Witness Name: CRAIG MURPHY
Statement No.: WITN0077001
Dated: 17 October 2025

THE NOTTINGHAM INQUIRY

WITNESS STATEMENT OF CRAIG MURPHY

I, CRAIG MURPHY, will say as follows: -

INTRODUCTION

1. My full name is Dr Craig Andrew Murphy. I am a medical doctor and have been fully registered with the General Medical Council ("GMC") since 2013. My GMC number is 7266609. I am a General Practitioner ("GP") and have been on the GMC's GP Register since August 2021.

2. This witness statement is made to assist the Nottingham Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request I received dated 10 September 2025.

3. I confirm that I have prepared this witness statement with legal assistance from my medical defence organisation, Medical Protection Society.

BACKGROUND

4. I have been asked to provide a summary of the topics covered in this witness statement. I confirm that this witness statement discusses my professional involvement, as a trainee GP at the time, with VC on 17 August 2020. This was my only interaction with VC.

5. At the time, I had just started my final (of three) years of GP training. I was on placement at Cripps Health Centre ("the Practice") in Nottingham. VC was a patient registered with the Practice, and I had a telephone consultation with him on 17 August 2020.

PROFESSIONAL QUALIFICATIONS AND EXPERIENCE

6. Given that this witness statement is provided in my professional capacity as a GP, below is a short summary of my professional qualifications: -

7. My professional qualifications include *BSc Hons* (Bachelor of Science with Honours) 2009 from the University of St Andrews; *MBChB* (Bachelor of Medicine, Bachelor of Surgery) 2012 from the University of Manchester; *DMCC* (Diploma in Medicine in Conflict and Catastrophe) 2016 from the Society of Apothecaries, London; and *MRCGP* (Membership of the Royal College of General Practitioners) 2021.

8. In respect of my professional experience, after my medical degree, I completed two years of foundation training, which is a work-based training programme between medical school and speciality training. I completed my foundation training at Queen Alexandra Hospital, Portsmouth NHS Foundation Trust between 2012 and 2014. In this time, I submitted my application to join the British Army as a medical officer.

9. After my foundation training I worked as a Senior House Officer, which is a hospital based junior doctor role, at NHS Dumfries and NHS Borders. This was between 2014 and 2015.

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GP TRAINEE PLACEMENT

15. As above, between November 2019 and November 2020, I was on placement at the Practice. My role at the Practice was as a general practice registrar (a GP trainee).

16. I have been asked to summarise the supervision arrangements in place at the Practice, including the name of my supervisor.

17. As a GP trainee, all my clinics were supervised throughout my time at the Practice; this included having an assigned GP each day to whom I could ask questions or seek guidance from during my clinic. Additionally, at the end of my clinic sessions (there is a morning session and an afternoon session), I would 'de-brief' each case with the supervising GP. This would involve a discussion of each case I had consulted on, with the GP reviewing my consultation entry, and discussion around learning points and opportunities for development, and advice on any additional input and/or follow-up for the patient after the consultation. 'Debriefs' are not documented unless, for example, there is an action point arising from the discussion needing to be taken and recorded in the patient's medical records.

18. My clinical supervisor at the Practice was Dr Sarah Hamlyn, (a qualified GP supervisor and a salaried GP at the Practice). When Dr Hamlyn was available, she was my supervisor for the day. In her absence, I would be allocated an available GP, and this was typically one of the senior salaried GPs or GP partners.

19. During a clinic, each patient is allocated 10 minutes for a GP consultation. Consultations run back-to-back. There is no additional time allocated for reviewing medical records, test results and clinic letters prior to seeing a patient. However, it is good practice, before a consultation begins, to review any pertinent information, including recent contacts with the patient for background and context to the consultation. This may include recent reviewing any

consultations notes and investigations (for example blood test results and x-rays), and any recent correspondence including clinic letters and/or discharge summaries from secondary care. This was my standard practice at the time and remains my standard practice now.

