Witness Name: Godwin Gonde

Statement No: WITN0140001

Dated: 5 November 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF GODWIN GONDE

I, Godwin Gonde, will say as follows: -

INTRODUCTION

1. I am a Crisis Care Practitioner at Nottinghamshire Healthcare NHS Foundation Trust ("**NHFT**"). I have set out further information on my career background below.

2. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 18 September 2025 (the "**Request**").

3. I have been asked to set out a witness statement including information on my career and role; my training and system of work at NHFT; my interactions with VC; and any recommendations or reflections I have in light of VC's attacks.

4. This witness statement was drafted on my behalf by external solicitors and counsel acting for the Trust in respect of the Inquiry, with my oversight and input, following discussions in writing by email and by video conference.

CAREER AND ROLE

5. I have been asked to set out a short summary of my nursing career and qualifications.

6. As set out above, I am a Crisis Care Practitioner at NHFT. I have been in my current role since 2021. I hold a Bachelor of Science in Nursing (Mental Health) from the University of Derby. I am a member of the Nursing and Midwifery Council and the Royal College of Nursing.

7. I qualified as a nurse in 2019. After qualifying, I began working for NHFT as a band 5 nurse in acute inpatient care. Since 2021, I have been working as a band 6 Crisis Care Practitioner in the community with NHFT.

8. I had interactions with VC in 2020 during his first and second admissions into hospital. During that time, I was working on Rowan 1 ward. My role involved providing care to patients who were acutely unwell on the ward, which is an acute inpatient psychiatry ward. This included helping to stabilise patients, build therapeutic relationships with them, monitor their presentation, and assess patients on a day-to-day basis so that I could feed that information back to the patient's wider multi-disciplinary team ("MDT"). I sometimes acted as the nurse in charge on the ward. In that role I helped to manage and allocate staff, and escalate any concerns that arose on the ward. I coordinated patients' care with other professionals, both those on the ward and outside of the ward (e.g. liaising with the community mental health team).

TRAINING AND SYSTEM OF WORK

9. I have been asked to set out information relating to the following matters:

    a. The training I received, both from NHFT and other bodies, on the assessment of risk for mental health patients of violence towards others;
    b. The sharing of information regarding patients I was involved with;
    c. Discharge planning; and
    d. Other mental health patients I have cared for.

10. I have set this information out below under the relevant sub-headings.

Risk Assessment Training

11. While I was obtaining my qualifications, I received some training from my university on the assessment of risk for mental health patients of violence towards others. This included breakaway training. This type of training helps students to prepare to encounter patients who are presenting with risky behaviour. It teaches students how to de-escalate in situations where a patient may be angry, or a fight is taking place. We are taught to use the least restrictive force possible, for example by de-escalating a situation verbally.

12. While I was at university I also participated in some simulation-based scenarios which were also designed to help students to develop their skills in terms of how to respond in complex clinical settings. For example, another student might act as a patient and present with challenging behaviour, and I would need to use my communication skills to de-escalate the situation.

13. When I finished my training and qualified as a nurse, I received training on the assessment of risks for mental health patients from NHFT. During my induction and preceptorship, I was given presentations by NHFT staff on risk assessment

and the management of risk. I also completed a 5-day training course on the Prevention and Management of Violence and Aggression ("PMVA") and every year, I would complete a refresher training. I also complete the Trust's Clinical Risk Assessment and Management E-Learning Academy course every three years.

Information Sharing

14. In 2020, which was the time I interacted with VC, I was working as a Staff Nurse at Rowan 1 Ward, Highbury Hospital. I have been asked to comment about how I shared and received information about patients when I was in that role.

15. In terms of how information was provided to me, this typically happened through handovers at the end/beginning of each shift. The handover process would start with a verbal handover, and I would also be given a handover sheet by staff leaving from the previous shift. During handover, the following information would typically be shared:

    a. The presentation of patients on the ward;
    b. Any interactions between staff and patients;
    c. Patients' medication concordance;
    d. Dietary and fluid intake;
    e. Patients' personal hygiene;
    f. The progress that a patient had made/was making;
    g. The types and levels of risks posed by patients;
    h. Whether a patient had been sectioned or was an informal (voluntary) patient;
    i. Whether patients were allowed to leave the ward;
    j. Any outstanding tasks that had been identified for a patient and needed completing.

