

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF FIONA PARKER

I, Fiona Parker, c/o, Nottingham City Council, Loxley House, Station Street, Nottingham, NG2 3NG will say:

- 1 I am an Approved Mental Health Professional (“**AMHP**”) in the employ of Nottinghamshire County Council.
- 2 Where the contents of this witness statement are within my personal knowledge it is true. Where it is outside my personal knowledge and derived from other sources, it is true to the best of my information and belief.

Introduction:

- 3 During the course of my duties as an AMHP, then employed by Nottingham City Council, I saw Valdo Calocane (“**VC**”) in January 2022.
- 4 This was my only work with VC and the Nottingham Inquiry (“**the Inquiry**”) has requested that I provide a statement about it.

Personal background:

- 5 I am currently employed by Nottinghamshire County Council as an AMHP within the Core AMHP Team. I have held that position with Nottinghamshire County Council since November 2024 and am based at the Sherwood Oaks Hospital in Nottinghamshire.

- 6 I confirm that I qualified as a Social Worker in July 2006 and I commenced employment with Nottingham City Council in January 2007 within the Adult Mental Health Team.
- 7 At that time, the Team was split into 3 teams and I undertook a Care Co-ordinator role.
- 8 The role changed slightly when the Council took on more responsibilities after the introduction of The Care Act 2014. I started to undertake more Care Act Assessments after the introduction of that legislation.
- 9 In February 2015, I qualified as an AMHP. I completed the Level 1 Training at the University of Birmingham in 2013. After a career break, I believe that I completed my Level 2 AMHP qualification in 2014, becoming an AMHP formally in 2015.
- 10 I was then seconded to the Emergency Duty Team ("**EDT**"), where I worked as a Generic Social Worker. I worked in this position on a permanent basis from January 2021 until I left Nottingham City Council in November 2024.
- 11 I had responsibility for fulfilling all statutory duties that Nottingham City Council has in relation to Social Services, including undertaking Mental Health Act Assessments (MHAAs) Child Safeguarding Referrals, Adult Safeguarding, dealing with Adult Care Packages that have broken down, difficulties in carers being able to look after Service Users and also signposting for additional support and other agencies.
- 12 My role was not just AMHP work but encompassed the full role of a Social Worker in addition.
- 13 I was initially seconded to the EDT in 2020 and became a full-time member of the EDT Team with effect from January 2021. I remained in that position until

I left Nottingham City Council to join Nottinghamshire County Council in my current role in November 2024.

- 14 I was on the AMHP Rota while at Nottingham City Council and would undertake one shift per week as an AMHP. Each shift that I worked on EDT was as an AMHP and part of my role was to constantly prioritise risk.
- 15 Child Safeguarding Referrals would take priority. There were always two social workers on the EDT but sometimes only one is a qualified AMHP. There would only be one member of staff on duty overnight.
- 16 In addition, quite a few members of staff within the EDT at that time were also AMHPs as well.

The referral process

- 17 In terms of Mental Health Act referrals, at that time, calls from referrers would go into a call centre, where details of the referral were logged. They were passed to the EDT by email and would be picked up by the AMHP as they were able to do so. If a referral was urgent, it would be marked with an exclamation mark within the subject line. In any event, I would triage that as one of the AMHPs in the EDT Team as soon as possible.
- 18 The EDT Representative would only attend and undertake an assessment if they thought the safety of the person could not wait until the following morning when the substantive day time team were back in work.
- 19 We would constantly prioritise risk and manage that in a safer way as possible.
- 20 EDT would undertake visits where the situation was unlikely to remain safe until the next day. EDT would always try and put a safety plan in place to

ensure that the situation was able to hold until the following day when the day time team could deal with the referral substantively.

Training and experience as an AMHP and professional background

- 21 I confirm that I have worked in mental health for all of my professional life as a Social Worker since 2007. I have worked with individuals from a range of different backgrounds and different types of mental health disorder, including schizophrenia, personality disorders, severe depression and mania.
- 22 I have had experience of people of various different ethnic backgrounds, both in the Team that I have worked in and also with people that I have supported. I also have personal experience of mental health care as some of my family members have suffered with mental health illness.

