Monday, 11 May 2026

(10.00 am)

(Proceedings delayed)

(10.02 am)

MR WESTON: Chair, I call Mr Christopher Atherton.

CHRISTOPHER JAMES ATHERTON (affirmed)

Questioned by MR WESTON

MR WESTON: Mr Atherton, you've prepared a statement for this Inquiry dated 13 November 2025.

A. That's correct.

Q. Are the contents of that statement true to the best of your knowledge and belief?

A. They are.

Q. Mr Atherton, you're employed by Nottingham City Council as the Strategic Director of Adult Social Care and Health?

A. That's correct.

Q. You qualified as a social worker in 2009.

A. Yeah.

Q. You specialised in adult social care?

A. That's true, yeah.

Q. You've previously worked at Haringey Council as a frontline social worker between 2009 and 2015?

A. That's correct.

Q. Thereafter, in about 2015, you took the role of

a Principal Social Worker?

A. *(The witness nodded).*

Q. From 2018 you became the Head of Quality Assurance and Development at Haringey.

A. That's correct.

Q. It's in September 2025, I believe, that you started work at Nottingham City Council --

A. That's correct, June 2025.

Q. -- thank you -- as the Strategic Director of Adult Social Care and Health.

A. Yeah.

Q. You've produced your statement in response to a Rule 9 Request from the Inquiry, and you say in your statement that you were considered the best placed person to assist the Inquiry from the perspective of Nottingham City Council.

A. That's correct.

Q. I want to ask you about the role of local authority and social care in mental health services. Now, if you'll forgive me, to do that I need to take you through some of the statute and guidance first, if that's okay?

A. Absolutely.

Q. So can I please start with the Care Act 2014, so it's RLIT0000035/001. So Section 1 of the Care Act:

"The general duty of a local authority, in

exercising a function under this Part in the case of an individual, is to promote that individual's well-being."

That's the starting point of the Care Act under Section 1.

If you just go over the page, please, we'll see that:

"'Well-being', in relation to an individual, means that individual's well-being so far as relating to any of the following ... "

And we see that at (b) it refers to "mental health and emotional well-being".

At (e) it refers to "participation in work, education, training or recreation".

At (f) "social and economic well-being".

At (g) "domestic, family and personal relationships".

At (h) "suitability of living accommodation".

If I can take you to the next page, please, Section 2 of the Care Act:

"A local authority must provide or arrange for the provision of services, facilities or resources, or take other steps, which it considers will --

"... contribute towards preventing or delaying the development by adults in its area ... for care and support".

So there's a focus there on preventing needs before they arise; is that correct?

A. That is correct, yes.

Q. The guidance tells us something about that. Can I please take you to RLIT0000034/022. So this the Care and Support Statutory Guidance, the Statutory Guidance that sits behind the Care Act 2014; is that correct, Mr Atherton?

A. That's correct, yes.

Q. Paragraph 2.40, states that, at 2.40:

"Prevention should be a consistent for local authorities in undertaking their care and support functions".

That's correct, isn't it?

A. That's correct.

Q. "However, there may be key points in a person's life or in the care and support process where a preventative intervention may be particularly appropriate or of benefit to the person. Approaches to identifying those people who may benefit from preventative support should consider how to locate people in such circumstances, for example ..."

The second bullet point refers to hospital discharge, doesn't it?

A. It does.

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

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

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

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

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

support so that local authorities can consider how to provide a proportionate response at the right time, based on the individual's needs. Prevention and early intervention are placed at the heart of the care and support system ..."
If I can take you to page 90. This is touching upon 6.13:
"Local authorities must undertake an assessment for any adult with an appearance of need for care and support, regardless of whether or not the local authority thinks the individual has eligible needs or of their financial situation."
So you need to assess even if you don't think they're going to have the eligible needs; is that correct?
A. That is correct. So if there is the presentation of care and support potential needs, then yes, absolutely.
Q. Thank you. Can I take you to page 110. Paragraph 6.100 touches upon eligibility:
"The national eligibility criteria set a minimum threshold for adult care and support needs and carer support needs which local authorities must meet. All local authorities must comply with this national threshold. Authorities can also decide to meet needs that are not deemed to be eligible if they [choose] to

do so."
A. Correct.
Q. So needs assessment first of all?
A. Yeah.
Q. Then you look if the eligibility criteria is met. If the eligibility criteria is method, you have to provide the care and support; is that correct?
A. That is correct.
Q. If the eligibility criteria is not met, it's a discretion the local authority has?
A. It is, yes.
Q. Finally, from the guidance, can I take you to page 117. 6.113:
"Individuals with fluctuating needs may have needs which are not apparent at the time of the assessment, but may have arisen in the past and are likely to arise again in the future. Therefore local authorities must consider an individual's need over an appropriate period of time to ensure that all of their needs have been accounted for when eligibility is being determined."
So if a patient, for example, has, or a person has, fluctuating mental health needs, it's really important, when undertaking the assessment of needs and eligibility to consider what their position is when they're unwell.
A. Yeah.

Q. Now, we've talked about the eligibility criteria. Those are governed by a set of regulations, aren't they? Can I take you to that, please, it's RLIT0000037, the Care and Support (Eligibility Criteria) Regulations 2015. Section 2:
"An adult's needs meet the exhibit criteria if --
"... the adult's needs arise from or are related to a physical or mental impairment or illness".
In this particular matter we know that VC had a mental illness.
A. Yes.
Q. 2(b):
"as a result of the adult's needs the adult is unable to achieve two or more of the outcomes specified in paragraph (2) ..."
I will take you to those in just a moment:
"and.
"... as a consequence there is, or is likely to be, a significant impact on the adult's well-being."
Just to take you to a couple of those specified outcomes, can I take you to 2(e):
"being able to make use of the adult's home safely".
It's right that "use of the ... home safely" can include whether the person can safely access the property and come and go; is that correct?

A. That is correct.
Q. The Inquiry has heard evidence of a number of incidents of aggression and violence involving VC towards those living in and around his accommodation. Mr Atherton, if the Chair finds those incidents as a fact, would VC, under the Regulations, be deemed, when unwell, not to be able to use his home safely?
A. So in relation to that, we would look at it from the perspective of their safety themselves, so their ability to come in and out of the home, to utilise the environment itself, and to ensure their own safety. It wouldn't necessarily apply to the safety of others when we're assessing the person's safety or managing their home safely.
Q. When people get involved in incidents, it's common sense that they can get injured themselves, can't they, if they're involved in incidents of violence or aggression?
A. That's correct, yeah.
Q. So that can compromise their safety as well as the safety of others, can't it?
A. It could, yes.
Q. In those circumstances, it seems that VC, on that factual premise that I have put to you, wouldn't have been able to use his home safely, at least when he was unwell.

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

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

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

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

has a distinct duty, doesn't it, to provide aftercare in circumstances where a patient is discharged under Section 3 of the Mental Health Act?
A. That's correct.
Q. That duty is under Section 117. Let me take you to that. It's NHSE0000312 and then it's page 355. It's the guidance in relation to Section 117, please.

First of all, it's right that care services or after-care services under section 117 have to be provided free of charge?
A. That's correct.
Q. Without assessment as regards eligibility?
A. That's correct.
Q. Without assessment of finances?
A. Correct.
Q. Turning to this guidance here, 33.3:

"After-care services mean services which have the purposes of meeting a need arising from or related to the patient's mental disorder and reducing the risk of a deterioration of the patient's mental condition (and, accordingly, reducing the risk of the patient requiring admission to hospital again for treatment for [the] mental disorder. Their ultimate aim is to maintain patients in the community, with as few restrictions as are necessary, wherever possible."

Then it goes on to say:

"CCGs and local authorities should interpret the definition of after-care services broadly. For example, after-care can encompass healthcare, social care and employment services, supported accommodation and services to meet the person's wider social, cultural and spiritual needs, if these services meet a need that arises directly from or is related to the particular patient's mental disorder, and help to reduce the risk of a deterioration in the patient's mental condition.

"After-care is a vital component in [a] patients' overall treatment and care. As well as meeting their immediate needs for health and social care, after-care should aim to support them in regaining or enhancing their skills, or learning new skills, in order to cope with life outside hospital".
A. Yeah.
Q. Mr Atherton, VC was discharged twice, under Section 3: on 31 July 2020 and on 18 October 2021. However, on those occasions, the local authority did not assess whether VC needed Section 117 after-care services; is that correct?
A. That is correct.
Q. I just want to understand why that was. Can take you to your statement, please, this WITN0225001, page 8.

Paragraph 26.

"Once released, a care coordinator..."

Once released from detention, you're referring to there:
A. Yeah.
Q. "... a care coordinator will be identified. That may be the hospital's Community Psychiatric Nurse ... or an OT depending in staffing in the Trust. If they identify social care needs, they can call in the local authority."

When you're saying "they" you mean the CPN or the OT.
A. What I meant by that is the clinical team who are -- would be supporting VC in hospital. They would make a decision on whether there was a requirement under Section 117 that required adult social care to be part of that assessment process.
Q. So it could be those assisting in the community; it could be those before discharge. The whole clinical team before and after --
A. Absolutely, yeah.
Q. Paragraph 28:

"Overall, however, the local authority is in the hands of the treating hospital when it comes to providing information about patients who are coming up

for discharge or have been released."

So it appears from your statement, Mr Atherton, that whether there's a need to assess under Section 117 under the Care Act, was not triggered in VC's case because the clinical staff didn't inform the local authority of any social care needs.

A. That's correct.

Q. So the decision on whether the local authority has needs and has obligations to meet those needs, that decision is effectively made by staff from another agency; is that correct?

A. That is correct. Obviously we have a number of people under the Section 117 arrangements with the mental health Trust, so it's a well established process for referral into the local authority where they are identified potential care and support needs.

Q. We've looked at the Care Act. Some of the needs for care and support are more obvious physical needs --

A. Yeah.

Q. -- nutrition and hygiene. Some of them are a bit more nuanced, aren't they?

A. They are.

Q. For example, information and advocacy, issues in relation to perhaps assistance with accessing the community or protecting someone so they're safe in their

home, these sorts of things. As I say, a little more nuanced.

