Witness Name: Amie Staples

Statement No: WITN0117001

Dated: 13/11/2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF AMIE STAPLES

I **AMIE STAPLES** of Nottingham City Council, Loxley House, Station Street, Nottingham NG2 3NG **will say** as follows: -

1 I am an Approved Mental Health Professional (AMHP), in the employ of Nottingham City Council.

2 Where the content of this witness statement is within my personal knowledge it is true. Where it is outside my personal knowledge or 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, I saw Valdo Calocane (VC) in September 2021. This was my only work with VC, and the Inquiry has requested that I provide a statement about it.

Personal background

4 I qualified with an MA Diploma in Social Work in 2005, and have worked for Nottingham City Council in adult social care since this time. Initially this was within an integrated Assertive Outreach Team with Nottinghamshire Healthcare NHS Foundation Trust from 2005 to 2011 and then the Mental Health Social Care Team South, where I am currently a Senior Practitioner.

5 The Mental Health Social Care Team is a social work team, providing Care Act Assessments, commissioning social care packages and undertaking Adult Safeguarding Duties. We also undertake assessments under the Mental Health Act 1983 (MHA), as AMHPs.

6 I qualified as an AMHP in 2009 and have practiced as an AMHP since this time. My experience in working in an Assertive Outreach Team as a Care Coordinator, with patients who struggle to engage with standard statutory Mental Health Services and with patterns of repeated admission to hospital and complex mental health needs has been extremely helpful in preparing me for practice as an AMHP.

7 I confirm that I am one of four full time equivalent Senior AMHP's across Nottingham City Council with two full time equivalents being based in the North team and two in the South team.

The work of an AMHP

8 The role and responsibility of the AMHP is to co-ordinate the Mental Health Act assessment (MHAA) process. It is the role of the AMHP to gather the information in preparation for the assessment and to speak to the referrer and to contact any other relevant professionals. The AMHP must review the information and determine whether it is appropriate for the assessment to go ahead. The AMHP is responsible for consulting the Nearest Relative in most instances. The AMHP should ensure the patient is interviewed in a "suitable manner" (section 13 MHA) and consider how best to coordinate the assessment to ensure the safety of the patient and the assessment team, and in order to maximise the potential for the patient to successfully engage with the process. This would include giving consideration to a safe, private and comfortable environment; with consideration of aspects such as the sensory needs of the patient and whether there is anyone appropriate who may be able to support or facilitate their engagement. The AMHP must consider the person's circumstances in the whole, in order to then reach a decision about whether it is necessary and proportionate to admit the person to hospital or whether there is any other less restrictive option available. Where the outcome is admission to hospital, the AMHP will liaise with the admitting hospital to facilitate admission and arrange conveyance.

9 The role is directed by the MHA as amended in 2007, together with the Code of Practice to the MHA [NHSE0000312]. My work is informed by local policy and guidance, such as shared policies around Section 136 and Section 135

[WITN0117002; WITN0117003], Regional Conveyance Policy [WITN0117004], Search Warrants- During Court Hours: Applications in the Midlands Region of HMCTS [WITN0117005], Multi agency Section 140 protocol [WITN0117006], Trans and Gender Diverse Patients Policy and Procedure [WITN0117007] and Lone working protocols [WITN0117008; WITN0117009].

10 Nottingham City Council have also prepared an in-house guidance document 'AMHP guidelines when allocated a MHAA' [WITN0117010].

The Referral Process

11 Referrals are usually received by the AMHPs from Health professionals (such as acute hospital staff, Community Psychiatric Nurses, Consultants psychiatrists and GPs), police or the patient's Nearest Relative. Those referrals are generally received electronically via email or through the online portal system on the Nottingham City Council website.

12 Currently the Mental Health Social Care teams are located within Nottinghamshire Healthcare NHS Foundation Trust buildings and occasionally, Health colleagues will make referrals in person. It is also possible to make a referral by calling the Health and Care Point central adult social care telephone number.

13 The online portal system came into effect in May 2025. That system includes a set of standardised questions, in order for the referral to be completed within the portal. This is a more rigorous and thorough process, as it is not possible to complete the referral until all of the information is included.

14 The information contained within these referrals is predominantly the person's demographic details, a brief summary of the immediate concerns for the person's mental state and information regarding the urgency of the assessment and the location of the person. This would also include whether the person is already on a Section of the MHA , whether they have a pre-existing mental health diagnosis (if known by the referrer) and basic risk information. Once the referral is received and processed it is passed to the Senior AMHP on Duty to complete initial screening and to allocate to a Duty AMHP.

