of paragraph 102:  
 8 "... if there [was] a mechanism and more capacity by  
 9 which teams could be more assertive, I suspect that  
 10 there would be fewer requests for [Mental Health Act  
 11 Assessments]."  
 12 I'm just trying to understand why that would be.  
 13 **A.** Thank you, yeah. So I suspect there would be fewer  
 14 Mental Health Act Assessments, suspect is -- I'm  
 15 speculating. If you've got an assertive engagement  
 16 function, which the Crisis Team do offer, it's not to  
 17 say that there isn't one there, the Crisis Team offer  
 18 it. That's going to be with, I believe, your sort of  
 19 long-term care team, so there's less sort of transition,  
 20 and I do think that that's beneficial for keeping people  
 21 well for longer.  
 22 **Q.** Yes. So is it that if there was an -- a more assertive  
 23 team, there would be less disengagement and therefore  
 24 less need for Mental Health Act Assessments that arise  
 25 because of someone disengaging from their Community

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1 Team? Is that the short causal relationship between the  
2 two?  
3 **A.** So I'm saying that if people are kept well for longer  
4 and supported within their team and have that resource  
5 and capacity and function, that would in turn result in  
6 possibly fewer Mental Health Act Assessments.  
7 **Q.** So if one was considering the resources required for an  
8 Assertive Outreach Team, one point to put on the other  
9 side of the scales might be potential impact on the  
10 council and the AMHP service?  
11 **A.** Just -- (*overspeaking*) --  
12 **Q.** Is that what you are saying?  
13 **A.** I'm not really thinking about the council resourcing,  
14 I'm more just thinking about people staying well for  
15 longer and not requiring Mental Health Act Assessments.  
16 **MR BAYNHAM:** I'm grateful.  
17 Chair, those are my questions.  
18 **THE CHAIR:** Yes, Mr Moloney.  
19 **Questioned by MR MOLONEY**  
20 **MR MOLONEY:** Only a very few, Ms Crane.  
21 If I could ask you about the circumstances of VC's  
22 second refusal of an informal admission. So you offered  
23 him an informal admission to start with, and that was  
24 refused, but then you spoke to Ellie Turner and you  
25 offered him a second informal admission or there was

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1 **A.** (*The witness nodded*).  
2 **Q.** You described that this morning to the Chair as not  
3 proportionate to the situation was the feeling you got  
4 about it.  
5 **A.** Correct.  
6 **Q.** You knew he was not fully concordant with medication.  
7 **A.** Correct.  
8 **Q.** And he was minimising his behaviour.  
9 **A.** We felt that he was minimising, for sure.  
10 **Q.** Yeah, and you knew from his history that he couldn't be  
11 relied on to comply with medication.  
12 **A.** I understand that there have been times that he stopped  
13 his medication.  
14 **Q.** Yes. Whilst telling people that he was taking  
15 medication.  
16 **A.** I can't recall what I've specifically read about him  
17 saying he has when he hasn't historically. I know that  
18 that was what occurred in my assessment.  
19 **Q.** All right. Thank you, Ms Crane. It's just this: on  
20 reflection now, and obviously it's very difficult with  
21 hindsight, anyone can speak with hindsight, but would  
22 you now have detained at that first assessment, given  
23 all of that that you knew?  
24 **A.** In terms of --  
25 **Q.** Given all of those circumstances, should you have

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1 a second offer made of informal admission.  
2 **A.** Yes.  
3 **Q.** Can you just describe what was said between you and  
4 where that was when you had that conversation with VC?  
5 **A.** So I had left the Cassidy Suite because I understood he  
6 had been discharged, and came round to find where he was  
7 waiting for a taxi, which was near to the car park.  
8 **Q.** Yes.  
9 **A.** And I informed him that I had spoken with the Uni and  
10 been told that he couldn't go back to the accommodation,  
11 and that this wasn't information that we'd shared in the  
12 assessment, and therefore there's still the option,  
13 and -- of bed, if he wants to come in as an informal  
14 patient, and he said, "I don't want to be an informal  
15 patient," and I said a bit more along the lines of "If  
16 you haven't got anywhere to stay, it's probably a good  
17 idea, you know, when you're informal you can ..." talked  
18 a bit about the difference in restrictions, and he said  
19 something along the lines of "I will resolve the  
20 accommodation issue."  
21 **Q.** Yes. So that he would solve that accommodation issue,  
22 yes.  
23 Can I just ask, finally, when you assessed VC, you  
24 knew he'd reacted to a situation in a violent way with  
25 his flatmates.

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1 detained at that point?  
2 **A.** So those circumstances are important and relevant.  
3 **Q.** Yeah.  
4 **A.** It was about the criteria, and I don't believe that  
5 those circumstances contrib -- can make the criteria be  
6 met. It was about the interview and it was about the  
7 presentation and the assessment of the doctors around  
8 mental disorder, degree, nature, that it felt we were  
9 stuck on in that particular assessment.  
10 **MR MOLONEY:** All right. Thank you, Ms Crane.  
11 **THE CHAIR:** Thank you.  
12 Yes, Ms Cartwright.  
13 **Questioned by MS CARTWRIGHT**  
14 **MS CARTWRIGHT:** Ms Crane, it's just one question. It was  
15 when you told us about you then were aware that VC had  
16 lost his accommodation. Did you know he'd had  
17 a detention under Section 3, so had an entitlement under  
18 Section 117 for the assistance of the local authority to  
19 help him find specialist accommodation?  
20 **A.** Yes, I did know he's been detained under Section 3.  
21 **Q.** But did you tell VC that he could get help with  
22 accommodation, and it would be free if he met the  
23 criteria?  
24 **A.** I didn't discuss 117 in that conversation. When  
25 I returned after the conversation I had with him,

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1 I understood that he was not homeless. If that had have  
2 been different, I feel that in terms of exploring  
3 possible options, 117 accommodation would have been  
4 something to consider at that time because it was  
5 important to his mental health and important to the plan  
6 and the decision that had just been made.

7 **Q.** Okay. Can I just ask you on accommodation, one other  
8 provision. There's a rehabilitation unit called Bracken  
9 House, is that correct, that's available that can help  
10 with rehabilitation, people with mental health problems  
11 but also to support with education? Were you aware of  
12 Bracken House Rehabilitation Unit and whether that was  
13 an option to raise with VC at that time also, that you  
14 could look to see if they had a place for him?

15 **A.** It's not something that I had come to me on the day.  
16 I've heard of Bracken House as a placement for people.

17 **Q.** Right.

18 **A.** I don't know about the rehabilitation side of it. I've  
19 not got a lot of knowledge on Bracken House.

20 **MS CARTWRIGHT:** Okay. Thank you very much indeed.

21 **THE CHAIR:** Yes, Mr Straw.

22 **Questioned by MR STRAW**

23 **MR STRAW:** Ms Crane, I represent VC's family.

24 Could we have document NOCC0000040 on screen,  
25 please. Page 4. This is your report from 19 January

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1 **Q.** She wasn't involved in his care at that point?

2 **A.** I didn't have any information to say that she was  
3 providing any care, but it sounds and is being said to  
4 me that they're having telephone calls.

5 **Q.** You note that she spoke to VC. She spoke by phone, she  
6 wasn't seeing him face-to-face, was she?

7 **A.** We didn't talk about her seeing him face-to-face. I  
8 know that they'd been speaking via phone. I didn't ask  
9 if they were seeing each other face-to-face.

10 **Q.** Were you aware that psychiatrists indicated that seeing  
11 VC face-to-face was important because he was someone  
12 that masked his symptoms?

13 **A.** When did they say that?

14 **Q.** It was significantly earlier, but were you aware of that  
15 at all?

16 **A.** Generally, it would be better, more than better, to see  
17 people face-to-face to understand their mental health  
18 and just general circumstances. We have to do that as  
19 part of the Mental Health Act, so that would suggest  
20 that it's helpful.

