Witness Name: Christopher James Atherton

Statement No: WITN0225001

Dated: 13 November 2025

IN THE MATTER OF THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF CHRISTOPHER JAMES ATHERTON

I **Christopher James Atherton** c/o Nottingham City Council, Loxley House, Station Street, Nottingham NG2 3NG will say as follows: -

1 I am employed by Nottingham City Council ("NCC") as the Strategic Director for Adult Social Care and Health. I make this statement in response to the Rule 9 request from the Nottingham Inquiry ("the Inquiry"), dated 5 June 2025.

2 Where the content of this 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 I am a social worker by profession, having obtained a degree in social work from Middlesex University. I also hold qualifications as a Best Interest

Assessor and a qualified Practice Educator. I specialise in adult social care. During my career, I have worked for two local authorities – Haringey Council and NCC. I began work at Haringey in 2005 under a scheme in which I would be trained on the job and undertake a degree at the same time. Initially I was working as an unqualified social worker and as part of that I did six months working in children's social care and six months working in an adults' social care with disabilities team. I qualified in August 2009. I decided to specialise in adult social care upon qualification, and I have undertaken that work since.

4 Initially I was a front-line social worker dealing with mental health and learning disability matters. In about 2015 I took the role of a Principal Social Worker. That developed in 2018 to me becoming the Head of Quality Assurance and Development. Inspection duties were added to that in 2024, so by then I was Haringey's Head of Quality Assurance, Development and Inspection. It was a head of service role, responsible to the director.

5 For personal reasons, I moved from London to the West Midlands in 2023. Subsequently, I decided to get a job nearer to home and was recruited by NCC as the Strategic Director for Adult Social Care and Health. I started work for NCC on 2 June 2025.

6 I make this statement in my capacity as Strategic Director for Adult Social Care and Health. At the time of the Rule 9 request, the Corporate Director above me was Vicky Murphy. She was away from work at that point in time. Accordingly, I am the best person to assist the Inquiry with this statement.

The Local Authority Role in Mental Health

7 NCC is the first-tier local authority for the City of Nottingham. This gives it responsibility for social services – both children and adults.

8 Local authorities have a central role in mental health care and support. There are duties in the Care Act 2014. These responsibilities include:

- Assessing need
- Providing support services
- Promoting well-being
- Preventing mental health issues from arising
- A duty to cooperate with other agencies and services to deliver good mental health outcomes

9 The legislation sets out the duties and functions of local authorities (including NCC). They also have the functionality of employing approved mental health professionals ("AMHPs"). Local authorities also commission mental health provision under the Care Act.

10 Turning to the Care Act, local authorities undertake a wide range of functions including: -

- Assessment of people with mental health issues

- Provision of support services, residential placements, supported living and education
- Prevention and early intervention
- Safeguarding. This is to safeguard vulnerable adults at risk of abuse or neglect.

11 In addition, the local authority's Care Act responsibilities will lead them to providing information and advice to those who don't meet the threshold for formal intervention. The aim of this is to prevent their needs escalating.

12 As with other local authority duties (such as intervention in families), there is a threshold under the Care Act which must be met for a vulnerable adult to receive assistance with day to day living. This is measured at 'two outcomes' they can't meet, such as being unable to dress or feed themselves properly. It also requires consideration to be given to the impact on the person's wellbeing as part of the eligibility assessment. It does not matter whether the inability is caused by a physical condition or because of mental health issues.

13 Turning to AMHPs, the local authority is subject to a duty under the Mental Health Act 1983 to provide them. One of the roles undertaken by AMHPs is to formally assess people who may require hospital treatment or assessment. This takes place under Section 2 of the Mental Health Act 1983 (Admission for Assessment); or Section 3 (Admission for Treatment).

14 AMHPs are mostly social workers, although some are appointed from an occupational therapy ("OT") background, some are psychologists, and some from a nursing background.

15 NCC has about 40 AMHPs.

16 The AMHP undertakes a crucial role under the Mental Health Act, in that they are contacted when a Mental Health Act assessment ("MHAA") is needed - which could lead to detention for assessment or treatment. There is no typical way in which an AMHPs involvement begins. They are sometimes summoned by the police in respect of somebody who has been arrested. Alternatively, it will be a GP or concerned family members who contact NCC directly through what we call the *'front door service'*. This is the gateway to adult social care, where initial contact is made by the public or service users.

17 Taking VC as an example (see below), NCC was contacted by the police in May 2020. They had arrested him for criminal damage and were concerned about his capacity to make healthcare decisions. An AMHP (Ben Williams) was sent for. He made an assessment of the situation and decided that there may be a need to detain VC. Accordingly, doctors were summoned to assess VC. One of those doctors must be a Section 12(2) MHA doctor (usually a psychiatrist).