CONSULTATION WITH VC

20. I had a telephone consultation with VC on 17 August 2020. I had no prior knowledge of or contact with VC before this consultation, and no contact with him, or in relation to him, afterwards.

21. The telephone consultation on 17 August 2020 was arranged following the Practice receiving VC's hospital discharge summary from 31 July 2020. A copy of the discharge summary from 31 July 2020 is enclosed as **Exhibit [CHCA0000028].**

22. I would not necessarily be aware of the reason for a consultation with a patient before the consultation begins and I was not aware of the reason for VC's consultation before I reviewed his notes prior to telephoning him. My review included reviewing his previous contacts with the Practice in his medical records (and a copy of his medical records is attached as **Exhibit [CHCA0000030]**). In VC's case I also focused on reviewing his discharge summary from 31 July 2020, and an earlier discharge summary from 17 June 2020, a copy of which is enclosed as **Exhibit [CHCA0000027].**

23. The two discharge summaries had been sent to the Practice, uploaded to the Practice's case management system, 'EMIS', and added to VC's medical records. I have been asked what written information I had in respect of VC's admissions to hospital. I confirm that I did not have any further information about VC's presentation in relation to his two hospital admissions other than the information contained in these two discharge summaries.

24. I was aware from the first discharge summary that VC had been sectioned for the first time on 25 May 2020 for an assessment of his mental health under Section 2 of the Mental Health Act. He was considered a risk to himself and others. He was admitted and following assessment was diagnosed as having suffered from a first episode of psychosis; it had been unclear at that stage whether this was an isolated episode. He was reported to have been hearing voices, responding to unseen stimuli, and having persecutory ideas believing people were 'after' him. He had been arrested after breaking into a neighbour's flat causing his neighbour to jump from her window out of fear, resulting in minor injuries to herself. VC had been started on antipsychotic medication by the Crisis Resolution Home Treatment Team ("Crisis Team"), and when this medication was stopped (in a controlled environment in hospital as part of the assessment), VC had returned to displaying psychotic symptoms. Aripiprazole, an antipsychotic medication, was subsequently started and this controlled his symptoms. He had also been started on colecalciferol (a vitamin D medication) because blood tests had revealed a vitamin D insufficiency. The plan on discharge was for the Crisis Team to follow-up with VC, following which his care would be transferred to the Early Intervention in Psychosis (EIP) Team and there were directions for the GP to arrange an annual health review and repeat prescriptions for his medications. I cannot see that there was a GP consultation following the first discharge on 17 June 2020. I cannot comment on why this was.

25. The most recent discharge summary from 31 July 2020 had served as the basis for my telephone consultation with VC that day and was my focus during the consultation. There was some context within this discharge summary which informed me of VC's presentation and behaviour in the lead up to his second admission. This had been 14 days after his discharge after his first admission. I was therefore aware when I telephoned VC that he had been sectioned for a second time, on 14 July 2020, for treatment of his mental health condition under Section 3 of the Mental Health Act. He was considered an increasing risk to himself and others. Given it was his second admission, I noted that he was admitted and diagnosed with "*likely paranoid schizophrenia*".

26. VC had been discharged on 31 July 2020, and so 17 days before my consultation with him. As above, the discharge summary contained quite a detailed summary of the circumstances surrounding his admission, treatment and progress. The circumstance surrounding his admission had been similar to those leading to his first admission; VC had reportedly barged into his neighbour's flat to confront him having heard voices which he attributed to his neighbour. VC reported during assessment in hospital that he had decided to stop taking his medication two weeks after his first discharge from hospital, believing himself to be well and that his medication was slowing him down when studying for an upcoming university exam. It was considered that VC stopping his medication had resulted in him hearing voices in the third person, which were mostly derogatory in nature.