15 Once the referral has been initially screened and allocated to an AMHP, they would begin gathering further information about the circumstances around the assessment. Where a patient is already known to a Community Mental Health Team, this would likely include discussion with the Community Psychiatric Nurse ("**CPN**") and allocated Psychiatrist; this would be to assess risk, gather background information about the patient and their circumstances and determine the urgency of the assessment.

16 When gathering information about an individual who has been referred for an assessment, we have access to the Nottingham City Council Liquid Logic Social Care System. I also have access to RIO which is a Nottinghamshire

Healthcare NHS Foundation Trust computer system. I have read only access rights to RIO. There is an Information Sharing Agreement in place to facilitate access between Nottingham City Council and Nottinghamshire Healthcare NHS Foundation Trust to allow access for the mental health social care staff and AMHPs [NHFT0004533]. This can be invaluable resource in accessing information about the patient's mental health history, their treatment, previous hospital admissions if relevant and risk information. In order to access RIO, it is necessary to complete a mandatory training session and have access authorised by Nottinghamshire Healthcare Trust.

17 We do not have access to information regarding hospital admissions outside of Nottinghamshire Healthcare NHS Foundation Trust except where updates have been provided to the Trust or where discharge summary information has been shared.

18 When I am allocated to an assessment, I would seek to gather as much information as possible about the person, their history and who is involved with their care, both professionals and friends or family. I would speak to relevant professionals involved with the individual. I try to establish whether there has been a previous admission; how urgent the need for assessment is; whether it would be appropriate to delay to allow for a professional to attend who has prior knowledge of the individual; what the family circumstances are and if the family are involved. I would usually contact the patient's Nearest Relative, however there are sometimes circumstances in which this may not be appropriate; for example if it is anticipated that to do so may jeopardise the likelihood of the

person being available for the assessment or whether there are safeguarding concerns towards the individual from their family member. However, it is important to recognise the value of the family's knowledge of and perspective on the individual. The MHA reflects the importance of this with the centrality of the Nearest Relative role. Where appropriate, the Nearest Relative may wish to attend the assessment, subject to the patient's consent, and this can be very helpful in the process.

19 Where the patient is known to a Local Mental Health Team, I would also seek to gather information from the Care Coordinator and/or CPN about how best to engage with the person, whether there are better times of day to visit, whether there is anyone the person trusts who may be able to assist with the assessment. This may include inviting the Care coordinator to attend the assessment. In some circumstances, I would attempt to contact the GP for further information about their physical health and treatment and if the GP is prescribing their mental health treatment, when this was last issued.

20 Once this information is gathered, I would then determine whether it is necessary for a full MHAAto go ahead at this point. A MHAA can seem a very overwhelming and potentially distressing experience for the person and therefore should only be undertaken when other less potentially coercive attempts to engage have been attempted or at least considered. This could include asking the Crisis team to offer an initial assessment instead to offer support or an informal voluntary admission to hospital in the first instance.

21 When an assessment needs to go ahead, I would consider the location of the assessment, who needs to be present and the urgency of the assessment. I would also consider how we would gain access to the patient to complete the assessment and whether a warrant under S135(1) MHA may be required.

22 A section 135(1) would only be required where there is no alternative means to safely assess the individual; this would include circumstances where the individual is refusing access for the assessment, where it is anticipated that there is a high risk of absconsion during the assessment or where there is felt to be a very high risk of harm to either the patient or the assessing team.

Need for Assessment

23 When undertaking an assessment and completing this process, my role as AMHP is to look holistically at the person's circumstances and consider alternatives and the least restrictive option for effective treatment. At all times, I am balancing the need to contain and minimise the risk, but also considering the individual and what would give them the best possible outcome.

24 In arranging an assessment, I would coordinate with appropriate Registered Medical Practitioners to undertake the assessment. This would include ensuring that at least one of the two Medical Practitioners involved is Section 12 approved and that ideally at least one has previous acquaintance with the patient. Where the patient is known to a Community Mental Health Team or

Crisis team, I would request that they provide a medical practitioner. If the patient is not known, I would usually attempt to contact their registered GP. When we are unable to arrange for a medical practitioner from the allocated team or the patient's GP to attend, we arrange for an independent Section 12 approved Doctor to attend as an alternative.