18 If they had concluded that it was necessary to detain VC for assessment or treatment, he could have been detained under either Section 2 or Section 3 of the MHA.

19 This is a collaborative assessment process in which the doctors make an assessment, and their views are then considered by the AMHP. Guidelines indicate that the least restrictive outcome is to be applied. Accordingly, detention is very much a last resort.

20 If the doctors consider that a person should be detained, the AMHP must ensure that the legal criteria for detention are met and that the rights of the individual are protected. This includes confirming that the decision is lawful, proportionate, and the least restrictive option, as well as contacting the nearest relatives and coordinating with other professionals involved in the assessment. The AMHP acts as an independent safeguard in this process, applying their specialist training and judgement to uphold the person's rights. Included within the VC notes are repeated references to NCC contacting his mother.

21 When an AMHP is summoned to examine a person, they will apply their professional training and judgement to what they see. Specifically, they will be looking for evidence of a mental health condition (which could include psychosis) or any other form of mental health problem, and assessing the risk presented by the patient. AMHPs undergo specific training and have a Continuing Professional Development ("CPD") requirement for 18 hours of

training a year. They are specifically tasked with identifying mental health conditions that may present a risk either to the patient or the public at large.

22 Once a patient is detained, the AMHPs role drops away. The patient is then the responsibility of the hospital. It is possible that the AMHP could become involved if the hospital was considering a Community Treatment Order, but the role is largely finished.

23 When the hospital is considering discharge, they will only notify NCC if they are looking for support from adult social care. Accordingly, they will notify us if they want adult social care involvement. If there are greater concerns, they might want a multi-agency meeting. The hospitals will not notify us if they simply intend to release.

24 This is where the distinction between Detention for Assessment (Section 2 Mental Health Act) and Detention for Treatment (Section 3 Mental Health Act) becomes important. If a patient has been admitted for treatment under Section 3, Section 117 (2) of the Mental Health Act provides that it is the duty of the healthcare provider and the local social services provider to offer aftercare services on discharge. This is the community care provision. The health provider is responsible for medical needs (provision of medication), and the local authority for the social care needs: as defined under the Care Act, that may include support with activities of daily living such as washing and dressing and accommodation. Very roughly this is the difference between medical treatment and social care needs such as dressing washing and feeding. Where

there is going to be a Section 117 discharge, the hospital and the local authority will assess the care and support needs of the patient.

25 That involves the social worker (who may coincidentally be an AMHP) in discharge planning, but only if there are social care needs. If there are no social care needs at all, then the local authority will not get involved. The hospital will deal with any medical needs.

26 Once released, a care coordinator will be identified. That may be the hospital's Community Psychiatric Nurse ("CPN"), or an OT depending in staffing in the Trust. If they identify social care needs, they can call in the local authority.

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

28 Overall, however, the local authority is in the hands of the treating hospital when it comes to providing information about patients who are coming up for discharge or have been released.

29 Once in the community, the local authority will only be involved if there is care in place – as defined under the Care Act. That may include support with activities daily living and accommodation. When the local authority is involved, it does give a second *'set of eyes'* on the patient in addition to the CPN. Adult social workers will be able to spot matters such as patients not taking their

medication, or deteriorating living standards, or the onset of greater social care needs. The distinction between health provision and social care provision is perhaps starkly illustrated by the question of medication compliance. An adult social worker who observed a patient who was not taking medication could prompt or remind them to do so. However, administering the medication (e.g. injection) is a medical matter and would have to fall to the CPN.

30 The system is meant to be organised so that health and social care work together. That is why central Government has a Department of Health and Social Care. There has been excellent collaboration between health services and local authorities over recent years – see the pandemic response. However, now that emergency has passed, we see health and social care starting to retreat towards preserving their own budgets. In that regard, disagreements do break out as to whether a particular patient needs health or social care support following discharge from hospital. In many respects, it would be better if the aftercare was provided under one budgetary umbrella as that would avoid these discussions.

31 Returning to the detention decision, if a patient is not detained, the AMHP's duties are limited. They will be making a social care assessment and if they have concerns that the patient cannot manage their daily activities, is showing signs of self-neglect, malnutrition or inability to function, then they will refer into the adult social care team. If it is an emergency, they would refer to the crisis home treatment team. Referral to the Crisis Resolution and Home Treatment Team ("CRHT") would be a way in managing the person effectively reducing

the risk of them requiring a hospital admission and works separately to the adult social care support that might be needed so a referral could be made to both. This is for a group of service users who are almost at the point of requiring hospital admission but are not quite there. The crisis team is a multi-disciplinary team made up of medical experts, and social care professionals with expertise in benefits and housing. If they observe any further deterioration in the patient's condition, the AMHP could be summoned again to consider referral again.

