THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR PETER FINCH

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1. I am Dr Peter Finch. I am providing this statement in response to a request from the Solicitor to the Nottingham Inquiry dated 20 October 2025.

My career and background

2. My qualifications are:
   MB.BS Bachelor of Medicine. Bachelor of Surgery 1983
   MCRPsych Member of the Royal College of Psychiatrists 2002
   LL.M Master of Laws 2006

3. I qualified in Medicine from The Middlesex Hospital Medical School, University of London in 1983. I worked in NHS medical posts until commissioning as a medical officer into the RAF Medical Branch in 1985. I commissioned into the Royal Army Medical Corps in 1993. I completed 34 years in Defence Medical Services until retirement at end of my Army commission in 2019 in the rank of Lieutenant Colonel. Over this time I was accredited as Consultant Psychiatrist in 2007 and served in British Forces Germany Mental Health Services from 2007 to 2010 and later as Clinical Director. From 2010 to 2019 I was Consultant Psychiatrist and later Clinical Lead at the Community Mental Health Team Catterick/Leeming, North Yorkshire delivering mental health services to military

personnel in military units over the north of England and advising the local general Army command on mental health matters. In 2011/12 I served as the visiting psychiatrist to the operational theatre in Afghanistan (Operation Herrick) reporting to Permanent Joint Headquarters Northwood. Since retirement from the Army in 2019 my main clinical practice part-time is conducting Mental Health Act assessments as an independent section 12 (MHA 1983) approved doctor. I am a member of the Independent Doctors Federation.

4. With regard to training I have received in assessing capacity of patients to make decisions in respect of their care and treatment, this would include the statutory 5 yearly section 12 (MHA 1983) re-approval training, Royal College of Psychiatrists (RCPsych) continuing professional development (CPD) and reference to the RCPsych publication on the Mental Capacity Act (MCA). In June 2025 I completed training on Deprivation of Liberty Safeguards provided by NHS England which included a review of the MCA and capacity assessments.

5. With regard to my experience in conducting MHA assessments, since 2019 to the present I have carried out between 750 and 800 MHA assessments annually, mainly in the North Yorkshire region. The locations range from psychiatric in-patient units, medical wards, A&E departments, police custody, 136 suites, home-based assessments and residential care homes. My professional background as a Consultant Psychiatrist with experience in the diagnosis, treatment and management of psychiatric conditions assists me in performing the duties of a section 12 (MHA 1983) approved doctor. I received initial statutory training prior to taking on this role. In addition, for section 12 re-approval every 5 years, I undergo a day's training involving updates on the MHA 1983 and case vignettes discussion. I provide an updated CV, RCPsych certification of good standing for CPD and 2 references to the regional regulatory approval panel. In performing these duties I work in accordance with the provisions of the MHA 1983 and guidance the MHA 1983 Code of Practice.

6. My involvement with a MHA assessment usually follows a direct request from an AMHP (Approved Mental Health Professional). Prior to the assessment we share

information and discuss the case, conduct an interview with the patient following which we would further discuss the case and share our opinions as to whether the patient should be detained in hospital under the provisions of the MHA 1983. If we are in agreement then I would make the medical recommendation to this to this effect and the AMHP would make the application for admission under the MHA 1983.

7. With regard to the general concept of 'risk' I would view this as the possibility or likelihood of an adverse event. The risk of harm to others varies over time and circumstances. This risk of harm over time would be assessed by reviewing past incidents of harm especially in the context of occurring within episodes of psychiatric illness; looking at the nature, circumstances and precipitants of the incidents, their relation to clinical features of the illness episode either from agitation/arousal in the situation or more direct links to the experiences of the patient such as the presence of command auditory hallucinations and paranoid delusions of a persecutory nature, the extent to which the patient sought help or otherwise when becoming unwell and the patient's willingness to engage with mental health services and adhere to treatment during the illness episode and degree of insight gained. Assessment of more immediate or short-term risks would also be informed at a consultation with the patient, incorporating a mental state examination, assessing for the presence of the above symptomologies and any expressed intention of the patient to harm specified others, the nature of the harm intended, the extent of planning and the presence of the opportunity to carry out the intention.

8. To my knowledge, I have not been involved in the care of a patient who, following discharge from hospital or when in the community, has killed or seriously injured a member of the public.