The AMHPs work

- 23 I see the role as an AMHP in supporting people who are in a mental health crisis in the least restrictive way possible. The role of an AMHP has significant and draconian powers. I would stress here that an AMHP should only intrude into an individual's life if it is necessary and proportionate, based on how that person is presenting.
- 24 The role also requires an understanding of what the individual is saying and how they are presenting in the context of any social factors that may be influencing their presentation.
- 25 I would utilise the Mental Capacity Act 2005 as part of my role. In the event someone was to present as lacking capacity, myself as an AMHP would make a decision in the person's best interest on treatment. For example, if they were refusing treatment but could not understand why we were using the Mental Health Act 1983 ("**MHA**") to enable treatment, then we would always act in their best interest.

- 26 I always start with the least restrictive treatment option possible, but the situation could change during the assessment and in my role as an AMHP I always need to adapt the outcome based upon that.
- 27 AMHPs need to take into account the human rights of the individual they are assessing but also the rights and safety of others.
- 28 As well as the statutory background, there is a Code of Practice to follow [NHSE0000312]. We always have to fulfil our role in an ethical way, which involves considering everyone in that situation. We work collaboratively together in order to achieve the best possible outcome for the individual.
- 29 We would only use our powers if they were absolutely necessary and where it is proportionate to the situation that individual finds themselves in.
- 30 AMHPs must always work within the confines of the legal and ethical framework.
- 31 In addition, there are local policies and procedures, particularly around the conveyance of patients to hospital and local agreements with the Ambulance Service.

MHAAs

- 32 In the EDT, referrals would come into a contact centre via telephone call. The EDT call handlers would take basic details of the referrer, together with very brief information on why they wanted EDT to investigate matters. The referral thereafter would be passed to the AMHP by email.
- 33 EDT cannot always respond immediately. There are some situations in an EDT where AMHPs cannot leave a particular case that they are working on at

- that time. If the next case is seeking an emergency response, then the referrer may well be advised to call "999" in that situation.
- 34 EDT referrals can come in from family members, police, nurses, doctors, A&E departments, schools, police stations. You could get calls about absolutely anything in that role.
- 35 The referral information email would contain very brief information about the person themselves and also the person making the referral.
- 36 I would go into the computer system and open up the referral, check the address to see if the referral is in fact the responsibility of the Local Authority in question (Nottingham City Council). If the address was out of area, I would check the system to see if the person was open to the Local Authority, as they may well be the responsibility of the Local Authority even if placed elsewhere.
- 37 Thereafter, I would call the person making the referral to try and gather more information about the individual and precisely what was going on. I would try and set up a safety plan to deal with what was going on at that particular point in time if it was felt appropriate.
- 38 I would describe EDT social workers as being the gatekeepers of the EDT Service and we would assess whether something required an emergency or urgent response at that time.
- 39 EDT had to be mindful of resources. If an issue was not sufficiently urgent, EDT would signpost or give advice or pass onto the daytime team to deal with.
- 40 I would work through referrals based the time that they came into the EDT AMHP Inbox. If we were dealing with cases prior to that email, we potentially would not deal with the latest referral as soon as it came in. There were only two EDT social workers on duty at any one time.

- 41 On average there were in the region of 10 to 30 EDT referrals every night. Not all of these would be AMHP referrals. Every night was always completely different. They were not always straightforward referrals, and some could be quite complicated.
- 42 I would do a bit of initial background work once I had received the referral to make sure the threshold had in fact been met for a MHAA under Section 13. If that was the case, then I would look at arranging the assessment and making a decision on whether it needs to be done out of hours or could wait until the morning.
- 43 If an individual only required treatment for their mental ill health and had objected to that treatment, then the person would automatically be ineligible for a Deprivation of Liberty ("**DoL**") Order.
- 44 Ideally, a Mental Health Act Assessment would take place in the day as assessments can be destabilising for the individual and also other agencies or professionals may not be fully available at night to support that assessment or with the care plan following the assessment.
- 45 It can escalate the situation if an assessment is undertaken and then a decision is taken not to detain, leaving the relatives and family members potentially to manage that situation in the aftermath. There is an even greater risk of escalation if a decision is made to admit to hospital but the assessing team does not have an allocated bed. This would not prevent an assessment from going ahead but each situation would need to be carefully risk assessed.
- 46 As to the information available for AMHPs to access prior to assessing, I would always refer to previous notes on the Liquid Logic System in order to get a history of what has happened in the past as well as any other information available to me from that system. I would also speak with the person making the referral and the Crisis team if applicable, along with the