How did the local authority, in the period we're concerned with, between 2020 and 2022, satisfy itself that the mental health staff understood the social care legislation and the guidance that we've been through?

A. That's a difficult question for me to answer, given that I wasn't in Nottingham at the time, and didn't have engagement with this case. I think the -- like I say, the establishment of the working arrangements between the mental health Trust, not just in Nottingham but from a national perspective of that interplay between adult social care and health services and mental health services, is obviously very well established.

The health practitioners and the clinical team will have a good understanding of what qualifies as adult social care needs and we see that from the amount of people we're supporting under Section 117. That is an established pathway. But it's difficult for me to talk specifically to that time having not been here.

Q. Are you aware of any particular training that was given to mental health professionals so they can properly understand your processes?

A. I'm not aware, no.

Q. Were there any checks undertaken to check that the

mental health staff understood the social care legislation and guidance?

A. Again, as I was not here at the time, I'm not aware if that took place or not.

Q. Were you aware of any protocols, for example, that would assist the mental health services to identify which cases they maybe need to pick up the phone and speak to a social worker about and say, "What about this case or that case?" Some sort of guidance on the ground?

A. Again, I'm not aware of particular guidance at that time and what would have been available. I am aware that there are good working relationships from a professional level, from professional to professional between the Mental Health Trust and Adult Social Care, and at that time there were. So whether there were informal conversations that took place between practitioners and clinicians, I -- that may have occurred but I wouldn't know for sure.

Q. We still have your statement on the screen. Can I take you to paragraph 27:

"Whilst the division of health and social care needs like this makes logical sense, there is a danger that vulnerable individuals can slip through the gaps where their needs do not fit easily into definitions of health or social care."

Isn't the point of Section 117 to make sure that people don't slip through the gaps between medical and social care?

A. It is, yes.

Q. Isn't the way to ensure that no one slips through the gaps, to make it necessary as a minimum that mental health services notify the local authority when a patient is being discharged from hospital and going into community mental health services?

A. I think the -- you strengthen that process by having teams that sit together and having social work expertise that sits within that clinical decision-making team. I don't -- I'm not aware that that was what was in place at the time. That was certainly strengthened, moving forward, ensuring that you had that level of expertise sat as part of that ongoing discussion.

Q. But we don't know whether there was social work involvement --

A. No.

Q. -- in any particular discharge, and we're talking here about safety nets --

A. Yeah.

Q. -- and making sure there's no gaps. Isn't the simple way to deal with that to make it a duty or requirement for the clinical services to tell the local authority

about what is happening at the point of discharge, given that it's a trigger point as we've seen in the guidance?
A. Yeah, absolutely. I think there is a challenge, and again, from a national perspective, around the resource available both between the Trust and the local authority or local authorities in their engagement, and their ability for every single patient that goes in to be informed of the discharge, potentially where isn't necessarily a requirement for care and support, or ongoing care and support, from adult social care.
So there's some challenge there in being able to do it in a way that doesn't flood local authorities with information around potential discharges of patients where there isn't a requirement for adult social care to be involved long term. I'm not referring to this case; I'm talking more broadly.
Q. Adult social care have an obligation to undertake needs assessment and to meet needs.
A. Where there's been a-- where there is -- where that's been identified, yes, absolutely.
Q. You're relying upon other professionals to identify the trigger points for when you might --
A. Yeah.
Q. -- meet those needs. You're not aware whether those individuals have got proper training in relation to the

Care Act.
A. *(The witness nodded).*
Q. In those circumstances, isn't the only way to avoid there not being gaps to ensure you're told about these discharges?
A. It would ensure a level of oversight. Again, we'll still be relying on the clinical team to provide information relating to those individuals, so we'd been informed of that to make an informed decision, but yes.
Q. Then you could undertake, for example, a screening assessment?
A. Absolutely, yes.
Q. With all those knowledge and those nuances in the Care Act that we've looked at, that could then be applied in that screening assessment couldn't it?
A. It could be, yes.
Q. An alternative route to ensure the local authority remains engaged, and there's no gap in the net, is for the AMHPs to potentially stay involved, the Approved Mental Health Professionals; that's an alternative way, isn't it?
A. It is an alternative way. It's obviously not stated that in any of the legislation that we have; it's a very bespoke role. You know, what I would say in relation to the AMHP role is that, you know, from a national

perspective it's a challenge, nationally, around having trained AMHPs in place. We have around 40 that sit across adult social care teams in Nottingham City, but it's a challenge with the demand coming through to ensure assessment, as defined by the legislation, is carried out.
The ongoing involvement would make -- a challenge would need significantly more AMHPs into the service to be able to ensure you've got a broader wraparound provision to be provided if that was something legislatively that was suggested moving forward.
Q. The latest Department of Health and Social Care guidance encourages there to be work on discharge during the whole period of detention, doesn't it?
A. That's right.
Q. The AMHP is there at the point of detention.
A. Yeah.
Q. They have some understanding of the case at that particular point. They can remain involved just in a sort of focal point at the local authority, and then can be there to, again, fill that gap, make sure there's the safety net there at the point of discharge.
A. I think there -- I think we would welcome the ability of being able to have a greater level of involvement moving through. I think anything that connects adult social

care and health services together in making some of those decisions would be welcome. But again, I would point to, you know, the scarcity of our AMHPs to be able to undertake that role, and also respond to the amount of Mental Health Act Assessments that they're required to do.
Q. Can I take you to document PAGR0000025, please.
There is a medical record concerning VC. It's dated 19 October 2021, and I want to take you to the entry timed at 19:23, and the last paragraph there, second sentence:
"City social work" -- that's probably Nottingham City Council?
A. *(The witness nodded).*
"... rung this afternoon as they had received a referral for a NOA."
What's an NOA?
A. I'm not sure. This is a health recording. I'm not sure what that relates to.
Q. "CN EP explained this was due to [VC] being NFA [no further action] however he has not secured accommodation ..."
I think that's probably supposed to say "Now secured accommodation":
"... an[d] therefore does not require further social

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

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

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

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

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

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

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

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

wouldn't meet that threshold.
Q. Okay, if they needed a package of support for a matter of weeks at home following the accident, that would be a need for care and support?
A. I guess not -- looking at it, and not to be pedantic, but looking at where it would be she wouldn't have had care and support needs at the time when it occurred.
Q. No, no, indeed. Afterwards. After the incident with the fractured spine, if they're out of action for a number of weeks, that's a care and support need under section 42(1)(a).
A. I would suggest that's ongoing health treatment for a short period of time. It wouldn't necessarily constitute a long-term requirement for adult social care. So I don't think that threshold is met.
Q. If the individual had -- and again these are factual findings from others --
A. Sure.
Q. -- but if the individual had problems with toileting, personal hygiene, maintaining their home for that period of time, then those are needs for care and support arising from the injury?
A. Again, it would be on the basis of us being aware of those care and support needs at the time, and referral being made into the service. Obviously, in my

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

So again, because it would be looking at the very specific incident when it occurred, the person didn't have care and support needs when that incident occurred. The idea that they happened afterwards, the safeguarding becomes redundant on the basis of -- if the individual has injured themselves post it, and there are care and support needs at the time when the incident happened they didn't have care and support needs -- am I making -- *(overspeaking)* --
Q. I understand. You're saying they didn't have care and support needs before the incident, but I want you to focus on the period after the incident. If they've got physical needs for support because of a fractured spine, then albeit that it might not be long term, they've got needs for care and support, haven't they?
A. They may have a period of time where their care and

support being in place and I suppose that's a question -- you're asking the question, it would be helpful to clarify: did they have carers going in providing care and support to them during that period of time?
Q. Well, we'll just -- that's a matter of fact for others, but we'll just leave it there. Then can I take you to 42(1)(b):

"is experiencing, or is at risk of, abuse or neglect ..."

Now "abuse" has quite a wide definition under the guidance, doesn't it?
A. It does.
Q. It can include threats of violence and harassment, and someone -- a neighbour trying to break into someone's property would probably potentially be experiencing abuse, wouldn't it?
A. Again, I think it goes to the -- the top bit has care and support needs and then you go to the bit around "is experiencing risk or abuse". Again, the carer did not have care and support needs at the point that that incident occurred, so ...
Q. But if there's been an incident and it meets the definition for abuse and these people are still neighbours, then is experiencing abuse, there's that

risk -- then there's an ongoing risk, isn't there?
A. I guess your point is they're an ongoing risk, again, dependent on the situation, that there may be.
Q. At (1)(c):

"As a result of those needs is unable to protect himself or herself against ... abuse or neglect or the risk of it."

If someone is out of action because of a fractured spine, they're going to be quite vulnerable, aren't they?
A. They are and I probably just go back to that point. I can appreciate you're going through each of those levels. The bits around that they can protect themselves against the alleged perpetrator and they should have care and support needs to protect themselves, so it goes to the incident that happened at that particular time, the individual did not have care and support needs at that particular time the incident occurred, and therefore section 42 wouldn't be triggered.
Q. If section 42, on the factual basis that the Chair reaches, was considered to be triggered, those enquiries would involve liaison with other agencies, wouldn't it?
A. There would, yes.
Q. There would be a need to speak to police and to health

services?
A. *(The witness nodded)*.
Q. Risk would then be triangulated, particularly in circumstances of an incident like this where somebody had tried to come into someone else's property, there would be a risk assessment?
A. Yes, there would be.
Q. Local authority would lead it --
A. Yeah.
Q. -- because it's a duty under section 42, but we would have a multi-agency risk assessment being undertaken at this particular stage; that would be necessary to meet the duty under section 42, wouldn't it?
A. So again, as a concept of section 42, yes, I would agree with that again. Again, I wouldn't necessarily refer it to the event that occurred, but yes, as a section 42 process, if triggered, then the involvement would be to involve other organisations and agencies that may have had contact at that particular time and to make decisions around risk assessment and safety moving forward.
Q. So you'd be looking to make a safeguarding plan?
A. Yes.
Q. That could involve not only social care but also health and potentially the police as well, acting together?