25 When determining whether to apply for detention in a hospital, I consider the person's prior engagement and willingness to work with services, their insight and understanding as to whether they are acutely unwell, the likelihood of the person complying with a Community plan and, if indicated, medication. Where the risks are assessed to be fairly low, a community plan may be attempted initially, with close review usually by the Crisis or Community Mental Health Team. However, if the community plan is unsuccessful, there may be a further referral for either admission using existing medical recommendations if applicable or for a further MHAA .

26 During the assessment, it is the AMHP's responsibility to ensure that the patient is interviewed in a suitable manner in order to elicit the best information and evidence to inform the assessment and maximise the meaningful participation of the patient. I am always mindful of the inherent power imbalance in the assessment process and that the patient may seek to present information in order to minimise the likelihood of admission or treatment being recommended. It is important to weigh the narrative the patient shares during the assessment against the wider collateral evidence and information gathered to reach a conclusion on the outcome of the assessment.

27 As an AMHP, I am aware that my role gives me huge power over the rights and liberty of another individual, and I always go into any assessment with a highly critical mind and utilise all sources of information as set out above as part of the assessment process.

28 As part of the risk assessment process, I seek to clarify what past incidents have occurred, their frequency, severity and context. This may be in relation to risk to self or to others. It is important to understand the context in which a risk arose; for example does the risk arise in a public place, where others may intervene or has the person alerted anyone to the potential for risk occurring. I also consider demographic factors such as age or gender and how that could impact the risk. I would also seek to explore any clinical factors which could disinhibit risk-taking, such as alcohol or substance misuse. I would also consider how their mental disorder might impact on risk behaviour – the impact of particular symptoms, such as command hallucinations, frontal lobe damage, periods of elevated mood or acutely low mood may result in increased risk of harm to self and or others.

29 Risk of harm to others is a central part of the assessment process and would include thinking about risks to immediate family members, the public and to professionals themselves undertaking the assessment. This information informs the decision around whether a s135 warrant is required. Information is gathered from a full range of sources, including the social care records, health records, speaking to the professionals involved and also consulting with family

members. However, I am also mindful of how the perception of people's behaviour and presentation is influenced by our own experiences, cultural background and understanding of mental health presentation. Unconscious bias can also play into this, particularly in relation to perception of risks in relation to race, age and ethnicity and gender. It is important to be mindful of this and apply a critical mind to the specific circumstances.

Prior cases

30 I confirm that I have had no involvement in the care of any other mental health patient who following discharge, killed or seriously injured a member of the public.

Involvement with and knowledge of VC.

31 I had no prior knowledge or involvement with VC before 3 September 2021.

32 After my assessment of him on 3 September 2021, I did not have any direct dealings with VC.

Referral of VC

33 A referral for MHAA was received on 31 August 2021 at 16:20. This referral was a telephone contact to the duty administrator Beverley Shepherd from Claudia Birtles CPN with EIP City South. It is recorded on the contact form generated by Beverley Shepherd that VC "*has history of psychosis. Became unwell after episode in May 2020 and was in hospital. Has had 2 episodes since then but has been fairly settled last year. During the last few months Claudia has noticed a difference in his presentation. She has been to see him today and he is very unwell. Struggling with delusional beliefs and feels there is a conspiracy with police and hospital who have created technology which creates voices. He has stopped taking his meds. He is not willing to discuss anything. He is very suspicious, paranoid and confrontational. He was accusatory and belligerent and told Claudia she had been mocking him. He has no insight and has said categorically that he doesn't want support. He doesn't trust them. Claudia believes he has never been fully better but he has never acknowledged his psychosis*." [NOCC0000077]

34 On the 1 September 2021, Neville Freestone Senior AMHP appears to have further triaged the referral [NOCC0000034]. His record states "*Claudia CPN not. Spoke to Gary Carter CPN*". I believe that that suggests that Claudia, who was the CPN, was not <u>available</u>; therefore he spoke to another CPN within the team. I interpret this as missing the word 'available', however it is not my record and therefore I am unable to confirm this. I took these records as being an accurate reflection of what occurred. I was allocated to complete the assessment on the 3rd September 2021 as I was one of AMHPs on duty on that date. Once allocated to the assessment, I would have read the previous

information recorded on Liquid Logic (Adult Social Care Records system) including the details of the attempts to assess VC on the previous day.