27. I noted that VC had made improvements whilst on the ward as an in-patient, had been established on Aripiprazole which had reportedly helped his condition, such that he was no longer suffering with the same symptoms which had led to his admission (including hearing voices and responding to unseen stimuli). I understood that while on the ward, he had improved both his insight into his mental health condition, and *"fully"* understood the need for, and importance of, his medication. I also noted that upon discharge, he had been given the contact numbers of crisis teams and safety netting advice.

28. I understood from the most recent discharge summary that VC was remaining under review with the Local Mental Health Team (LMHT). The discharge care plan included three-day follow-up after discharge by the EIP and Crisis Team and subsequently, regular review by the LMHT. In addition, there were actions for the GP related to monitoring VC's physical health and arranging repeat prescriptions for his medications prescribed by the LMHT. These were the same directions as noted in the first discharge summary from 17 June 2020. As a result of the GP actions set out in the discharge summary, VC was invited by the GP Practice, upon receipt of the discharge summary, to make an appointment, which he did, leading to him being added to my list on 17 August 2020.

29. My consultation with VC, as the GP, was focussed on the need to set up the follow-up in primary care, as directed by the GP actions set out in the most recent discharge summary.

30. Having noted the diagnosis of *likely paranoid schizophrenia* by the specialists, this indicated to me the need to confirm with VC his understanding of the reason for him being admitted to hospital, his treatment, and that he understood his condition. The information in the discharge summary informed me that he had made considerable improvement on this medication, which was very positive.

31. Although I was seeing VC for GP tasks as part of the discharge summary, his diagnosis guided the consultation in that I was conscious it would be a mental health focussed interaction. This is why my documentation of the consultation focused on his insight, ensuring he was not suffering any more symptoms, and an assessment of his risk.

32. As part of my assessment of risk, I took into account VC's two recent in-patient admissions, and the events leading to those admissions including auditory hallucinations which had put him at risk of injuring himself and others. I sought to ask VC directly about these in my consultation with him, which I did, and documented.

33. I discussed VC's most recent admission with him during the consultation and recorded this in my entry in his notes. VC reported to me that he had been feeling well since his discharge, with no further intrusive thoughts or voices experienced and that he had been taking his Aripiprazole, which he confirmed he was receiving from the LMHT, whom he was seeing regularly.

34. My impression was that VC presented on the telephone as insightful as to both his condition and the need for him to continue his medication. This was evidenced to me during our consultation and discussion of these, further supported by his calm tone, articulate speech and polite manner. There were no long pauses in our conversation and no tangential speech; he remained focussed on our conversation throughout the time on the phone. His comments

to me were considered and appropriate in nature and he came across as insightful.

35. I have been asked if VC seemed withdrawn or guarded during the consultation, whether his presentation may have given rise to any concern that he may be masking his symptoms, and whether there was any indication or sign of aggression or violence. I had no concerns about VC's demeanour when he was speaking to me. It did not seem to me, and there was no objective evidence available to me at the time, that he was masking his symptoms (or trying to conceal anything). He was not withdrawn or guarded, and he did not display any sign of aggression, irritability, or violence. I would have documented such behaviour had this been the case.

36. In addition to him being able to demonstrate insight into the need for him to be on Aripiprazole, VC also demonstrated awareness and understanding that this medication required monitoring. This is on the basis that he had contacted the GP for an appointment and through our discussions. The discharge summary indicated that VC had satisfied the psychiatric in-patient team during his most recent in-patient stay that he had an understanding of, and insight into his condition, and the importance of taking his medication for this. I therefore felt confident, based on the most recent discharge summary, in addition to my own assessment of his presentation and insight that day, that VC had insight into his medical condition, and the importance of, and need for his medication.

37. I was conscious, given the comments in the first discharge summary that VC's symptoms had returned in hospital when his medication had been removed, and again when he stopped taking his medication, ultimately leading to the second admission. This highlighted to me the place for medication in his management by the specialist team. Given his reported improvement on this medication and his suitability for discharge on this medication, I understood this to mean that VC had made sufficient improvement and that the medication was working for him. This was confirmed during my consultation with him in which he appeared to me to have retained good insight both into the place for medication in his treatment, and his mental health condition. Additionally, he

reported no further symptoms including intrusive thoughts and voices which I had asked him directly about in view of the information available to me within the discharge summaries concerning his presentation in hospital.

38. I did consider the risk of VC not taking his medication as prescribed given I had understood from the second discharge summary that he had stopped taking his medication two weeks after his first discharge and that this had resulted in him starting to hear voices again. Again, this highlighted to me the place for medication in his management by the specialist team. I asked VC where he was currently getting his medication from and he told me he was getting it from the LMHT, which correlated with the follow-up plan in the discharge summary.

39. In light of the comments relating to the insight and understanding he had developed in hospital resulting in his release from hospital, and his presentation to me that day, I had no immediate reason to think that VC would not take his medication as prescribed. I also did not consider there was an overt risk of him stopping his medication when I saw him. VC told me that he had an adequate supply of Aripiprazole, and I advised VC that he must contact us when he began to run low on medication, and he confirmed he understood.

40. I have been asked if I felt able to trust and rely on the information VC provided. I was reassured by VC's improvement in hospital on medication, the insight he demonstrated both in hospital, and to me, and his presentation to me on the day of the consultation. I took VC's presentation, and his comments to me, at face value, whilst still being conscious of risk, and I felt confident in the insight he had shown. I had no objective evidence not to trust VC.

ACTIONS AFTER THE CONSULTATION

41. After the consultation on 17 August 2020, I had a de-brief with my supervisor, Dr Hamlyn, in line with standard practice. We discussed the Aripiprazole owing to it being a specialist medication prescribed by primary care only after a formal

care plan has been established between the specialists in secondary care and the GP in primary care. We consulted the Nottingham anti-psychotic prescribing guideline which highlighted the medication as an 'amber 2' medication, meaning initiation and stabilisation was for a specialist team only. I am unable to exhibit a copy of the version of the guideline which was available in August 2020; the current version available online was published in June 2025. However, at the time this guideline advised that the GP should monitor the physical health of the patient, hence the invitation for VC to attend for monitoring to establish baseline health parameters in anticipation of a formal handover of prescribing to the GP once a shared care plan had been issued. This would ensure safe prescribing practice was adhered to from primary care. To issue Aripiprazole as a GP, without baseline health parameters being established first could be considered unsafe. However, given that VC was being supplied this medication from the LMHT directly and that no care plan had been sent as yet, we sought to arrange these baseline parameters in anticipation of a care plan being issued in the future, once the LMHT were content that VC had been established on this medication and that prescribing could then be handed over to primary care. In the meantime, I had advised VC that he must contact the Practice if he started to run low on his Aripiprazole (so that we could, if needed, then liaise with the Mental Health Team to assist VC at all in seeking a prescription from them until such time as we, the Practice, could start to formally prescribe the medication, in line with the shared care plan).

42. It was also the Practice's policy not to place medication pertaining to management of mental health conditions (such as anti-depressants and anti-psychotics) routinely on repeat as this can lead to patients not being reviewed for some time. Standard practice at the Practice was to invite the patient for a review prior to issuing this type of medication.

43. After my debrief with Dr Hamlyn, I followed up with VC by SMS text message (this was sent through the practice management system) advising him of the need to book in to attend for a nurse appointment so that several baseline parameters could be measured and recorded, which would enable us, as the

GP, to establish a baseline for follow-up and issue prescriptions for his Aripiprazole safely going forward.

44. I also arranged for VC to have further monitoring blood tests at six months and a cardiovascular assessment at 12 months. It is important for patients taking Aripiprazole to be monitored as this medication can be associated with causing cardiovascular complications resulting from weight gain, raised blood pressure, blood lipid level elevation and a risk of raised HbA1c and developing diabetes. Additionally, this class of medication can cause a prolonged QTc interval seen on ECG, unmonitored this can lead to cardiac arrhythmias.

45. Finally, I added colecalciferol (for vitamin D insufficiency) to VC's repeat medications and issued a prescription for this.

46. This telephone consultation was the only contact I had with VC.

EVENTS AFTER MY INVOLVEMENT

47. As discussed above, my placement at the Practice ended in November 2020 following which I moved on to my last placement in my GP training elsewhere. However, I am aware from the medical records I have been provided with that aside from my consultation with VC on 17 August 2020, he did not have any other consultations regarding his mental health, having only one further contact with the Practice on 10 September 2020 which was unrelated to mental health; a suspected ear infection was diagnosed.

48. There were no appointments with the Practice following VC's subsequent mental health related admissions in September-October 2021 and January-February 2022. I note, however, from the GP records that multiple continued attempts were made by the Practice, albeit they were unsuccessful, to contact VC and have him attend for review for both GP and nurse appointments. I

cannot comment as to why VC did not make an appointment following the September-October 2021 and January-February 2022 admissions.

SHARING OF VC'S MEDICAL RECORDS

49. I have been asked if the notes from my consultation with VC were shared with anyone else, such as secondary mental health services or VC's family. I confirm that I did not share them and to the best of my knowledge, my former colleagues at the Practice are unlikely to have shared them for confidentiality reasons.

50. VC was an adult, with capacity when I saw him, and he presented to me as insightful and expressed no wishes to disclose this information to his family. Additionally, I was not concerned about his presentation to me on the phone hence I felt that I had put together a plan which actioned the requests from the specialist team.

51. Unless requested, there is usually no need for closed loop communication (meaning writing back to the Mental Health Team to confirm the GP actions have been taken) following receipt of a discharge summary.

RECOMMENDATIONS

52. I have been asked whether there any recommendations I consider this Inquiry should make to address any of the issues raised. This is a tragic case and one which I was deeply saddened to hear of. Nottingham was a home for me through this part of my training and a time I remember fondly, including working closely with the staff at the Practice, the people of Nottingham, and students of Nottingham University as patients. My heartfelt condolences go to the families of all those affected by the events leading to this Inquiry.

53. While a patient is under specialist care, including from mental health services, as VC was, the input from the GP can sometimes be more limited because the specialists are taking the lead in relation to the care needed and being provided. As a GP, I often see patients with mental health issues including anxiety and depression. Whilst schizophrenia is seen in GP practice, it is not seen commonly. Therefore, having reflected on the issues raised by this case for the purposes of providing this witness statement, I have considered whether it may be of value for the hospital discharge summary, in cases of patients being discharged from psychiatric in-patient units, and where relevant, to state when the GP can expect a formal care plan to be sent to the GP and when this should be actioned by the GP. This may have been helpful in respect of VC's July 2020 discharge summary, as it was unclear when the GP was intended to begin prescribing the Aripiprazole. Indeed, I wonder, where relevant and practicable, if there may be scope for the GP to be invited to join a multidisciplinary team ("MDT") meeting with regards to any of their patients being discharged from psychiatric in-patient units, therefore ensuring the GP is fully read into the expectations and needs of the patient and care plan going forward.

STATEMENT OF TRUTH

I believe the content 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 a statement of truth without an honest belief of its truth.

Signature: GRO-B

GRO-B

Digitally signed by Craig Murphy
Date: 2025.10.17 15:49:04 +01'00'

Date: 17 October 2025

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Exhibit No.	Document URN	Document Description
1	CHCA0000028	Medical Records of VC from 14/07/2020 to 31/07/2020, Highbury Hospital, Re: Discharge Summary
2	CHCA0000030	Medical Record of VC from 19/11/2014 to 28/01/2022, UNHS Cripps Health Centre, Re: Local Record
3	CHCA0000027	Medical report of Discharging clinician, Dr Ibrahim Hakam, Nottinghamshire Healthcare NHS Foundation Trust Re: Discharge Summary of VC