21 **Q.** You note here that Celeste understood VC was taking his  
22 medication at that point. You were aware he wasn't  
23 taking it, weren't you?

24 **A.** I had been informed that he would have run out of  
25 medication by now if he was fully concordant.

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1 and you were referred to a section earlier about it.  
2 It's at the top of the page. It's about the telephone  
3 conversation you had with Celeste Calocane on 19  
4 January 2022, the first line was read out and it goes  
5 on:

6 "Celeste advised that she had spoke to [VC] the day  
7 before, he had asked if she was okay. That was it.  
8 Celeste advised that he stated he is taking his  
9 medication as well as stating he was seeing the doctor  
10 next week. Celeste advised she was frustrated about  
11 often not being involved in [VC's] care, often only ever  
12 receiving a call when there was a Mental Health Act  
13 Assessment. Celeste feels hopeless in [VC's] care,  
14 however acknowledges that [VC] has said that she can't  
15 talk with professionals so that is why they do not ring.  
16 Celeste advised that she accepts [that] if [VC] needs to  
17 go to hospital stating what needs to be done should be  
18 done."

19 A few questions about that, please. Firstly, is it  
20 right that you were aware that Celeste wasn't receiving  
21 information from professionals about VC at that point?

22 **A.** Yes, I was aware that phone calls to VC's mum were often  
23 limited to Mental Health Act Assessments. I can see  
24 that there's a record around them being Mental Health  
25 Act Assessments.

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1 **Q.** So would you agree it appeared he was hiding things from  
2 Celeste?

3 **A.** That was what I had taken from this conversation against  
4 the Mental Health Act Assessment and other information  
5 I had.

6 **Q.** Thank you. Could we then please move on to Ms Crane's  
7 witness statement, so WITN0177001, and page 15. Thank  
8 you. In the bottom of paragraph 48 you continue on this  
9 topic so you say:

10 "I also sensed she [Celeste] was despairing because  
11 VC would not let her be involved. I did not conclude VC  
12 was likely well as a result of the conversation, however  
13 could be well enough to mask his symptoms when speaking  
14 to his mum."

15 In summary of all of this, was it your view she  
16 wasn't really in a position, because of all of those  
17 factors, to make an informed judgement about his mental  
18 state?

19 **A.** I wasn't looking for an informed judgement around mental  
20 state and I do consider that her availability of seeing  
21 him and maybe having a judgement might be impaired by or  
22 would be impaired by the distance and the -- even  
23 distance around his care and his support needs that he  
24 had put in place with his mother.

25 **Q.** Thank you. Finally, just a different topic, in

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1 paragraph 41 of your statement, if we could just look at  
2 that please, it's page 12, you referred to some  
3 information you received from Abigail Parsonage, and you  
4 say this so:

5 "The references to VC being paranoid, angry and  
6 confrontational [I think that came from Ms Parsonage]  
7 recorded in the contacts are important ... The  
8 significance of this information is that VC was probably  
9 unwell."

10 Can you explain, please, why you considered that VC  
11 was probably unwell.

12 **A.** So when I read that or was provided that information on  
13 the telephone call, that was the significance I've taken  
14 from that information from Abi at face value. That was  
15 because these presentations seemed to be linked to his  
16 relapse indicators around his mental health, paranoid  
17 specifically, and then angry, linking it to agitation.

18 **Q.** Okay, thank you very much.

19 **THE CHAIR:** Mr McNamara.

20 **Questioned by MR McNAMARA**

21 **MR McNAMARA:** Thank you. Just couple of questions, please,  
22 Ms Crane. You were asked about a place called Bracken  
23 House; are you familiar with it?

24 **A.** I've heard of that as a placement where people sometimes  
25 are, if I've worked on a case, a duty system, and that

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1 had -- the evidence that's been given is that they had  
2 left, they had taken a few belongings, but they were  
3 always going to return because they had exams. Were you  
4 aware of that?

5 **A.** I was aware of a delay around the place of safety.  
6 I don't know if that put the incident a couple of days  
7 before my assessment. So there's a delay around place  
8 of safety, there's getting the warrant, there's getting  
9 the referral to us. So I was aware that the flatmates  
10 had been relocated as a result of the incident. But if  
11 it was the day before --

12 **Q.** It was.

13 **A.** -- then that means they might have been in there with VC  
14 directly after the incident for a few days, and I didn't  
15 know that.

16 **Q.** All right. If we could turn to your report,  
17 NOCC0000040, we can see what you're told about that.  
18 It's page 4 of that document. Can you see about halfway  
19 down the page, telephone call with Ellie Uni mental  
20 health team?

21 **A.** Yes.

22 **Q.** You can see there:

23 "Ellie advised that there were risks regarding [VC]  
24 being at his property waiting for an assessment. Ellie  
25 advised that the other students were not at the

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1 that would be probably like a residential-type placement  
2 which would indicate residential or above level of  
3 support, but I don't know what it is.

4 **Q.** Do you know who runs it?

5 **A.** Who what's it?

6 **Q.** Do you know who runs it?

7 **A.** No.

8 **Q.** So would it be news to you if it was run by the Trust,  
9 for example, rather than by the local authority?

10 **A.** Those two things are relevant, at that particular time.

11 **Q.** Would it be news to you, for example, to discover that  
12 it's usually for residential mental health care for  
13 those who are already known to mental health services?

14 **THE CHAIR:** Well, that's evidence, isn't it? She doesn't  
15 know anything about it.

16 **MR McNAMARA:** Very well. Thank you. No more questions.

17 **THE CHAIR:** Yes, Ms Patry, I missed you out.

18 **Questioned by MS PATRY**

19 **MS PATRY:** Thank you, Chair.

20 Ms Crane, I ask questions on behalf of the  
21 University of Nottingham.

22 Three short topics. Before I ask my questions, can  
23 we situate ourselves in time. Your involvement was on  
24 19 January. The day before, VC's flatmates had been  
25 moved out of the flat that he shared with them. So they

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1 property, however this was temporary as they need to be  
2 back home so they can study for exams."

3 And she wanted an update.

4 So can we be clear, when you first spoke to  
5 Ms Turner, she told you this was a temporary  
6 arrangement, didn't she?

7 **A.** Yes, it was a temporary arrangement.

8 **Q.** They needed to come back to the flat so they could study  
9 for the exams?

10 **A.** It was temporary and, yes, they needed to be back where  
11 they lived to study for exams, yes, she did say that and  
12 I did understand that at the time.

13 **Q.** I'm really grateful. Can we turn on in the bottom of  
14 this document to page 5, please. Again, discussion with  
15 Ellie, uni, mental health, right at the bottom of that,  
16 and then over on to page 6 and ambiguity re his  
17 residence there.

18 Can we see where it says in the second line on  
19 page 6:

20 "Dr Skelton provided some input to Ellie, advising  
21 that a community plan is the least restrictive option,  
22 however he would require home in order to do this."

23 Then right at the end:

24 "It was emphasised that stability for [VC] was  
25 important to the community plan being successful."

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1 Do you recall that conversation?

2 **A.** So I am not present when this conversation was  
3 happening, this is my summary of when the conversation  
4 is fed back to me and then sort of a bottom line on how  
5 the status of accommodation stability is left.

6 **Q.** All right. But do you accept or do you agree that by  
7 offering alternative accommodation to his flatmates on  
8 a temporary basis, this was the most flexible option to  
9 allow for stability for VC during this period prior to  
10 the Mental Health Act Assessment?

11 **A.** The offer of alternative accommodation, that safeguard  
12 was very flexible for those that offered it, and those  
13 that co-operated with it, the flatmates in VC's benefit  
14 and in the safety of them, definitely.

15 **Q.** You accept it was also for VC's benefit -- kept him  
16 stable, meant he stayed in the flat, he didn't have to  
17 move and you kept him stable pending the Mental Health  
18 Act Assessment; do you agree?