16. At times, information was also shared between staff members during the course of a shift if observing staff noticed any concerning presentations from a patient.

17. I was also able to obtain information on patients by accessing their digital records. I was only able to access patient records held on Rio. There were no restrictions on my access to patient records on Rio. I was not able to access records held on SystmOne.

18. At the beginning of a shift and/or prior to dealing with a patient, my practice was to read a patient's information contained in the handover sheets, and their core assessment documents and running records on Rio. That information would give me an understanding of the patient's current presentation, risks, and progress on the ward.

19. In terms of how I recorded and shared information with other members of staff, I did this in several different ways. First, I recorded information by completing patients' running records and other assessment forms on Rio, and by completing paper form handover documents. Second, I would share information by engaging verbally with my colleagues during shifts and during MDT meetings. Sometimes I shared information by phone with other professionals/teams involved and with patients' family members.

20. During my shifts I was able to share any concerns that I had about any risks posed by patients to others with my colleagues on shift. Where appropriate, I would escalate these concerns to the clinical lead nurse on shift, and with my ward manager. The clinical lead nurse would change on a daily basis. In the time I worked on Rowan 1 the managers changed three times, so I had three ward managers. From reviewing VC's clinical notes, I can see that Angela Purdue was my manager at the time of VC's admission. She was later replaced by Amanda Smillie. I also shared concerns during MDT discussions. I felt comfortable raising these concerns as all the clinical team members who I worked with were very supportive.

Discharge Planning

21. In my role with in-patient services at NHFT, I did contribute to discharge planning for patients under my care. As a nurse, there were some tasks that I was best placed to perform in patients' discharge planning. For example, if a patient needed to be referred to an accommodation provider, this would be my role. I would also share information about patients with consultant, such as my opinion of the patient's presentation and mental health, to help in discharge planning.

Care of Other Mental Health Patients

22. I have not been involved in the care of any other mental health patient (other than VC) who, following discharge or in the community, has killed or seriously injured a member of the public.

INTERACTION(S) WITH VC

VC's First Admission (25 May 2020 to 17 June 2020)

23. I remember VC's first and second admissions to Rowan 1 Ward. I have refreshed my memory of his time on the ward by looking at his medical records, as my interactions with VC took place around five years ago and I have worked with many other patients since then.

24. During VC's first admission to Rowan 1 Ward, my role within his inpatient MDT was as a staff nurse. My role was to observe VC on a daily basis, and to discuss my observations of him with the wider MDT. As a nurse, I saw VC on a much more regular basis than other members of the MDT. For example, consultants may only see patients once per week. I therefore had a better understanding of VC's presentation on a day-to-day basis than other members of the MDT. I was able to feed that information into MDT discussions so that consultants could

make decisions about VC's treatment and care. This is what I understood the purpose of my observation records to be.

Observations and care plan

25. Prior to my first involvement with VC during his first admission, I believe that I received a handover document from the nurse who had been working with VC during the previous shift. I do not remember which nurse gave me the handover document. I do not remember what specific information I read prior to my first interaction with VC, however my practice at the time was to review a patient's admission records, which were available on Rio. These would have included VC's risk assessment, core assessment, and his MDT and progress notes. Reviewing VC's medical records now, I believe that I would have understood that VC posed a risk of aggression, as most of his progress notes indicated that he could be aggressive (see, for example, the record at NHFT0000168 pp.7-8, in which Aisha Yusuf noted that VC's risks included aggression).

26. My understanding was that VC was admitted to the ward because he had been arrested for criminal damage after kicking the door of another resident. At the time, the incident was believed to have been an attempted burglary. My understanding of VC's psychiatric presentation and his condition was that he was hearing voices and responding to unseen stimuli, which is why he was admitted to the ward for assessment under section 2 of the Mental Health Act 1983 ("the **MHA 1983**").

27. My first interaction with VC was on 28 May 2020, two days after his first admission to Rowan 1 Ward. As part of my role within VC's MDT, I was responsible for observing VC and recording information about his behaviours, presentation, dietary and fluid intake, medication concordance, mood and mental state.

28. VC's medical records for his first admission include 7 medical entries recorded by me [NHFT0000168 at pp.12-13, 16, 25-26, 44 and 46-47]. My overall clinical impression of how VC presented during these observations is that he used to maintain a low profile on the ward, spending a lot of time on his own. However, in most cases he would also engage in activities when prompted to. In the time that I observed him VC would only speak when spoken to. He presented as polite and amenable during the interactions that I had with him.