My involvement with and knowledge of Mr VC

9. I can confirm that I had no knowledge of Mr VC prior to the MHA assessment on 24 September 2021.

10. With the passage of time since carrying out the MHA assessment and the high number of MHA assessments that I have conducted since, I have no actual memory of the MHA assessment. However, I have reviewed the documents provided for me by the Inquiry, in particular my joint medical recommendation with Dr Shoilekova Consultant Psychiatrist and Ms Jaques' AMHP report (NOCC0000038). In this witness statement I have endeavoured to interpret and answer the questions put to me by the Solicitor to the Inquiry to best of my ability. My usual practice is that prior to carrying out MHA assessments at Cygnet Darlington, County Durham, the hospital Mental Health Act Office arranges for me to review a hard copy print out of the medial documentation- the 'pink notes' **(CYGN0000050)**. Accordingly, prior to Mr VC's MHA assessment I would have reviewed details of Mr VC's previous psychiatric history, his relapse into illness and the events leading up to his hospital admission to Cygnet Darlington, current diagnostic formulation, his clinical response to treatment and the extent of his recovery in hospital. In addition, prior to the MHA assessment, I would have discussed the case with Dr Shoilekova and Ms Jaques. At Cygnet Darlington a member of the ward staff will normally provide an update on the patient's progress and how the patient is faring on the day. This information in its entirety would have assisted my general understanding of the case. It would also have provided objective evidence against which to weigh Mr VC's presentation and his own account and his views expressed later at the consultation. The information gathered would have confirmed the diagnosis and that it was defined as a 'mental disorder' under the MHA 1983 and would have contributed to determining the nature and level of risks.

11. I would have understood the reason for carrying out the MHA assessment being that it was considered that Mr VC required further treatment in hospital and that it was likely that the treatment was required to be provided under section 3 MHA. This would have been because of his wish to decline treatment and/or to leave

hospital, and/or that he may not have been able to make capacitous decisions about his further treatment and care in hospital.

12. With regard to the events leading up to Mr VC's admission to Highbury Hospital on 3 September 2021 under section 2 of the MHA 1983, I would have had knowledge of these events from discussions prior to the MHA assessment at Cygnet Darlington on 24 September 2021 although I would not have spoken to the previous AMHP who had produced the AMHP Report (NOCC0000049). The fact that a section 135(1) MHA 1983 had been required to gain access to Mr VC due to concerns about his mental health would have demonstrated to me that he was not engaging with mental health services at that point. His assaultive behaviours towards the police would have been of concern to me. I would have factored in the likelihood of Mr VC disengaging from care and being at risk of being assaultative alongside other information in deciding whether to make the medical recommendation for section 3 of the MHA 1983.

13. I would not have accessed other information for the purpose of conducting the MHA assessment and believe that the information available to me would have enabled me to fulfil the task of coming to a clear decision as to whether to make a medical recommendation for section 3 MHA in my role as the section 12 (MHA 1983) approved doctor.

14. I now have no recall of the consultation with Mr VC and am unable to address the questions put to me regarding Mr VC's body language, how he communicated, what he was doing at the consultation or whether I had felt safe in his presence.

15. With regard to the observations documented in the AMPH report (NOCC0000038) as set out in para 17 of the request from the Solicitor to the Inquiry, I am unable to recall how these observations were reached. However, they were of significance and would have influenced my decision-making; Mr VC was accepting treatment because he had no choice whilst under a section of the

MHA but didn't see the need for it and perceived no benefit – this would have indicated to me that Mr VC did not have insight that he was unwell or that he was in need of treatment. In stating his wish to resume his university his studies I would have seen this as a positive in that he was future-orientated in productive way. However, at the same time, his intention to leave hospital and not have contact with mental health services would have indicated to me, again, that he lacked insight and if he was not in hospital he would have remained unwell in the community with the accompanying vulnerability and risk to others. Mr VC's behaviour having settled since admission but only being passively accepting of this, rather than showing any insight or engagement, would have indicated to me that he was likely to have been beginning to benefit from treatment in hospital but not to the extent that he had gained an acceptance of the benefits of engaging with mental health professionals. The fact that Mr VC no longer required care in a PICU (Psychiatric Intensive Care Unit) would have indicated to me that he was generally settled at that point, with no further challenging behaviours in hospital. All the above would have indicated to me that Mr VC was beginning to benefit from treatment but that he required to continue treatment towards further recovery from his psychosis including gaining insight, that this treatment required to be delivered in hospital, and under the provisions of the MHA 1983.

16. The AMHP report records that, at consultation, Mr VC did not believe that he had any mental health problems - that he said that he was not experiencing any psychosis, that his mental health disorder stopped in early August 2021 and so he had stopped his medication and that he did not feel he had had any mental health symptoms since. Although I have no recall of the consultation or the further questions asked of Mr VC about these beliefs I would have regarded these beliefs as having significance; the objective evidence was that he was unwell throughout August 2021 leading up to his admission to Highbury Hospital on 3 September and that he still had little insight into his illness.

17. The AMHP reports records that Mr VC was asked about the incident with the police officers on 3 September 2021 on the day of his admission to hospital

which he described as an ‘altercation’ and he said that it was poor judgement on his behalf, that he didn’t feel like talking and felt frustrated that he was being forced into custody when he believed he had done nothing wrong. Although I no longer recall the consultation or the further questions put to Mr VC about the events it would have indicated to me that he did not have insight into the fact that he was unwell at the time, also that he was minimising the extent of his assault on the police officer.