19 **A.** So I was never informed that this arrangement was just  
20 into the lead-up of a Mental Health Act Assessment.

21 **Q.** All right.  
22 My second topic is this: can I ask you to turn to  
23 page 15 of your witness statement WITN0177001. Page 15,  
24 paragraph 49, please.  
25 Did you see it refers to the GP, but then about

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1 a criticism; it was just a statement of fact that there  
2 wasn't information shared.

3 **Q.** Thank you very much.  
4 Then finally I want to ask you about what happened  
5 after the Mental Health Act Assessment had taken place.  
6 You corrected paragraph 91 of your statement this  
7 morning to say that Ms Turner told you that VC could not  
8 come back to the accommodation.

9 **A.** Yes.

10 **Q.** Right. Now, are you sure about that?

11 **A.** So it was -- he's been discharged and he -- I'm passing  
12 on the information of the assessment and then the  
13 outcome and that that would mean that he was being  
14 discharged home is how the conversation starts. And  
15 then she says that he couldn't go back to his  
16 accommodation, which is what I'm -- respond to in that  
17 moment, because we were aware that he -- the placement  
18 was at risk, was shared before, and we were working with  
19 that. It's at risk, there's not scope for anything to  
20 be further occurring, is essentially what I'm  
21 understanding before. But after, it was that we're  
22 discharging him to somewhere he can't go, which is --

23 **Q.** Is it possible, Ms Crane, that you misunderstood the  
24 position? The reason I say that is he was in the  
25 accommodation when you came to conduct the Mental Health

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1 halfway down the paragraph:  
2 "The university may also have insights from tutors,  
3 no additional information in this view was shared from  
4 Ellie so I worked with the assumption that there was no  
5 further information to explore ..."  
6 Now, I don't know if you heard the evidence of  
7 Mr Atherton earlier this morning. He seemed to accept  
8 that AMHPs should be proactively seeking information  
9 from education establishments such as the University.  
10 Did you seek any information from Ms Turner or anyone  
11 else relating to what the tutors might think about all  
12 of this?

13 **A.** I didn't ask about the tutor's impression of his mental  
14 health. I don't think I'd ask about mental health, but  
15 I didn't -- I'd accept if they shared things but  
16 I wouldn't be looking for their opinion on his mental  
17 health. But around his studies isn't something that I  
18 sought. And for the purpose of the assessment, it  
19 doesn't link directly to the criteria that we're  
20 assessing.

21 **Q.** You seem in this paragraph to be criticising Ms Turner  
22 for not having provided additional information. Do you  
23 accept that it is your responsibility to ensure that you  
24 proactively seek and acquire salient information?

25 **A.** I have a responsibility to seek information and it's not

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1 Act Assessment, he went back to the accommodation and  
2 remained there until February. Right?

3 **A.** Yeah.

4 **Q.** Ms Turner has no power to evict him from non-university  
5 accommodation. Is it possible that you misunderstood?

6 **A.** So we were talking, the further information was --  
7 I think it's in a case note that I write directly after  
8 the conversation around unfit grounds to study, and  
9 something else. There was two phrases that I'd taken  
10 from the conversation with Ellie after. I'm not going  
11 to rule out any possible miscommunication, however,  
12 looking at how I've responded quite quickly and urgently  
13 to my perceived -- happy to use that word -- change in  
14 accommodation status, and the information that I then  
15 relay to VC to say, "It's quite possible you can't go  
16 back" or "You can't go back" we're on these lines, and  
17 it was a few years ago, that reaction was to new  
18 information, or what I had understood and felt was new  
19 information.

20 **Q.** Again, can we agree it was your responsibility to find  
21 out what the accommodation position was for VC after the  
22 Mental Health Act Assessment had taken place?

23 **A.** I would have -- it's the conversations before because  
24 afterwards it is -- it's less helpful to find out things  
25 afterwards.

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1 Q. It is, which is why you should have asked the question.  
 2 A. Before?  
 3 Q. Yes.  
 4 A. So before, when I had spoken with Ellie, I had  
 5 understood that he was in accommodation and that the  
 6 status was a temporary plan around the students and VC.  
 7 It wasn't about this plan is until this particular time,  
 8 like the assessment, or it wasn't about this plan isn't  
 9 working and cannot continue. So they would indicate  
 10 a risk of homelessness, but I got that information after  
 11 the assessment.  
 12 MS PATRY: Thank you very much. Those are my questions.  
 13 Thank you, Chair.

14 **Questioned by THE CHAIR**

15 THE CHAIR: Yes, I just wanted to ask you a couple of  
 16 questions, Ms Crane. Just turning to that page, I think  
 17 it's NOCC-- it's your report -- 0000040, at page 7.  
 18 Do you have that? I think it'll come up in  
 19 a moment.  
 20 A. Not at the moment. I think it's coming.  
 21 THE CHAIR: Just looking at that and the risks, the two with  
 22 high severity are "Further decline of mental health" and  
 23 the "Risk to Others", who -- "Physical and verbal risk  
 24 to members of the community ... who live in close  
 25 proximity". Do you agree with that? The others are

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1 A. So when I'm looking at the least restrictive option I'm  
 2 thinking about the Act and the decision. I do accept  
 3 that that as a response to a flatmate is highly  
 4 impacting on the flatmates.  
 5 THE CHAIR: Yes. All right, thank you.  
 6 We'll now take a five-minute break and then we'll  
 7 come back. Thank you.

8 (12.38 pm)

9 (A short break)

10 (12.44 pm)

11 MS LANGDALE: Chair, may I call Helen Foster, please.  
 12 THE CHAIR: Yes.  
 13 HELEN FRANCES FOSTER (sworn)  
 14 Questioned by MS LANGDALE  
 15 MS LANGDALE: Ms Foster, you gave a statement to the Inquiry  
 16 dated 12 February 2026. Can you confirm the contents  
 17 are true and accurate as far as you're concerned?  
 18 A. Yes.  
 19 Q. And you tell us in that statement that you qualified as  
 20 a nurse in 2000 and you were a Charge Nurse at the  
 21 Priory hospital between March 2018 and August 2022; is  
 22 that right?  
 23 A. Correct, yeah.  
 24 Q. And you stopped nursing in February 2024.  
 25 A. Yes.

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1 medium severity.  
 2 A. Yes, I can see it now it's highlighted. Sorry  
 3 -- (overspeaking) --  
 4 THE CHAIR: Yes, you can see those two are the high risks.  
 5 You understood that the students had been temporarily  
 6 moved out, and in fact for their safety?  
 7 A. Correct.  
 8 THE CHAIR: So this plan could only work if they stayed out,  
 9 couldn't it?  
 10 A. The immediate safeguarding relied on the temporary  
 11 relocating of the students.  
 12 THE CHAIR: And what is put in risks -- other risks that he  
 13 was "Unable to complete [his] academic studies", and  
 14 you've also put "Stigmatisation from peers". Did you  
 15 balance that against the fact that they -- you were told  
 16 that they had to complete their studies as well?  
 17 A. It's a very fair point that the impact of --  
 18 THE CHAIR: Moving them out.  
 19 A. -- moving them out and the incident and everything that  
 20 was occurring would also be impacting the peers'  
 21 academic studies, which could have been captured in the  
 22 other box that doesn't say if it's self or others.  
 23 THE CHAIR: No. And as far as least restrictive option,  
 24 that's not of itself the criteria, is it? It has to be  
 25 consistent with the risks -- and safety?