- nearest relative, to gather as much information as possible. It was more time limited within EDT, but that never stopped me from looking at the notes and gaining as much information as possible.
- 47 Typically, you would not be able to go back as far in time. You have to gather information quickly and are reliant on other professionals bringing information to the location of the assessment. For example, I would consider previous admission history, previous AMHP reports, Liquid Logic Records and any warrant information on the system. I would also speak with the nearest relative, the Crisis team and the person making the referral.
- 48 The type of documents I would look at would depend upon how detailed the referral had been. Sometimes, the referral itself is extremely detailed and has enough information to enable me to go out very quickly. In that situation, there would not be a need for me to review large amounts of records on the system.
- 49 I confirm that I did not have access to the NHS case management system known as RIO at the time.
- 50 I would receive medical information from the assessing doctors and any information from AMHPs who had assessed an individual during the daytime.
- 51 In terms of the medical history, I would need to know whether an individual had a diagnosed mental health condition or whether they were presenting with a mental disorder. I would also need to know whether the individual was taking medication or whether they had any physical health issues.
- 52 I would consider all risks, taking into account all the circumstances of the case.
- 53 Risk is based on an individual's circumstances and the individual you are dealing with. Having said that, my approach may be different when you see

an individual for a second time, based upon what had happened since the last time you had seen them. It is always important to take into account everything in all the circumstances of the case.

The MHAA process

- 54 I personally would gather all relevant information to make a decision as to the priority of an MHAA in line with my duty to consider an assessment under Section 13 of the MHA. I would make this decision taking into account the information being shared on how the risks were presenting or how they were described within the records system and how they could impact the time and date of that assessment.
- 55 The question for me was whether it was necessary and proportionate for an assessment to take place out of hours. It is about weighing up the risks to the person and to the assessing team.
- 56 Within EDT, my role was to triage information to determine whether it was necessary and proportionate for it to be completed out of hours. I needed to consider whether it is proportionate for the person and the service to do it out of hours. I have a responsibility, under section 13 MHA, to ensure that all options, particularly the least restrictive options, have been explored.
- 57 Once I deemed that assessment to be necessary and proportionate, I would arrange a time with relevant assessing doctors. One of those doctors would always be the "on call" Specialist Psychiatric Registrar.
- 58 I would obtain details of that individual from the Trust switchboard. There is always an "on call" Specialist Psychiatric Registrar after 18:00 hours every night, all the way through to 8 am in the morning. There is one for the North, one for the South and one for Mansfield.

- 59 EDT also had access to the Nottinghamshire Emergency Medical Service (“**MEMS**”). This was an “out of hours” service based on Derby Road in Nottingham.
- 60 I would thereafter contact the Bed Management Team (“**BMT**”), to see if a bed was available and to alert them as to what time the MHAA was going ahead. If there was no bed available at that time, I would agree to let them know the outcome of the assessment as soon as possible.
- 61 I would then speak to the nearest relative to see if they had any objections to admission under the Act and if it seemed that there may be an objection to Section 3 then I would alert the daytime team. If a relative were to object, I would consider whether that objection was unreasonable and whether the displacement of that person as the nearest relative should be considered. This would then be followed up by daytime services.
- 62 If I felt that I had not got sufficient information from that nearest relative, I may make contact with another relative, but I always need to be mindful of the need to act quickly. The nearest relative is typically the best person to understand their relative, they know what they are like when well and when they are unwell.
- 63 I do not like undertaking assessments where I haven’t been able to speak to the nearest relative. It is a legal requirement for Section 3 but is also good practice for Section 2 as well.
- 64 Sometimes, the practicalities and urgency of the assessment means it is not possible to speak with them before carrying out an assessment under Section 2. A consultation may well happen after the assessment has taken place, but before the report is written. We have 14 days to consider an application once two doctors have made medical recommendations for admission. It would become more complicated if someone was on a Section 2 detention in a hospital that was due to expire in the near future should their relative object.

