Witness Name: Roseanna Tiffany Crane

Statement: WITN0177001

Dated: 13 November 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF ROSEANNA TIFFANY CRANE

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

1. At the time of the events described below, I was an Approved Mental Health Practitioner ("AMHP"), employed by 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 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, I saw Valdo Calocane (VC) in January 2022. This was my only work with VC, and the Nottingham Inquiry ("the Inquiry") has requested a statement about it.

PERSONAL BACKGROUND

4. After completing my GCSEs, I went to Leicester College and undertook a BTEC National Diploma in Health and Social Care. I then went to Nottingham Trent University and obtained a degree in Psychology with Special and Inclusive Education. Subsequently, I have undertaken further courses including an MSC in Criminology, and a PGDip in Social Work. Between April and September 2021, I undertook a course to become an AMHP through Sheffield Hallam University.

5. I began work as a Mental Health Social Worker in April 2019 and then moved on to take the AMHP course. It was a mixture of in work training, portfolio learning, and academic modules. This meant that I observed and led Mental Health Act assessments ("MHAA") with a qualified AMHP as part of my training.

6. I qualified as an AMHP in October 2021. I remained in the role of a Mental Health Social Worker until February 2022 and an AMHP until June 2025.

7. Once qualified, I began to undertake assessments independently. I estimate that I was doing about six MHAAs a month. Therefore, by the time I saw VC, I had done perhaps 18 to 20 assessments.

8. At that point, I had been working in adult social care for about two years. I also have personal experience of what it is like to have a relative who is under the care of secondary mental health services.

9. The Nottingham City Council ("the Council") AMHPs are subject to supervision. We are also required to do 18 hours of continuing professional development per year and there is monthly supervision of our work.

THE WORK OF AN AMHP

10. The AMHP is an independent person who is part of a team working with doctors who between them, decide whether a person should be detained under the MHA. The AMHP has a predominant focus on the rights, social care needs, and the wider picture for the person being assessed rather than the medical nature of citizen needs. The AMHP's presence prevents the MHAA from becoming a purely medical process.

11. That said, once it is decided to detain a person, it is the AMHP who must make the application to hospital, founded upon the medical recommendations of the doctors and the judgment of the AMHP. The AMHP is not there to challenge the doctors' medical assessment. The AMHP is there to contribute to the discussion of the legal Framework for the threshold for detention under the Mental Health Act 1983 ("MHA"), under the principles of Least Restrictive Option.

12. It is the AMHP that is responsible for organising the process and to ensure that all relevant people are engaged and consulted within the legal framework. That means organising for the two doctors to attend and consulting with the nearest relative in line with the MHA. The AMHP also champions a social model perspective to considering a citizen's needs and circumstances.

13. AMHP work is governed by national policies and local conventions. Examples of national and local conventions considered in an assessment are: MHA Code of Practice to support in applying the MHA in a legal and ethical way [NHSE0000312], for example around consulting the nearest relative where appropriate and involving the citizen in decisions as much as possible; the Mental Capacity Act 2005 in considering capacity to consent to hospital admission or community treatment; and the Equality Act 2010 which considers protected characteristics of people and reducing prejudice and discrimination. I also considered the Local Conveyance Policy [WITN0117004] which is an agreement with East Midlands Ambulance Service ("EMAS") regarding the transport of citizens detained under MHA where appropriate.

14. In Nottingham, the Hospital Trust's Crisis Team does the gatekeeping in respect of requests for MHAAs. This means there will be some considerations around exploring other least restrictive options such as Community Treatment and informal admission prior to conducting a MHAA. Referrals for hospital beds are also made by Hospital Trust colleagues, such as doctors and nurses.

15. It is the AMHP's responsibility to organise the process and to protect the citizen's rights. The AMHP is part of the beginning, middle, and end of the MHAA process.

16. AMHPs do consider risk – the risk of the citizen to themselves, property, and the public. The citizen's rights need to be considered throughout. The AMHP is connecting together lots of information to inform the assessment. As well as being part of the core minimum assessing group.

17. Referrals come into the AMHP service through a call or email to a single mailbox. It is assessed by a Senior AMHP cover who undertakes the initial triage and will make a judgment on whether the matter can be allocated. Baseline information is collected, such as the referrer, their number, and what information the referrer shares about the citizen. Details are inputted into a computer system called Liquid Logic as a contact form. The AMHP will then receive a call or email in respect of this.

18. My role progresses this information, reviewing other information we hold in the system, tacit information from colleagues and what other information sources I can access. If the AMHP is based in a shared office (with the Hospital Trust) it will be possible to get access to the Trust's system for mental health, RIO. GP records are only accessible by calling the GP.

19. When investigating, the AMHP will call whoever they believe to be important for background information. If the citizen is open to acute adult mental health services, then they will call the Community Psychiatric Nurse

(CPN) or duty worker if not available, the nearest relative, and others who seem to be relevant. Often the AMHP will try to call the GP. In this case, the university was also a key contact for information.