29. My clinical impression of how VC presented during each of these observations is as follows:

    a. At 6:02PM on 28 May 2020, VC is recorded as presenting as calm and socially engaged, demonstrating appropriate interpersonal interactions with both staff and peers. His participation in a structured activity (chess) suggests positive engagement and cognitive focus. He maintained adequate dietary and fluid intake, and his appearance was appropriate for the ward setting, indicating a level of self-care. Despite being identified as at risk of aggression, there were no observed behavioural concerns during this period. No additional needs were identified at the time. I did not conduct a formal mental capacity assessment for VC during this interaction. However, I believed that he had capacity because during his ward review on 28 May 2020 at 11:57, he was able to understand the reason why he was admitted and the MDT confirmed that he had insight into his current mental health [NHFT0000168, pp. 10-11].
    b. At 6:23PM on 28 May 2020, I requested that VC provide a urine sample that he agreed to provide. I tested the urine sample, and it was positive for benzodiazepines that were prescribed on the ward. The sample tested negative for any other illicit substances. VC was cooperative in providing his urine sample. Although my interaction with him was brief he was amenable. During this encounter I did not conduct any formal capacity assessment for VC, but I believe that VC

had the capacity to provide a urine sample. He also understood why I needed the urine sample, indicating that he was able to process information to make decisions.

c. At 3:34AM on 2 June 2020, VC appears to be socially withdrawn, spending most of his time in his bedroom with minimal interaction in communal areas. His behaviour suggested low engagement with the ward environment and possibly with staff or peers. Despite an appropriate appearance, he continued to present a risk of aggression, indicating that his mental state may have still been unsettled or that underlying triggers remained unaddressed. The reason why I consider that VC presented a risk of aggression was because of his history of aggressive incidents. He had exhibited violent and aggressive behaviours earlier during his admission, and in previous episodes of illness, including physical aggression and threatening behaviour towards others when feeling acutely unwell [NHFT0000168 pp.4, 5] Additionally, VC's sleep pattern (retiring at 23:00 and being asleep at the time of writing) may suggest some stability in routine, but the overall presentation warranted continued monitoring for risk and engagement. During this encounter I did not have much interaction with VC and I cannot tell whether I thought he had capacity or not, as he was socially withdrawn.

d. At 8:48PM on 7 June 2020, VC presented as initially ambivalent toward engaging in escorted leave, which may reflect underlying anxiety, low motivation, or mistrust. However, with encouragement, he was able to participate and maintained appropriate behaviour throughout, suggesting a capacity for engagement and self-regulation when supported. His comment about the ward being "bizarre" may indicate some level of insight or discomfort with the ward environment, possibly reflecting perceptual disturbances, cognitive dissonance, or a reaction to the social dynamics on the ward. VC was able to understand the information about going out on

leave, retain and process that information, and agree to go out on leave.

e. At 5:44PM on 7 June 2020, VC presented as withdrawn and minimally engaged, spending most of the day asleep or in solitary activity (reading the Bible). His refusal of meals (breakfast and dinner) may indicate low mood, reduced motivation, or possible depressive symptoms. Despite this, he remained compliant with medication and accepted tea, suggesting some level of cooperation. His refusal of Section 17 leave and limited interaction may reflect a lack of interest in external stimuli or possible anhedonia. VC's appearance was moderately kempt, which may suggest some preserved self-care. Given his history of violence and aggression, he remained a risk and required ongoing monitoring.

f. At 8:17PM on 14 June 2020 VC presented as settled and cooperative during the shift. His engagement in communal areas and presence during mealtimes suggests a degree of social interaction and routine participation. Acceptance of medication and adequate dietary/fluid intake indicate compliance with treatment and basic self-care. His moderately kempt appearance reflected partial personal care, though not optimal. Despite a low profile, the ongoing risk related to his history of violence and aggression remained a concern and warranted continued monitoring. I did not conduct a formal capacity assessment for VC on this occasion, although the MDT notes on 11 June 2020 at 14:02 indicated that he had capacity [NHFT0000168, pp.34-35].

g. At 8:27PM on 15 June 2020 VC presented as settled and stable in his environment. He demonstrated appropriate self-care, maintained adequate nutrition and hydration, and was compliant with prescribed medication. His social withdrawal, spending most of his time in his bedroom and engaging minimally with others, may have reflected a preference for solitude although he remained polite and appropriate when approached. There were no acute behavioural concerns

observed during the reporting period. However, risks remained due to his historical patterns of violence and aggression, which necessitated ongoing monitoring and risk management planning. On this occasion VC was socially withdrawn, making it difficult to assess capacity. However, he remained concordant with his treatment indicating some levels of insight.