35 I was also able to access the RIO records as explained above [NHFT0000168]. I believe that I also spoke with Claudia Birtles CPN, but cannot clearly recall that discussion. I routinely would have spoken to her as she was the referrer and the relevant CPN for VC. I would also have read the previous AMHP reports and would have identified that prior to his last admission, he had stopped his medication without informing his community team [NOCC0000046]. I would also have been aware that the referral from Claudia Birtles on 31 August 2021 included the information that VC had stopped his medication currently [NOCC0000077].

36 Following gathering all of the information available, I formed the view that it was necessary to apply for a S135(1) warrant under the MHA. This was based on the information from Claudia Birtles referral that he did not want further support or contact from Mental Health Services and was “confrontational” and “accusatory” believing that these services had installed technology to manufacture “voices” in his home. It was also based on the fact that there had been three attempts to assess VC the previous day coordinated by Jen Shaw, AMHP, on the 2 September 2021 namely at 11:30 am, 3:30 pm and 6.30 pm, and there had not been any answer [NOCC0000034]. I believed that given his stated intention not to allow further contact with services, it was entirely possible that the failed attempts on the 2 September 2021 were due to VC deliberately refusing entry. On this basis, an application under s135(1)

appeared to be the only way to successfully undertake a MHAA with VC.

37 I therefore prepared the warrant application and submitted this to the Court [NOCC0000047; NOCC0000050]. I recorded on Liquid Logic that I had submitted the warrant application and confirmed a hearing date with the Listings Clerk on 3 September 2021 at 12:47 [NOCC0000034]. Following a telephone hearing with the magistrates Court, the warrant was sent to me via email at 14:59 hrs.

38 I attach here for the sake of completeness an extract from a handwritten note from my notebook at the time [WITN0117011]. These notes were written contemporaneously as I was preparing for the assessment and acted as a prompt for the preparation of my AMHP report, and the note deals with discussions with VC's Mother and possibly Claudia. VC had informed his mother that he had been attending a "course" the previous day and it seemed appropriate therefore to plan the assessment for the evening, when he would perhaps be more likely to be at home. His mother also advised that she believed VC was currently working, whilst awaiting his University studies to restart in October 2021. However my impression was that because VC had withdrawn from his usual level of contact with family, it was difficult to know quite what his current daily activities were.

39 It appeared from my initial enquiries that there was a deterioration in VC's mental health. I formed this view on the basis of the information from Claudia Birtles CPN at the point of the referral; that he was stating that Mental Health

services were conspiring to trick him into believing that he was unwell by using "technology to broadcast voices" into his home [NOCC0000034]. This indicated that he was both paranoid about services seeking to harm him and also that he was hearing voices; auditory hallucinations and paranoia were clear indicators of relapse of his psychosis. I also was aware of Jen Shaw AMHP's documentation of her discussion with VC's mother on 2 September 2021; that he wasn't answering mum's call which was unusual and that she felt he was "deteriorating" [NOCC0000034]. I also spoke with VC's mother and she informed me that during their conversation the previous evening, he had seemed preoccupied with government conspiracies and that much of the conversation didn't seem to make sense; again indicating the likelihood that his mental health was deteriorating.

40 It was my impression that VC was suspicious of the behaviour and motivation of Professionals involved in his care and feared that they were persecuting him by "implanting devices into his home" [NOCC0000050]. I note that in my assessment I confirmed that he appeared suspicious towards the assessing team when we went to execute the warrant on the evening of 3 September 2021.

41 I had been told, as set out above, that VC was not taking medication. I cannot recall which anti-psychotic medication he was supposed to be taking. It was clear, however, that he was not engaging with this in the community and steps were required to undertake the assessment.

42 I did not consult with Jen Shaw AMHP as the 3 September 2021 was a Friday and it was her non-working day. It was my impression that her notes on Liquid Logic were a comprehensive summary of her actions with regard to VC on 2 September 2021 [NOCC0000034].

43 I do not believe there was any further information that I could have accessed at this time but was unable to do so. We do not have access to Police records; so it is possible that they had additional information that I was not aware of. I was aware that there had been two previous instances of him entering a neighbouring property, but nothing in relation to physical violence to other people.

The Warrant

44 I confirm that I applied for a warrant under Section 135 (1) of the MHA on 3 September 2021. I confirm that I prepared documents in support of that, to include "*the information in support of application for warrant to search for and remove patient*", and a document entitled "*report on application for warrant under the Mental Health Act*". [NOCC0000049; NOCC0000047]

45 The purpose of the completion of those documents was to obtain a warrant under Section 135(1). Once completed, I sent them electronically, via an email, to the court address and thereafter the legal adviser would return it, once approved.