18. I would have reached the views recorded on the AMHP report from my knowledge of Mr VC’s previous psychiatric history, the events leading up to his admission, accompanying clinical features over that time, his diagnostic formulation and response to treatment and progress up to the date of the MHA assessment on 24 September 2021, and the consultation with Mr VC on the day. I would have considered the risks as significant. Mr VC harboured paranoid delusions of a persecutory nature which included mental health services colluding with the Government and judiciary to conspire against him. This would likely represent to him a reason to disengage from mental health services if he was discharged from hospital at that point and that this risk would have been high. Mr VC’s assault on the police officer may have been exacerbated by persecutory thinking. The current risk of such an assault happening in hospital would have been low as it would have been unlikely that Mr VC would have been visited by the Police whilst in the PICU. These overall would have indicated to me reasons for the requirement for treatment to continue in hospital under the provisions of MHA 1983.

19. With regard to the Mr VC’s Mental Health Tribunal prior to the MHA assessment, this would have been discussed with Dr Shoilekova at the MHA assessment. I would have been aware that VC had expressed an ‘altered view’. The AMHP reports records that this view was that his mind was no longer being affected by agencies. I would have considered that his rejection of this belief was not ‘authentic’ as he still believed that this had happened to him and that it had not been due to a psychiatric illness. I would have likely been concerned that Mr VC

was minimising the extent of his persecutory delusions at the Tribunal or demonstrating a lack of insight. This would have provided more evidence to me that he should continue treatment in hospital, and under the provisions of the MHA. As I have no recall of the MHA assessment I cannot say what Mr VC told myself, Dr Shoilekova and Ms Jacques at the consultation. That fact that Mr VC had made an application to the Tribunal I would have considered as significant as it would have indicated that he was likely seeking his discharge from hospital.

20. Ms Jacques, AMHP spoke with to Mr VC's mother prior to the MHA assessment. I can confirm that I myself would not have spoken with his mother or any other members of Mr VC's family. This is the statutory duty of the AMHP under the MHA 1983 who must confirm with the Nearest Relative (NR) of the patient that the NR is not objecting to the patient being detained in hospital under the provisions of Section 3 of the MHA. I have no actual memory or recall at the MHA assessment of the discussion with Dr Shoilekova and Ms Jaques of what Mr VC's mother had said.

21. Paragraph 24 of the request from the Solicitor to the Inquiry relates to questions put to me regarding the narrative of the section 3 MHA joint recommendation on Form A7 (**CYGN0000013**). Although I have no actual memory or recall of the MHA assessment I have endeavoured to interpret and answer the questions to the best of my ability based on the Form A7 narrative content and what would have been discussed between Dr Shoilekova and myself. I would have been satisfied that the information provided was correct at the time of the MHA assessment. I don't recall how we came to provide a joint recommendation; the other option would have been to provide recommendations on two separate A8 Forms. Dr Shoilekova set out the narrative on the Form A7. We would have been in agreement and signed the Form A7 recommending that Mr VC be detained in hospital for treatment under the provisions of section 3 MHA. I would have come to the view that Mr VC was suffering from a paranoid psychosis from information collated from my review of the in-patient medical records, my discussions with the other assessors and the consultation with Mr VC himself at the MHA assessment. The term paranoid psychosis is a general one indicating

that a patient is experiencing abnormal perceptual experiences which have led to paranoid delusions of persecutory or grandiose content. The narrative on Form A7 sets out Mr VC's clinical features which were consistent with a paranoid psychosis that would have required a medication regimen, monitoring and nursing care in hospital. It is likely that we would have discussed the specific hallucinations, conspiracy and thought insertion that Mr VC was complaining of. I have encountered these symptoms before in many patients I have seen in MHA assessments. The term 'blunted affect' meant a restricted range of emotions and is a feature of schizophrenia. I don't recall Mr VC explaining in detail why he considered that he was under the dictation of auditory hallucinations when he had previously entered neighbours' flats or whether I understood that these were actually directing him to act violently. Whether the auditory hallucinations were commanding him or whether he was misattributing the voices to those of his neighbours, Mr VC seems to have acted on the hallucinations and gained access to the neighbours' properties, causing distress. I would have been concerned by this. The unintentional harm would have referred to a neighbour jumping out of a a window to avoid Mr VC when he had gained access to their property. The clinical features of 'technological interference', 'artificial intelligence' and 'psychological harassment' would have indicated symptoms of abnormal perceptual experiences and secondary paranoid beliefs of a persecutory nature which are features of psychosis. I confirm that in my clinical practice in the past I would have treated patients with symptoms of this nature. I would have been concerned that Mr VC did not believe that the voices he was hearing were a symptom of a mental disorder or that he required treatment. He was compliant with medication whilst in hospital but I would have been concerned that he would not have adhered to a medication regimen outside of a hospital setting. I would have considered that further treatment in hospital towards recovery would have afforded the opportunity for Mr VC to gradually gain insight to the extent of recognising the need to engage with mental health services and to adhere to a medication regimen. I would have considered that Mr VC lacked capacity to consent to a voluntary admission; he lacked insight into the fact he was unwell and his continued persecutory delusions would have influenced his weighing up of any decisions about remaining in hospital, so would have indicated the need for the provisions of section 3 MHA. The Form A7 recommendation narrative