30. As I have said above during the course of VC's first admission, and during the interactions that I had with him at that time, I had no reason to doubt that he had capacity to consent to assessment and/or treatment. VC's MDT meetings indicated that he was able to understand information relevant to his admission and treatment, retain that information long enough to weigh up the pros and cons, and to communicate his decisions. I can see this from the MDT meetings on 2 June 2020 at 16:44 [NHFT0000168, pp.16-17], 9 June 2020 at 10:22 [NHFT0000168, pp.27-28], and 11 June 2020 at 14:02 [NHFT0000168, pp.34-35]. If I had any concerns about VC's capacity, I would have raised this in MDT meetings.

31. I have been asked to comment on what my understanding was of the risks associated with VC's condition and the care and treatment plan that was being pursued to assess his condition during his first admission. VC was consistently identified as presenting a risk of aggression, even during periods of calm or cooperative behaviour. Although no acute incidents occurred during his first admission, the potential for aggression remained a concern, requiring ongoing monitoring. VC experienced hallucinations, which he acknowledged during a keyworker session at 01:50 on 29 May 2020 [NHFT0000168, p.13]. VC's engagement on the ward varied, with some days showing positive participation and others marked by withdrawal. At 17:44pm on 7 June 2020, for example, VC was offered escorted leave but declined [NHFT0000168, pp.25-26]. However, as I have discussed above, at 20:48 VC agreed to go for escorted after being encouraged [NHFT0000168, p.26].

32. My understanding was that VC was under continuous observation on the ward, especially due to his history of aggression. Staff documented his behaviour regularly to assess changes in his mental state and risk level. VC was compliant with prescribed medication, including benzodiazepines, as was confirmed by the urine test carried out on 28 May 2020 [NHFT0000168, p.13]. I understood that medication was a key part of managing VC's symptoms and stabilising his condition. He was prescribed antipsychotics that he was taking on the ward. VC was encouraged to participate in structured activities (e.g., chess, escorted leave and OT session), which helped assess his cognitive focus and social engagement. Staff used gentle prompting and support to facilitate participation, especially when VC was ambivalent. MDT meetings were used to assess VC's capacity, insight, and willingness to engage in treatment. VC was found to have capacity to make decisions about his care, and he expressed a willingness to seek help as indicated in the MDT on 11 June 2020 [NHFT0000168, pp.34-35]. VC's appearance, dietary intake, and sleep patterns were monitored as indicators of mental health stability. His moderately kempt appearance and partial engagement in meals suggested some preserved self-care.

Clinical reviews

33. On 4 June 2020 at 14:43 I attended an MDT discussion related to VC [NHFT0000168 at p.22]. I do not remember what specific information I provided about VC during this meeting, by my role was to provide a nursing report. This would involve providing the type of information I have summarised above at paragraph 24, namely information on VC's presentation, risks and progress based on my observations of him while on shift. This information would then have helped clinicians to plan for VC's care and treatment.

34. The record for this meeting records that VC "*[did] not want to be on any medication for now*" [NHFT0000168 at p.22]. I do not recall VC saying that he did not want to take medication, so I am unsure where that information came from. My role as a nurse involved administering medication and make sure that

VC was compliant with his treatment plan. I do not remember ever having a conversation with VC where he declined to take his medication. I have reviewed VC's medical records and cannot see any entries before 4 June 2020 in which I recorded that VC did not want to be on medication.

35. The meeting note also says that VC's Responsible Clinician requested that "*ward staff take [VC] out for escorted leave on hospital grounds*" [NHFT0000168 at p.22]. Later, I recorded VC as being reluctant to go for escorted leave, but eventually he did agree [NHFT0000168 at p.26]. These types of interactions with VC did help me to engage with VC and build rapport with him. Taking a patient on escorted leave also helps nursing staff to monitor a patient's behaviour outside the ward, where the environment is uncontrolled. This is the main purpose of escorted leave. I therefore would have been able to observe VC's mood and mental state during this meeting, as well as his presentation in a public area. I remember talking to him and engaging him. I think that at this time VC was presenting as stable. Normally, we would not take patients who present a particular risk off the ward for escorted leave.