46 After the warrant was approved by the Magistrates, I sent it to the police in order to then execute the warrant [NOCC0000048].

47 In order to apply for and obtain a Section 135 warrant, all of the information was gathered, as set out above. Thereafter I completed the application forms for the warrant and emailed them to the court. [NOCC0000159] I also spoke to the court in order to ensure that there was time for a remote hearing that day. I was sworn in and gave evidence over the telephone to the Magistrate and the Magistrate then granted the warrant. Once granted, I contacted Nottinghamshire Police via telephone to make arrangements for them to attend the execution of the warrant as per the legal requirement and also provided the information which I knew about VC's current mental state and risk history. I also provided a copy of the warrant to the Force Control email address [NOCC0000159].

48 In terms of the wording of the warrant application, particularly that VC was "*believed to be suffering from mental disorder, being unable to care for him or herself*" [NOCC0000048]. That is the wording from the Act itself. The criteria was met, in my opinion, because VC was refusing treatment for his mental health disorder, refusing to see the CPN, was unable to answer his door on three separate occasions on 2 September 2021 and therefore was within the definition of the Act "unable to care for himself". It was therefore necessary that the warrant was applied for and obtained in order to consider detention under the MHA , with an admission to hospital.

49 Prior to executing the warrant, I spoke with VC's mum, Celeste. She had spoken with VC around 8 pm the previous night and spent about an hour on the phone to him. He seemed preoccupied with "government conspiracies" and was "not making sense" which I understood she interpreted as signs that he was relapsing and she stated that she was very concerned about VC. She told me that she didn't think he was taking his medication; which was consistent with his own disclosure to Claudia Birtles on the 31 August. She did not think that there was anyone else staying in the flat at the time.

50 It was my impression that Celeste believed the talk of "government conspiracies" was all part of VC's paranoia and delusions. It appeared to me that Celeste's concerns echoed those raised by VC's CPN and therefore added weight to the concern for his current mental state and need for assessment.

51 Celeste informed me that VC had told her that he had been attending a "course" on the 2nd September; and it is my recollection that she was not certain of any details of this or in fact whether what VC had told her that evening was true. It was my impression that there may have been a course connected to some casual work he was undertaking, and on balance, it seemed appropriate to plan to execute the warrant in the early evening in case, he was out of the house.

52 Celeste also told me that VC was not in such regular contact as usual with the family. This, combined with the apparent persecutory ideas, increased her concern. I had a sense, having spoken to mother that she was worried VC was

not telling her everything. I wondered if he was presenting to her as being quite "guarded". I believe Celeste explained a little about VC's life; such as that he was studying at University in Nottingham and was completing an Engineering degree. I have handwritten notes in my notebook as exhibited above [WITN0117011]. I do not recall how long we spoke for at this time but would think it was at least 15 to 20 minutes to gather information on her current concerns and the background information. I also would have explained the warrant process to Celeste and the arrangements to undertake an assessment of VC's mental health.

53 I cannot recall discussing anything else with VC's mother at that time.

54 The conversation with VC's mother certainly did influence my decision making. Family members generally know individuals better than anybody else. I would describe the call with VC's mother as a helpful one. In general, it can depend upon family relationships and as to whether they are close. If they are likely to be acting in their best interests, then we would always take into account what family members are saying. It was my impression that family were caring and concerned for VC and keen for him to engage and access support and treatment from mental health services.

55 I recorded that VC was withdrawing from family involvement and I understood this to be out of character. I do not now recall whether Celeste specified if he was reducing contact just with her or with all of the family. However I noted on

my AMHP report that he had reduced telephone calls to “every week or two” which I understood to be a substantial reduction [NOCC0000050].

Events of 3 September 2021

56 The summary of what occurred when we sought to execute the warrant, as contained in the AMHP report, is accurate [NOCC0000050].

57 I arrived at the location of VC’s home, at approximately 6 pm, and was standing approximately 50 yards or so away from the entrance to VC’s building. I was with Dr Manzar and Dr Lomas. Police officers and an ambulance crew had not by that time arrived.

58 A car drove up and parked in between where we were stood and the entrance to VC’s building. Dr. Manzar, who had previously seen VC, thought that it could have been VC arriving. Dr. Lomas had not met VC before and neither had I.