20. We do not normally ring the citizen. This could increase the risk to themselves or others, for example if a family member had requested the assessment, or if the citizen then absconded into the community, making themselves vulnerable and difficult to locate.

21. I see from my AMHP Report Referral and Assessment form dated 19 January 2022 that I had spoken with the CPN, Abi Parsonage, VC's mother, and also the university [NOCC0000040]. Speaking to VC's mother is a statutory requirement for a section 3 MHA admission, unless there are prevailing circumstances. On this referral, I also received a telephone call from my colleague Amie Staples, who was Senior AMHP cover that day, and she shared information about her previous assessment with VC, and his assault on a Police Officer.

22. Turning to the way in which I conduct MHAAs, before considering whether to exercise the power to 'section' under the MHA, it is important to gather as much information as possible. The more information gathered, the better the MHAA. However, obtaining information needs to be balanced with the impact of delaying an assessment. It is also vital to know if there is a bed available, which was an essential required part of this assessment as I was executing a warrant so needed a Place of Safety [NOCC0000041 – Authorised Warrant to Enter Premises to Search for and Remove Person].

There was a Place of Safety available before I was allocated the MHAA of VC.

23. It may seem basic, but it is also important to work out where the citizen is and who the people around them are likely to be.

24. Turning to the doctors, the preference runs as follows:

- First, if the citizen is open to a team, then the doctor in that team. If not, I would try and get a Crisis Team Consultant. I would then secure another doctor, ideally MHA section 12 approved doctor, prioritising those with previous acquaintance with the citizen.

- We should try to engage with the GPs. Sometimes they can act as one of the doctors depending on their availability. In this case I did not contact VC's GP. This was because I had secured a Crisis Consultant and section 12 Doctor, both with previous acquaintance [NOCC0000040]. I also considered that VC's GP in Nottingham was a university GP and I felt it unlikely to have a personal/ knowledgeable relationship with VC when compared to the doctors I had sourced.

- We look at the demographic details and needs of the person such as their gender, ethnicity and history. For example, if arranging an assessment for a female with significant trauma history, I would consider not having a male dominated assessing team.

25. It can be challenging to get the most appropriate doctor on a warrant because warrants take longer to execute and can be unpredictable in relation to time, and as such the supporting doctor needs to have availability within the working day to wait for those needed to execute the warrant such as Police and EMAS, and then conduct the MHAA at a different location with another Dr. There are a lot of opportunities for this process to not run smoothly. Here, this was not an issue. Dr Manzar had previous acquaintance with VC and was able to commit to both the warrant and the assessment. I felt Dr Manzar was the appropriate doctor to support the warrant execution.

26. Once we have the team in place, there will be a discussion between the professionals before the warrant is executed. In this instance I am referring to the Police, AMHP, Doctor and EMAS.

27. We take risk into consideration throughout all stages of the assessment process. This includes conversations with professionals and family members, the professionals' discussion both before and after the MHAA, and during the MHAA itself. The risks will feature within the medical recommendations and the AMHP report, which are both handed over to the ward if the citizen is detained under the MHA. I document much of this in my AMHP report, which I completed on 19 January 2022 [NOCC0000040].

28. Risk analysis and assessment is part of the professionals' discussion and is covered both before and after the meeting. If the threshold is met for possible detention, we will look at the risks of detaining in hospital versus

not detaining in hospital. We also consider risk when assembling the MHAA team. If we are dealing with an outwardly violent individual, I may look to devise an assessing team with an assertive presence, and consider the use of security and police, depending on the setting. We do consider risk to the public at large and also the risk of retaliation to the citizen by the public at large.

29. On risk, a good predictor of the future is the past, and we look at previous events and who is most at risk from the citizen. With VC, the risk was linked to his delusions when unwell, and we had to consider who was most at risk from him, which at the time was those who lived closely to him [NOCC0000040]. I describe this as '*proximity risk*' when unwell [NOCC0000040].

30. Police presence in itself can be triggering for citizens as such it is important to balance the citizen's rights and dignity against the need to do a safe and efficient assessment. Reaction to the police and to professionals can be part of the delusional belief systems. Prior to executing the warrant, in the professionals' discussion we discussed VC as being triggered previously by Police and needing to bear that in mind. This is recorded in the Liquid Logic Case Notes [NOCC0000034].

31. During my time as an AMHP, I was never involved in the care of a mental health citizen who following discharge killed or seriously injured a member of the public.

INVOLVEMENT WITH AND KNOWLEDGE OF VC

32. On 19 January 2022, I undertook a MHAA of VC at the Cassidy Suite, Highbury Hospital. My dealings with VC on 19 January 2022 were my first and only dealings with him personally.

33. I was working from home on 19 January 2022, when I received a referral on VC [NOCC0000034]. He was completely new to me. The referral showed that there was a warrant and the assessment would need to be at a Place of Safety. Amie Staples was Senior Cover and provided me with a brief overview of the referral information by phone, adding the police had used a taser to subdue him on a previous occasion as VC had assaulted a Police officer. This was significant because I had not encountered this before.

34. The papers indicated that a fellow AMHP, Clarisse Bagtas, had done some work on VC the day before [NOCC0000041] [NOCC0000034]. I did not see any information or become involved until 19 January 2022.

35. The papers showed that Clarisse had spoken with an individual called Chris Hopkins the day before [NOCC0000034]. He was an accommodation manager in respect of where VC was living. I called him to see if VC was at home and to find out if we could gain access without damaging the property. Hopkins would be able to give us access to the block, corridors and VCs flat.

36. The notes also record that Clarisse spoke with the Emergency Duty Team ("EDT") at 16:58 on 18 January 2022 [NOCC0000034] [NOCC0000069].

The notes say that she passed on information in case they came into contact with VC after hours on 18 and 19 January 2022. The EDT is the Emergency Duty Team out of hours cover for Children's and Adult Social Care. I did not speak with EDT.

37. Once I had completed the assessment of VC, I recorded all my work on a standard document which the Council issues – AMHP Report Referral and Assessment [NOCC0000040]. At this distance in time, that document is very important for refreshing my memory.

38. Turning to the AMHP report, I see that the original referral (18 January 2022) was made by Abi Parsonage, CPN [NOCC0000062] [NOCC0000040]. She made a referral at 11:50 hours in respect of an incident that had happened at the university halls of accommodation. She felt that VC's mental health was relevant to this because previous contact with him had not been consistent or positive. He was not taking his medication and there was a high chance of relapse in his mental health. The CPN is an important role, if they are working with a citizen. They become the eyes and ears of the Trust's team. They also provide information to us and make referrals.

39. Turning to my conversation with Abi, she indicated that he had missed five appointments. She didn't give specific details of each one, it was the fact that he had missed five that was significant because it is a large number for missed appointments.

40. Abi mentioned that VC had last collected his medication on 17 December 2021 (over a month before) and had been paranoid and short with the worker at the time. She did not tell me who the worker was. However, the lapse of time meant that VC should have run out of his medication by 19 January 2022. The references to his paranoia and apparent shortness were indicators that he could be relapsing.

41. The references to VC being paranoid, angry, and confrontational recorded in the contacts are important [NOCC0000040]. The significance of this information is that VC was probably unwell. It was not clear if VC had been taking any of his medication, and if not, for how long. A citizen can collect medication and still not take it. If VC had been taking his medication, it could be that it is not having the desired therapeutic effect. Regardless, he could not have taken the full prescribed amount for the period of time as he would have run out.

42. VC had been in hospital recently, which suggested that there was a recent assessment and viable treatment plan, leaving open the possibility of a section 3 assessment [NOCC0000040]. Regardless, it was clear from my conversation with Abi that, in my professional opinion, there were more than sufficient grounds to undertake a MHAA [NOCC0000040].

43. As indicated, Clarisse Bagtas had applied for a warrant the day before (18 January 2022) [NOCC0000051] [NOCC0000041]. I was not involved in that and have no recollection of discussing VC with her. The warrant had clearly been sought because we wanted an appropriate environment for the assessment to take place. The previous time, there had been an incident

with the police, and we wanted him in a place where we could assess him safely without putting the VC, the public or professionals at risk. For this, we wanted a Place of Safety, such as the Cassidy Suite at Highbury Hospital. This is a designated place, where the citizen and professionals can be secure/safe in undertaking the assessment. The Cassidy Suite is basically a secure hospital setting.

44. I also spoke with Ellie Turner, who was Head of the Mental Health Advisory Service at the University of Nottingham [NOCC0000040] [NOCC0000034]. She confirmed the information which I had seen in the referral. There had been an incident with VC and his housemates, which had resulted in VC's housemates being temporarily moved to another flat. I did not receive any understanding of why VC had become violent. All I knew was that there had been an incident with the housemates. Ellie was supportive of hospital admission. In considering Ellie's account, I understood Ellie's considerations of risk was focused on the impact of VC's decline in mental health on VC's housemates, a concern I shared. This was a factor I considered in the MHAA, however this was in the balance with other factors and the least restrictive principle [NOCC0000040]. An AMHP is entirely independent, and it is important that we are not swayed by singular perspectives. We must evaluate the evidence as we see it through the MHAA. Ellie's concerns were considered that VC was not well, and people did not want to return to their halls of residence at that time due to feeling scared of VC. As such the university had responded flexibly to offering alternative temporary accommodation to those affected. Ellie did not

disclose to me that VC could not return to his accommodation during that phone call.

45. I also spoke with VC's mother before the assessment. VC's mother was not in the city as VC had moved to Nottingham to attend university. My notes record [NOCC0000040]:

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

46. I was trying to establish if he had spoken to her recently and whether he had presented anything that worried her. The nearest relative is normally a good source of information; however information was limited as VC did not live with his mother.

47. The relevance of this conversation is that VC's mother had spoken with VC the day before and was not worried. I needed to balance this information

though because VC's mother was not involved in VC's care. I did suspect VC had not been fully open with his mother about his mental health. I also had to be careful in what I said to VC's mother about the concerns as the purpose of my phone call was to consult as nearest relative rather than to overshare information. This was because I had understood VC had asked for his Mum to not be involved in the detail of his care, as this is what she had said in the phone call with her. Therefore, I would need to respect this in order to maintain professional trust and protections of VC's exercised rights around his sensitive information.

48. My conversation with VC's mother indicated that she did not object to using section 3 MHA if needed and also supported section 2 admission if the assessing team felt VC needed hospital [NOCC0000040]. I also understood she was not involved with VC's care and treatment in the community as this was VC's wish, compounded by not living locally. I also sensed she was despairing because VC would not let her be involved. I did not conclude that VC was likely well as a result of the conversation, however, could be well enough to mask his symptoms when speaking to his Mum.

49. I did not obtain information from VC's GP. As VC had a CPN, and recent admissions with the Trust, I worked with the supposition that salient information regarding VC's health could be provided by the CPN. University GPs can often have limited knowledge of the citizen. Accessing GP records can also be costly in time. The university may also have insights from tutors, no additional information in this view was shared from Ellie so I worked with the assumption there was no further information to explore with

the university. I would not usually contact university tutors. I did not speak to any other family members. I was happy that I had enough information to undertake the MHAA. The views that were required were represented by the people I spoke to.

50. I also spoke with Dr Manzar and touched on the history [NOCC0000040].

THE EXECUTION OF THE WARRANT ON 19 JANUARY 2022

51. To prepare for execution, I printed off four copies of the warrant [NOCC000132 – Emails from Roseanna Crane to Mental Health Social Care Team North dated 19 January 2022]. I am required to leave one at the citizen's premises, one is for the police, one for me, and one for the court. I had also sent an email to the police and had called them after that to go through their risk assessment form as they have their own risk assessment process [NOCC0000135 – Emails between Roseanna Crane and Nottinghamshire Police Force Control dated 19 January 2022]. I believe that we chose to rendezvous in a car park near to VC's accommodation. I drove myself there and met with the police, EMAS (who are referred to as 'mass' in the AMHP report, due to a typographical error from dictation software as part of my reasonable adjustments) and Dr Manzar [NOCC0000040]. I provided them with the background and the warrant so that they understood what we were doing and why. I let everyone know the time. It transpired that a number of the police officers who turned up knew VC.

52. Neither I nor any other member of the adult social care team contacted VC prior to executing the warrant. It is not usual practice to contact the citizen prior to execution of the warrant because it may increase danger if they decide to abscond and/or hide from practitioners or increase the risk to others if they are suspicious of them for requesting the assessment.

53. When I arrived at the rendezvous point, I was met by around 15 police officers. I was surprised that there were so many. My initial reaction was we were dealing with a young black male at university, and I was uncomfortable with the heavy police presence. It made the warrant very public and I wanted to consider VC's right to private and family life at the university as much as possible. However, it became clear to me that the police knew VC and they stated their presence was justified. I trusted their professional judgement. There were also three ambulance staff on site, who did not know VC, and Dr Manzar (who did).

54. When we arrived, I had a conversation with Dr Manzar and whoever the leading police officer was [NOCC0000040].

55. The strategy was that the police would be at the forefront. Where suitable, it would usually be the AMHP and the doctor who would lead because we take the least restrictive approach, especially if the doctor has previous acquaintance. This is because the reason for the warrant is medical not judicial reasons, often, and therefore not to conflate criminality into the process, The strategy for VC's warrant was about the potential dangers. In fact, the police engaged well with VC in a very kind and professional way,

with many of the officers down the stairs out of VC's initial sight. They engaged him out of his room, and he came with us of his own accord. I cannot say whether he would have behaved differently if there were no police or if there had been less than 15. Either way, he was cooperative and got into the ambulance for transport to the Cassidy Suite. The ambulance was provided by East Midlands Ambulance Service (EMAS).

56. Returning to the execution of the warrant itself, when I first saw VC, he presented as sleepy [NOCC0000040]. I believe he had been asleep or resting when we arrived. He was sleepy, compliant, but a little surprised. There wasn't anything particularly unusual about my initial judgement of VC's presentation at this time. He went to the Cassidy Suite in an ambulance as it is not appropriate practice for us to use the police for conveying citizens [NOCC0000040]. I did not go into VC's flat, and the police did not give me any concerns about the state of it or his living conditions. He was escorted out of his accommodation by the police but was cooperative and walked on his own accord.

57. When we left the site, VC was in an ambulance, and I followed in my car. I was not in close proximity to VC through the process and there was no question of me being unsafe. Here I was comfortable with the police leading the matter as it turned out.

THE MENTAL HEALTH ACT ASSESSMENT – 19 JANUARY 2022

58. When we arrived at the Cassidy Suite, VC was taken in through one set of doors and us through another. That is the normal process. I alerted Dr Skelton we had arrived, Dr Skelton advised he would join shortly.

59. I had a conversation about the police strategy [NOCC0000040].

60. The Police wanted to leave as soon as VC was at the Cassidy Suite. Practically speaking, that's where they feel their responsibility has ended as the hospital has security staffing and they have completed their duties under the warrant. The police were technically right on this. In order to see what the potential dangers of VC might be, Dr Manzar and I spoke to him briefly. He was cooperative and VC said he was ready to talk and have the MHAA. Dr Manzar still wanted the police to stay for the assessment. Dr Manzar and I discussed this with Police, with Dr Manzar explaining about having previous acquaintance with VC being concerned about his unpredictable nature as observed in the previous assessment whereby Police were assaulted. We had a discussion about this and it was quite forthright. After a number of back-and-forth exchanges of reasoning, it was eventually agreed that two police officers would stay. Nurse staff at the Cassidy Suite are also available nearby with reactive means such as sedative depot injections if required [NOCC0000040].

61. I trusted that Dr Manzar's concerns were based on something, and I did not disregard them out of hand. However, based on my interactions that day I did not feel scared and was not afraid of VC. I didn't feel persistent for the police to stay for my benefit.

62. Turning to the assessments itself, VC engaged in a two-way dialogue. However, he tended to answer or rationalise what was being said and then stop. He did not try to talk over us; he would simply answer the question and stop talking when he had finished his point. He was dressed appropriately for where we had found him – in bed. We did get some direct eye contact. I could see he was measured and considered. His answers were just about on topic but evasive and superficial [NOCC0000040].

63. VC came across as intelligent, but his delivery was monotonal and flat. He was sitting in a normal way and answering, rather than leading the discussion. When he felt he had answered a point he would stop and wait for the next question. I got the impression he knew what to say and what not to say. I didn't feel threatened during the interview [NOCC0000040].

64. I recorded that VC did "*not feel he had psychosis, not now or before.*" [NOCC0000040] It is significant that VC did not initially make or vocalise the link between the incident and his mental health. However, in the context of an MHAA, the citizen can often downplay symptoms and risks, I believe this is to avoid hospital admission. I do believe that VC had a good understanding of the outcomes of MHAAs, based on him having assessments in the past. It was my understanding and VC's assertation he

didn't want to go to hospital, he didn't want to be detained, so he was looking to minimise what had happened. As such, it would be part masking, part minimising, and I can't be sure to what degree he had insight of the severity into the incident.

65. When I asked him about the incident, VC himself said that it was an argument between friends, 'just guys living together' about house duties. It was a scuffle, and it was short [NOCC0000040]. He downplayed the incident and made it sound playful. There appeared to have been nothing of a build-up and VC did not appear to be ruminating about the experience. VC's account was it had just happened. As far as VC was concerned, there was nothing to be remorseful about. My analysis of this was VC did not see the severity of the incident and was minimising the impact of his actions on others, displaying little to no empathy [NOCC0000040].

66. My notes also record that VC had described the incident with his flat mates as a *"normal interaction between peers over household tasks*." [NOCC0000040] I did not challenge him on that account, it was Dr Skelton who did, to assist VC in thinking about his mental health and the incident. Dr Skelton prompted him to think about what a proportionate response to a cleaning rota problem might be, with this not normally being violence. Dr Skelton elaborated on what could make it disproportionate was the context of his diagnosis, missed medication, and failure to engage with medics. By putting this to him, he could either discredit that view or gain some understanding of what was going on. I don't recall VC's precise response;

there was a shift and kind of admission around his personal responsibility and about him not being proportionate in the way a well person might be.

67. From the assessment, both the doctors and I felt that there was a direct link between VC's mental health and the incident with the flat mates. The incident alleged was not proportionate to the problem with his flatmates in the way VC described it (relating to chores) [NOCC0000040].

68. I also held the view it was slightly contradictory that VC didn't think he had a mental health problem, but at the same time he was not protesting about previously being in a mental health hospital, had been assessed under MHA, and was supported by Local Mental Health Team. VC also accepted that he was taking medication in the context of his mental health but there was an element of downplaying his mental health needs.

69. During the course of our interview, VC did say that he had been taking his medication as prescribed but also claimed to have misunderstood the dosage when challenged if he had run out. For us, it was not mathematically true that he could have been taking the prescribed amount of medication because he would have run out [NOCC0000040].

70. It is possible for a MHAA to move on without pushing the citizen to admit wrongdoing or illness. The assessment is not about finding facts in the sense that the police or a court might. The assessment is about looking at the citizen and identifying the least restrictive approach in supporting their care and treatment needs whilst balancing their rights and the protection of themselves and others.

71. Personally, I did not believe this was due to dose confusion. I felt that VC understood that hospitalisation was a consequence of having a relapse of mental health, with concerns around concordance of medication. As such, if he could not be treated in the community he would need to come into hospital. As a result of our discussions, I felt that he would take his medication if he was under the supervision of the hospital's Crisis Team and if he didn't we would have attempted least restriction options first. It would be up to the Crisis Team to refer VC for another MHAA if it did have concerns around compliance and deteriorating mental health, at which point the least restrictive option available may well have been detention [NOCC0000040].

72. This was not about trusting him to take his medication independently as we already had the evidence base that he could not be trusted to do this. It was about him being given prescribed medication under the supervision of a Crisis Team, with access to nurse and doctor input. It was clear that if he did not take the medication, a MHAA would be revisited on the basis supervised treatment had not worked and that it no longer remained an option, detention may well have been the least restrictive approach to deal with VC's mental health.

73. I was concerned that VC had been masking his symptoms during the assessment, which I have already outlined I felt was in the context of wanting to avoid hospital admission. That is a type of rational thinking. In this case, VC was well enough to understand that. It is important that he

had been under our observation since the point he was detained. The day had started with him being woken up by a lot of police officers. During all of that time, there was no violence and no concern in his behaviour. He was exercising a great deal of self-control over that period which he had not done previously. Therefore, whilst there was a clear element of masking, his behaviour and motives did show some underlying rational thinking and motivation not to be in hospital and therefore to engage with the community team's more assertive approach. In that regard, the assessing team decided to attempt a least restrictive option of Community treatment.

74. Turning to my risk matrix, I have recorded the following risks for VC: risks to self; risk to others; other risks [NOCC0000040]. What I was doing here was looking at the likelihood of an event happening and what the consequences of it would be.

75. Starting with risk to self, unless there was some treatment for his mental health, it was highly likely it would decline. If it did, his situation would get worse, and the outcome could have high severity because VC has a diagnosis which exhibits acute symptoms, such as delusions, paranoia and physical aggression.

76. For risk of retaliation from others, I thought this was a medium likelihood/medium severity situation because information I had available to me about previous incidents did not present VC as a victim [NOCC0000040], however it is not to say that this could not happen if antagonising the wrong person. VC has usually been a perpetrator than a victim in the incidents I had been aware of.

77. Turning to his risk to others, VC has a history of assault to others, including the Police officer in his former MHAA [NOCC0000040]. In the build up to this MHAA, there had been an incident with the flat mates. As such, at the time I felt this was a medium likelihood, as the flatmates had been temporarily relocated and VC did not present as having an ongoing dispute towards the flatmates based on the interview. I risk assessed the consequences could be high severity if there was conflict because it is extremely serious when someone becomes physically and verbally risky to the community.

78. Turning to the 'other' risks, if he became unwell, it would be difficult for VC to complete his academic studies [NOCC0000040]. This was a medium to high likelihood, depending in particular on whether he was detained, and also if his mental health was not improved with treatment. VC could not adequately prepare or take exams whilst detained in hospital. The severity would be medium as it would probably have required him to redo a year or more of his course.

79. I also considered the possibility of stigmatisation from peers [NOCC0000040]. I gave this a medium/high likelihood with medium severity. If VC was unwell, that would impact on friendships and relationships within his environment. VC did describe his peers as friends suggesting he had friendship relationships. That is not to say relationship breakdown is not as serious as violence or aggression to others.

80. At the conclusion of the MHAA, all three of us (me, Dr Manzar and Dr Skelton) decided there was an opportunity for attempting a least restrictive option therefore did not make the decision to detain under MHA. VC had missed appointments with his community team and seemingly had not taken medication, however, there didn't seem to be an assertive approach from community treatment services to proactively engage him and explore more support around medication concordance. VC was expressing he was willing to engage with this kind of approach from the Crisis Team. This approach would also provide more evidence that he would not be compliant with medication [NOCC0000040].

81. I recorded in my notes that VC could benefit from hospital admission [NOCC0000040]. This was because we believed he was poorly, suffering from mental health symptoms that would benefit from treatment and a hospital could provide that. VC was not agreeable to informal admission, so the only way VC could have been admitted to hospital would have been if compulsory admission had been the outcome of the MHAA

82. As to capacity, we felt that VC understood why we were having the MHAA, what the conversation entailed and what the outcomes are. This was explained to VC at the beginning and he presented as understanding and also verbally confirmed this [NOCC0000040]. VC appeared to accept that he had been diagnosed with mental health problems and prescribed medication which he was required to take to stay well. I acknowledge there is a grey area around the degree he accepts his diagnosis and reason for treatment however he was confirming in the MHAA that he would take the

prescribed medication for mental health and agreed there could be a benefit in his circumstances as a result. I also feel VC knew that he needed to engage with a medical team in respect of his disorder and that if he did not engage, he would likely be reassessed under the MHA resulting in hospital admission.

83. From our discussions, I felt that on the balance of probabilities he was on board with the Community Treatment plan and would co-operate. Community treatment as the least restrictive option. VC would be provided with medication by nurses and therefore had access to medical professionals frequently. This plan also meant VC would be more likely to attend to his studies [NOCC0000040].

84. It is important that the plan was about treatment. This was not an MHAA for the purpose of assessing his condition, this was about treatment because we already knew what his diagnosis was.

85. I recorded in my notes that VC was not presenting to the degree that he had previously [NOCC0000040]. I say this because he was exercising self-control and engaged with the MHAA. Whilst there was an element of masking, he seemed to know what he was doing. He was clear in his knowledge that he knew he needed to engage and to take his medication.

86. VC's previous assessment had started with an incident where he had been violent. Here he had come out of his room, gone downstairs got in an ambulance taken a seat in the ward waited for us and had a conversation. He was engaging with us at a level.

87. In terms of our work, if we had detained VC that would have interfered with his ability to sit exams and do his course. The exam time was clearly sensitive for him as it would be for anyone. I did not clarify with the university what VC's exam schedule was.

88. I remember Dr Skelton was clear in his view that VC could be discharged to the community and supported by the Crisis Team. Dr Skelton began writing up prescriptions almost as soon as the discussion was over. Support by a Crisis Team giving regular contact with nurses, therapeutic conversations, support and of course the medication can be a successful plan for many people and VC was stating willing engagement and rationale for doing so.

89. After we had seen VC, there was discussion between me and the two doctors. We reached agreement on the way forward. I thought this was a balanced case. On the one hand, all community options had not been explored with him. We were required to take the least restrictive option. On the other hand, he has a mental health diagnosis categorised by symptoms of paranoia, being a risk to others and evidence of not being concordant with his medication, which would support the basis or rationale for compulsory detention in hospital [NOCC0000040].

90. We discussed this and there was agreement between all three of us about the way forward [NOCC0000040]. I felt it was significant Dr Skelton and Dr Manzar had previous experience with VC. Dr Skelton was comfortable to own the risks associated with this from the perspective of the Crisis Team.

Dr Skelton also represented the Hospital Trust in this process and supports the gatekeeping of hospital beds [NOCC0000040]. The Crisis Team consultants are highly experienced and exhibit positive risk taking as they assess appropriate. 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. I was reassured that if there were any problems identified by that team (such as not taking his medication), another assessment could be arranged and more restrictive approaches, including hospital detention, could be explored again.

91. After we had made the decision against detaining, and VC has been informed and discharged from the section 135(1) warrant, I called Ellie at the university to share the outcome of the MHAA and details of the Community Treatment plan [NOCC0000040 [NOCC0000034]. This was after the assessment had concluded, VC had been informed of the outcome of the MHAA and Dr Manzar had left. Ellie stated VC's accommodation was at risk as they did not feel it was suitable for him to return to his accommodation. This was a significant risk factor and undermined the premise of the Community Treatment plan, in the sense that VC risked not having somewhere to live and additional stress to resolve this, losing the stability of remaining in the Community. This information had not been shared by Ellie to me in my previous call.

92. I was still with Dr Skelton and updated him immediately of the new information [NOCC0000040]. This information from Ellie felt like a tipping

point for me. I passed Dr Skelton the phone to Ellie who was still on the line and I went out into the car park to speak with VC. My worry was this MHAA outcome was now concluded. At this point, VC had been discharged. I went out into the car park to inform VC of what Ellie had shared about his accommodation being at risk. I tried to persuade VC to agree informal admission. This was a one-to-one conversation between me and VC. VC reconfirmed he did not want to be admitted to hospital even informally and VC would resolve what he needed to with the university. I went back to the Cassidy Suite and informed Dr Skelton that VC had not accepted informal admission in light of the new information. Dr Skelton updated me that he had informed Ellie that making VC homeless at this point was not conducive to the Community treatment plan. I cannot remember the exact words of this conversation however the outcome was that the decision was final and VC would be returning to his accommodation and Crisis Team would still be supporting him there.

93. After the assessment, I spoke with my colleague Amie Staples. She was Senior cover, my manager and more experienced AMHP. I explained that this had not been a straightforward assessment, and I had encountered a balanced situation, complicated further by the additional information from Ellie around the stability of VCs accommodation, after the decision not to detain had already been made. I was seeking a reflective conversation around the decision making of the assessment.

94. Returning to my notes, VC had told us that he did not want future appointments to take place at his home address [NOCC0000040]. I understood this as the Crisis Team involvement being visible and carries the possibility of stigma from peers or neighbours. Although it is preferred to support people in their homes, the Crisis Team is a flexible service and sometimes deals with people who are homeless. Medication concordance away from the home address is possible which was the primary aim of the Community treatment plan, before then considering longer term support back from the Local Mental Health Team VC was open to.

95. The significance of not wanting to be seen at home is likely to be privacy and also controlling the situation. VC has been subject to removal from his home via warrant and formally detained against his will on this occasion and in the past, therefore if there are reasonable opportunities to respect a citizen's wishes then this should be considered. Here, the aim of the exercise was to get VC to take his medication. Further, it is important to note that if VC did not meet the Crisis Team at an appointed location there was nothing that would prevent them from going to his house. Provided that VC was seen and took the medication, this was fine. Indeed, if VC was co-operative with being seen away from his home it might actually be more effective.

96. I did record that the professionals' discussion was short. First, Dr Skelton had a clear view and was prepared to take ownership of the risks of a community plan. Dr Manzar was over-committed time wise, due to the

warrant execution, delay in starting the assessment due to negotiation with Police and Dr Skelton finishing his prior commitments. That said Dr Manzar did not leave before the discussion was complete. Whilst the meeting was short, we were able to cover all of the issues, and the salient points remained the same. We had considered the options, agreed a viable community plan and discussed mitigations if the plan was unsuccessful. Dr Skelton confirmed the Crisis Team was prepared to take ownership of the risk of VC in the community [NOCC0000040].

97. It was clear in our discussions that VC did not want to be in hospital but understood that was a real possibility. As such I felt it was likely he would engage with the community treatment if given an opportunity to do so. If he did not, we had the option of reassessing him and we would have the evidence base required to conclude that hospital detention was necessary. On that basis, I felt that he would co-operate with the proposed community treatment and take the medication because he wanted to stay out of hospital. The fact that he had the self-control to try and mask his symptoms during our interview showed that he did not want to be in hospital. He also agreed to take the medication subject to Crisis Team supervision.

98. That plan was advocated by Dr Skelton and agreed by Dr Manzar, I supported the decision to be final. Dr Skelton went on to prescribe VC's medication. The medication was not given in my presence.

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99. I have no specific recollection of the events and how I came to apply for a warrant [NGPF0003316] [NGPF0003318] [NOCC0000034]. If documents record that I spoke to Jude Modern, then that will have occurred. My notes on the warrant application set out what I will have known and been informed of at that time [NGPF0003318]:

"Valdo has since disengaged and there are recent (27.01.2022) reports that V is being threatening towards other students. V is at risk of being kicked out of his accommodation and course due to his behaviours. V's peers are at risk of harm from V due to a relapse in V's mental health. V needs a Mental Health Act assessment at a place of safety in the interest of protecting the assessing team and V's peers. This view has been supported by the crisis team consultant Dr Skelton."

100. I do not recall the circumstances in which I was instructed to create that warrant, or who provided me with the information. In contrast to my MHAA of VC, this was a paperwork exercise that was not as memorable.

101. What I can say is that I will have acted on the information I was given and created the warrant. As to its necessity, that is quite clear from what is said in the warrant and also from what I knew of VC's history from my visit that another assessment would be necessary to manage VC and the associated risk if VC's mental health continued to decline. I was not involved in the execution of that warrant [NOCC0000034].

RECOMMENDATIONS

102. Looking at VC's case, there is something about the interplay between community teams and Crisis Teams. VC had the benefit of a team but was not turning up to see them. Community teams are under resourced and have had the Assertive Outreach function removed in many cases. I feel the Crisis Team absorbs more of these citizens who need this approach. Thus, if there were a mechanism and more capacity by which teams could be more assertive, I suspect that there would be fewer request for MHAAs.

103. I also wonder if there could be more training for teams around the interplay of disguised compliance and capacity at the point of being in acute mental health crisis. This is a challenging area, balancing the degree of capacity for a particular decision, as well as what other motivations for presenting as having capacity need to be considered. That said, I am still satisfied with the assessment of capacity I made on the day in question however it was a complex issue to subjectively determine.

104. From a practical lens, I do feel that GP records and GP attendance could and should be more accessible for MHAAs. The current process requires contacting the GP surgery and, in my experience, attempting to secure GP availability for a call back to share records. This can be timely, and in this example, not prioritised. In my experience, GPs scarcely have the availability to attend MHAAs for their patients. If there was an AMHP contact route for MHAAs that could access and share information for this

purpose, as well as a recognition in GPs diaries that accommodated for the attendance to MHAAs, I feel GPs would be utilised more.

105. I also think it would be useful for all of the professionals involved in this area, AMHPs, Crisis Teams, the Trust, and police to get together for training or group working. Co-development courses would be useful in this regard as each of these services sees a citizen from different perspectives. It would also help professionals understand the pressures within each service and bridge the siloed working.

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: ……Roseanna Crane….…..

Dated: …13/11/2025………

Index to the First Witness Statement of Roseanna Crane

No	Inquiry URN	Document Description
1	NHSE0000312	Mental Health Act 1983: Code of Practice
2	WITN0117004	Conveyance Policy
3	NOCC0000040	AMHP Report Referral and Assessment dated 18 January 2022
4	NOCC0000041	Authorised Warrant to Enter Premises to Search for and Remove Person dated 18 January 2022
5	NOCC0000034	Liquid Logic Case Notes
6	NOCC0000069	Emails between Clarisse Bagtas and EDT dated 18 January 2022
7	NOCC0000062	Contact Record dated 18 January 2022 (by Megan Taylor)
8	NOCC0000051	Application for Warrant to Search for and Remove Person dated 18 January 2022 (by Clarisse Bagtas)
9	NOCC000132	Emails from Roseanna Crane to Mental Health Social Care Team North dated 19 January 2022
10	NOCC000135	Emails between Roseanna Crane to Nottinghamshire Police Force Control dated 19 January 2022
11	NGPF0003316	Authorised Warrant to Enter Premises to Search for and Remove Person dated 27 January 2022
12	NGPF0003318	Application for Warrant to Search for and Remove Person dated 27 January 2022 (by Roseanna Crane)