Systems and Guidance

32 Local authorities and hospital trusts maintain separate records and separate databases. There is some ability amongst the AMHPs to read across both systems because they have access to both systems. Accordingly, AMHPs do not experience any significant difficulties with information sharing and the NCC AMHPs are pretty positive about the collaboration with local hospitals.

33 When asked about this, the NCC AMHPs also felt that there were good levels of communication across the wider health and social care system. They did not report significant difficulties in obtaining information.

34 The position is not formalised, some AMHPs have read-only access to Rio (the Trust's system). All the Health and Social Care Co-ordinators ("HSCC") have read only access to Rio. It has never been 'compulsory' and as far as I am aware is not written into any NCC policy. There are logistical issues about

accessing it - most people cannot access Rio from home or from a non NCC work base, but usual practice is that AMHPs will routinely ask colleagues who have access to email over relevant case notes. A way of working does operate in practice but could be easier.

35 At the time of these events, there was no statutory guidance around discharge. Since then, the Department of Health and Social Care published Discharge from Mental Health Inpatient Settings on 26 January 2024. I exhibit that document at [PHSO0000010].

36 I am not aware of any applicable local practices here.

The VC case and NCC's involvement

37 I did not have any direct involvement with VC. This section reflects what is shown in documents held by NCC Adult Social Care teams.

May 2020

38 On 24 May 2020 NCC's Emergency Duty Team ("EDT") received contact from the police in relation to VC. I exhibit at [NOCC0000034] the Adult Social Care case notes. It was confirmed that VC had been arrested for criminal damage in his student accommodation. VC had been taken to A&E to rule out organic causes due to him being very delayed in his communications however he had since been taken back to Bridewell. The notes confirm that VC was not known

to health or social care. It was agreed for an MHAA to take place, and the assessment was handed over to Ben Williams, AMHP. I exhibit at [NOCC0000044] the AMHP Report Referral and Assessment dated 24 May 2020.

39 An MHAA was completed the same day at Bridewell custody suite by Ben Williams, Dr Ghandi, Dr Malki and Annette Palmer (CRHT). The assessment confirms it was VC's first presentation, and he did not have any previous mental or physical health issues. The circumstances leading to the assessment state that VC moved to the UK in 2007, and he had lived with his parents in Wales before moving to Nottingham for university. He was studying Mechanical Engineering at the University of Nottingham, and he was in his third year of his four-year course. The AMHP report states VC had been arrested for burglary the previous evening (23 May 2020) after breaking into the flat of another resident in his apartment block. VC told police he thought he could hear his mother screaming in the flat.

40 The MHAA was completed at 2:00pm on 24 May 2020. VC seemed to struggle to follow the thread of the conversation, he said he had not slept for seven days, and he felt confused and tired. VC explained that he could hear screaming and voices telling him his mother was being raped, and this is why he broke into the flat. VC said he had been hearing voices for a few days, that they do not talk directly to him, but he can hear them talking about him or his family. VC became guarded and suspicious when asked if he felt he was being watched in his apartment. VC could not identify any social stressors and stated

he had been keeping up with university, he was in contact with friends and he speaks to his mother on the phone. VC noted his experiences were abnormal and he wanted help with them. He agreed to consider taking medication. VC asked if his mother was ok and became tearful. Permission was given to speak with his mother.

41 VC's mother was spoken to by telephone. She became concerned about VC's mental health after he told her over the phone two days ago that "I don't know myself". She confirmed he had never experienced any difficulties with his mental health in the past and he has never been violent or aggressive.

42 It was agreed by the assessors that VC was experiencing a psychotic episode. He had been hearing voices, and he also had paranoid delusions that he was being watched by others in his flat. It was unclear what the risk factors were. The police Sergeant in charge of the case explained there was no violence from VC when he broke in the home. The assessing team decided not to detain VC. It was VC's first presentation to mental health services, there was no history of mental health issues, and the risk was deemed low enough for home treatment to be explored. VC agreed he needed help. He agreed to CRHT input and medication. CRHT were to visit twice daily, and Dr Ghandi prescribed 2.5ml Olanzapine.