59 VC had clearly noticed us standing on the pavement and after few minutes he approached us. He asked us if we were from the hospital and I had the impression that he may have recognised Dr Manzar from his previous acquaintance. We asked if he was VC and he appeared understandably a little reticent but did confirm that he was VC. After explaining the purpose of us being there, he agreed to allow us to walk over to his flat with him and to then go into the flat. It appeared initially that he might be willing to allow us into the flat to complete the assessment without need of the warrant, however as Dr.

Lomas started to enter the flat with VC, I had the sudden impression that VC had changed his mind and appeared increasingly suspicious of us. I had the impression that VC was unhappy about us being in the flat. I recall indicating to Dr. Lomas to suggest that we leave, as VC's responses and demeanour suggested to me that he was clearly not comfortable with us being there. However, he remained polite and calm throughout this time.

60 We explained again that we had a warrant under S135(1) to facilitate an assessment and that if necessary the police would attend to execute the warrant with us. However we tried to persuade VC to let the assessment take place by consent in his home as this would be much less coercive than being taken to the hospital suite for assessment, but he appeared fixed on the notion that he would not allow the assessment to take place by this point. I explained that we would need to return when the police arrived and he responded with words to the effect of "just let the process happen". It is not uncommon that people do not understand that the Court can grant legal powers to ensure an assessment takes place through a warrant and that police can be needed to convince people of this. However often the presence of the police is sufficient to persuade the person to accept the process. I anticipated that once the police arrived, VC would be likely to then cooperate with the admission to the S136 suite for assessment.

61 As I have said, throughout this time VC presented as being very polite and calm. He was clearly suspicious about our intentions but did not seem particularly agitated or angry. It appeared that he could simply not accept that

we had a legal power to make him go to hospital. I did not anticipate that he would violently resist the police, as there had been no agitation or aggression at all at this point.

62 I distinctly gained the impression that he was scared about the whole process. I do not think that he really believed that we were trying to get him to go to hospital. Given the nature of his delusions that services were deliberately trying to make him think he was unwell, I do wonder if he thought we were all part of the government conspiracy and intended to harm him in some way.

63 At all times I was really transparent with VC about the process. We talked about the assessment and the fact that there were a range of potential outcomes which could include either hospitalisation or treatment at home. However he would not agree to be assessed and said that we should wait for the police and he closed the door.

64 The police arrived fairly quickly to execute the warrant with us. VC took a little time to respond to the police officers knocking at his door. Once he had opened the door, the process of the assessment was explained again. He didn't say very much and went back into the flat. VC walked from the living room area into a bedroom space. The police followed and we all went in to try and explain what was happening and the fact that he needed to come with us to the hospital for the assessment. There was one male police officer and two female police officers.

65 VC spoke to the male officer and said words to the effect of “if it going to happen, then it’s going to be with you”. It appeared to me and, I think to the police officer, that he was agreeing to come out to the ambulance with him. The police officer therefore stepped forward in order to walk with VC out of the flat, and thereafter VC attacked the police officer by punching and headbutting him. The officers all attempted to restrain him but were unsuccessful in doing this. I was on the edge of the bedroom door at this point, and went to the doorway entrance to the flat, waiting with the ambulance crew while the altercation took place. The police officers had called for backup and lots of police officers arrived very quickly.

66 I did not have a clear view of the entire altercation but was aware that a taser had been deployed.

67 I had the impression that VC did not wish to hurt the female police officers, hence had asked the male officer to step forward. However it seemed more an act of violent resistance than a desire to harm anyone else. There was no prior indication at all that he was violent or aggressive.

68 Once VC had been taken out to the ambulance, we were able to establish that there was a bag of unused medication in the flat dating back to February 2021. It was apparent that VC had not been taking that medication. It was not appropriate to ask VC about this at this point as he was being taken to the ambulance for medical attention. In leaving the property, there was no overt evidence of any problems in VC’s living conditions within the flat. These were

well kempt, and it appeared that he was keeping his living space in reasonable order. Dr Lomas and I secured the property and provided the keys to the police to travel with VC along with any other belongings.

69 Following the assault on the police officer, I was subsequently contacted by Nottinghamshire Police in December 2021. I advised that I was happy to provide a statement if needed, however it appeared that they required information about his mental state and treatment and I was not best placed to provide this. As I did not know the detail about VC's treatment, I suggested they speak to Dr. Lomas about it. I was not contacted again regarding this and I did not therefore subsequently give any statement either about the assault or the treatment received by VC.