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1 Q. We asked you about your interactions with VC whilst he  
 2 was at the Priory Arnold, and you tell us at  
 3 paragraph 9:  
 4 "It is hard to recall VC as a patient because  
 5 I never even had a conversation with him."  
 6 You do recollect some matters. What do you  
 7 recollect generally about him? And I'm going to take  
 8 you to the nursing notes in due course. We'll go  
 9 through some of them.  
 10 A. He was very isolative, stayed a lot in his bedroom.  
 11 Hardly ever saw him. Never had a conversation with him.  
 12 He just wondered in and out of his bedroom when he was  
 13 on the ward, otherwise he would be out on the community  
 14 somewhere. So I didn't really have anything to do with  
 15 him really.  
 16 Q. And what was your role on the ward, and your job when  
 17 you were at the Priory?  
 18 A. My job, staff nurse, just giving out medication,  
 19 assessing patients' needs, organising the shift as to  
 20 who was doing what on the shift, you know, if there's  
 21 any sorts of escorts out, arranging staff to go with  
 22 people. Speaking to people on a one-to-one basis, you  
 23 know, as a named nurse for different patients.  
 24 Q. But he wasn't your -- (overspeaking) --  
 25 A. He wasn't mine, no. He wasn't mine.

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1 Q. Can we just go to some documents then, please. So  
2 paragraph 25, page 11. As I've said, Ms Foster, we know  
3 most of these are not yours, but let's just go through  
4 those --

5 A. Right.

6 Q. -- so that we have a sense, when he left the Cygnet,  
7 what was happening in the Priory.

8 So if we go, please, to page 11. We see there this  
9 is the risk assessment completed by a doctor at the  
10 Priory, we know that from the page overleaf --

11 A. Yes.

12 Q. -- 12. We don't need to go to that. But if we look at  
13 what the risk management plan was we see here, if it's  
14 possible to enlarge the first six items, and if we look  
15 as well at the beginning:

16 "... full physical health screening on admission ...  
17 [including] physical examination [and] blood tests ..."

18 Do blood tests involve using needles?

19 A. Yes.

20 Q. If we look, please, at number 2:

21 "Given ... current presentation ... require  
22 a minimum of four intermittent nursing observations  
23 within an hour."

24 We see "... restricted access to items" at 3 that he  
25 could use to harm himself. So it goes without saying

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1 bottom, if we have that box enlarged, please, what we  
2 see here, Ms Foster, is a description as follows, line  
3 three of that top box:

4 "His admission was preceded by an episode of  
5 psychosis. He recounts hearing male and female voices  
6 in his head telling him someone is being raped next  
7 door. This made him act by barging into his neighbours  
8 apartment thereby causing them distress. There was  
9 associated history of violence and aggression. He had  
10 had to be de-escalated by police officers who he  
11 assaulted in the process. Tasers and gas ... had to be  
12 used to keep him under control."

13 Reading that, would you have thought that was  
14 describing a single event or different events,  
15 factually? Or wouldn't you know?

16 A. Maybe a single event at that point but it's very risky  
17 behaviour.

18 Q. Risky behaviour, and factually if you were to deduce  
19 from that one event when the police were called and he  
20 heard voices relating to a rape, factually incorrect  
21 because we know there was more than one event, so that  
22 wouldn't make it clear to you that there were three or  
23 four events?

24 A. No, no not really.

25 Q. -- (*overspeaking*) -- compiled within that.

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1 that he wouldn't have weapons --

2 A. Yeah.

3 Q. -- or implements that could cause self-harm --

4 A. Yeah.

5 Q. -- or harm to others.

6 A. Yes.

7 Q. And we see at 6:

8 "... encouraged to work with the psychology team who  
9 will offer input by way of 1:1 as well as group  
10 sessions."

11 So that's documented as the plan at the beginning.

12 A. Yeah.

13 Q. Would nurses routinely look at the plan or would you  
14 write your own notes -- (*overspeaking*) --

15 A. Well, if I was the person actually admitting a patient  
16 I would go through all the different parts of that  
17 assessment process. So it would be the -- his history,  
18 his family, physical needs, health needs, if he's on any  
19 medication. It would be absolutely everything and that  
20 would be done, you know, at the side of the admitting  
21 doctor.

22 Q. So let's have a look at what was done in fact. So  
23 paragraph 25, page 9, we see here the new admission,  
24 this is in fact completed by the doctor, I think. Title  
25 "New admission". Do you see under the "Medical" at the

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1 A. That's just talking about that particular incident.

2 Q. Right, so you'd take that as one incident?

3 A. Yeah.

4 Q. If we look at the paragraph above, please, the nursing  
5 notes, at the top of the box. Again, it repeats in the  
6 admission on the day note, five paragraphs down --  
7 sorry, five lines down:

8 "[VC] spoke ... had got into an altercation with  
9 'hospital staff' at his home ... he thought someone was  
10 being raped in his neighbours homes ... admits ... these  
11 ... thoughts he was having at the time ... appeared to  
12 be a symptom of ... illness."

13 So again, would you think that hearing someone being  
14 raped and getting into an altercation with hospital  
15 staff was the same event, or would you think it was  
16 different events or wouldn't you know?

17 A. From that, I sort of deduced that there's been previous  
18 events that's happened.

19 Q. But would you consider them carefully explained or  
20 described or factually clear from these summaries?

21 A. No.

22 Q. If we go, please, to paragraph, same document, page 8.  
23 We see in the box at the bottom of page 8, 2 October,  
24 right at the very bottom:

25 "[VC's] property has been placed on his property

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1 list."  
 2 So just to be clear, we know he's accompanied by two  
 3 staff in an ambulance to the Priory. The property list,  
 4 what's the role of the property list? What happens when  
 5 a patient comes in?  
 6 **A.** The property list, anything the patient brings in, that  
 7 is clothing, any toiletries, anything at all that we,  
 8 you know, we actually search through everything, we have  
 9 to write it all down on a property list and then it has  
 10 to be transferred on to the, you know, to the  
 11 documentation system as to what they've got, and  
 12 everything, and check with them. Anything that we  
 13 thought was a risk, you know, we'd check for drugs and  
 14 weapons and anything. It should be written down.  
 15 **Q.** So these are properties they're able to have --  
 16 **A.** -- (*overspeaking*) -- and remove it.  
 17 **Q.** -- on the ward, as it were, or with them.  
 18 **A.** Yes. What paragraph, sorry?  
 19 **Q.** -- (*overspeaking*) -- not concerned about. It's the  
 20 bottom line, can you see?  
 21 **A.** Bottom line.  
 22 **Q.** Yeah. So "[VC's] property has been placed on his  
 23 property list."  
 24 **A.** Yeah.  
 25 **Q.** So there's a documentation of what the patients have --

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1 **A.** But I don't think that other nurses did actually wake  
 2 patients (*unclear*) they sleep, they'd just probably omit  
 3 it. Maybe they tried, but I don't know in this  
 4 instance.  
 5 **Q.** Was that at the Priory or generally in your nursing  
 6 experience?  
 7 **A.** The Priory, the Priory.  
 8 **Q.** You didn't think people did wake people up there?  
 9 **A.** No.  
 10 **Q.** Was that different to your experience nursing in other  
 11 environments?  
 12 **A.** Yes, yes.  
 13 **Q.** Can we look, please, at the entry at 5.15, two boxes up.  
 14 **A.** Yeah.  
 15 **Q.** We see:  
 16 "[VC] was in bed at the start of the shift. ...  
 17 maintained a low profile and remained in his bedspace  
 18 the rest of the shift ... took his medication though he  
 19 did not attend the clinic when he was prompted but when  
 20 the nurse took it down to his bedroom he accepted."  
 21 So the system for taking medication, did you  
 22 encourage patients to go to collect the medication at  
 23 the clinic? To actively engage with that?  
 24 **A.** Yeah, we did. I mean we didn't just take it down to the  
 25 patient, you know, that's that particular nurse who took