- 65 I would always ask the nearest relative for their view of the situation at the present time. I would ask them what the individuals were like when they were well and unwell, I would ask them what they would enjoy and ask them what their hobbies were, as that could be helpful at building a rapport and putting them at ease and making conversation with them later. This also supports in identifying any social stressors that the person may have.
- 66 The Crisis Team gatekeep beds as well. They offer community support daily to support mental health and monitor medication compliance. They can monitor mental health in the community if that is felt appropriate. It is often challenging to get through to them out of hours, but it can be helpful to speak to them to see what they are currently worried about.
- 67 It is fair to say that access to psychiatric beds has been chronic for a long time now.
- 68 In terms of access to the doctors, there is a Section 12 doctor list and someone is on a rota every night as a Section 12 doctor. I would use that list to see who was on the rota and then make contact with that individual.
- 69 As to understanding and assessing the risk, I would always take into account past risks, having regard to previous AMHP reports and information gathered from crisis workers. Those risks usually present when the person has been acutely unwell and are a good sign of potential future risks. I always have regard to the present risk and will ask anyone I speak to about the risks, including the person who is the subject of the assessment.
- 70 It is always about considering the severity and frequency of risk and the type of risks posed when the individual is acutely unwell.
- 71 Historic risks when acutely unwell can be a good indicator. However, there is a need to take into consideration all of the circumstances of the case when

undertaking a MHAA, including any protective factors that could reduce the likelihood of the risk occurring.

- 72 If I was to see an individual who is not taking medication, not engaging with services, starting to have suicidal thoughts, and continuing to deteriorate; the risks associated with this deterioration may well increase in frequency and severity. However, human nature is so unpredictable. You can undertake a risk assessment and it can be a really good and thorough risk assessment but you cannot always predict what is then going to happen.
- 73 Individuals can also mask real symptoms within the assessment, and we always have to be mindful of that and formulate an assessment of how that individual presents. We would always consider this issue with the Section 12 doctor and the other assessing doctor as well.

Prior case

- 74 I confirm that I have been involved in the care of another mental health patient who went on to seriously injure a member of the public. I believe this occurred in 2015. I was this person's social worker and had provided services to them under the Care Act. However, I was not involved in the person's care at the time of the incident and do not remember anything further about it.

Involvement with VC

- 75 I confirm that I had prior involvement with VC before 28 January 2022. I had triaged and accepted an MHAA on 24 May 2020 at 09:38 hours [NOCC0000034].
- 76 I allocated that referral to Ben Williams, AMHP at 12:00 hours when he started his shift [NOCC0000034].

- 77 I believe that VC was in police custody at that time and the police were not going to discharge VC until the MHAA took place [NOCC0000034].
- 78 I note that I acknowledged an email from Clarisse Bagtas on 18 January 2022 [NOCC0000069]. Clarisse Bagtas had emailed the EDT but had not asked us to do anything within the team. It was me simply acknowledging receipt of her email.
- 79 In terms of the MHAA which I undertook on 27 January 2022, I was not part of the referral to the Nottingham Adult Social Care Team. I understand that was dealt with by Roseanna Crane [NOCC0000034].
- 80 I could see from the system that Roseanna Crane was setting up an assessment that day, prior to it then coming into EDT [NOCC0000034].
- 81 I understand that the initial referral came from the Crisis Team. I have not recorded this at the start of the AMHP Report, as it had been referred to EDT by Jude Modern [NOCC0000034].
- 82 The referral information would have been passed over to me by Jude [NOCC0000034]. I recall it being a lengthy conversation between myself and Jude via Teams or the telephone. There had not been a Place of Safety (“**POS**”) available for the day time team to execute the warrant as there was no POS available until 21:00 hours. A police cell would not be used as a POS for the purposes of a MHAA. We would only assess individuals in cells where they have been arrested under the Police and Criminal Evidence Act 1984 (“**PACE**”) and where there are concerns about their mental health whilst in custody.
- 83 The referral came through into the EDT, so that VC could be taken to the Cassidy Suite for assessment.
- 84 I confirm that Jude Modern gave me a really good verbal handover.