MHAA in hospital

70 My memory of the interview with VC while in the Cassidy Suite, within the Highbury Hospital on 3 September 2021 is limited but I recall that he was resistant to engaging with us. The assessment was undertaken by Myself, Dr. Manzar and Dr. Lomas at approximately 8.20 pm in the presence of the restraint team, due to what had happened when the warrant was executed earlier that evening [NOCC0000050]. This was following medical assessment at the Queens Medical Centre hospital to ensure that VC was physically fit for interview.

71 VC was sitting at the table for the assessment and we explained the purpose of the assessment and roles of the staff present. In my report I note that VC stated that the restraint team "might be required" which we interpreted as a potential threat. [NOCC0000050] VC stated that he would not be assessed and would not engage with the process. We tried to talk to him about the concerns he had voiced to Claudia Birtles earlier in the week but he would not comment on this. He would not comment on his views about hospital admission but when asked if he would accept medication for his mental disorder he responded "of course not".

72 I cannot recall how long I was with VC in the Cassidy Suite, but do not think it was very long as he was unwilling to speak with us further.

73 In reaching a decision on the outcome of assessment, we considered all the information provided by VC's CPN, his family and from the records of his previous intervention from Mental Health Services. Whilst he was reluctant to speak with us, it was evident that he was paranoid about our intentions in bringing him to the hospital for assessment, as he had expressed delusional beliefs that services were conspiring to make him think he was unwell. The level of aggression to officers clearly showed his reasoning was impaired, which appeared likely to be associated with his mental disorder and warranted further assessment in a hospital environment. His clearly stated refusal to accept any medication, in addition to the physical evidence of several months' worth of community medication having been stockpiled, meant that the only way in which treatment could be administered would be through compulsory

hospital admission. We were satisfied that further assessment and treatment in hospital was both necessary and proportionate to the established risks.

74 I identified the risks as being risk of further deterioration in mental state if left untreated in the community; risk of harm from others as a result of his past behaviour (such as past break-in to neighbouring property); and risk that his current paranoid mental state would impair his ability to sustain his employment and studies. I also identified that he presented a risk to others through his actions which were motivated by his delusions; whilst there was no evidence he had attempted to harm his neighbours, there was a clear risk of trauma from him breaking into their homes in the past. I also noted a high risk of physical harm to Police officers in the context of compulsory admission to hospital as evidenced by his response to the execution of the warrant on 3 September 2021. In addition, there was a risk of harm to him through police restraint and intervention in the event he resisted. Again, as evidenced by what happened with restraint and the taser deployment on 3 September 2021.

75 In terms of capacity, I did not believe that he had capacity as he did not understand the key relevant information to treatment decisions which was that he was suffering from a mental disorder. However the Mental Capacity Act was not the relevant legal framework for admission in this situation as VC actively objected to admission and treatment for the primary purpose of treating his mental disorder. The statutory criteria for admission under the MHA was met. I agree with Dr Manzar's observations as expressed on his Medical Recommendation on 3 September 2021 that VC had poor insight and lacked

capacity [PAGR0000153]. I also agree that VC needed to be in hospital and require 24 hour nursing observation and care, which is what is provided in the hospital environment.

76 The decision to place VC on Section 2 was based on the understanding that this was only his second period of acute relapse; the previous two admissions appeared to relate to the same episode of mental disorder in 2020. He was not well-known to mental health services and prior to the last week, appeared to have been functioning well and engaging with services for many months. His previous hospital admission was over a year before this assessment. It was unclear what had triggered his decision to stop his medication and the consequent deterioration. Given VC's reluctance to speak with the assessing team, it appeared there were further aspects of his mental state which warranted on-going assessment as part of formulating his treatment plan; for example the degree to which his delusional ideas may have impacted on the level of aggression presented to the police. Neither Dr Lomas nor Dr Manzar were part of his usual clinical team and it was therefore unclear what the longer term treatment plan was likely to be. I was also mindful that there is an established argument that Section 2 with its shorter duration with faster recourse to First Tier Tribunal is potentially a less restrictive initial section. This allows for further assessment of whether the person may soon be able to consent to their treatment and to establish whether the provisions of Section 3 are subsequently required. In addition, Section 3 places a requirement on the assessing doctors to specify in which hospitals appropriate treatment could be

provided, however this was not known at the time of assessment due to the lack of available hospital beds.

77 I do not recall any disagreement between myself, Dr. Lomas and Dr. Manzar regarding the decisions taken. I was the applicant on behalf of Nottingham City Council.