43 The case notes [NOCC0000034] confirm that EDT were contacted by Brandy at the City Crisis Team at 9:03pm on the evening of 24 May 2020. It was confirmed that VC was to be seen in the community by the Crisis Team tonight

however he had been arrested by police for smashing a neighbour's property. He was back in custody and stated to be 'staring into space and vacant'. At 1:16am on 25 May 2020 there was contact from Jenny Finney, Nurse at the Bridewell custody, requesting an MHAA. Ms Finney confirmed VC was non communicative and his presentation was the same as the previous night but when he spoke to his mother on the phone he had normal communication.

44 An MHAA was completed on 25 May 2020 at 3:45pm by Eleanor Cullen (AMHP), Dr Sadraei and Dr Malik. I exhibit at [NOCC0000045] the AMHP Report Referral and Assessment dated 25 May 2020. It is noted that VC had been arrested again approximately one hour after being released the previous day. He had broken into a neighbour's apartment and terrified the female occupant to such an extent that she jumped out of the first-floor window. CRHT did not attend the assessment as home treatment had been trialled and failed.

45 VC was seen in his cell for the assessment. The AMHP's report states VC seemed to struggle to follow the thread of the conversation. He stated he heard a woman screaming last night and that is why he entered the flat. Other than this, VC was non communicative and appeared distracted. VC answered 'yes' when asked if he thought he needed to go into hospital. He did not respond when asked if he felt he was mentally unwell.

46 The outcome of the assessment was that VC warranted detention under section 2 of the Mental Health Act 1983 for a period of assessment. Home treatment was not an option as this was tried yesterday, and informal admission

was not an option as VC did not appear to have capacity to make decisions about his mental health. Detention was considered the least restrictive option available to manage the risks identified. The risks included a risk of further mental health deterioration, lack of sleep and/or self-neglect, aggression towards his neighbours due to two incidents occurring in 48 hours and a disruption to his studies.

47 VC's mother was spoken to by telephone and the outcome of the assessment was explained. VC's mother stated she had been unable to get a hotel in Nottingham as they were for key workers only at that time. Family were also currently unable to visit the ward due to Covid-19. It was confirmed that VC was not registered with a GP.

48 There was no current care package in place, and no social care needs were identified.

49 It was arranged for VC to be transported to and admitted to the Rowan 1 ward.

July 2020

50 On 14 July 2020 EDT were contacted by the Cassidy Suite at Highbury Hospital [NOCC0000034]. An MHAA was requested, and it was stated that VC had been put on a section 136 at 11:50pm the previous evening (13 July 2020). Section 136 of the MHA 1983 provides emergency powers to police to remove

someone from a public place to a place of safety for a mental health assessment, and to ensure their well-being and the safety of others.

51 An MHAA was completed at 3:00pm on 14 July 2020 at the Cassidy Suite, Highbury Hospital. The assessment was completed by Geoff Culpin (AMHP), Dr Manzar and Dr Seedat. Dr Seedat had recently managed VC's care on Rowan 1. I exhibit at [NOCC0000046] the AMHP Report Referral and Assessment dated 14 July 2020.

52 The AMHP report confirms VC was recently discharged from hospital on 20 June with a treatment plan, he was with the local mental health team ("LMHT") south and had medication of 10mg aripiprazole. When placed on section 136 VC had been experiencing auditory hallucinations relating to upstairs neighbours which he then confronted, and they called the police. VC had not been compliant with his medication primarily as he did not believe he needed it or that he was unwell. VC had found it more difficult to his concentrate on revision and wondered if this was linked to the medication he was taking.

53 Contact was made with VC's mother. She confirmed she had become concerned over the weekend that VC's mental health appeared to be deteriorating. She did not object to VC being admitted to hospital.

54 The outcome of the assessment was detention under section 3 as his presentation indicated that he remained mentally unwell and he required treatment. As VC had been recently discharged from hospital, a further period

of assessment was not required. The risks of discharging VC included further risk to others including aggression towards neighbours and deterioration of his mental health. He had not worked effectively with the crisis team when recently assessed and an admission was clearly indicated. VC would not consent to an informal admission.

55 There was not a current care package and no social care needs were noted.

September 2021

56 On 1 September 2021 there is an entry in the Adult Social Care case notes [NOCC0000034] which states Gary Carter (CPN) stated VC was deteriorating and he believed people were using technology against him, he was suspicious, not willing to engage and he was not taking his medication. He said VC was currently not a risk to himself or others and an assessment could wait until a discussion was had with Dr Lloyd the following day. Dr Lloyd was spoken to by telephone on 2 September 2021. Dr Lloyd felt VC needed an MHAA today and he could not be sustained in the community.

57 An MHAA was attempted at 11:30am on 2 September 2021 by Jen Shaw (AMHP), Dr Jan and Dr Lloyd [NOCC0000034]. There was no answer at VC's flat, it did not appear that anybody was home, and VC did not answer his phone. A further attempt to complete the MHAA was made at 3:30pm that day [NOCC0000034]. There was again no answer. Consideration was given to setting up a rearranged MHAA for 8:00am Friday however no AMHPs were

available to set this up out of hours and the crisis medic was concerned to leave VC in the community given his previous risks when unwell. It was offered to attempt the MHAA again at 6:30pm and attempts were to be made to speak to VC's family to obtain information on his whereabouts.

58 VC's sister and brother were spoken to by telephone [NOCC0000034]. Both of VC's parents were at work until around 8:00pm. VC's siblings confirmed VC was not at the family home in Wales and there were no plans for him to return home for his birthday in two days' time. They believed he may be working nights in a warehouse but were unsure. They raised concerns with his mental health and said he had seemed paranoid recently, and conversations had been confusing. An office number was left for VC's parents to make contact tomorrow. VC's mother called back at approximately 6:00pm and agreed to attempt to contact VC. She called back a few minutes later to confirm VC would not answer his phone which was unusual. VC's mother was concerned about VC. She felt his mental health had deteriorated and she did not think he was taking his medication. She said she does liaise with his CPN and LMHT, supports him to engage and provides emotional support. VC's mother did not object to his hospitalisation, if required.

59 A further MHAA was attempted at 6:30pm with Dr Lomas and Dr Manzar [NOCC0000034]. There was no answer. A neighbour left her flat and stated she had not seen VC. His flat appeared empty, and it appeared VC may have left. A handover was provided to the daytime AMPH to follow up the next day. VC's mother was updated and asked to encourage VC to engage with his mental

health team if she had contact. She was also advised to call emergency services if she had immediate concerns.

60 An application was made for a warrant under section 135(1) of the MHA by Amie Staples (AMHP). I attach at [NOCC0000047] the Report on Application for a Warrant under Mental Health Act (undated). This document confirms VC was discharged from hospital on 31 July 2020 and he had been broadly accepting his treatment, support and monitoring from secondary mental health services following discharge. VC had deferred his final year studies but appeared motivated to recommence this in October 2021. He worked and was accepting of his appointments with his CPN. Over recent weeks, there was a marked disengagement with support and signs of his mental health relapsing. On a visit three days prior, VC disclosed he had stopped treatment, and he did not intend to see mental health services ever again as they conspired to trick him into believing he was unwell by creating technology to broadcast the voices to him. He believed his CPN was actively involved in this conspiracy. There had been three unsuccessful attempts to visit VC since this meeting. There was no indication that VC was intending to harm anyone else however his previous behaviours demonstrated a significant risk to himself and others.

61 On 3 September 2021 a warrant was granted under section 135(1) of the MHA 1983 enabling a constable accompanied by an AMHP and registered medical practitioner to enter the premises of VC. I exhibit at [NOCC0000048] and [NOCC0000049] a copy of the Warrant to search for and remove patient, dated

3 September 2021 and the Information in support of application for warrant to search for and remove patient, dated 3 September 2021.

62 VC's mother was spoken to by telephone [NOCC0000034]. She confirmed she had spoken to VC last night. He was very focused on the government and much of it did not make sense. He told her he had been out all day on a course.

63 An MHAA was planned for 6:00pm on 3 September 2020. I exhibit at [NOCC0000050] the AMHP Report Referral and Assessment dated 3 September 2021. VC would not accept the assessment. VC assaulted a police officer by hitting him repeatedly. The other officers sought to restrain VC but could not as he resisted violently. VC managed to obtain the handcuffs and used these to hit the male police officer. Police used CS gas to attempt to subdue him with no effect. He was tasered three or four times. Police restrained VC in handcuffs and leg restraints. VC was taken to A&E to be assessed before being transferred to the Cassidy Suite. On leaving the property, a bag of unused medication was seen dating back to February 2021.

64 VC was received at the Cassidy Suite at around 8:00pm. The assessment was re-convened with Dr Manzar, Dr Lomas and Amie Staples (AMHP). VC said he would not engage with the assessment. He refused to comment on the concerns presented to him or on being admitted to hospital. He said he would not take medication for his mental health. VC's father was consulted as nearest relative as part of the assessment.

65 The assessors agreed that detention under section 2 MHA was necessary. VC appeared to be suffering from a release of psychosis, characterised by conspiratorial delusions and auditory hallucinations. He appeared suspicious and paranoid of others. The risks identified included further deterioration of his mental health, reprisals for his behaviour, that he will be unable to engage with his university studies if untreated, serious risk of physical harm to police officers in the context of his MHAA and a risk of harm through resisting police intervention.

66 VC was admitted to the Cassidy Suite, Highbury. No social care needs were identified and there was no current care package.

67 Following this, NCC were contacted by Cygnet Hospital on 22 September 2021 as the section 2 was due to expire on 30 September 2021 [NOCC0000034]. It was noted that Dr Shoilakova was the Responsible Clinician and a section 3 recommendation would be completed. A request was made to the local AMHP service to assist with the assessment on NCC's behalf. However, the Darlington team did not have capacity, and it was arranged for NCC to send an AMHP to complete the assessment.

68 An MHAA was completed at Cygnet Darlington on 24 September 2021 by Alison Jacques (AMHP), Dr Shoilakova and Dr Finch. I exhibit at [NOCC0000038] the AMHP Report Referral and Assessment dated 24 September 2021. The AMHP report states that VC had required restraint and seclusion for several days at Highbury. VC was then moved to Cygnet

Darlington as there were no local Psychiatric Intensive Care Unit ("PICU") beds available. An MHAA had been requested as VC appeared to require further treatment in hospital and he was refusing this. VC's CPN spoke with VC's mother who had no objections to section 3.

69 During the assessment, VC referred to the previous incident with police and said it was poor judgment on his part. VC denied that he thought the police and mental health team were part of a conspiracy to control his mind and harm him. VC said he was not experiencing any psychosis, his mental health disorder stopped in early August 2021, and he stopped his medication. He did not feel he had any mental health symptoms since then. VC said he read online about agencies using technology to gather information from people's minds to monitor and control remotely. He said he felt this happened to him but now he doesn't hold that view. VC said he spoke to his family two days ago and they convinced him of this. He did not feel the beliefs he had could have been due to paranoid psychotic illness. VC felt he did not need treatment. VC said if the section ends, he will leave hospital and resume university and not have contact with mental health services.

70 VC's mother was consulted as part of the assessment.

71 A discussion was held with the doctors following the assessment. It was confirmed that on 21 September VC had remained fixed in his views that authorities were controlling his thoughts, and he showed no insight into his illness, the need for treatment or risks associated with it. VC had no remorse for

the attack on the police. VC had presented the altered view at the Mental Health Tribunal hearing on 23 September. All assessors felt that VC's denial of any symptoms and rejection of his firmly held beliefs did not feel authentic, he had not shown any insight or engagement. The assessors felt he continued to have psychotic symptoms which required treatment, and that as he stated a refusal to accept this or acknowledge the high risks associated with relapse, detention in hospital was required. VC was detained under section 3 and a request was made for him to return to a local acute bed.

72 It was confirmed that VC did not currently have any social care needs and whilst he was an inpatient VC was independent with his self-care.

73 It is noted that VC had planned to end his current tenancy and move into student housing. In the event he was too unwell to restart his course, he may have required support to consider housing options.

January 2022

74 On 18 January 2022 Clarisse Bagtas (AMHP) applied to the Court for a warrant under section 135(1) MHA. I exhibit at [NOCC0000051] the Application for warrant to search for and remove person, dated 18 January 2022. This was following an incident the previous night where VC had assaulted one of his housemates as well as trapping them inside the flat. There was police involvement however no arrests made. The other housemates had been moved to alternative accommodation by the university to manage the risk of

aggression from VC. The application refers to VC being hostile when presenting to collect his medication, missing five appointments and having previous incidents resulting in arrest. Attempts were made to assess VC's mental health however he had disengaged. He appeared to be suffering from psychosis, and he was not allowing access to his property or engaging with the community team. He was considered a high risk of further mental health deterioration and risk of harm to others.

75 Nottingham Magistrates Court granted the warrant on 18 January 2022. I exhibit at [NOCC0000041] the Warrant to enter premises to search for and remove person, dated 18 January 2022. A Place of Safety was awaited as other patients were due to be transferred to other wards. There was a plan to attempt to execute the warrant the following day by daytime AMHPs.

76 VC's mother was spoken to on 19 January 2022, and she stated she was happy for whatever needed to be done, however felt generally left out of VC's care planning [NOCC0000034].

77 I exhibit at [NOCC0000040] the AMHP Report Referral and Assessment dated 19 January 2022. Police and East Midlands Ambulance Service ("EMAS") arrived at 1:30 on 19 January 2022. There were approximately 15 police officers and 3 members of the mass staff. The warrant was executed efficiently, police gained entry from the manager of the student halls and VC was in bed asleep. VC was compliant in getting into the ambulance, escorted by police.

78 An MHAA was completed on the same day at the Cassidy Suite by Roseanna Crane (AMHP), Dr Skelton, Dr Manzar and a Crisis Nurse [NOCC0000040].

79 The AMHP report notes that VC's engagement with his mental health team had been limited, and the covering CPN reported that VC had been guarded on his last two contacts in November and December. He had missed five appointments. VC last collected his medication on 17 December 2021 and he was reported to be paranoid and short with the worker. It was questioned whether he had been taking his medication since discharge. VC was noted to have been paranoid, angry and confrontational in recorded contacts.

80 During the assessment VC discussed an altercation with his housemates which related to the bathroom cleaning rota. VC stated it started as verbal and then became physical in a '40 second scuffle'. With prompting from Dr Skelton, VC was able to make a link between his behaviour becoming more agitated and aggressive, and a decline in his mental health. VC stated he had been taking his medication as prescribed however when challenged he confirmed he had taken a lower dose but had been taking the correct dose for the last two weeks. VC acknowledged if he did not take his medication he would end up in a similar situation to last year (his admission). VC did not feel he had psychosis now or previously. VC said he had not engaged with the community team as he was time limited due to his studies. VC agreed to a community treatment plan with the crisis team. VC's main emphasis was on completing his studies.

81 All professionals agreed VC could benefit from a hospital admission. Dr Manzer and Dr Skelton advised they felt a community plan was most suitable based on the interview, balanced with VC being in the middle of his exam period. Roseanna (AMHP) could see the balance of the argument for and against however it was mutually felt the community plan was the least restrictive and VC's presentation did not present to the degree it did previously. Dr Manzar and Dr Skelton both had previous acquaintance**.** It was agreed VC would be offered a community plan with the crisis team. This would be daily visits for medication concordance. VC agreed to a community plan with the crisis team visiting daily. VC is noted to have understood that hospital admission was highly probable without engagement with community plan.

82 No social care needs were identified.

83 On 27 January 2022 Dr Skelton requested an MHAA due to VC not engaging with the home treatment team. It was felt due to the nature of VC's disorder and his history that a warrant and police presence was necessary [NOCC0000034].

84 On 28 January 2022 Judith Modern (AMHP) applied for a warrant under section 135(1) MHA. I exhibit at [NOCC0000042] the Report on application for warrant under mental health act (undated). It is stated that VC was experiencing relapse of psychosis, and he was not engaging with services. He was considered a significant risk to others including other flatmates, the public,

police and services due to psychosis. The crisis plan put in place on 19 January is stated to have failed.

85 VC's mother was spoken to by telephone as nearest relative. She was unaware of the situation. She had no immediate concerns but did not object to admission if it was felt he needed this [NOCC0000034].

86 A telephone call was received from the University mental health team [NOCC0000034]. VC was noted to be at risk of losing his student accommodation and his studies were also at risk as he was attempting to engage but not doing so adequately, which was believed due to his acute illness.

87 The bed management team confirmed that a Place of Safety would be available at 9:00pm [NOCC0000034]. Dr Lomas agreed the assessment could not wait until the following day due to the high level of risk to others [NOCC0000034].

88 I exhibit at [NOCC0000043] the AMHP Report Referral and Assessment dated 28 January 2022. The AMHP report refers to VC's engagement in the community being superficial. VC had been seen to put medication into his mouth, decline water and leave. He was seen once to put his hand to his mouth and put something in the bin, which was believed to be his medication. VC had been unwilling to discuss his mental health, and it was difficult for the team to assess him properly. VC had disclosed that he felt the team were involved in a conspiracy plan in that they were contributing to his mental health by

manufacturing this, using neuro-mapping technology and imagery. VC had not attended appointments and had been difficult to contact at times. The community team were not convinced VC was taking his medication and his mental health was deteriorating.

89 An MHAA was arranged for 8:30pm on 28 January 2022. The warrant was not required as VC answered the door and agreed to go to Highbury willingly, although he did not agree that he had not taken his medication and/or engaged enough with the mental health team.

90 At Highbury, VC refused to go into a bedroom, and he was assessed from the office door. VC did not believe he was mentally unwell and continued to question why he was at Highbury as he felt he was doing what was expected of him. VC did not fully engage in the assessment. VC declined that he had MH or concerns that health could read his thoughts/he could hear voices. Concerns raised around VC holding a girl hostage, beating a police officer significantly, VC's studies being affected/he is failing, his housemates not returning to the flat and his accommodation being at risk. VC denied all of this. VC not willing to accept informal admission. Dr Manzar and Dr Lomas both had previous acquaintance with VC and felt he needed to be in hospital to manage his mental health, the risk to others was high and although during the assessment VC did not appear overly psychotic, they believed he was masking his symptoms and was very guarded. Community treatment was no longer a viable option. VC not fully engaged and was refusing to meet in a more private place

for fuller discussions. The assessors agreed for VC to be detained under section 2 on the MHA due to community treatment no longer working.

91 VC was admitted to the Cassidy Suite at Highbury. VC was noted to have no social care needs, and he did not have a current care package. It was stated that VC had been independent with self-care when an inpatient previously. Some care needs were noted around VC's dry skin, and he appeared dehydrated. His fluid intake was to be monitored.

Reflections and Recommendations

92 Following these events, there was a desktop review from the AMHP service. No systemic or practice concerns were identified. The service did what it was required to do. They were summoned by the police and made appropriate arrangements. This is the system, and we would do the same now. Once VC was admitted to hospital, he was safe, and the public was safe from anything that he might do. That was the AMHPs work done. **NOCC0000193**

93 There would have been no opportunity for the local authority to involve itself further in matters whilst VC was in hospital.

94 Upon discharge, VC was an individual who had a life and a home. He was a student and returned to student life and student accommodation. He did not have social care needs. This is important because no social care threshold was met for us to intervene.

95 Given the facts of this case, it would be understandable for an inquiry to consider recommending that adults social services should be notified when patients are discharged into the community. An inquiry might recommend some degree of monitoring or social supervision. However, it is extremely important to bear in mind that patients discharged should be monitored by the Care Co-Ordinator and their medical needs are met as part of the discharge process. To the extent that there might be additional social care needs, the legislation contains thresholds for local authorities to act. If the inquiry is minded to recommend that those thresholds should be lowered or changed, then there would be a greater involvement from adult social care. These, however, are matters of public policy and go to questions about how much supervision of patients should take place. That must be considered in the context of Article 8 rights, and the resources that the state is prepared to devote to this.

96 I have consulted with the AMHP service so that I can provide their views on what might change. They were reluctant to see more restrictive mental health legislation based on one case, but they did have concerns about the system in practice:

- They remained concerned that lack of resources in Nottinghamshire Healthcare NHS Foundation Trust resulted in citizens, having long waits for support in community and/or were not assertively followed up.

- Some citizens experienced referral for MHAA quickly after hospital discharge, which indicated that they were not sufficiently well at the point of discharge.

- Referrals received for MHAA for citizens who have been on long waiting lists for community support from the Trust.

- Strong alternatives to admission are not always available locally (intensive crisis support for example) which increases admission and/or detention rates due to lack of safe alternatives. That in turn increases pressure on beds.

- Bed delays also include delays in available Health Based Places of Safety so that s135 warrants cannot be executed in a timely manner – there were Health Based Place of Safety delays in VC's case.

97 Finally, NCC is currently undertaking a rapid review of its mental health and AMHPs services. The results of that review are not yet available. The aim of this rapid review will be to find a level of consistency across the adult social care teams. This work is being undertaken as part of the wider improvement role that exists for all local authorities. The aim is to find a new delivery approach and it may be that we move to the neighbourhood model going forward.

98 That review has not been commissioned as a result of the events in this Inquiry.

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: Christopher Atherton

Dated: 13/11/25

Index to First Witness Statement of Christopher James Atherton

No	Inquiry URN	Document Description
1	PHSO0000010	DHSC statutory guidance, 'Discharge from Mental Health Inpatient Settings'.
2	NOCC0000034	Liquid Logic Case Notes
3	NOCC0000044	AMHP Report Referral and Assessment dated 24 May 2020
4	NOCC0000045	AMHP Report Referral and Assessment dated 25 May 2020
5	NOCC0000046	AMHP Report Referral and Assessment dated 14 July 2020.

No	Inquiry URN	Document Description
6	NOCC0000047	Report on Application for a Warrant under the Mental Health Act
7	NOCC0000048	Authorised Warrant to Search for and Remove Person dated 3 September 2021
8	NOCC0000049	Information in Support of Warrant to Search for and Remove Person dated 3 September 2021
9	NOCC0000050	AMHP Report Referral and Assessment dated 3 September 2021
10	NOCC0000038	AMHP Report Referral and Assessment dated 24 September 2021
11	NOCC0000051	Application for Warrant to Search for and Remove Person dated 18 January 2022
12	NOCC0000041	Warrant to Enter Premises to Search for and Remove Person dated 18 January 2022
13	NOCC0000040	AMHP Report Referral and Assessment dated 19 January 2022
14	NOCC0000042	Report on Application for Warrant under the Mental Health Act
15	NOCC0000043	AMHP Report Referral and Assessment dated 28 January 2022
16	**NOCC0000193**	**Desk Top Review for VC**