- 85 Jude Modern had completed a lot of the AMHP report, to include the risk assessment of VC, which she completed at 18:15 hours on 28 January 2022 [NOCC0000043].
- 86 I was unclear as to who had obtained the warrant but believed that it was Jude Modern who had obtained it [NGPF0003316]. I took hard copies of the warrant with me in order to pass those to the Police as good practice.
- 87 I believe that there was a clear requirement for an MHAA. This was because, there was a significant risk history information to suggest that VC was not fully engaging with the Care Plan in the community and there was evidence to suggest that his mental health was deteriorating.
- 88 Following a previous MHAA, he had agreed to a Community Mental Health Support Plan [NOCC0000040]. There were concerns that he was not complying and there were potential increases in risk [NOCC0000043].
- 89 I deemed it necessary for EDT to carry out the plan put in place by the daytime team, namely to execute the warrant and to assess VC in a place of safety. I also note there were significant concerns for the safety of flatmates and neighbours within VC's student accommodation [NOCC0000043].
- 90 I confirm that I spoke with the crisis doctor, Dr Ben Lomas, while waiting for everyone else to arrive on the scene and he updated me about the events of 17 to 19 January 2022 as documented in the AMHP Report [NOCC0000043].
- 91 I understood that VC had initially agreed to a Community Care Plan between 19 January 2022 and 28 January 2022. However, he did not want Community Psychiatric Nurses ("CPNs") going into his address. He had agreed to meet them outside the address and to take his medication [NOCC0000040]. However, there were concerns as he was disposing of medication shortly after putting it into his mouth, suggesting that he may well not be complying with

taking the medication. It was clearly thought he was not complying with the Community Treatment Plan [NOCC0000043].

- 92 Superficially, it appeared that he was complying to a degree, as he was agreeing to go and then meet the CPNs within the community. However, the CPNs were of the view that he was not taking his medication due to his presentation and behaviour. There was a clear risk here that things could escalate and his mental health condition could deteriorate further.

Warrant

- 93 I initially thought that Jude Modern had applied for and obtained the warrant but I was not clear on that point.

- 94 I confirm that having reviewed the case notes and the application for the warrant document, it was in fact Roseanna Crane who applied for and obtained the warrant on 27 January 2022 [NGPF0003573].

- 95 I recall that VC had been subjected to CS gas and had been tasered by the Police on a previous occasion [NOCC0000043].

- 96 Myself and Dr Lomas wanted to approach the assessment in the least restrictive manner possible, using the Code of Practice Principles to ensure that VC was assessed in a dignified way and in a way that did not escalate the situation.

- 97 My view was that if we were to go in with significant numbers of police officers, without saying why we were there, then that could escalate the situation as demonstrated by what had happened previously. It was also recorded in Liquid Logic that Jude had spoken to Mum, who had explained to Jude that VC was highly traumatised by what had happened to him in the past. [NOCC0000034] Jude also mentioned this conversation to me when doing the verbal handover.

Events of 28 January 2022

- 98 When I met VC on 28 January 2022 at his home address, I was very surprised about how calmly he presented and the fact that he ultimately agreed to attend hospital voluntarily [NOCC0000043].
- 99 I would never ask the police to determine the number of officers required to execute a warrant and I do not know any AMHPs who would make such a decision. The Police were informed of the risk and thereafter I assume they undertook their own risk assessment to determine number of officers required.
- 100 When we attended on 28 January 2022, there were approximately 6 to 8 police officers present and my view was that there were a lot of police officers present. Ultimately, none of them were needed as the warrant did not need to be executed. VC was treated with dignity throughout. I explained why we were there and what was going to happen [NOCC0000043].
- 101 I confirm that I did speak to Dr Lomas before executing the warrant. There is a summary of that within my AMHP Report regarding my discussion with Dr Lomas [NOCC0000043].
- 102 The description of the discussion that I had with Dr Lomas is accurate and full and the words used within that report are my own. I cannot recall if anything further was discussed due to the passage of time.
- 103 The information from this conversation indicated that VC could be unwell and there was also a clear suspicion that he was not in fact taking his medication.
- 104 We agreed with all professionals that the warrant would be executed at VC's home address on 28 January 2022 [NOCC0000043].

- 105 When we first arrived at VC's residence, I initially waited in my car in the car park for the police, Dr Lomas and the ambulance crew to arrive [NOCC0000043].
- 106 Once everybody had arrived I briefed those who were present as to why they were there, the purpose of having a warrant and the history of known risk. I explained that we needed the warrant in order to convey VC to the Cassidy Suite and carry out the MHAA safely, in a manner that was both safe for him and others [NOCC0000043].
- 107 When we went into the communal area of the flat leading into VC's place of residence, I cannot say for certain as to why it was decided that Dr Lomas and I would knock on VC's door initially. However, my practice as an AMHP is always to consider the least restrictive options with dignity and respect of the individual. There was no evidence that he had tried to harm any of the other Mental Health workers he was meeting in the community.
- 108 I decided to approach VC in the least restrictive manner possible and knocked on VC's door [NOCC0000043].
- 109 He opened the door willingly. Dr Lomas and I spoke to him in calm and polite terms. There was a strong Police presence next to us should reasonable force have been required [NOCC0000043].
- 110 We explained that we knew that he was meeting the Crisis Team and we were worried about his mental health [NOCC0000043].
- 111 We had concerns regarding VC's mental health as he was not engaging with mental health services. Executing the warrant ensured an assessment of his mental health in a safe manner for all involved.
- 112 VC opened the main door into the flat when we knocked. You could immediately see that he was confused and could not understand why we