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1 **A.** Yeah.  
 2 **Q.** -- and it looks as though that happened here.  
 3 **A.** Yeah.  
 4 **Q.** If we go two boxes up, please, to 3 October, we see  
 5 he's:  
 6 "... fast asleep during the night drug round, hence  
 7 he missed his night medication of Haloperidol."  
 8 **A.** Mm-hm, yeah.  
 9 **Q.** So he's prescribed presumably medication he should be  
 10 taking at night and he is asleep and doesn't have it.  
 11 Is that typical at the Priory or would you wake someone  
 12 up and make sure they had it, or wouldn't you like to  
 13 comment on that?  
 14 **A.** I would wake him up, really. I think it's quite  
 15 important, looking at his history and things, I think  
 16 it's quite a risky thing to miss, really. I mean I'm  
 17 not sure how long, obviously I'm not a doctor, I'm not  
 18 sure how long but I don't think it's a good idea for  
 19 somebody with his history to not take prescribed  
 20 medication that's been prescribed. He could have been  
 21 woken.  
 22 **Q.** Did that happen much, that you would wake patients to  
 23 give it, or not?  
 24 **A.** I would personally.  
 25 **Q.** Did that --

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1 it to him. But yes, we did encourage people to get up.  
 2 And obviously you can't assess somebody if they're in  
 3 their bedroom, you can't see mental state or anything,  
 4 you can't assess anything about a patient if they're  
 5 just in their bedroom taking medication. We don't know  
 6 what's going on, really. So I'd prefer it then to come  
 7 out and take it.  
 8 **Q.** 4 October, above:  
 9 "Keeping Well: ... spent the shift mainly in his  
 10 room ... accessed the lounge and communal area but  
 11 remained mainly in his room. Attended ward round and  
 12 was able to communicate that he no longer [heard] ...  
 13 voices and he hoped to be discharged soon. Discharge to  
 14 Beacon Lodge was discussed and [VC] was keen on this  
 15 option."  
 16 You weren't party to this conversation but did you  
 17 know what Beacon Lodge was?  
 18 **A.** Beacon Lodge was like a place which was -- people go  
 19 there, and it was like, more like a supported living  
 20 area. I don't think there were, like, many restrictions  
 21 on things, but a lot of people used to come to the  
 22 Priory and then actually go to Beacon Lodge before being  
 23 discharged either back home or into the community or  
 24 wherever they came from before.  
 25 **Q.** Because they had some support there, did they?

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1 A. Yeah, yeah.  
 2 Q. And we see VC is recorded as being "keen on this  
 3 option", and this is three days after his admission to  
 4 the Priory.  
 5 A. Mm.  
 6 Q. If we can go to page 7, please. We see the entry at the  
 7 bottom of that, page 7.  
 8 A. Yeah.  
 9 Q. At the very bottom. 6.39.  
 10 "[VC] was polite upon interactions on a needs led  
 11 basis."  
 12 And if we can have a document while I ask you about  
 13 needs-basis, please, on the screen. This is an extract  
 14 of a witness statement from Dr Aziri, Priory Health  
 15 Care. WITN0229001, page 39, please. It's page 39,  
 16 paragraph 153.  
 17 A. Yeah.  
 18 Q. We see Dr Aziri says:  
 19 "Engaging on a 'needs-led' basis means the patient  
 20 interacts with the staff or services only when perceive  
 21 an immediate or practical need, rather than engaging  
 22 consistently in ongoing treatment or recovery work.  
 23 Such patients may approach staff for specific requests  
 24 (... medication, meals, discharge discussion) but  
 25 otherwise remain withdrawn or avoid therapeutic  
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1 "He has spent time in his bed space isolating  
 2 himself during the shift. He has had minimal  
 3 interaction during the day and has been asleep at times  
 4 in his bedroom. [VC] has attended for his medication  
 5 and has attended for meals during the shift. He  
 6 utilised his escorted community leave in the afternoon  
 7 and this appeared to have gone well. [VC] has his ward  
 8 round this afternoon it went fairly positively, he was  
 9 granted unescorted grounds leave [and he was] ...  
 10 prescribed aripiprazole ..."  
 11 I'm not going to ask you about medications. There's  
 12 a doctor giving evidence this afternoon about that.  
 13 A. Yeah.  
 14 Q. "Granted unescorted grounds leave"; what was that?  
 15 A. Unescorted grounds leave -- two checks. Yeah. So he  
 16 was given -- I mean I don't know exactly what he got but  
 17 it meant that he could go out after having what he was  
 18 wearing on, you know, where he was going, what time he  
 19 went out, what time he came back, and that would all be  
 20 documented on a piece of paper and then signed by the  
 21 nurse.  
 22 If he's been given -- and it would be  
 23 unescorted grounds leave would be whatever the doctor  
 24 felt was appropriate at that time.  
 25 Q. And we see he's got "escorted community leave" at that  
 123

1 interaction."  
 2 Would you agree with that description of needs-led  
 3 basis?  
 4 A. Yes, mm-hm.  
 5 Q. If that can go down, please, and we go back to  
 6 paragraph 25, page 7. It was the bottom entry at  
 7 6.39 am, where that is mentioned.  
 8 A. Yeah.  
 9 Q. And you say that fits with your impression that he  
 10 wasn't around and in the communal areas and generally  
 11 engaging?  
 12 A. No, he wasn't. He wasn't. I mean he was saying what he  
 13 wanted people to hear. You know, about when he went --  
 14 you know, the Beacon Lodge after three days after  
 15 admission. He's not going to say, "I'm hearing voices"  
 16 because he wanted to leave, he wanted to go.  
 17 Q. Is that typical, nursing patients, you need to be alert  
 18 to that kind of --  
 19 A. You certainly do because, you know, you wonder why  
 20 people are saying these things. It's only from  
 21 experience and knowing the patient, and we didn't know  
 22 him very well, because he was very isolative, because we  
 23 didn't really know what was going on with him.  
 24 Q. If we go to the top of page 7, the entry at 18:38, we  
 25 see at the top:  
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1 time, so out in the community, not just in the grounds.  
 2 A. Unescorted grounds leave, yeah, sorry.  
 3 Q. Unescorted grounds leave, two lines up --  
 4 A. Yeah, that's just in the actual grounds itself  
 5 -- (*overspeaking*) --  
 6 Q. In the grounds is unescorted but outside is escorted at  
 7 that point.  
 8 A. Right.  
 9 Q. It looks like, doesn't it? Says he utilises "escorted  
 10 community leave in the afternoon"; is that different,  
 11 going escorted into the community rather than  
 12 -- (*overspeaking*) --  
 13 A. Oh, escorted community.  
 14 Q. -- unescorted grounds.  
 15 A. Yeah, that's it, that's right, sorry. Escorted  
 16 community leave would be with somebody going out in the  
 17 community, but he could go round the hospital grounds  
 18 themselves unescorted.  
 19 Q. Understood. If we go to page 6, please, of the records,  
 20 and the second from the bottom, the box at 19.41 under  
 21 "Keeping connected":  
 22 "His mum called today inquiring about him and his  
 23 university course and wanting to know what can be done  
 24 to help ..."  
 25 Was it typical, if nurses took calls, to record it  
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1 in the records, with families?

2 **A.** Yes.

3 **Q.** And what's the importance, where there is a next of kin,  
4 of those conversations with families? How does that  
5 help?

6 **A.** Well, the family know the patient better than we do.  
7 You get a lot of information. You know, when patients  
8 are admitted to hospital, you get a lot of information  
9 from them about how they really are. You know, and  
10 sometimes information that they don't disclose when  
11 they've been assessed.

12 **Q.** And we see at 7.04, as you've described in your  
13 statement:  
14 "Keeping Well: [VC] mainly bedroom based ... came  
15 out the lounge area on occasion."  
16 if we go further up, on 10 October there's an  
17 entry, and this one is by you, to say:  
18 "There have been no issues regarding his safety. He  
19 remains on level 2 x 2 checks per minute. [VC] had  
20 brought some belon[g]ings ... in when he went on  
21 community leave ..."  
22 Presumably sometime between the 7th and the 10th,  
23 and it says:  
24 "[VC] ... brought a hammer in his rucksack ...  
25 unclear ... whether he picked this up by accident or  
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1 a support worker.