78 In terms of what information was provided to the hospital, they had full access to their own system in the form of RIO. A verbal handover was given by me. I explained that VC had been to A&E prior to attending the Cassidy Suite due to taser deployment. After he was deemed medically fit to attend, he was brought to the Cassidy Suite and the doctors were present for an assessment with me. Nurses formed part of that discussion. I had been in conversation with the Cassidy Suite prior to executing the warrant, so they were able to keep the assessment space clear for me. Following completion of the MHAA, I provided a copy of my AMHP report to the Cassidy Suite [NOCC0000050].

79 Following the assessment, I spoke with VC's mum and explained to her what had occurred during the assessment and outcome. I advised her that she was able to visit him, albeit the distance was extremely challenging for her. I also provided her with information about how her husband could delegate the role of NR to her and sent her a copy of this via email that evening [WITN0117012; WITN0117013; WITN0117014].

Recommendations

80 I do not have any recommendations.

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: …Amie Staples……

Dated: ……13/11/2025……

Index to First Witness Statement of Amie Staples

No.	Inquiry URN	Document Description
1	NHSE0000312	Policy document dated 01/01/2015 compiled by Department of Health RE: Mental Health Act 1983: Code of Practice
2	WITN0117002	Nottingham and Nottinghamshire Multi-Agency Policy & Procedure Review Group Memorandum of Understanding: Joint Agency Sections 135 and 136 Mental Health Act 1983 Procedure October 2017
3	WITN0117003	Nottingham and Nottinghamshire Multi-Agency Policy and Procedure Review Group Memorandum of Understanding: Joint Agency Sections 135 and 136 Mental Health Act 1983 Procedures December 2024
4	WITN0117004	East Midlands Ambulance Service NHS Trust Regional Mental Health Conveyance Policy
5	WITN0117005	Search Warrants – During Court Hours Applications in the Midlands Region of HMCTS
6	WITN0117006	The Mental Health Act Section 140 Guidance for admissions in cases of special urgency Nottingham and Nottinghamshire Multi-Agency agreement November 2021

No.	Inquiry URN	Document Description
7	WITN0117007	Nottinghamshire Healthcare NHS Foundation Trust Trans and Gender Diverse Patients Policy and Procedure
8	WITN0117008	AMHP – Lone Working after 17:00 – Guidance for Managers
9	WITN0117009	AMHP Lone Worker Device Operating Procedure
10	WITN0117010	AMHP Guidelines when allocated a MHAA
11	NHFT0004533	Policy Document; Re Data Sharing Agreement between Nottinghamshire Healthcare NHS Foundation Trust and Nottingham City Council in relation to sharing of Trust Data with Approved Mental Health Professionals (AMHPs), NHFT
12	NOCC0000077	Contact Form Referral by Claudie Birtles on 31 August 2021 regarding Valdo Calocane
13	NOCC0000034	Report undated, compiled by Nottingham City Council Re: Nottingham Adult Social Care Teams
14	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, RE: Patient Record Summary
15	NOCC0000046	AMHP Report Referral and Assessment Form of Valdo Calocane, dated 14/07/2020
16	NOCC0000047	Report compiled by Nottinghamshire Police, RE: Report on Application for Warrant Under Mental Health Act,

No.	Inquiry URN	Document Description
		undated
17	NOCC0000050	AMHP Report Referral and Assessment Form of Valdo Calocane
18	WITN0117011	Notes undated, Amie Staples handwritten notebook entry regarding Valdo Calocane
19	NOCC0000049	Information in Support of Application for a Warrant to Search for and Remove Patient, dated 03/09/2021, by Amie Staples
20	NOCC0000159	Emails from Force.Control to Amie Staples, RE: s 135 (1) Warrant to search for and remove patient (with date) VC 03.09.21
21	NOCC0000048	Warrant to search and remove patient, Valdo Calocane under Mental Health Act 1983, S.123 (1) dated 03/09/2021 Mrs V Loughton
22	PAGR0000153	Forms H3 (Record of detention in hospital), A4 (Medical recommendation for admission for assessment), A2 (Application by an approved mental health professional for admission for assessment) and AMHP report referral and assessment of Valdo Calocane
23	WITN0117012	Email from Amie Staples [Nottingham City Council] to Celeste Mendes, re: Nearest Relative delegation 3 September 2021

No.	Inquiry URN	Document Description
24	WITN0117013	ASSIGNING OF NEAREST RELATIVE FUNCTION AND RESPONSIBILITY form - Blank
25	WITN0117014	Policy Document, RE: Nearest Relative (Mental Health Act 1983), Mind