- would all need to visit him. VC said that he had been doing everything that was asked of him. He was a bit baffled and caught off guard, not least because it was nighttime [NOCC0000043].
- 113 At no stage did he show any aggression to anyone present. He could understand the reason why we were there but he did not understand the necessity [NOCC0000043].
- 114 He was fully clothed when we arrived. I have no recollection of the state of the flat and general living conditions. If I had had any concerns about living conditions that would have formed part of my AMHP Report. This would have alerted the ward to consider any social care input VC would require to manage his home environment at the point of discharge.
- 115 VC was removed from his accommodation but essentially left willingly. He agreed to come for the MHAA. I informed him of a range of potential outcomes of that assessment which would include potentially continuing to receive support in the community, informal admission to hospital or admission under MHA [NOCC0000043].
- 116 I think that he got himself ready, but I can't remember that clearly. Ultimately though he did agree to attend for the assessment.
- 117 I got the impression that he thought he was going to be home by the end of that assessment. My impression was that he did not think that he had any mental disorder so he thought that the assessment would not end in him being admitted [NOCC0000043].
- 118 Bearing in mind what Mum had expressed to Jude Modern around the prior admissions, I suggested that he took some things with him to hospital, such as clothing and toiletries. However, as he did not think that he was ill, he did not want to take anything as he thought he would be back home quickly. I did not wish to push this with him as he was compliant [NOCC0000043].

- 119 The ambulance crew who had attended transported VC to hospital. I travelled in my own transport and met the ambulance and VC at hospital [NOCC0000043].
- 120 I would never travel within an ambulance in this situation. If I felt that there was a risk to the ambulance crew, then I would have identified that to the police, but I cannot recall in this situation if the police travelled in the ambulance with VC.
- 121 At no stage did I feel threatened or intimidated by VC. I do not recall the context of everything but would always remember if I had felt threatened in an assessment and would have identified that. VC displayed no aggression whatsoever during my encounter with him. I remained constantly cautious and vigilant that this could potentially change at any time, given the recent incident with VC.
- 122 As identified within my AMHP report, VC did question why he was at Highbury Hospital for the MHAA as he said that he had done everything that was asked of him and had stuck to his agreement [NOCC0000043]. I understood that that agreement was that VC would see the Crisis Team in the Community and take his medication as made at the previous MHAA on 18 January 2022 [NOCC0000040].
- 123 VC may partially have been complying, given the fact that he was attending the meetings with the Community Psychiatric Nurses but the suggestion was that he was not taking his medication.

The Assessment

- 124 The MHAA took place at the Cassidy Suite at Highbury Hospital. Dr Lomas and Dr Manzar were present for the assessment [NOCC0000043].

- 125 VC did not fully engage with that assessment. He believed that he had followed the prior agreement about meeting the Crisis Team in the community and by taking his medication. He constantly repeated that during the MHAA [NOCC0000043].
- 126 He was very fixated upon the fact that he thought that he was complying. He would ask questions as to "*why am I here*". This went round in circles, and he could not move on from that [NOCC0000043].
- 127 I cannot recall VC's body language during the assessment in any great detail. I would describe him though as being calm but assertive. He maintained his position as, "*I don't need to be here as I am taking my medication*" [NOCC0000043].
- 128 The assessment took place within the communal area of the Cassidy Suite. VC refused to leave that area to go into one of two bedrooms. I believe that this was on the basis that he thought there was nothing wrong with him and he would be leaving the hospital following the assessment. He remained standing throughout the assessment [NOCC0000043].
- 129 At no point did he make any threats or demonstrate any aggressive behaviour towards me or the others present. It was not necessary to use reasonable or proportionate force or in fact to remove VC from the communal area. We were in a confidential place in any event.
- 130 I do not recall any specifics of the interview with VC beyond what is recorded in my assessment. I cannot recall if we discussed the "conspiracy theories" that VC was said to believe in. I felt safe during the MHAA but was always conscious of the risks.
- 131 VC remained fixated on the fact that he was continuing to receive support in the community and he felt that he was not unwell. He showed very little insight into his mental disorder and in fact denied any mental health illness.