2 **Q.** So do support workers check what people bring back in?

3 **A.** Definitely, yeah, you have to do because obviously  
4 people can bring anything in, they bring drugs and all  
5 sorts of things in so --

6 **Q.** So a proper search when they come back --

7 **A.** Yeah, a proper search, an actual physical search as well  
8 because it's unescorted, especially because he'd not  
9 been there very long. So it should be a physical  
10 rubdown search and then checking through all what he's  
11 brought in.

12 **Q.** Would that support worker ask questions about why he had  
13 it or not?

14 **A.** Well, I would hope so, yeah, because it's a hammer. So  
15 definitely.

16 **Q.** Did you have a conversation with anybody about what VC  
17 had said at the time about having that hammer?

18 **A.** No, I can't remember having a conversation about it.

19 **Q.** But to be clear, he didn't have a hammer, unlikely on  
20 the property list, when he first came from Cygnet, did  
21 he?

22 **A.** No, no.

23 **Q.** So here he is on the 10th with a hammer?

24 **A.** Yeah.

25 **Q.** Clearly that's a potential weapon, isn't it?  
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1 whether it was intentional."

2 When did you discover that he had a hammer in his  
3 rucksack?

4 **A.** I cannot recall the person who actually brought in --  
5 you know, when he came in from his leave, who reported  
6 it to me. I can't remember the name of the person who  
7 actually told me about that, what he did, whether, you  
8 know, he filled in an incident report form about it,  
9 which obviously it's really serious. So I just can't  
10 remember the person who said, because obviously that  
11 should have definitely been recorded, and he should have  
12 had his leave stopped immediately.

13 **Q.** Well, you recorded it here. Is that because somebody  
14 had told you that? Did you see the hammer yourself?

15 **A.** No.

16 **Q.** So this was what you had been told?

17 **A.** Yeah.

18 **Q.** By somebody who --

19 **A.** To be honest, I can't remember if I saw the hammer or  
20 not. I just can't remember. Because it's such a long  
21 time ago.

22 **Q.** Yours appears to be the only note about it, so the  
23 person who told you, what was their capacity, a nurse,  
24 or somebody who checked property items or --

25 **A.** I think it was a support worker -- (*overspeaking*) --  
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1 **A.** Absolutely, yeah.

2 **Q.** So you recognise it was serious, but you don't remember  
3 now how that was followed up?

4 **A.** I don't, no. I assume obviously he would have got it  
5 when he was on unescorted leave, he's gone and brought  
6 this back. So I don't know what his thinking was about  
7 bringing that in.

8 **Q.** Can we go to PAGR000025 Page 5, please, the 11/10, 3.47  
9 entry:  
10 "Keeping well, [VC] is in the lounge area, has not  
11 been observed having any conversations with staff or  
12 other patients in his bedroom on checks." (*As read*)  
13 "Keeping connected: [VC] not observed to have made  
14 any external contact with family or friends."  
15 Is that your entry, can you see, Helen Foster? Or  
16 was that confirmed by you as the senior nurse?

17 **A.** Yeah.

18 **Q.** So over -- 3.47, so in the nighttime, then, he's in the  
19 lounge area; is that right?

20 **A.** Yes.

21 **Q.** So up at night; is that right?

22 **A.** Yes, it was.

23 **Q.** "Not observed to have any conversations with anybody and  
24 awake when he's in his bedroom." (*As read*)  
25 So he's already awake at night now; is that clear  
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1 from that? Is that what it looks like? It's in the  
 2 night --  
 3 **A.** Yeah.  
 4 **Q.** -- that he's in the lounge area, presumably by himself  
 5 not with other patients during the night. Do people  
 6 normally go to bed at night?  
 7 **A.** There might have been other patients up, but I don't  
 8 know at that time. Sometimes there are patients who are  
 9 unsettled and not --  
 10 **Q.** Move around?  
 11 **A.** Yeah.  
 12 **Q.** If we go, please, to the penultimate box at the top,  
 13 0721 in the morning.  
 14 **A.** Yeah.  
 15 **Q.** This is on the 13th:  
 16 "He requested to be escorted to the vending machine  
 17 where he bought himself a drink of pop. Came back and  
 18 stayed in his room throughout the night. Appeared to  
 19 have not slept at all throughout the night, but spent  
 20 the night on his laptop. No management issues  
 21 encountered though. [VC] had no night medication."  
 22 *(As read)*  
 23 So awake all night with no night medication again  
 24 can be pursued with the doctor, but if he was due to  
 25 have had medication he should have had medication,

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1 assuming he used the -- because we had a computer in  
 2 there, and where they could watch whatever they wanted,  
 3 but there wouldn't be any reason that's been raised by  
 4 anybody to say monitoring what this guy is actually  
 5 watching.  
 6 **Q.** So computer, would it be his own computer or a hospital  
 7 computer?  
 8 **A.** It would be -- there was a hospital computer, there was  
 9 a computer room there where you can go --  
 10 **Q.** You can check a search history on a computer normally,  
 11 can't you? Did you ever do that?  
 12 **A.** No, I wouldn't know how to do it.  
 13 **Q.** You don't know how to do it. Was that ever discussed  
 14 generally on the ward if they were using a ward  
 15 computer, checking in what people might have looked at?  
 16 **A.** No, it wasn't a general sort of --  
 17 **Q.** It's not something you had any training about, asking  
 18 people "What have you been at? Anything that has  
 19 disturbed you?"  
 20 **A.** No.  
 21 **Q.** Just introducing it in some form of conversation?  
 22 **A.** No.  
 23 **Q.** Can we have look, please, at the top, 16:57, a colleague  
 24 a staff nurse:  
 25 "... had a one session with [VC] this afternoon, he

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1 shouldn't he?  
 2 **A.** Yes, certainly.  
 3 **Q.** If he wasn't due to have medication, it didn't look like  
 4 he was getting into a routine of --  
 5 **A.** -- (overspeaking) --  
 6 **Q.** -- being awake in the day and sleeping at night which is  
 7 worrying, isn't it?  
 8 **A.** Yeah.  
 9 **Q.** Why is that worrying?  
 10 **A.** Because it shows that his mental state is probably  
 11 declining if he isn't taking the medication as  
 12 prescribed. I mean, I don't know whether he was on the  
 13 one, you know. It was changed to aripiprazole and  
 14 I don't know if it was the one previously, the  
 15 haloperidol. So obviously, it's not helpful to his  
 16 mental state that he isn't taking that medication.  
 17 **Q.** Or getting sleep by the looks of it?  
 18 **A.** Or getting any sleep because that's just going to make  
 19 his mental health deteriorate even more, and he's going  
 20 to become more paranoid.  
 21 **Q.** Were you able to monitor site visits by patients or  
 22 activities online if they're up at night and on  
 23 a computer or anything else; did they have any way of  
 24 monitoring what --  
 25 **A.** Monitoring what people -- not really, no. I mean, I'm

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1 expressed he is settled and well and that his medication  
 2 particularly the Aripiprazole is better than the one he  
 3 had in the past because it gives him no side-effects."  
 4 Second paragraph:  
 5 "We ... discussed his current accommodation issues.  
 6 [VC] explained he was in a shared accommodation and that  
 7 the suggestion about Bracken House seems plausible,  
 8 however, he indicated that he is also looking for  
 9 accommodation on his own."  
 10 So on the 13 October, that's three days after he'd  
 11 been found in possession of a hammer, it was clear he  
 12 was looking for accommodation, he didn't have  
 13 accommodation, he wasn't settling himself into  
 14 accommodation, there was nowhere he was hammering nails  
 15 up or getting a place ready for accommodation?  
 16 **A.** No.  
 17 **Q.** Can we look at paragraph 25, page 4, please. 14 October  
 18 at 7.07. It's clear from this entry:  
 19 "VC is not prescribed any nighttime medication and  
 20 returned to bed. [VC] appears to have slept well during  
 21 the night. ... no further concerns to report."  
 22 The box above at 5.40:  
 23 "... remains on level 2 one check an hour."  
 24 What's level 2?  
 25 **A.** Level 2 is just one check an hour. There's like level

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1 one, where you'll have somebody -- you know, different  
2 levels, let's say one check an hour. So it basically  
3 means in one hour the person with the, like, a clipboard  
4 will have all the different patients and different  
5 levels of observation and will just check that person  
6 once per hour. You know, there's somewhere people are  
7 one-to-one observations where there's somebody with them  
8 all the time 24 hours a day, and there's like one check  
9 an hour, two checks an hour three checks an hour, four  
10 checks an hour, five checks.