36. On 8 June 2020, a further MDT Meeting took place for VC at 13:16 [NHFT0000168 at p.26]. I was not in attendance at this meeting. During the meeting, VC's responsible clinician (Dr. Faizal Seedat) asked members of the MDT to *"please try to dig deeper when [VC] declines an activity -, if anything is really behind the refusal."* I cannot recall whether I was told about this request by other members of VC's MDT.

37. On 9 June 2020 at 10:47 VC's medical record says that I attended a "Board Review" in respect of VC [NHFT0000168, at p.29]. The record says: "*Team discussion: LMHT [referral] to be refreshed today*." I attended a further Board Review on 11 June 2020 at 09:00, for which there are no notes of the discussion [NHFT0000168, at p.33].

38. I do not remember what matters were discussed at these specific meetings. However, in general the purpose of these reviews was to look at all the patients on the ward and review any tasks that needed to be completed for those patients. Usually, after a patient's MDT meeting the team would have agreed to carry out certain tasks in relation to a patient. At the Board Review meetings, we looked at a general overview of the tasks outstanding for each patient, to make sure that jobs arising from the MDT discussions had been assigned and followed up by members of staff. I do not remember what observations or feedback, if any, I provided about VC's mental state and presentation during these meetings.

39. I have been asked to comment on whether the information I provided during any of these meetings was relied upon by VC's clinical MDT to demonstrate that he had made progress in terms of his insight into the risks he posed to others when he was acutely unwell prior to his first admission. I do not remember what specific information was relied upon by the MDT to demonstrate VC's progress in terms of his insight. However, in general information provided by nursing staff was relied upon by VC's clinical MDT in the way I have explained above. As nursing staff, we interacted with patients much more frequently than other practitioners, so the information that we provided was important in planning patients' care and treatment. That is not to say that my observations went unchallenged. Other colleagues were able to scrutinise and/or challenge any information provided at the MDT, where necessary. For example, if another member of staff disagreed with an observation that I had made about VC based on their own observations or opinions, I am sure that this would have been raised at the MDT meetings.

40. The note of the Board Review dated 11 June 2020 [NHFT0000168, at p.33] records that the MDT should discuss the "*discharge plan*" with VC. At this stage, my understanding was that the discharge plan for VC was to refer him to the Early Intervention in Psychosis (EIP) team and for the crisis team to follow up. I anticipated that this would include a comprehensive package of care tailored to individuals experiencing a first episode of psychosis. Specifically, I expected the

EIP team to provide the following types of support, which are consistent with the EIP model which aims to reduce relapse risk, promote recovery, and improve long-term outcomes:

a. Regular clinical monitoring and assessment, including mental state reviews and risk management.
b. Medication management, ensuring adherence, reviewing effectiveness, and addressing any side effects.
c. Psychological interventions, such as Cognitive Behavioural Therapy for psychosis (CBTp) and family-focused support.
d. Social and functional support, assisting with education, employment, housing, and benefits where required.
e. Physical health monitoring, including screening for medication-related health risks and promoting healthy lifestyle choices.
f. Relapse prevention and crisis planning, with rapid access to care if symptoms deteriorated.

41. At this time, the plan was not for VC to go back to his previous address in Nottingham. At this time, it was unclear where VC would be going to live. There was a plan in place for VC to continue taking his prescribed medication in the community. VC had agreed to continue taking his medication in the community, as he had been doing on the ward. During my interactions with VC around this time, I did feel that he was starting to understand his mental health. I believed that he had the capacity to manage his condition in the community, with support from the community mental health team (EIP). At each of the MDT meetings on 2 June 2020, 9 June 2020, and 11 June 2020, the MDT had commented that VC had capacity [NHFT0000168, pp.16-18, 27-29, 34-37].

42. On 11 June 2020 at 14:02, VC's medical record notes that I attended a separate Ward Review in respect of VC [NHFT0000168, at p.35]. The aim of the ward review was to assess VC's progress, clarify his diagnosis, manage any risks, and set goals and plans for his discharge. My role at the review meeting was to

share my nursing observations and to provide a nursing report. During the meeting, I informed the MDT that VC was settled on the ward and engaging better, and that his interactions with staff on the ward were present. At this time I did not have any concerns about VC's presentation, because I had not observed any concerning behaviours from VC.