- He was quite guarded in information sharing. He was undoubtedly an intelligent man and I believe he understood the outcomes and that he had been detained previously and wanted to avoid that. The information he was providing did not match all the information I had gathered previously about him [NOCC0000043].
- 132 The conversation was like talking to someone else. He did not appear psychotic but clearly had been displaying worrying behaviours. We erred on the side of caution here. He didn't give us any further information to change our minds and, therefore, a decision was taken to detain him [NOCC0000043].
- 133 The risk was that if he deteriorated further, the frequency and severity of that risk would increase.
- 134 Had he been more open with us and talked about his condition, then potentially there may have been a different outcome.
- 135 We did though have clear information to believe that he was not taking medication.
- 136 VC remained so guarded and there was further information in the light of previous risks, assaults and others moving out of his student flat that the decision was made to detain him.
- 137 I did identify on my AMHP Report that VC had "*a very dry lip with skin peeling off – appears dehydrated*". I saw that and asked him about it. I was concerned that he was not drinking for a specific reason, potentially around his paranoid beliefs. I wondered whether he was paranoid about eating and drinking [NOCC0000043]. If there was anything further, I would have noted that within my report.

- 138 I had understood that Jude Modern had discussed with VC's mother prior to the execution of the warrant and the MHAA [NOCC0000034].
- 139 Jude provided me with a very detailed verbal handover. It did not seem proportionate to call Mother again. She had lengthy discussion with Jude earlier in the day [NOCC0000034]. I updated Mum on the outcome following the assessment. I had no time to speak to her before the warrant was executed but I would have made time if I felt this was necessary. On this occasion I did not feel it was proportionate to delay the assessment since my colleague had already gathered the nearest relative's views. I lived approximately 45 minutes' drive from the location of VC. The assessment was set up for 20:30 hours and it was agreed at approximately 18:00 hours.
- 140 I spoke to Mum following the assessment and confirmed the outcome [NOCC0000034]. I had no conversation with any other relatives.
- 141 In relation to risks, there was a clear risk of further decline of VC's mental health and also a risk of retaliation from others, particularly flatmates or those in the community.
- 142 I saw that Jude Modern had written that and I agreed with her views on risk [NOCC0000043]. If I had wanted to update it or amend it, I would have done so. The analysis had been done by Jude Modern but I could rationalise everything and felt there was no need to amend that. I was aware that VC's neighbours had moved out of the student accommodation as they had felt frightened by being in close proximity to VC.
- 143 There were also other risks in that VC was potentially not going to be able to complete his academic studies and therefore was at risk of losing his accommodation.
- 144 His inability to complete his academic studies and any loss of his accommodation could worsen his mental health condition. There was also a

risk of stigmatisation and therefore social isolation which in turn are known contributing factors for poor mental health.

Capacity:

- 145 I believe that VC understood everything that I said to him, but he did not feel that he had a mental disorder that warranted detention.
- 146 I took the view therefore, that he lacked capacity as he was not able to weigh information up and also lacked insight into his mental health condition. As he was ineligible for a DoL Order, the MHA was the most appropriate framework to detain VC. As VC completely denied any mental disorder of any nature, he also lacked insight into the degree of his mental health illness [NOCC0000043].
- 147 I believe that he understood what was being asked of him but did not agree with the assessment or any of the concerns presented to him.
- 148 When we informed VC of the decision to admit VC to hospital, he did not challenge myself or the other professionals present. He did not react violently or aggressively or indeed at all. He did not appeal or ask to have an Independent Mental Health Advocate (“**IMHA**”) act on his behalf, which it is our duty as AMHPs to inform him of his rights in relation to this. He was accepting of the decision and at no stage did he become challenging [NOCC0000043].
- 149 I understood that “*he had been seen spitting the medication into his hand and putting it into the bin*” [NOCC0000043]. I believe that was occurring between the MHAA on 18 January 2022 and 28 January 2022. There was therefore a clear risk of VC remaining untreated and therefore deteriorating into a full-blown mental health crisis. The risk of that was high in likelihood and could be high in severity.