11 **Q.** What are you checking for?

12 **A.** Checking their wellbeing, making sure that they are safe  
13 in the bedroom and what they're actually doing as well.  
14 You have to record what a person is doing. If they're  
15 sat there, you know, if they're watching TV, if they're  
16 just reading, or anything.

17 **Q.** We see the paragraph above the entry on the 10th:

18 "Spent his time in his bed space using his laptop,  
19 completing some drawings, requested a ruler from staff."

20 If we go, please, to page 3 in the notes, again we  
21 see the third entry from the top, 7.36 in the morning on  
22 the 18th.

23 **A.** Yeah.

24 **Q.** "[VC] was already in his bedroom using his computer at  
25 the commencement of the shift. Continued to be

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1 reported he'd fallen over. He had a cut to the bridge  
2 of his nose, he didn't allude as to how this happened  
3 and accepted a plaster." (*As read*)  
4 We see no description anywhere of a fall or the  
5 injury to the bridge of his nose. Was that common, that  
6 you'd notice something like that and you couldn't  
7 describe or explain how --  
8 **A.** It should have been documented, that definitely should  
9 have been documented. They should have had a body map,  
10 they should have documented it. It should be documented  
11 incident. What happened. Just given a plaster isn't  
12 really adequate.

13 **Q.** Also the cause, what in fact actually happened to cause  
14 that injury?

15 **A.** Yeah, definitely. That should be recorded.

16 **Q.** We see -- and it does look as though, at least on the  
17 chronology of it, the community leave to the city centre  
18 follows, I think, if you look at those entries, in order  
19 to sign up for an engineering course at the University  
20 of Nottingham. So the majority of the day he'd spent  
21 out of the hospital perimeter.

22 **A.** Yeah.

23 **Q.** "[VC] returned to ward around 1530 this afternoon  
24 invited to attend the community meeting though he  
25 declined and stated he was busy." (*As read*)

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1 isolative and withdrawn. Pleasant on approach but  
2 giving closed answers. VC visible in the lounge during  
3 supper. He attended the supper and engaged briefly with  
4 staff, [VC] spent time on his computer in his bed space  
5 and remained low profile. Stayed awake on his computer  
6 until around midnight."

7 So an extensive amount of time on the computer.

8 **A.** Mm, yeah.

9 **Q.** Page 2, please. The bottom entry.

10 "[VC's] presentation in mood and mental state  
11 continues to present as settled. Still maintains a very  
12 low profile on the ward throughout the shift being  
13 solemnly bedroom based. Pleasant upon interaction, no  
14 difficulty approaching staff on a need led basis."

15 So by the 18 October, the same reference to the  
16 need-led basis rather than actively engaging and  
17 proactively --

18 **A.** Yeah.

19 **Q.** -- involved in therapeutic discussions or the like; is  
20 that fair?

21 **A.** Yeah.

22 **Q.** If we go, please, to the third box from the top on  
23 20 October, we see a reference:

24 "Keeping healthy, concordant with prescribed  
25 medication. [VC] attended the clinic this morning and

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1 **A.** Mm.

2 **Q.** The entry is actually made at 7.01. Can you deduce from  
3 that whether the injury has happened before the  
4 community leave or after, or what?

5 **A.** I mean, possibly before he came back from his leave.  
6 But I don't know what, obviously, happened when he was  
7 out, where he got injured.

8 **Q.** It would be important to know, wouldn't it, if that  
9 happened in the community? Really important.

10 **A.** Well, really important because if there's no sort of  
11 supporting evidence or documentation to say what  
12 happened, you just don't know.

13 **Q.** We see at the top of this at 10.44 am:

14 "Claudia Birtles is asking [that's his care  
15 coordinator] information about the outcome of his ward  
16 round. [VC] is planned to be discharged tomorrow." (*As  
17 read*)

18 So if we go to page 1, please, the note at the  
19 bottom, 1920:

20 "[VC] maintained a low profile on the ward being  
21 mainly bedroom based. Continues to actively approach  
22 staff on a need led basis, has minimal engagement with  
23 other peers on the ward." (*As read*)

24 If we look at the entry above at 7.50:

25 "In his bed space at the start of the night shift,

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1 later was in the lounge area using his mobile phone for  
2 some time. Remained low profile, minimal engagement."

3 Then we see the entry above:

4 "[VC] discharged to his new flat, given 14 days  
5 aripiprazole. He was asking a friend to drive his car  
6 to the flat and no psychotic features noticed." (As  
7 read)

8 Do you agree, as per your statement and going  
9 through the records, it's clear that he remained  
10 isolated and spent a lot of time in his room during the  
11 time he was there?

12 A. Yes, I do.

13 Q. He also spent a considerable amount of time on his phone  
14 and his laptop?

15 A. Yeah.

16 Q. Whether it was university work or what he was looking  
17 at?

18 A. Yeah.

19 Q. Did anyone ever ask him, looking at the notes?

20 A. I don't think so, no.

21 Q. Doesn't look like he engaged with any therapeutic  
22 activities on the ward in accordance with the plan?

23 A. No, all he want -- like I say needs led basis was just  
24 whatever he wanted, whether he wanted a drink or wanted  
25 to go out or whatever. But no engagement, not in my

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1 A. Definitely.

2 Q. If we go, please, to 4.1 which is page 4 of the policy:

3 "All incidents and near misses must be concisely  
4 recorded on a data incident reporting system." (As  
5 read)

6 A. Yes.

7 Q. Did you think about doing that, or were you told about  
8 it, should you have put that on the Datix system?

9 A. It's because the person -- well, the person reporting it  
10 to me -- actually, I don't know if I was the nurse in  
11 charge, but the person making me aware of that should  
12 have filled in a Datix.

13 Q. Did you say to them, or you can't remember now, "fill in  
14 a Datix"?

15 A. No.

16 Q. They didn't anyway, did they?

17 A. They didn't do it obviously, but it should have been  
18 done. This was obviously -- how The Priory operates is  
19 that a lot of staff are bank staff, a lot of staff don't  
20 know how to record incidents, and it's better coming  
21 from the person who actually got the hammer -- sorry,  
22 who actually spoke to him because we didn't know where,  
23 how he'd got it, or anything, you know, and obviously if  
24 it's not recorded, it didn't happen. Because it has to  
25 be recorded.

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1 view, not as a nurse, definitely not.

2 Q. There were instances when he did not proactively attend  
3 for his medication?

4 A. Yes.

5 Q. It had to be taken to him, and there were instances when  
6 he missed his medication --

7 A. Yes.

8 Q. -- or night medication.

9 In terms of the hammer event incident, having the  
10 hammer in his possession, that doesn't look like it was  
11 followed up at all.

12 A. I don't think it was, no.

13 Q. If we look, please, at PAGR0000083, page 1, the incident  
14 management reporting system that was policy in place at  
15 The Priory.

16 A. Yeah.

17 Q. Defines at page 2:

18 "An incident is an event that has caused or has the  
19 potential to cause harm."