43. The note of the Ward Review, under the heading "*Discharge Planning*", VC's records state as follows: *"[W]hat needs to happen prior to discharge? more clarity around his mental health and insight, safety planning."* At this time, I had no reason to doubt that VC's insight had improved. I can see evidence of this from VC's records around this time. On 29 May 2020 VC had a 1:1 with his keyworker, and the keyworker felt he had insight into his current condition. He agreed that he experienced hallucinations, but at that time there were no hallucinations indicated [NHFT0000168, p.13]. In the entry at 10:22 on 9 June 2020, during the MDT VC made a conscious effort to embrace his illness although agreeing that it was not easy [NHFT0000168, p.28]. This indicated that he had some level of insight about his mental health and risks. At 14:02 during the MDT on 11 June 2020, VC agreed that there may be some difficulties in his mental health, and he was agreeing to seek help and support in addition to taking medication. The MDT felt he had capacity to make decisions for his care and treatment indicating that he had some insight.

44. During VC's first admission and my observations of him, I did not feel that he was 'masking' any of his symptoms.

45. I cannot recall whether, during VC's first admission, I undertook or contributed to any risk assessment in respect of the risks that VC posed to himself and/or others.

<u>Observed incidents and information relating to aggression during First Admission</u>

46. From reviewing VC's records, I can see that at 17:35 on 26 May 2020, Nurse Aisha Yusuf recorded VC as walking to the end of a corridor and starting to kick a glass door. An alarm had to be triggered, and VC was restrained and administered with 2mg Lorazepam. He subsequently attempted to budge the main door of the ward [NHFT0000168, at p.7-8]. This incident was recorded as incident response number IR1 334434.

47. In my role within VC's MDT, I was made aware of this incident. I would have been made aware of this during a handover. The incident helped my understanding of the risks associated with VC's condition in that it confirmed to me that he could be aggressive. Within the nursing team, it was the responsibility of the staff who had witnessed the incident to incorporate the incident into MDT discussions. I do not remember whether this incident was discussed in MDT meetings that I attended. I would expect that an incident of this nature would have been discussed within an MDT meeting. Aggressive behaviour, such as kicking a glass door requiring lorazepam, is clinically significant because it highlights potential risks to the patient and to others.

48. At 05:18 on 1 June 2020, Nurse Tafadzwa Matosi recorded VC as hiding in another patient's bedroom toilet, then falling asleep on the sofa at 03:30 in the ward's communal area. In my view, this observation would have indicated that VC presented with some risky behaviours. VC entering another patient's bedroom during the very early hours of the morning, for reasons unknown to staff, was odd behaviour. This might have been an indicator that VC was responding to unseen stimuli, or was otherwise confused, distressed or had bad intentions towards the other patient [NHFT0000168, at p.15]. I do not recall if this matter was escalated or discussed in any MDT meetings. However, the MDT would normally review progress notes and incidents like this would normally be picked up during MDT.

Discharge to CRHT

49. On 15 June 2020, I attended an MDT meeting with the Crisis Resolution and Home Treatment Team ("**CRHT**") [NHFT0000168 at p.45]. I understood that VC was being discharged to the care of the CRHT because he was no longer acutely unwell, and so no longer required ongoing hospitalisation. CRHT was to follow up with VC and continue to assess his presentation, mood and mental state in the community. These follow ups help to identify whether a patient needs more support in the community.

50. My main concern towards the end of VC's admission was whether he would stay in Nottingham, move to Birmingham, or move back home to stay with his family. VC was encouraged to go back to live with his family. Both VC's consultant and I agreed that this would be the best plan. This is because I had concerns about whether or not VC had a sufficient support network in Nottingham or in Birmingham, where he had previously worked, to do well in the community after being discharged from hospital. VC did not want to return home, though, and he ended up deciding to stay in Nottingham on a current tenancy. After the end of his tenancy, he said that he planned to move to Birmingham.