records that Mr VC could not be safely managed in the community due to the severity of his risks and risks to the safety of others when unwell. These risks would have been those present at the time of the MHA assessment and would have been the risks of further deterioration in Mr VC's mental health and his vulnerability, and the accompanying risks to others. That would have been my focus in the role of an independent section 12 (MHA 1983) approved doctor. It would not actually have meant that he could never be managed in the community in the future. He would have required further treatment in hospital progressing his recovery to a stage when he was demonstrating some insight and adhering to a medication regimen.

22. I made the decision to recommend that Mr VC be admitted to hospital under section 3 MHA 1983. I would have determined that he was suffering from a mental disorder of a nature (paranoid psychosis with a relapsing and remitting course, and associated with risks) and current degree (significant) which made it appropriate for him to receive treatment in hospital and that it was necessary for Mr VC's health - he was unwell, lacked insight and would likely not have adhered to a medication regimen in a community setting or engaged with community mental health services which would have led to a deterioration in his mental health, Mr VC's own safety – he would have been generally vulnerable in a psychotic state in a community setting, and for the safety of others – demonstrated by his actions linked to his experience of hallucinations and harbouring persecutory delusions. I would have been satisfied that the statutory criteria for the provisions of section 3 MHA had been met. Given the facts of case, there would likely have been a full agreement between myself, Dr Shoilekova and Ms Jacques.

23. I was not consulted regarding the use of a Community Treatment Order (CTO) for Mr VC following his release from section 3 MHA detention following his transfer from Cygnet Darlington to Priory Hospital Arnold, Nottinghamshire. In my duty as an independent section 12 (MHA 1983) approved doctor I would not have been involved in Mr VC's treatment. I consider it would have been

appropriate to consider a CTO for Mr VC to assist in maintaining treatment adherence and monitoring in a community setting, and to force a prompt recall to hospital if concerns were subsequently raised about not adhering to CTO conditions or his mental health.

24. In the discussion about a patient in hospital under section 2 MHA prior to an assessment to consider recommendation of section 3 MHA, the in-patient Consultant/Responsible Clinician (RC) may express an opinion that a CTO would be appropriate when the patient is eventually discharged from hospital - for which the patient would need to be under a section 3 MHA in hospital. I believe that the prospect of releasing a patient under a CTO is something that could reasonably be factored in when I am considering whether to recommend a section 3 MHA. In addressing this issue in the MHA assessment, I would examine certain aspects of the 'nature' of the 'mental disorder' - a relapsing and remitting course of the 'mental disorder,' the frequency and severity of the illness relapses, responses or otherwise to treatment, associated risks to the patient and/or others when unwell and the overall prognosis. These aspects of the 'nature' may indicate that the patient will benefit from a CTO. During the period of recovery in hospital many of the patient's symptomologies will have reduced such that the current 'degree' of the 'mental disorder' is minimal. However, if the 'nature' criterion is satisfied and any one of the risks to patient's health, their safety or that of others are present then I would make the decision to recommend section 3 MHA; the criteria for section 3 MHA will have been met. If the criteria are not met then I would not make a recommendation.

25. I confirm that I had no input or involvement in the care or treatment of Mr VC beyond my MHA assessment on 24 September 2021.

Recommendations

26. I have no specific recommendations for the Inquiry.

Statement of Truth

27. I believe that the contents of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by statement of truth without an honest belief of its truth.

Signed:

GRO-B

Dated: 6 December 2025

Index to First Witness Statement of Dr Peter Finch

No.	Inquiry URN	Document Description
1	NOCC0000038	MHP Report Referral and Assessment of Valdo Calocane dated 24 September 2021
2	CYGN0000050	Medical records of Valdo Calocane from 11/09/2021 - 01/10/2021, Cygnet Victoria House Albert Ward, Re: Pink Notes for Valdo Calocane
3	NOCC0000049	Information in support of application for warrant to search for and remove patient dated 3 September 2021
4	CYGN0000013	Forms H3, A7 & A6 record of detention in hospital dated 24 September 2021