20 1.3:

21 "All colleagues have a responsibility to ensure all  
22 measures are in place to prevent the likelihood of such  
23 incidents." (As read)

24 It would have been important to find out the basis  
25 upon which he had that hammer, wouldn't it?

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1 Q. Page 6 of the document paragraph 4.15:

2 "Successful incident notification is depending on  
3 a comprehensive knowledge of the facts surrounding the  
4 event". (As read)

5 So as you say it should have been identified when he  
6 got hold of it, why it was with him and what that  
7 represented?

8 A. Yeah, absolutely, because obviously if we don't record  
9 things, people are just completely unaware of it and  
10 it's a really serious thing.

11 Q. That's the point about incidents, isn't it?

12 A. Yeah.

13 Q. There might not be a particular harm or immediate  
14 impact, but it's what they represent and it's important  
15 to risk, isn't it?

16 A. Absolutely, what's going on, yeah.

17 Q. There was a CQC report in respect of The Priory Arnold,  
18 CQCM0016484, page 1, please. Inspection on  
19 15 June 2021, publication of report 22 July.

20 If we go to page 2, we see third line down:

21 "Staff did not always assess and manage risk to  
22 patients and themselves well."

23 Can we highlight that?

24 A. Yeah.

25 Q. Then we see:

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1 "Leaders did not always demonstrate they had the  
2 skills to perform their roles and ensure the ...  
3 patients and staff".  
4 **A.** Mm.  
5 **Q.** If we go, please, to page 5, penultimate paragraph of  
6 the first box:  
7 "Before this inspection ... received information of  
8 concern from anonymous contacts and from a relative ...  
9 about incidents that happened on the wards and the  
10 management of patient risk."  
11 Do you see that? It should be highlighted two  
12 paragraphs above the "How we carried out this  
13 inspection", it's that two lines.  
14 **A.** -- is it the (inaudible), yes.  
15 **Q.** No, it's not that box. It's two lines above the "How we  
16 carried out this inspection"?  
17 **A.** Ah, yeah, I've got that.  
18 **Q.** Go further down the page again, page 5. Do you see  
19 "Before this inspection ..."? There we are.  
20 **A.** Yes.  
21 **Q.** We see:  
22 "... received information of concern from anonymous  
23 contacts about incidents that happened ... and the  
24 management of patient risk."  
25 We see over the page, areas for improvement.  
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1 say they're going to do. I've always felt that there.  
2 **Q.** Can we have, please, NHN0014406, page 1. The overall  
3 rating was inadequate, whether the services were safe,  
4 inadequate. Was that discussed with you as staff, that  
5 it was ranked as inadequate and what needed to be done  
6 or not?  
7 **A.** It was discussed but it's always been a sort of a blame  
8 culture, where it's our fault we're not doing certain  
9 things and having imposed loads of paperwork, loads of  
10 documentation, you've got to fill this in, you've got to  
11 fill that in, which we were running really busy wards  
12 with very vulnerable patients. What we're looking at,  
13 very high risk, and then they'd introduced load of  
14 things like 'oh, you've got to clean down every hour,  
15 you've got to do this every hour'. They'd have, like,  
16 things where 'oh, you must record everything all the  
17 time'. And all this adds to the number of jobs that  
18 you've got to do as a nurse and all the other staff  
19 that's working with me. So sorry, I forgot the question  
20 now.  
21 **Q.** How many doctors were there working there roughly?  
22 **A.** Well, there's usually one Consultant Psychiatrist for  
23 each ward. I mean, at the time I think there was only  
24 two wards open because the other two had been closed, so  
25 we didn't admit anybody, but there was only, like, two  
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1 Page 6:  
2 "The provider must ensure [the last point] ...  
3 audits and Government systems fully assessed and  
4 identify risks to patients and staff and improvements  
5 are made as a result."  
6 Page 9, please. Again, records showed the last  
7 paragraph, that:  
8 "... staff completed risk assessments for each  
9 patient on admission and reviewed this regularly.  
10 However, before ... inspection we were informed of an  
11 incident where a patient self-harmed showed staff did  
12 not manage well the risks to the patient."  
13 Were you aware of any steps taken between June,  
14 July, 2021 and when you left, I think, in October 2021,  
15 to improve staff training on risk assessment and risk  
16 management? Did you have any such training?  
17 **A.** We had some training but The Priory hospital tends to  
18 have a bit of a knee-jerk reaction to incidents and they  
19 don't follow up a lot of things. They don't follow up  
20 incident reports, you know, sort of like support for  
21 staff, after an incident's happened and that's quite  
22 commonplace. I worked there for four years and I can  
23 only remember one occasion when somebody came down and  
24 discussed an incident and like the way forward and  
25 things like that. I just don't think they do what they  
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1 actual Consultant Psychiatrists. Then you'd have a ward  
2 doctor which was he probably would come down and do the  
3 actual assessments when they were admitted.  
4 **Q.** Who were the consultants at the time that you were  
5 there?  
6 **A.** The Consultant Dr Gurusinghe, what's his name now.  
7 **Q.** Dr Gurusinghe?  
8 **A.** That's him. Dr Gurusinghe at the time, yeah.  
9 **MS LANGDALE:** Those are my questions, Chair.  
10 **THE CHAIR:** Yes, thank you.  
11 Yes, Mr Moloney.  
12 **Questioned by MR MOLONEY**  
13 **MR MOLONEY:** Ms Foster, if I may just very briefly, please.  
14 You spoke essentially of a view of VC not really  
15 engaging on the ward.  
16 **A.** Mm-hm.  
17 **Q.** Where patients are isolated in situations like that it's  
18 your view that direct questions need to be asked of them  
19 rather than making assumptions?  
20 **A.** Absolutely. You can't assess anybody if you don't speak  
21 to them. I mean, as a former nurse I would have gone  
22 into the actual bedroom and sat with them and asked them  
23 things, specific questions, people that don't want, you  
24 know "Why did you do this? Well, what's going on in  
25 your head?" Try to sort of get an insight into what's  
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1 actually happening. You can't just assume anything, in  
 2 nursing. You certainly can't. Because people are very,  
 3 very poorly, a lot of them, and they won't talk to you  
 4 because they've got all these thoughts in their head and  
 5 yet it's your duty as a nurse to go in there and  
 6 actually find out what is going on. He should never  
 7 have been left to his own devices and nobody bothered  
 8 engaging, just assuming that he was all right because  
 9 obviously he wasn't all right.

10 **Q.** When you're face-to-face, can you get a better sense of  
 11 what they're actually saying and whether there's  
 12 -- (*overspeaking*) --

13 **A.** You certainly can. Yeah, you certainly can. Because  
 14 some people will not come out of the bedrooms. I've had  
 15 patients where you've had to go in and start speaking to  
 16 some about different things. But you have got to ask  
 17 those questions that nobody else dare because you can't  
 18 possibly have an assessment of a patient's mental state  
 19 if you don't talk to them properly, you know, on  
 20 a one-to-one basis.

21 **Q.** Can I ask you more generally: was there a limited focus  
 22 at The Priory on engaging patients who were more  
 23 isolated? Was there not a great deal of effort made to  
 24 engage people who were more isolated?

25 **A.** No, there wasn't, not in my view, no.

1 **Q.** Can I just very quickly ask you, on the back of that, in  
 2 terms of the training for most of the staff, was it  
 3 mostly centred around containing physically destructive  
 4 behaviours by patients rather than more general things?

5 **A.** I think so, yeah, it wasn't as therapeutic as it should  
 6 have been.

7 **Q.** Did you get the sense of whether there was much effort  
 8 put into getting a sense of who each patient was and  
 9 what their specific needs were to help them recover?

10 **A.** No.

11 **MR MOLONEY:** All right. Thank you very much, Ms Foster.

12 **THE CHAIR:** Yes, thank you.

13 Right, well, I've got no questions, so we'll stop  
 14 there and we'll start again at 2.20.

15 **(1.25 pm)**

16 **(The short adjournment)**

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