51. Based on my interactions with VC and the nursing observations that had been recorded throughout VC's First Admission, I considered that the risks associated with his mental health had improved towards the end of his hospitalisation. The MDT on 02 June 2020 at 16:44 reduced VC's observation from intermittent (also known as 10minutes observations) to general observations (also known as hourly observations). Reducing VC's observations to general observations would usually indicate that a patient's risks have reduced. The same MDT notes also indicated that there were no current incidents of violence. There was no further evidence that VC was responding to unseen stimuli or was thought disordered. VC acknowledged that there were difficulties with his mental health and agreed to seek support and help. The MDT noted that VC had capacity to make decisions for his care and assessment [NHFT0000168, pp.16-17]. From 02/06/20 general observations were maintained for VC until he was discharged, and so there was no concern that his risks had increased again.

52. My understanding of VC's risks towards the end of his first admission are reflected in the risk assessment set out in the MDT meeting on 11 June 2020. VC's risks to himself were accidental injury/self-neglect. VC's risks to others were that he believed others were trying to spy on him or torment his mind, and that he had tried to enter a neighbour's flat to confront them. Violence would be a potential concern if VC was acutely unwell [NHFT0000168, p.36]. However, as I have said above, towards the end of VC's first admission it was considered that these risks had lowered.

VC's Second Admission (13 July 2020 to 31 July 2020)

53. VC was admitted to Rowan 1 from the Cassidy Suite at the hospital on 15 July 2020. VC was admitted under s.3 MHA 1983 [NHFT0000168 at p.59]. During VC's second admission, I also acted as a staff nurse within his MDT, performing the same role as I had done during his first admission.

54. At the start of VC's second admission, my understanding was that he had been detained under s.136 MHA 1983 because he had knocked at someone's door and entered their property when the door was opened. My understanding was that it was believed that VC was not compliant with his medication, which had led to him having a relapse.

55. At the start of VC's second admission, my understanding of his psychiatric condition was as follows. This was VC's second admission to Rowan 1 a few weeks after he had been discharged from the same ward. On his first admission, VC was experiencing a psychotic episode that was treated on the ward until he was stabilised. However, after discharge VC had stopped taking his medication, as he did not want the medication to slow down his thoughts. This led to a relapse. I also understood that the ward consultant, who was Dr Seedat at the time, felt that VC was suffering from schizophrenia.

56. In terms of why VC was detained under s.3 MHA 1983 and not s.2 MHA 1983, my understanding was that this was because there was a clear indication that VC was suffering from a mental disorder that required long-term hospital treatment. The nature of his illness and his treatment plan had already been established, and so admission for assessment under s.2 was not the correct approach.

Observations and Care Plan

57. My first interaction with VC following his second admission was on 16 July 2020 [NHFT0000168 at p.62]. Before my first involvement with VC on that date, I received a handover from the nurse who had been managing the previous shift. I cannot recall the name of that nurse. The nurse would have explained to me the reasons why VC was admitted for the second time, and his current risks, during the handover. The nurse would also have highlighted that VC was detained on section 3 of the MHA, and relayed VC's level of observations on the ward. I would have reviewed VC's risk assessment, core assessment, care plan and his progress notes. I do not remember whether I reviewed VC's notes and assessments from his first admission.

58. During VC's second admission I recorded 5 entries summarising my nursing observations and interactions with VC [NHFT0000168 at pp.62, 70-71, 103, 109, 116]. These interactions can be summarised as follows:

    a. On 16 July 2020 at 04:11 I recorded VC as being briefly visible in communal areas at the start of the shift, before retiring to bed. He had interacted appropriately when spoken to and complied with his medications. He remained in bed presenting himself as asleep at the time of writing. I recorded his risks as being that he reacts to hallucinations.
    b. On 19 July 2020 at 04:04 I recorded VC as having positively engaged with staff, walking in communal corridors before he went to bed. At

the time of writing he presented as asleep. At 05:07 I recorded that VC's mother had collected his house keys from the ward, and that she would bring in his clothing later that day.

c. On 28 July 2020 at 14:00 I recorded that VC had maintained a low profile throughout the morning shift. He had interacted appropriately when spoken to, and accepted good dietary and fluid intake. His risks were recorded as "*Meds non-concordance*" and *"Breaking into others properties*".

d. On 28 July 2020 at 20:26, I recorded VC as spending most of his time being bedroom based, having been observed reading books in his bedroom. He attended the dining room and accepted good dietary and fluid intake. He was observed to be kneeling on the floor in a praying position before retiring to bed. His risks were recorded as "*Meds non-concordance*" and *"Breaking into others properties*".

e. On 31 July 2020 at 05:45, I recorded that VC was already in his bedroom at the start of my shift and was not observed spending time in communal areas. He had retired to bed and was asleep at the time of writing. His risks were recorded as "*History of breaking into other people's bedroom*".