Section 2/Section 3:

- 150 As VC denied any mental health illness, Section 2 of the MHA was agreed as being the most appropriate way to proceed with VC. This was to enable an assessment to be undertaken of his mental health condition and for any treatment to thereafter continue [NOCC0000043].
- 151 VC had not engaged in any meaningful way with community mental health services, albeit he had turned up and engaged superficially. In order to be fair to VC, Section 2 was put into place, as it is always important to assess a new presentation. Section 2 has a shorter period of detention, albeit Section 3 is available at the end of a Section 2 assessment.
- 152 I confirm that myself and the two attending doctors, Dr Lomas and Dr Manzar agreed with the decision to detain [NOCC0000043].
- 153 I can only make an application with two doctors in support. I do not believe that they would have completed the relevant paperwork had they not agreed.
- 154 I do not recall any discussion with them around a Section 3 Order.
- 155 After the MHAA, myself and Dr Manzar and Dr Lomas discussed the decision and thereafter they would have written their medical recommendations. I would have reviewed and checked over their recommendations and completed the application afterwards.
- 156 The application was made by me to Highbury Hospital [NHFT0000070]. The agreement was that VC would remain within the Cassidy Suite until a bed became free on the ward. The bed within the Cassidy Suite was “*stepped up*” in order for him to be formally admitted under Section 2 of the MHA. The risks were such that he had to be detained and treatment started as soon as possible.

- 157 I sent my AMHP Report to the hospital later that night after midnight [NOCC0000034].
- 158 On 29 January 2022, I telephoned the hospital to see how VC was and spoke with Christina Narz. She advised me that VC had "*continued to refuse to go into the room in the suite*" and "*had been in the reception area all night and had not slept*" [NOCC0000034].
- 159 I had phoned the Cassidy Suite just to see how VC was. I clearly had no power to make him go into his room. My report was sent over to the hospital. The case notes confirm it was sent to BMT and also the Cassidy Suite so that they had all the relevant information. I recall nothing else from my conversation with Christina Narz.
- 160 Following that, I do not believe there was any further contact between myself and VC. As an AMHP, my role ends once an assessment is completed.

Recommendations:

- 161 There were clear risks with VC not taking his medication in the community. I believe that hospital wards should make requests for Section 3 assessments sooner if they know that the person needs a longer course of treatment or requires a Community Treatment Order.
- 162 Hospitals should think more clearly about discharge planning for those with significant risk histories. It is of course much harder when people like VC, who present as intelligent and articulate and potentially do not meet the threshold for re-admission.
- 163 I believe that professionals should consider Section 3 admissions sooner, where there is a clear diagnosis and treatment options when there are increasing risks when unmedicated.

- 164 Both Section 2 and Section 3 hold the same restrictions. The person cannot leave a hospital for a certain period of time. It does not matter in reality on what legal basis they are deprived of their liberty.
- 165 Doctors are generally trying to get AMHPs to agree to Section 3 admissions more these days. We will always be mindful of the individual themselves and the impact of detention on their rights but there is definitely scope for detention where there is a clear diagnosis and risk to self or to others and all the least restrictive options have been exhausted.
- 166 We should also consider discharge and I will always mention Community Treatment Orders in my AMHP Report if it could be of benefit for the hospital to consider further down the line.

Statement of truth:

I believe that the facts stated in this witness statement are true. I understand that Proceedings for Contempt of Court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth

Signed: **GRO-B**

Print name: ...Fiona Parker.....

Dated: ...05/11/2025.....

Index to First Witness Statement of Fiona Parker

No	Inquiry URN	Document Description
1	NHSE0000312	Mental Health Act 1983: Code of Practice
2	NOCC0000043	AMHP Report Referral and Assessment, dated 28 January 2022
3	NOCC0000034	Case Notes
4	NGPF0003573	Warrant to enter premises to search for and remove person, dated 27 January 2022
5	NHFT0000070	Form H3 – Regulation 4(4) and (5) Mental Health Act 1983 – Record of detention in Hospital, dated 28 January 2022
6	NOCC0000069	Email from Fiona Parker to Clarisse Bagtas, dated 18 January 2022
7	NOCC0000040	AMHP Report Referral and Assessment, dated 19 January 2022
8	NGPF0003316	Warrant to enter premises to search for and remove person dated 27 January 2022