A. Yes, absolutely. It's a multi-agency approach, so again, dependent on what the safeguarding concern that is being raised is, and the section 42 enquiry that takes place, it can involve a range of partners and should do, particularly where those partners have contact with the individual.
Q. Some of that package may well look like the sort of measures we've already touched upon, medication support, potentially assistance with accommodation, greater social inclusion, these sorts of matters could have been part of that. Towards VC?
A. Well, and I guess that's the important distinction, isn't it? Here we're talking about VC being the perpetrator at this incident or the incidents being provided and our duty is to safeguard the adult with care and support needs who is the alleged victim of the abuse or neglect that may have occurred to them. So it would be to safeguard the individual.

Of course, if the perpetrator in any case -- and again I'm not making reference to this particular incident because I don't think it necessarily mirrors up correctly -- if there is the responsibility for that to be undertaken and there is a person with care and support needs that meets the criteria you've identified, that is at risk of abuse or neglect and also the

perpetrator may have care and support needs themselves, then of course there would be more of a broader, wider look at the individuals from both sides and what support could be provided.
Q. If the best way to safeguard Feven was to reduce the risks from VC, then the package would have a number of measures in it involving VC, wouldn't it? As I've said, medication, social inclusion, potentially accommodation?
A. Again, the safeguarding itself would primarily look at the victim of the abuse and neglect, the safeguarding process itself would -- perhaps it would trigger another part of the Care Act from an assessment perspective where there is somebody with care and support needs who is the perpetrator for an assessment process. So as part of that broader, wider wrap around, then yes, that would be triggered.
Q. Even if section 42 hadn't been triggered, even if someone had just turned their mind to whether section 42 was triggered, they should have then have been thinking: well, does VC have needs under the Care Act as well, shouldn't they?
A. I think obviously at the time of the incident and obviously the assessment that was undertaken, that had the involvement of certainly obviously health colleagues and ongoing health support, and therefore you would look

at the expertise of those individuals while working with VC to make a decision as to whether there was an ongoing care and support needs that needs to be referred into adult social care moving forward.
Q. It would have a social worker looking at VC's situation and then considering whether there's care and support needs there, wouldn't they?
A. If that's -- again, if that referral had come into the service, then yes, it would be looked at by the social worker who would be picking up the referral being made in by Health at that point.
Q. When undertaking Section 42 enquiries, the local authority remains very much at the centre of a multi-agency investigation?
A. That's correct.
Q. When a Mental Health Act Assessment is undertaken by Approved Mental Health Professionals, again, through the local authority, the local authority is at the centre of multi-agency work there as well, aren't they, working with Health?
A. Yes, that's correct.
Q. If this Inquiry is looking at ways to enhance multi-agency cooperation for patients with mental health needs, the local authority is uniquely placed to be a focal point or coordinator for that sort of protocol

or multi-agency working?
A. I think we already are, not in this specific example that you're giving, but certainly around where we look at other risk management frameworks that we operate within. So MAPPA and MARAC. We've got a SERAC, so a Slavery and Exploitation Risk Assessment Conference, we've got a Complex Persons Panel, we have a Hoarding Panel. So there's lots of things we either lead on or are part of as part of ongoing risk assessments for identified individuals. We would expect obviously to be involved in anything relating to a level of complexity where we could bring something of value to those conversations.
Q. I want to touch upon AMHP services, please. I'm not going to ask you to give indirect evidence about the actual assessments that were undertaken with VC. I want to look at some higher level issues with you, if I may.
A. Sure.
Q. Can I start with information gathering guidance. Can I take you to a document, please: WITN0114004. This is the first page of a Nottingham City Council operational policy for approved mental health professional services. Do you recognise this?
A. I do, yes.
Q. It was extant at the time we're concerned with, 2020 to

2022; is that correct?
A. That's correct.
Q. Can I take you to page 8, please. Apologies, page 4. Section there on "Information and communication". I'm not going to read it out, it's quite lengthy, but you're familiar with it, no doubt, Mr Atherton?
A. Yes, through the information that's been provided I am aware of it. Obviously again, at the time I wasn't in Nottingham but I am aware of the document, yes.
Q. It continues over the page, please, touching upon further matters, including giving information after a Mental Health Act Assessment.

Now, it touches -- does touch upon this operational policy, it does touch -- and perhaps if you can go back to the previous page, please. It does touch upon gathering information from CareFirst and Castle. CareFirst is a local authority resource?
A. That's correct, yes. At the time that's what was being used, I believe.
Q. And Castle?
A. I'm afraid I don't know what Castle is.
Q. It also discusses getting information from healthcare?
A. Yeah.
Q. Also advises the AMHP to speak with the nearest relative as is required under the Act?

A. That's correct.
Q. There's no mention here about getting any information from the police.
A. No, there isn't.
Q. Would you expect an AMHP to do that if they're considering a risk of violence in relation to an individual they're assessing?
A. I would, yes. I would expect the AMHPs to be in contact with the police and potentially the police may already have some involvement, depending on the Mental Health Act Assessment that's taking place, but yes, I would agree that police would be an important partner in which to have the conversations with.
Q. As an operational policy that this is, would it not be helpful to put that into the policy to assist AMHPs?
A. It would do, yes.
Q. There's no mention either of housing or education?
A. No, there's not.
Q. Again, in the right circumstances, where it's relevant --
A. *(The witness nodded)*.
Q. -- particularly if there's been incidents at someone's accommodation --
A. *(The witness nodded)*.
Q. -- and they're a university student, that could be very

useful as well, couldn't it?
A. It could do, yes.
Q. Again, useful to have that in the policy, wouldn't it?
A. Indeed.
Q. Medical intervention is mentioned. We've heard quite a lot about the RiO health systems record. At the relevant times, so we're talking 2020 to 2022, there was no formal arrangement in place for social workers to have access to RiO; is that correct?
A. That's correct.
Q. Series of *ad hoc* approaches need to be made by AMHPs towards healthcare colleagues to try to look at RiO if possible?
A. Yeah, and I'm aware that some AMHPs have access, those probably who are embedded in the mental health teams and aligned much more closely to mental health colleagues. Obviously our AMHPs are placed in other teams as well, and I'm aware that the access is not the same for all of the AMHPs and there are ongoing issues with gaining access to the RiO notes.
Q. This lack of a formal arrangement, have any steps been taken to remedy that since the relevant period?
A. I'm not aware that any formal additional steps have been taken. It's sort of a by-person request that goes in to the Trust and the Trust makes the decision as to whether

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

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

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

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

information communication after Mental Health Act Assessments, or on how to do a risk assessment?
A. I couldn't answer that having not been there at the time. I can only probably talk to obviously the last 11 months where I've been in post.
Q. But you've said in your statement you're the person that was nominated as best person to give evidence -- *(overspeaking)* --
A. That's correct.
Q. If there had been any new policies or protocols, you should be able to tell us that, shouldn't you?
A. I can tell you from the period of myself coming in at that time, and I'm not aware of anything from my time of coming in to the role in June 2025 of new policy documents or guidance that's been provided to our AMHPs since then.
Q. One final document, please. It's PHSO0000010. This is statutory guidance that's been issued by the Department of Health and Social Care since the attacks. It's dated 26 January 2024. Can I take you to page 18, please. "Principle 6":
"information should be shared effectively across relevant health and [social] care teams and organisations across the system to support the best outcomes for the person."

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

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

Adult Social Care. So that's being worked on over a number of months now. I believe it is at the point of sign-off.
Q. Is that going to lead to joint funding mechanisms?
A. There are already joint funding mechanisms in place, when we talk about Section 117, obviously there wasn't in the case of VC, but we have hundreds of other people that are supported through Section 117.
MR WESTON: Yes, thank you. I don't have any further questions, but if you stay there, others might.
THE WITNESS: Thank you.
MR MOLONEY: *(Off microphone - inaudible)*.
THE CHAIR: Yes.

Questioned by MS CARTWRIGHT

MS CARTWRIGHT: Good morning. I ask questions on behalf of the survivors. Can I just briefly go back to the review that was commissioned that you were taken to by Mr Weston, NOCC0000192, please.
Thank you. This obviously was commissioned after you came into post in the June. Can I ask you, just first of all, before we move to the section I want to look at on page 20 regarding Section 117 aftercare, can you help us in terms of VC? We know that you've got Mental Health Social Care Team North and South, which are very differently configured.

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

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

social care now have bespoke singular Section 117 aftercare documents for assessments of those entitled?
A. So the work we've been doing with Section 117 with the ICB and our county colleagues, that policy will then support the changes that are required to be made around section 117 documentation moving forward. So no, it hasn't been done at this time, but it will be done in the coming months as we move through our improvement plan within adult social care services.

This rapid review was commissioned on the basis that we identify that there are areas for improvement, it also happened at the same time we did a peer review, so we are inviting external challenging(?) because we recognise there is areas we absolutely need to improve on. That will form part of our further development around our new target operating model.
Q. Okay, but you'd agree, wouldn't you, that this review found that the continued use of inappropriate templates may result in individuals being wrongly assessed, denied access to their entitlements or directed into alternative service routes that are not appropriate? This introduced risks not only of unmet need, but also of legal challenge, financial liability, and reputational damage for the local authority.
A. So I would agree that there's certainly a risk there,

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

a register in its current format, but it will be moving forward.
Q. Will that then mean that immediately on being aware that someone in the locality has been detained under Section 3 that they are automatically added to that Section 117 register?
A. It wouldn't, no, because it would be dependent on whether Section 117 duty would be triggered on the basis of there being identified care and support needs.
Q. But Section 117 aftercare is triggered automatically when someone has had Section 3, so would you agree that at least someone should be continually reviewing or assessing whether there is that need?
A. So the next 117 register, from our perspective, would be those individuals we're providing ongoing funding for because the threshold for care and support has been met under 117. It wouldn't be for anybody who was -- had a treatment order under the Mental Health Act, would be ultimately put onto that, it would be the register of the ones we have an ongoing supporting responsibility to.
Q. It's right, isn't it, for mental health individuals who have been repeatedly detained under Section 3, that also engages the need for specialist accommodation to be commissioned by the local authority?

A. Again, it would -- it's absolutely dependent on the individual at the time and the assessment what their current support needs are assessed as and what would be most appropriate. I couldn't say for VC's case what would be most appropriate for him.
MS CARTWRIGHT: Thank you.
THE WITNESS: Thank you very much.
THE CHAIR: Thank you.
Yes, Mr Straw.
Anyone from the council? Mr McNamara.

Questioned by MR MCNAMARA

MR McNAMARA: Mr Atherton, one of the last questions you were asked by Ms Cartwright on behalf of the survivors was in relation to section 117. If a person is successfully treated in hospital, would you expect to be involved in the provision of aftercare?
A. That would depend on the identified care and support needs for the individual coming out, and whether there was an ongoing requirement for support to be in place. It will vary from individual to individual, depending on their ongoing presenting needs, or also whether there is something additional than just their mental health need they need support with.
Obviously having looked at some of the information related to VC, the requirement for admission or

readmission seemed to be for his non-concordance with his medication at the time, which sits obviously from a health perspective. But obviously if somebody in that position is well and treated and has ongoing support around their medication, then there may not necessarily be any involvement for adult social care.
Q. I understand. I appreciate it doesn't fit with the facts here, but theoretically in the event that someone is treated successfully and they are discharged from hospital even if they're detained under Section 3, it wouldn't automatically mean --
A. No.
Q. -- that there would be a need for the provision of aftercare.
A. No, that is correct.
Q. Working backwards through the questions, you responded in relation to, I think, Mr Weston's questions in particular about multi-agency involvement and you made reference to various agencies such as MAPPA and the like.
A. *(The witness nodded)*.
Q. Building on that, what happens in the event that somebody isn't already, for example, known to the criminal justice system? What would you do in those circumstances?

A. Can you give a bit more context to the question, please?
Q. Yes, forgive me, MAPPA obviously depends on we're talking about --
A. Yeah.
Q. -- about public protection in the event that somebody already has a criminal record?
A. Yes, that's correct.
Q. Or they've been discharged from, for example, hospital order with various provisions put in place by the MoJ. If you were confronted by somebody with whom there was nothing like that by way of history, so here on the face of it there's no established criminal record, what provision would you put in place for multi-agency involvement?
A. It would depend on the presenting need of the individual, it would depend on what other organisations, agencies were involved. We would -- what we would look to do is bring together agencies for discussions in relation to that particular individual and that particular presentation.
So the ability to have multi-agency meetings isn't defined just by the sort of formal ones we have in place; they should be accessed by the professionals involved, working with the individuals to provide the best possible care for that person moving forward.

Q. Thank you. You've been asked a number of questions about care needs and in particular when section 42 is triggered, and it was suggested, for example, that in relation to Feven, the young woman who was injured when she leaped to safety, clearly she had to have hospital treatment and quite serious care and treatment as a result of that. But she was also the victim of a crime. Does the local authority investigate the care needs of all victims of violent crime who sustain physical injury?

A. We do not, no.

Q. Are you customarily told about the needs of all victims of violent crime who sustain physical injury?

A. We are not, no.

Q. Absent some sort of surveillance of the healthcare system or the criminal justice system, how would you discover that somebody required the input of the local authority for the purposes of section 42?

A. We would -- if that -- if something had occurred, there would be the referral process that would need to come into Adult Social Care from -- well, that's a safeguarding concern can be raised by any number of partners or public.

MR McNAMARA: Thank you very much. Those are all my questions.

THE CHAIR: Thank you.

Right, I have no questions. So we'll break now and we'll take the morning break and we'll come back at 11.30. Thank you.

(11.20 am)

(A short break)

(11.30 am)

MR BAYNHAM: Chair, may I please call Roseanna Crane.

ROSEANNA TIFFANY CRANE (affirmed)

Questioned by MR BAYNHAM

THE CHAIR: Yes.

MR BAYNHAM: Ms Crane, you have provided a witness statement to the Inquiry dated 13 November 2025.

A. Yes, I have.

Q. I understand there's a correction you'd like to make to that statement; is that correct?

A. That's correct.

Q. What is the correction?

A. The correction is in paragraph 91, it's referencing the telephone call I have with Ellie from the University after the assessment, and in the statement it says:

"Ellie stated VC's accommodation was at risk".

And that should say: "Ellie had said that he could not return to his accommodation."

So my response to everything after then is

responding to Ellie saying he could not return to his accommodation.

Q. Okay, so it's essentially a firmer position than here. It wasn't at risk, he couldn't return to it.

A. Yeah, Ellie had said the placement was at risk prior to the assessment.

Q. Right. Subject to that correction, can you confirm the contents of your statement are true to the best of your knowledge and belief?

A. Yes, I can.

Q. Briefly by way of background, you are a social worker by training; is that right?

A. I have social worker training, yeah.

Q. Then you qualified as an Approved Mental Health Professional in October 2021?

A. That is correct.

Q. It was in that role you participated in a Mental Health Act Assessment of VC on 19 January 2022?

A. That is correct.

Q. You've therefore only been in the role for some three or four months by that point; is that right?

A. Yes.

Q. I think you say you'd done no more than 20 or so assessments?

A. That's what I suspect it to have been around, yes.

Q. Given your limited practical experience, do you feel your training as an AMHP had sufficiently equipped you for the assessment on 19 January?

A. Yes, I was qualified as an AMHP on 19th January.

Q. The Inquiry has already hearing evidence from Dr Manzar and Dr Skelton, who were the two doctors attending the assessment, and they've addressed a lot of the decision-making, the rationale, et cetera, already. So I'm not going to go through every issue with you, I just have a few short topics to ask you about.

If we can, firstly, turn to the referral, which is NOCC0000062. We can see there the referral assessment was made by Ms Abi Parsonage, who we've heard evidence from, on 18 January 2022?

A. Yes.

Q. And you say your colleague Ms Bagtas had already done some of the work on the referral on that day, including obtaining the warrant.

A. That's correct.

Q. And so you then picked up the referral on the 19 January?

A. Correct, when a place of safety was available.

Q. If we just see there the reason for contact:

"[Mental Health Act Assessment] ... request. Flat tenants have contacted the [mental health] ... team due

to having concerns as an incident happened last night resulting in [VC] assaulting one of them. All other tenants have been removed from himself as hostile and has missed five appointments."

So it's clear there that the incident is being described in the referral as an assault.

A. Yes, that is correct.

Q. VC has been described as hostile, and it also says there that he's missed five appointments.

A. Yes.

Q. Is that right?

A. Yes, that is correct.

Q. If we then turn to the Nottingham City Council case notes, NOCC0000034, and page 7. Would you have reviewed these notes before or when you became involved and picked up the referral on the 19th?

A. Yes, I would have.

Q. We can see there a note at the top of the page entered by your colleague, Ms Bagtas, which provides some further information which is that:

"... [VC is] showing relapse of Psychosis, increased aggression, disengagement ... [and there is an] Incident occurred where he assaulted his flatmates and trapped them in the room. Police [were] called but no further action as no injuries sustained."

Can you see that?

A. Yes, I can see that.

Q. Was there any doubt, therefore, in your mind, that the incident triggering this assessment was a serious assault?

A. There was no doubt this was a serious assault -- assault, a serious incident.

Q. Nonetheless, did you consider contacting the police to get more information on the assault?

A. I had --

Q. -- *(overspeaking)* --

A. So I had these case notes and I had the information used for the warrant application. I didn't contact the police when I was arranging the warrant about the assault. We had some conversations, prior to execution, about their notes and risk history but we didn't discuss this assault.

Q. Okay, so you had conversations with officers when executing the warrant.

A. Just prior.

Q. Just prior to executing the warrant. But not about the incident immediately precipitating the assessment.

A. Not more detail than what I had in these notes and the warrant application about the assault.

Q. Would it have been helpful to try and find some further

information on what had happened from the police?

A. I believe more information about anything relating to VC history and leading up to the assessment is helpful.

Q. Why didn't you seek that information from the police?

A. I was working with headline information from this document and the warrant application. I didn't seek the information specifically, and ordinarily I don't have high confidence it would have been available. However, I didn't explore that myself.

Q. Why do you say you wouldn't have had confidence that wouldn't have been available?

A. Within the timeframes that I was working towards to go from being allocated the assessment and completing the assessment.

Q. Okay, so simply practically the amount of time you had?

A. The time limitation.

Q. Would there have been any other barriers to you obtaining further information or seeking further information from the police?

A. Largely I feel that the time limitation would be the barrier in getting the information from the people that had it within the police.

Q. And so is it essentially the case that, in the circumstances, you felt you had sufficient information to conduct the assessment?

A. It's usual to use headline information. We have a summary of the assault, the police attendance and the outcome, and that was the information we used for the assessment.

Q. If we turn to your report, which is NOCC0000040, and you'll see the front page. So if we just go to the front page just to familiarise yourself, we can see the date of the referral, the date of the assessment, and your name as the AMHP there; can you see that?

A. Yes, I can see that.

Q. If we turn to page 4, we have a note of your telephone call with Celeste, VC's mother. And it says there that:

"Celeste advised that she was not aware of any issues with [VC's] mental health."

That's not a positive statement that there were no issues, is it?

A. What I'm trying to say with this sentence was that VC's mother was not communicating concerns about VC's mental health at around the time of when she reports of speaking to him. I do believe she's aware that he has mental health difficulties.

Q. Forgive me, so what I'm asking is, did you interpret this as her saying that VC was well, or as her saying that she wasn't aware of any reason -- not aware of any issues with his health at that point?

A. I believe I talk about this in my statement that at this time VC's mother was not raising any concerns about things that she had heard or spoken to him about recently about relapsing with his mental health. That didn't mean, to me, that they couldn't be there. I think in my statement I say that they don't live in the same property, so it may be easier for the picture of how she understands it to maybe be different from how it actually is.

Q. As well as them not living together, you understood that VC had withdrawn his consent for her to be kept involved and updated as to his care; is that right?

A. Yes, I did.

Q. I think you also say in your statement you suspected that VC may not have been fully open with her.

A. Yes, I put that in my statement.

Q. And you note here that Celeste was frustrated about not being more involved in VC's care; is that right?

A. Yes, I've put that there.

Q. Ultimately, her view was that she had no objection to admission if that's what the professionals thought was required.

A. That's correct, and that would have been relevant if we were pursuing a Section 3 detention.

Q. Thank you. If we then look just further down the page

we can see your -- the note of your call with -- that's Ellie Turner at Nottingham University. What does she tell you?

A. Ellie advised me that VC -- I'm just reading the note here, so I don't know if I'm -- *(overspeaking)* --

Q. Take your time to read your --

A. -- meant to say something in addition, but in large, it was that there had been the incident of assault at the property and that police were called, and that students were temporarily relocated out of the flat.

Ellie had concerns about VC's mental health as being a risk indicator of aggression and how that could impact the other students, and I advised Ellie when I introduced myself that I was the AMHP that was going to be doing a Mental Health Act Assessment on that day.

Q. I think you say that you were not told during that conversation that VC was going to be unable to return to his accommodation or that that was a possibility; is that right?

A. No, I wasn't. My working knowledge at that time was that there was temporary safeguards in place and that there was still a sense of worry about risk, but it wasn't that he could not be there or that day, or after the assessment.

Q. Did you not ask that question proactively yourself?

A. It would be usual for such a salient point, within the context of me being an AMHP, to do a Mental Health Act Assessment, and I do -- I'm not sure if Ellie worked with the AMHP service or she knew the AMHP service, but I have a sense that she knows our team, and I can't tell you exactly how I know that so I'm sorry if that feels speculative. But I think she believes she understood what I was there to do, so something so salient like that, when we're talking about the plan, would usually be furnished to me quite immediately.

Q. So you relied on her to say that, rather than asking about whether there were any accommodation issues yourself?

A. She's saying that the placement is at risk. She's worried about him being there. But we're not talking about an instance of he can't be there.

Q. Okay. Turning to the execution of the warrants, I think you say in your statement that when you arrived VC was sleepy, perhaps a little surprised, but there was nothing particularly unusual you felt about his presentation; is that right?

A. That's what I wrote down at the time.

Q. And you say VC co-operated in being taken to the Cassidy Suite.

A. He went with police and EMAS staff, yes.

Q. If we can turn to your witness statement, WITN0177001, page 20, and it's paragraph 62 I want to look at first. You say that VC did respond to questions. If we can just display paragraphs 62 and 63. Thank you. You say VC did engage in a two-way dialogue. However, his answers were "just about" -- to the bottom of that paragraph -- "just about on topic but evasive and superficial."

Can you see that?

A. Yes, I can see that.

Q. And then paragraph 63: "... his delivery monotonal and flat."

And then you say you got the impression -- last sentence of that paragraph, that "he knew what to say and what not to say."

What do you mean by that?

A. What I mean is that it felt that we were leading the questions and then he would consider his answer and to say something back, so it didn't feel like he was offering up lots of information. So that impression gives me he's saying the minimal amount of information needed to progress the assessment. And I also felt that when we got to topics of medication concordance, risk, and hospital admission, he would steer his answers towards what he felt was the right thing to say to

minimise or present those things as less risky.
Q. Is what you're describing there VC knowing what to say in order to avoid being detained?
A. I did get the impression that he did not want to be detained to hospital during that assessment.
Q. It sounds like you're describing a capacity or propensity to manipulate; is that fair?
A. I'm describing somebody who doesn't want to go to hospital, and is filtering the information that he's sharing. I understand why you're using the word "manipulate" but it's not the word I'm using. It might be "persuasion" or "selective information".
Q. Were you concerned by that?
A. Yes, when you're not completely confident in the information that you're getting, it will increase uncertainty in the decision-making and the information that you've got to support the decision-making.
Q. Did you make those concerns that you had clear to Dr Skelton and Dr Manzar?
A. Yes, and I believe this was a mutual feeling within the assessment, and when there were opportunities to present other evidence to VC in the interview, myself, Dr Skelton, Dr Manzar, were doing that in the moment as well.
Q. If we just go back to your AMHP report NOCC0000040, and

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

Can you see that?

A. Yes, I can see that.
Q. And if we go to page 7, this is where you're setting out the rationale for the decision, you note again that:

"[VC] stated ... the altercation with the flatmate was a normal interaction between peers over household tasks."

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

A. No, this is just putting what his account was regarding how he had explained the incident of assault.
Q. Was it concerning that VC was describing a serious assault as a normal interaction?
A. Yes, it is concerning and it felt for myself, and I believe for the assessing team, that he was minimising the incident of assault, and that ... one sec, I'll just leave the sentence there because it's gone.
Q. Okay. So your view is this was obviously a serious assault?
A. Yes.

Q. And I think you say in your statement that you also considered it to be an incident that related to VC's mental health.
A. Yes, and thank you, you've just sort of re-found me on what I was trying to say. It was about his response not being proportionate; that we could anchor ourselves into being confident and being able to put that forward, because, regardless of what he may discuss as the cause, that's not a proportionate response to what he was describing.
Q. It had also been reported to you that VC had disengaged from his Community Mental Health Team; is that right?
A. Yes, that's correct.
Q. And we can see on page 4 of your report the note of your call with Ms Parsonage that VC had missed five appointments, and last collected his medication on 17 December 2021.

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

A. Correct.
Q. Did you consider that to be a likely explanation?
A. It wasn't possible to be correct, and we did not consider it to be likely, and it was helpful that we had been provided with -- and we could work out that he

would have ran out because we were able to put that forward to him that he would have run out if he was taking his medication, which was the first account that he gave, and then changed the account after being told he would have run out.
Q. So it was clear that he wasn't concordant at this point.
A. I don't know if it was clear; what was clear was that he hadn't been taking it as prescribed.
Q. Is that not the same thing? Forgive me.
A. Yes, I suppose where I've understood it differently is if he'd taken any, that's what I was trying to respond to.
Q. Okay, so it's a question of total non-concordance or partial concordance, but not full concordance.
A. It could not be full concordance.
Q. I asked you questions earlier about whether you thought VC was manipulating or attempting to manipulate. Did you therefore think that VC wasn't being truthful about this point?
A. It was a probability that he could be not being honest about his medication concordance in the assessment.
Q. And again, did you make your view on that clear to Dr Skelton and Mr Manzar?
A. I believe that this was a working knowledge between us and we had discussed prior and after about the risk

around medication non-concordance.
Q. Turning to the decision itself, why was VC not detained?
A. VC, the assessment itself, it was difficult to discuss in terms of the legal criteria for detention, that the outcome of least restrictive option was a hospital detention under the Mental Health Act. Therefore we couldn't detain him, and for my decision as an independent decision with no medical recommendations, I was then not making an application for detention.
Q. If I can just turn to a couple of paragraphs in your witness statements, first of all paragraph 88 on page 28. You say there:
"I remember Dr Skelton was clear in his view that VC could be discharged to the community and supported by the Crisis Team."
And that he then started "writing up prescriptions ... as soon as the discussion was over."
Paragraph 90 at the bottom of that page, you say:
"Dr Skelton was comfortable to own the risks associated with this [ie, the community treatment plan] from the perspective of the Crisis Team."
Then over the page, if we just go down a little, in the middle of that paragraph there, you say:
"Dr Skelton had an influential perspective, and I trusted the judgement of the doctors. It was after

our professionals' discussion that I held the view that I was comfortable in applying the least restrictive option Community treatment."
You say you were comfortable with that plan after the discussion. What was your view going into the discussion?
A. So I hadn't made a decision or an assessment within that assessment around the treatment in the community because it's not something that is my focus from a Crisis Team perspective, and I feel that before going into the assessment it felt quite high that he would be detained, just generally looking backwards at the history.
Q. So you don't know the details of the Crisis Team and what they can provide because that's not your role?
A. To this detail, and that's not what I was focused on in the assessment, that is what I would be deferring for the input from. If it wasn't from Dr Skelton on this occasion it would likely be another practitioner from the Crisis Team. I don't confidently say they definitely can do this particular treatment plan.
Q. And you repeat again at -- we don't need to turn to it -- at paragraph 96, you repeat twice more that Dr Skelton was comfortable to own the risk or take ownership of the risk of that plan.
Were you persuaded by Dr Skelton, effectively, that

this was an appropriate plan?
A. It's not "persuaded" because I wasn't saying that it wasn't and he was saying that it is.
Dr Skelton's input is to inform me about the appropriateness of this plan. If I had something that was -- felt quite stark, I could challenge that, but I'm not leading the appropriateness of that plan within that team. So "persuaded" is a difficult word, but he is influential because he is able to put that plan forward and to own that plan. So I am influenced by that position, but I wasn't persuaded.
Q. Okay, but you went into the conversation thinking it was quite a high chance that VC was going to be detained until Dr Skelton gave further information on what the community treatment plan could look like?
A. No, I mean I went into the Mental Health Act Assessment with that feeling --
Q. Okay.
A. -- not the professionals' discussion. Then I believe I used wording of it was feeling balanced.
Q. Right.
A. So ...
Q. Just briefly, if we can look at paragraph 84 in your statement, you say -- sorry, page 27, paragraph 84. You say:

"It is important that the plan was about treatment. This was not an [assessment] ... for the purpose of assessing his condition, this was about treatment because we already knew what his diagnosis was."
By that, do you mean that this was really a choice between no detention or Section 3?
A. It felt that this assessment -- we didn't, because we weren't detaining, we didn't get into the conversation as a group around Section 3. My view was looking at a recent discharge, and I'd spoken to Mum to make sure that if we were looking at Section 3, which felt very much on the table, for want of a better phrase. That was a possibility, so it was about treatment.
Q. Yes, so you're faced with what seems to be a relapse of a known condition, recent admission, it's a question of whether admission is necessary to treat that condition; as you say here, it's not about assessing the condition.
A. So we didn't go into that conversation --
Q. Didn't get to that stage -- *(overspeaking)* --
A. -- as an assessing team around what's happened between discharge to now? What's typical? Is there anything that feels different? So that would have come afterwards, but it was very much on the table, a Section 3 assessment.
Q. You have some administrative involvement in the

assessment a week later, just over a week later, on 28 January. Are you able to say from that involvement whether it's likely the assessment there would have been the same choice, ie, looking really at Section 3 or no detention, or are you not able to comment on that?

A. We didn't discuss it in the assessment that I was a part of and I wouldn't want to speculate.

Q. If we can go back to your AMHP report, I just briefly want to look at the risk summary. It is page 7 of the report NOCC0000040. You assessed the risk to others as medium likelihood. Why was that? Can you see that in the page now?

A. Yes, I can see this. So this risk assessment has identified a risk to others. This is looking at the historical information and then the incident of assault and the severity of that is that it's highly severe for that risk to occur.

The medium likelihood rating is given after the assessment and this is considering the safeguards in place, agreed between the University accommodation, Uni and police at the time. The closer supervision in the community from the Crisis Team and supervised medication concordance which links VC being treated and well to be reducing this risk, but I'm not saying that VC is treated and well at that time, but it's about having

that plan in place.

Q. Yes.

A. -- *(overspeaking)* --

Q. So if he was treated and well, the risk would be medium?

A. So at that time I've put it as medium because that plan is in place. So it's -- my thinking at the time was that those measures or that plan that was in place had reduced the risk around safeguarding and increased supervision and supervised treatment as a plan.

Q. When you talk about mitigations and provisions, are you talking about VC's flatmates being relocated?

A. Yes, the -- *(overspeaking)* --

Q. If they hadn't been relocated, would the risk be high?

A. Like -- possibly, but I think there'd have to be more exploring with VC, with the flatmates, about how they felt, and that wasn't something that I had done at the time to see if that was going to be high. It's -- I didn't do that.

Q. Did you understand the risk to be uniquely posed to those that VC lived with?

A. Yes, or lived around.

Q. Well, quite, because here it says there's a risk, particularly those who live in close proximity such as neighbours and flatmates.

A. Yes.

Q. The flatmates may have been moved, but wherever he is, he's going to have neighbours, he's going to have other people in close proximity, isn't he?

A. Yes, that's correct.

Q. So that mitigation measure only addresses the risk to a certain number of individuals; it doesn't address the risk to others in proximity with VC or indeed the wider public?

A. Correct, and I do understand the point that you're making. So we've got the incident of assault that has taken place and the safeguards for that immediate environment inside of the flat. There's a bit of time that passes with -- from the incident to executing the warrant, where we don't see further, and it's not to say that that means everything's resolved, and then we've got the closer monitoring. So it's not eliminated. A risk assessment, it is difficult and it's not -- you can't fully predict, but it was looking at the -- those things together, and seeing if that felt proportionate, and it can be dynamic and respond to further information, further evidence.

Q. Forgive me. So part of the reason for the medium likelihood is the fact that the flatmates have been moved, which addresses the risk to them but not to others; is that right?

A. In part that -- *(overspeaking)* --

Q. Forgive me, the other aspect of the plan is the treatment plan that's been put in place, closer supervision; is that right?

A. Supervision and supervised treatment.

Q. Yes. But that of course relies on that plan working, VC complying with it; yes?

A. Yes.

Q. Also, it's not going to immediately reduce the risk because there would be time for that treatment to take effect?

A. That's correct.

Q. Bearing those points in mind and his history of violence and aggression, on reflection do you think that risk should have been assessed as high?

A. It's high, it can have high, and the reasons that I've put, I'd put medium. The severity absolutely is high, and it was the likelihood that was felt to be a medium because of those things that had been put in place.

Q. Just on reflection, going through those issues, do you think the likelihood should also have been high?

A. So in this particular incident with the flatmates, it was with the flatmates, and we didn't have anything to indicate further delusions, that would be a bit more generalised. I do understand that the cause was more

interpersonal within that flat rather than something that linked VC's aggression to the public at large for this particular incident.

So I do understand what you're saying. However, this is how I'd understood it at the time, to be medium.

Q. Okay. Just moving on to after the assessments, you then speak again with Ms Turner; is that right?

A. Yes.

Q. From the university?

A. Yes, that's correct.

Q. It's that conversation that -- well, tell us what she says about VC's accommodation in that conversation?

A. Ellie shares that he can't return back to the placement. That was the sentence, maybe not word for word, but to that effect.

Q. You say that information felt to you like a tipping point; is that right?

A. It felt in that moment, yes, as a tipping point. If there's no accommodation for a community treatment plan, it would undermine the successfulness, and then thus increase the risk more widely, including risk to the public at large.

Q. Yes, but at that point Dr Manzar had already left, I think; is that right?

A. That's correct.

Q. But you spoke to Dr Skelton?

A. Yes, we were --

Q. What was his response?

A. So we agreed that I would provide this additional information to VC because we hadn't shared that in the assessment, and that might impact his decision around informal admission, and then I passed the telephone to Dr Skelton because I didn't want to -- Ellie's phone call to be terminated. It wasn't finished at that point, but I didn't want to miss the opportunity to speak to VC.

Q. So VC then reviewed an informal admission that you put to him?

A. That's correct.

Q. So the decision was made to carry on with the plan that had already been discussed before this information came to light?

A. So the decision was already made prior to the conversation with VC and VC declined informal admission again, even in light of the new information.

Q. But there was nothing you could do to revisit your decision, one, because you require supported medical opinion which wasn't available to you, Dr Manzar had left, and Dr Skelton, it didn't cause him to revisit his view on the appropriateness of the plan, did it?

A. So we had concluded that assessment prior to speaking to Ellie ... VC has been discharged so what I could do it would be starting a new process. So when I've gone back to the Cassidy Suite, I'm informed the placement, he can return to the placement. The placement is at risk, which is as I had understood it to be at the beginning of the assessment.

Q. Right. Just finally, you set out a number of reflections and recommendations at the end of your statement. The first is that an Assertive Outreach capability would be of benefit in cases such as VC's and, in particular, you say that might have the effect of reducing the need for Mental Health Act Assessments. Can you just expand briefly on that?

A. So I understand that there used to be Assertive Outreach functions in this Trust where I work. I don't work -- I work alongside, and they have more resource and smaller caseloads to work with more challenging people to engage.

Q. I'm not talking about just specifically what benefit the team might have been for VC's treatment, but the specific points on the interrelation between that and demand on the AMHP service. You say that an Assertive Outreach Team or function, you think, might reduce the need for Mental Health Act Assessments; is that right?

A. Um -- can I see it?

Q. We can turn to it if we need to.

A. Can I see it?

Q. Yes, it's the final page of your witness statement. Page 34.

A. Yes, okay. Thank you.

Q. At the end of paragraph 102:

"... if there [was] a mechanism and more capacity by which teams could be more assertive, I suspect that there would be fewer requests for [Mental Health Act Assessments]."

I'm just trying to understand why that would be.

A. Thank you, yeah. So I suspect there would be fewer Mental Health Act Assessments, suspect is -- I'm speculating. If you've got an assertive engagement function, which the Crisis Team do offer, it's not to say that there isn't one there, the Crisis Team offer it. That's going to be with, I believe, your sort of long-term care team, so there's less sort of transition, and I do think that that's beneficial for keeping people well for longer.

Q. Yes. So is it that if there was an -- a more assertive team, there would be less disengagement and therefore less need for Mental Health Act Assessments that arise because of someone disengaging from their Community

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

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

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

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

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

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

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

Q. Right.

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

MS CARTWRIGHT: Okay. Thank you very much indeed.

THE CHAIR: Yes, Mr Straw.

Questioned by MR STRAW

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

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

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

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

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

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

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

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

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

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

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

A. When did they say that?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Okay, thank you very much.

THE CHAIR: Mr McNamara.

Questioned by MR MCNAMARA

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

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

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

Q. Do you know who runs it?

A. Who what's it?

Q. Do you know who runs it?

A. No.

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

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

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

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

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

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

Questioned by MS PATRY

MS PATRY: Thank you, Chair.

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

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

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

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

Q. It was.

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

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

A. Yes.

Q. You can see there:

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

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

And she wanted an update.

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

A. Yes, it was a temporary arrangement.

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

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

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

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

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

Then right at the end:

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

Do you recall that conversation?
A. So I am not present when this conversation was happening, this is my summary of when the conversation is fed back to me and then sort of a bottom line on how the status of accommodation stability is left.
Q. All right. But do you accept or do you agree that by offering alternative accommodation to his flatmates on a temporary basis, this was the most flexible option to allow for stability for VC during this period prior to the Mental Health Act Assessment?
A. The offer of alternative accommodation, that safeguard was very flexible for those that offered it, and those that co-operated with it, the flatmates in VC's benefit and in the safety of them, definitely.
Q. You accept it was also for VC's benefit -- kept him stable, meant he stayed in the flat, he didn't have to move and you kept him stable pending the Mental Health Act Assessment; do you agree?
A. So I was never informed that this arrangement was just into the lead-up of a Mental Health Act Assessment.
Q. All right.
My second topic is this: can I ask you to turn to page 15 of your witness statement WITN0177001. Page 15, paragraph 49, please.
Did you see it refers to the GP, but then about

halfway down the paragraph:
"The university may also have insights from tutors, no additional information in this view was shared from Ellie so I worked with the assumption that there was no further information to explore ..."
Now, I don't know if you heard the evidence of Mr Atherton earlier this morning. He seemed to accept that AMHPs should be proactively seeking information from education establishments such as the University. Did you seek any information from Ms Turner or anyone else relating to what the tutors might think about all of this?
A. I didn't ask about the tutor's impression of his mental health. I don't think I'd ask about mental health, but I didn't -- I'd accept if they shared things but I wouldn't be looking for their opinion on his mental health. But around his studies isn't something that I sought. And for the purpose of the assessment, it doesn't link directly to the criteria that we're assessing.
Q. You seem in this paragraph to be criticising Ms Turner for not having provided additional information. Do you accept that it is your responsibility to ensure that you proactively seek and acquire salient information?
A. I have a responsibility to seek information and it's not

a criticism; it was just a statement of fact that there wasn't information shared.
Q. Thank you very much.
Then finally I want to ask you about what happened after the Mental Health Act Assessment had taken place. You corrected paragraph 91 of your statement this morning to say that Ms Turner told you that VC could not come back to the accommodation.
A. Yes.
Q. Right. Now, are you sure about that?
A. So it was -- he's been discharged and he -- I'm passing on the information of the assessment and then the outcome and that that would mean that he was being discharged home is how the conversation starts. And then she says that he couldn't go back to his accommodation, which is what I'm -- respond to in that moment, because we were aware that he -- the placement was at risk, was shared before, and we were working with that. It's at risk, there's not scope for anything to be further occurring, is essentially what I'm understanding before. But after, it was that we're discharging him to somewhere he can't go, which is --
Q. Is it possible, Ms Crane, that you misunderstood the position? The reason I say that is he was in the accommodation when you came to conduct the Mental Health

Act Assessment, he went back to the accommodation and remained there until February. Right?
A. Yeah.
Q. Ms Turner has no power to evict him from non-university accommodation. Is it possible that you misunderstood?
A. So we were talking, the further information was -- I think it's in a case note that I write directly after the conversation around unfit grounds to study, and something else. There was two phrases that I'd taken from the conversation with Ellie after. I'm not going to rule out any possible miscommunication, however, looking at how I've responded quite quickly and urgently to my perceived -- happy to use that word -- change in accommodation status, and the information that I then relay to VC to say, "It's quite possible you can't go back" or "You can't go back" we're on these lines, and it was a few years ago, that reaction was to new information, or what I had understood and felt was new information.
Q. Again, can we agree it was your responsibility to find out what the accommodation position was for VC after the Mental Health Act Assessment had taken place?
A. I would have -- it's the conversations before because afterwards it is -- it's less helpful to find out things afterwards.

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

Questioned by THE CHAIR

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

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

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

(A short break)

(12.44 pm)
MS LANGDALE: Chair, may I call Helen Foster, please.
THE CHAIR: Yes.

HELEN FRANCES FOSTER (sworn)

Questioned by MS LANGDALE

MS LANGDALE: Ms Foster, you gave a statement to the Inquiry dated 12 February 2026. Can you confirm the contents are true and accurate as far as you're concerned?
A. Yes.
Q. And you tell us in that statement that you qualified as a nurse in 2000 and you were a Charge Nurse at the Priory hospital between March 2018 and August 2022; is that right?
A. Correct, yeah.
Q. And you stopped nursing in February 2024.
A. Yes.

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

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

A. Right.

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

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

A. Yes.

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

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

Do blood tests involve using needles?

A. Yes.

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

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

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

that he wouldn't have weapons --

A. Yeah.

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

A. Yeah.

Q. -- or harm to others.

A. Yes.

Q. And we see at 6:

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

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

A. Yeah.

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

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

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

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

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

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

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

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

A. No, no not really.

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

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

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

A. Yeah.

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

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

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

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

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

A. No.

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

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

list."

So just to be clear, we know he's accompanied by two staff in an ambulance to the Priory. The property list, what's the role of the property list? What happens when a patient comes in?

A. The property list, anything the patient brings in, that is clothing, any toiletries, anything at all that we, you know, we actually search through everything, we have to write it all down on a property list and then it has to be transferred on to the, you know, to the documentation system as to what they've got, and everything, and check with them. Anything that we thought was a risk, you know, we'd check for drugs and weapons and anything. It should be written down.

Q. So these are properties they're able to have --

A. -- *(overspeaking)* -- and remove it.

Q. -- on the ward, as it were, or with them.

A. Yes. What paragraph, sorry?

Q. -- *(overspeaking)* -- not concerned about. It's the bottom line, can you see?

A. Bottom line.

Q. Yeah. So "[VC's] property has been placed on his property list."

A. Yeah.

Q. So there's a documentation of what the patients have --

A. Yeah.

Q. -- and it looks as though that happened here.

A. Yeah.

Q. If we go two boxes up, please, to 3 October, we see he's:

"... fast asleep during the night drug round, hence he missed his night medication of Haloperidol."

A. Mm-hm, yeah.

Q. So he's prescribed presumably medication he should be taking at night and he is asleep and doesn't have it. Is that typical at the Priory or would you wake someone up and make sure they had it, or wouldn't you like to comment on that?

A. I would wake him up, really. I think it's quite important, looking at his history and things, I think it's quite a risky thing to miss, really. I mean I'm not sure how long, obviously I'm not a doctor, I'm not sure how long but I don't think it's a good idea for somebody with his history to not take prescribed medication that's been prescribed. He could have been woken.

Q. Did that happen much, that you would wake patients to give it, or not?

A. I would personally.

Q. Did that --

A. But I don't think that other nurses did actually wake patients *(unclear)* they sleep, they'd just probably omit it. Maybe they tried, but I don't know in this instance.

Q. Was that at the Priory or generally in your nursing experience?

A. The Priory, the Priory.

Q. You didn't think people did wake people up there?

A. No.

Q. Was that different to your experience nursing in other environments?

A. Yes, yes.

Q. Can we look, please, at the entry at 5.15, two boxes up.

A. Yeah.

Q. We see:

"[VC] was in bed at the start of the shift. ... maintained a low profile and remained in his bedspace the rest of the shift ... took his medication though he did not attend the clinic when he was prompted but when the nurse took it down to his bedroom he accepted."

So the system for taking medication, did you encourage patients to go to collect the medication at the clinic? To actively engage with that?

A. Yeah, we did. I mean we didn't just take it down to the patient, you know, that's that particular nurse who took

it to him. But yes, we did encourage people to get up. And obviously you can't assess somebody if they're in their bedroom, you can't see mental state or anything, you can't assess anything about a patient if they're just in their bedroom taking medication. We don't know what's going on, really. So I'd prefer it then to come out and take it.

Q. 4 October, above:

"Keeping Well: ... spent the shift mainly in his room ... accessed the lounge and communal area but remained mainly in his room. Attended ward round and was able to communicate that he no longer [heard] ... voices and he hoped to be discharged soon. Discharge to Beacon Lodge was discussed and [VC] was keen on this option."

You weren't party to this conversation but did you know what Beacon Lodge was?

A. Beacon Lodge was like a place which was -- people go there, and it was like, more like a supported living area. I don't think there were, like, many restrictions on things, but a lot of people used to come to the Priory and then actually go to Beacon Lodge before being discharged either back home or into the community or wherever they came from before.

Q. Because they had some support there, did they?

A. Yeah, yeah.
Q. And we see VC is recorded as being "keen on this option", and this is three days after his admission to the Priory.
A. Mm.
Q. If we can go to page 7, please. We see the entry at the bottom of that, page 7.
A. Yeah.
Q. At the very bottom. 6.39.
"[VC] was polite upon interactions on a needs led basis."
And if we can have a document while I ask you about needs-basis, please, on the screen. This is an extract of a witness statement from Dr Aziri, Priory Health Care. WITN0229001, page 39, please. It's page 39, paragraph 153.
A. Yeah.
Q. We see Dr Aziri says:
"Engaging on a 'needs-led' basis means the patient interacts with the staff or services only when perceive an immediate or practical need, rather than engaging consistently in ongoing treatment or recovery work. Such patients may approach staff for specific requests (... medication, meals, discharge discussion) but otherwise remain withdrawn or avoid therapeutic

interaction."
Would you agree with that description of needs-led basis?
A. Yes, mm-hm.
Q. If that can go down, please, and we go back to paragraph 25, page 7. It was the bottom entry at 6.39 am, where that is mentioned.
A. Yeah.
Q. And you say that fits with your impression that he wasn't around and in the communal areas and generally engaging?
A. No, he wasn't. He wasn't. I mean he was saying what he wanted people to hear. You know, about when he went -- you know, the Beacon Lodge after three days after admission. He's not going to say, "I'm hearing voices" because he wanted to leave, he wanted to go.
Q. Is that typical, nursing patients, you need to be alert to that kind of --
A. You certainly do because, you know, you wonder why people are saying these things. It's only from experience and knowing the patient, and we didn't know him very well, because he was very isolative, because we didn't really know what was going on with him.
Q. If we go to the top of page 7, the entry at 18:38, we see at the top:

"He has spent time in his bed space isolating himself during the shift. He has had minimal interaction during the day and has been asleep at times in his bedroom. [VC] has attended for his medication and has attended for meals during the shift. He utilised his escorted community leave in the afternoon and this appeared to have gone well. [VC] has his ward round this afternoon it went fairly positively, he was granted unescorted grounds leave [and he was] ... prescribed aripiprazole ..."
I'm not going to ask you about medications. There's a doctor giving evidence this afternoon about that.
A. Yeah.
Q. "Granted unescorted grounds leave"; what was that?
A. Unescorted grounds leave -- two checks. Yeah. So he was given -- I mean I don't know exactly what he got but it meant that he could go out after having what he was wearing on, you know, where he was going, what time he went out, what time he came back, and that would all be documented on a piece of paper and then signed by the nurse.
If he's been given -- and it would be unescorted grounds leave would be whatever the doctor felt was appropriate at that time.
Q. And we see he's got "escorted community leave" at that

time, so out in the community, not just in the grounds.
A. Unescorted grounds leave, yeah, sorry.
Q. Unescorted grounds leave, two lines up --
A. Yeah, that's just in the actual grounds itself -- *(overspeaking)* --
Q. In the grounds is unescorted but outside is escorted at that point.
A. Right.
Q. It looks like, doesn't it? Says he utilises "escorted community leave in the afternoon"; is that different, going escorted into the community rather than -- *(overspeaking)* --
A. Oh, escorted community.
Q. -- unescorted grounds.
A. Yeah, that's it, that's right, sorry. Escorted community leave would be with somebody going out in the community, but he could go round the hospital grounds themselves unescorted.
Q. Understood. If we go to page 6, please, of the records, and the second from the bottom, the box at 19.41 under "Keeping connected":
"His mum called today inquiring about him and his university course and wanting to know what can be done to help ..."
Was it typical, if nurses took calls, to record it

in the records, with families?
A. Yes.
Q. And what's the importance, where there is a next of kin, of those conversations with families? How does that help?
A. Well, the family know the patient better than we do. You get a lot of information. You know, when patients are admitted to hospital, you get a lot of information from them about how they really are. You know, and sometimes information that they don't disclose when they've been assessed.
Q. And we see at 7.04, as you've described in your statement:
"Keeping Well: [VC] mainly bedroom based ... came out the lounge area on occasion."
if we go further up, on 10 October there's an entry, and this one is by you, to say:
"There have been no issues regarding his safety. He remains on level 2 x 2 checks per minute. [VC] had brought some belon[g]ings ... in when he went on community leave ..."
Presumably sometime between the 7th and the 10th, and it says:
"[VC] ... brought a hammer in his rucksack ... unclear ... whether he picked this up by accident or

whether it was intentional."
When did you discover that he had a hammer in his rucksack?
A. I cannot recall the person who actually brought in -- you know, when he came in from his leave, who reported it to me. I can't remember the name of the person who actually told me about that, what he did, whether, you know, he filled in an incident report form about it, which obviously it's really serious. So I just can't remember the person who said, because obviously that should have definitely been recorded, and he should have had his leave stopped immediately.
Q. Well, you recorded it here. Is that because somebody had told you that? Did you see the hammer yourself?
A. No.
Q. So this was what you had been told?
A. Yeah.
Q. By somebody who --
A. To be honest, I can't remember if I saw the hammer or not. I just can't remember. Because it's such a long time ago.
Q. Yours appears to be the only note about it, so the person who told you, what was their capacity, a nurse, or somebody who checked property items or --
A. I think it was a support worker -- *(overspeaking)* --

a support worker.
Q. So do support workers check what people bring back in?
A. Definitely, yeah, you have to do because obviously people can bring anything in, they bring drugs and all sorts of things in so --
Q. So a proper search when they come back --
A. Yeah, a proper search, an actual physical search as well because it's unescorted, especially because he'd not been there very long. So it should be a physical rubdown search and then checking through all what he's brought in.
Q. Would that support worker ask questions about why he had it or not?
A. Well, I would hope so, yeah, because it's a hammer. So definitely.
Q. Did you have a conversation with anybody about what VC had said at the time about having that hammer?
A. No, I can't remember having a conversation about it.
Q. But to be clear, he didn't have a hammer, unlikely on the property list, when he first came from Cygnet, did he?
A. No, no.
Q. So here he is on the 10th with a hammer?
A. Yeah.
Q. Clearly that's a potential weapon, isn't it?

A. Absolutely, yeah.
Q. So you recognise it was serious, but you don't remember now how that was followed up?
A. I don't, no. I assume obviously he would have got it when he was on unescorted leave, he's gone and brought this back. So I don't know what his thinking was about bringing that in.
Q. Can we go to PAGR0000025 Page 5, please, the 11/10, 3.47 entry:
"Keeping well, [VC] is in the lounge area, has not been observed having any conversations with staff or other patients in his bedroom on checks." *(As read)*
"Keeping connected: [VC] not observed to have made any external contact with family or friends."
Is that your entry, can you see, Helen Foster? Or was that confirmed by you as the senior nurse?
A. Yeah.
Q. So over -- 3.47, so in the nighttime, then, he's in the lounge area; is that right?
A. Yes.
Q. So up at night; is that right?
A. Yes, it was.
Q. "Not observed to have any conversations with anybody and awake when he's in his bedroom." *(As read)*
So he's already awake at night now; is that clear

from that? Is that what it looks like? It's in the night --
A. Yeah.
Q. -- that he's in the lounge area, presumably by himself not with other patients during the night. Do people normally go to bed at night?
A. There might have been other patients up, but I don't know at that time. Sometimes there are patients who are unsettled and not --
Q. Move around?
A. Yeah.
Q. If we go, please, to the penultimate box at the top, 0721 in the morning.
A. Yeah.
Q. This is on the 13th:
"He requested to be escorted to the vending machine where be bought himself a drink of pop. Came back and stayed in his room throughout the night. Appeared to have not slept at all throughout the night, but spent the night on his laptop. No management issues encountered though. [VC] had no night medication."
(As read)
So awake all night with no night medication again can be pursued with the doctor, but if he was due to have had medication he should have had medication,

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

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

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

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

Q. What are you checking for?

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

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

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

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

A. Yeah.

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

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

So an extensive amount of time on the computer.

A. Mm, yeah.

Q. Page 2, please. The bottom entry.

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

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

A. Yeah.

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

A. Yeah.

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

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

reported he'd fallen over. He had a cut to the bridge of his nose, he didn't allude as to how this happened and accepted a plaster." *(As read)*

We see no description anywhere of a fall or the injury to the bridge of his nose. Was that common, that you'd notice something like that and you couldn't describe or explain how --

A. It should have been documented, that definitely should have been documented. They should have had a body map, they should have documented it. It should be documented incident. What happened. Just given a plaster isn't really adequate.

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

A. Yeah, definitely. That should be recorded.

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

A. Yeah.

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

A. Mm.

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

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

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

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

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

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

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

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

If we look at the entry above at 7.50:

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

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

Then we see the entry above:

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

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

A. Yes, I do.

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

A. Yeah.

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

A. Yeah.

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

A. I don't think so, no.

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

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

view, not as a nurse, definitely not.

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

A. Yes.

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

A. Yes.

Q. -- or night medication.

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

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

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

A. Yeah.

Q. Defines at page 2:

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

1.3:

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

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

A. Definitely.

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

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

A. Yes.

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

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

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

A. No.

Q. They didn't anyway, did they?

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

Q. Page 6 of the document paragraph 4.15:

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

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

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

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

A. Yeah.

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

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

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

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

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

Can we highlight that?

A. Yeah.

Q. Then we see:

"Leaders did not always demonstrate they had the skills to perform their roles and ensure the ... patients and staff".

A. Mm.

Q. If we go, please, to page 5, penultimate paragraph of the first box:

"Before this inspection ... received information of concern from anonymous contacts and from a relative ... about incidents that happened on the wards and the management of patient risk."

Do you see that? It should be highlighted two paragraphs above the "How we carried out this inspection", it's that two lines.

A. -- is it the (inaudible), yes.

Q. No, it's not that box. It's two lines above the "How we carried out this inspection"?

A. Ah, yeah, I've got that.

Q. Go further down the page again, page 5. Do you see "Before this inspection ..."? There we are.

A. Yes.

Q. We see:

"... received information of concern from anonymous contacts about incidents that happened ... and the management of patient risk."

We see over the page, areas for improvement.

Page 6:

"The provider must ensure [the last point] ... audits and Government systems fully assessed and identify risks to patients and staff and improvements are made as a result."

Page 9, please. Again, records showed the last paragraph, that:

"... staff completed risk assessments for each patient on admission and reviewed this regularly. However, before ... inspection we were informed of an incident where a patient self-harmed showed staff did not manage well the risks to the patient."

Were you aware of any steps taken between June, July, 2021 and when you left, I think, in October 2021, to improve staff training on risk assessment and risk management? Did you have any such training?

A. We had some training but The Priory hospital tends to have a bit of a knee-jerk reaction to incidents and they don't follow up a lot of things. They don't follow up incident reports, you know, sort of like support for staff, after an incident's happened and that's quite commonplace. I worked there for four years and I can only remember one occasion when somebody came down and discussed an incident and like the way forward and things like that. I just don't think they do what they

say they're going to do. I've always felt that there.

Q. Can we have, please, NHNB0014406, page 1. The overall rating was inadequate, whether the services were safe, inadequate. Was that discussed with you as staff, that it was ranked as inadequate and what needed to be done or not?

A. It was discussed but it's always been a sort of a blame culture, where it's our fault we're not doing certain things and having imposed loads of paperwork, loads of documentation, you've got to fill this in, you've got to fill that in, which we were running really busy wards with very vulnerable patients. What we're looking at, very high risk, and then they'd introduced load of things like 'oh, you've got to clean down every hour, you've got to do this every hour'. They'd have, like, things where 'oh, you must record everything all the time'. And all this adds to the number of jobs that you've got to do as a nurse and all the other staff that's working with me. So sorry, I forgot the question now.

Q. How many doctors were there working there roughly?

A. Well, there's usually one Consultant Psychiatrist for each ward. I mean, at the time I think there was only two wards open because the other two had been closed, so we didn't admit anybody, but there was only, like, two

actual Consultant Psychiatrists. Then you'd have a ward doctor which was he probably would come down and do the actual assessments when they were admitted.

Q. Who were the consultants at the time that you were there?

A. The Consultant Dr Gurusinghe, what's his name now.

Q. Dr Gurusinghe?

A. That's him. Dr Gurusinghe at the time, yeah.

MS LANGDALE: Those are my questions, Chair.

THE CHAIR: Yes, thank you.

Yes, Mr Moloney.

Questioned by MR MOLONEY

MR MOLONEY: Ms Foster, if I may just very briefly, please. You spoke essentially of a view of VC not really engaging on the ward.

A. Mm-hm.

Q. Where patients are isolated in situations like that it's your view that direct questions need to be asked of them rather than making assumptions?

A. Absolutely. You can't assess anybody if you don't speak to them. I mean, as a former nurse I would have gone into the actual bedroom and sat with them and asked them things, specific questions, people that don't want, you know "Why did you do this? Well, what's going on in your head?" Try to sort of get an insight into what's

actually happening. You can't just assume anything, in nursing. You certainly can't. Because people are very, very poorly, a lot of them, and they won't talk to you because they've got all these thoughts in their head and yet it's your duty as a nurse to go in there and actually find out what is going on. He should never have been left to his own devices and nobody bothered engaging, just assuming that he was all right because obviously he wasn't all right.

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

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

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

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

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

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

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

A. No.

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

THE CHAIR: Yes, thank you.

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

(1.25 pm)

(The short adjournment)

I N D E X