59. During VC's second admission, the observation notes that I recorded did not specifically list "*aggression*" under the heading *"Risks*". I did however note that VC had a history of breaking into other people's bedrooms and properties. I also noted his risks as including medication non-concordance, and reacting to hallucinations. In my view, these types of risks could also have indicated that VC was aggressive. When recording his risks, I wanted to highlight VC's specific risk behaviour that had led to his second admission.

60. My understanding of the purpose of my nursing observations, in the context of the wider care and treatment plan provided to VC during his second admission, was that they would help to provide continuous care and clinical oversight of VC, and that they would assist in conducting detailed mental health assessments,

monitoring VC's mental and physical health and wellbeing, and contributing to risk management and safety planning. Nurses acted as key points of communication between VC and the wider MDT, ensuring that his care plan was implemented effectively and adjusted as needed. I also offered therapeutic support, promoting VC's recovery and advocating for his needs during MDT discussions.

61. My understanding of the risks associated with VC's condition during his second admission came mainly from information about the time that he had spent outside of hospital. I understood that VC had been medication non-concordant in the community, which had led to a relapse, resulting in him responding to unseen stimuli and being paranoid about his neighbour. I believed that VC's main risk was a risk that he presented to other people due to the circumstances of his admission, in particular his violent and aggressive behaviour.

Clinical Reviews

62. On 23 July 2020 I attended a Board Review in relation to VC [NHFT0000168, at p.88]. As I have explained above, the purpose of these Board Review meetings was to review all the patients on the ward, and ensure that tasks that had come out of MDT meetings were being implemented. I do not remember what types of observations and feedback, if any, I provided about VC's mental state and presentation in this meeting.

63. On the same day, as indicated in VC's medical records, I had a telephone conversation with Kath Gent [NHFT0000168 at p.88], after which I recorded the following information:

> *"T/C to Kath Gent and she wanted to know about more about Valdo status. Information was given as to why he was admitted on the 14th and that he is on section 3. I have informed her that his IDD is next Thursday. I have asked Kath about the plan for his exams due in August and she*

agreed to discuss this with her team and inform the ward. Valdo consented for me to give information."

64. Looking back at this record, I think that Kath Gent was someone at Nottingham University, where VC was studying at the time. I would have had a conversation with VC about the phone call to observe whether he was able to understand, retain, and weigh the information relating to the phone call, and communicate his consent to me sharing his information with Kath Gent.

65. In terms of other information that I shared about VC at this time, I discussed the risks that VC posed with colleagues on Rowan 1 Ward at the start and end of every shift during handovers. I also discussed VC's risks during MDT and other meetings, as recorded in VC's medical records. I cannot recall the names of any other staff members with whom I shared information.

66. During the time of VC's second admission I did feel comfortable raising concerns about risks posed by VC (and other patients under my care) within MDT discussions and with senior members of clinical teams. This is because all my senior colleagues on the ward were very supportive.

REFLECTIONS

67. Since learning about VC's attacks, I have reflected and learned that continuity of care for mental health patients in the community is very important. Continued care in the community could have ensured that VC was compliant with his treatment. Given VC's history of risky behaviours, when he was unwell his mood and mental state needed ongoing monitoring.

68. In terms of the way that I practice, one consequence of VC's attacks is that I have changed the way that I document information to ensure that important information is not missed. I have learned to take risk behaviours very seriously,

as even patients whose risks are regarded as being very low can become extremely high risk, especially if they are not monitored.

69. I have not given any interviews or otherwise made any comments about VC's actions, or any other matters under investigation by the Inquiry.

RECOMMENDATIONS

70. I do not know what recommendations that the Chair of this Inquiry should make to ensure that lessons are learned and to prevent similar attacks in the future. However, I would reflect that in this case, I think that a Community Treatment Order ("**CTO**") should have been used for VC. I can see from VC's records that other practitioners did consider using a CTO at a later date, after I was no longer involved in VC's care [NHFT0000168 at pp.238, 242, 246, 251]. This may have been beneficial, as CTOs can help where a patient is not taking medication or engaging in the community.

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.

Signed: GRO-B

Dated: 05/11/2025

Index to First Witness Statement of Godwin Gonde

No	Inquiry URN	Document Description
1	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary