Witness Name: Dr Faizal Seedat

Statement No.: WITN0163001

Exhibits: See attached list

Dated: 03 February 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF

DR FAIZAL SEEDAT

I, Dr Faizal Yusuf Seedat will say as follows; -

1. I have worked for Nottinghamshire Healthcare NHS Foundation Trust ("the **Trust**") since October 2004. Details of my career and roles at the Trust are set out below.
2. This witness statement is to assist the Nottingham Inquiry (the '**Inquiry"**) with the matters set out in the Rule 9 request dated 08 September 2025 (the "**Request**"). This witness statement was drafted on my behalf by the external solicitors acting for the Trust in respect of the Inquiry, with my oversight and input, following discussions in writing by email and by video conference.

3. I have disclosed to the Inquiry emails and other electronic documents that I have which are relevant to Valdo Calocane ("**VC**") [WITN0163002 - WITN0163009, UNIN0001527, WITN0163011 - WITN0163048].

Qualifications

4. I obtained my primary medical degree MBChB in 1992 from the University of Zambia medical school. I passed the PLAB (Professional and Linguistic Assessments Board) exam with the UK General Medical Council in 1997 and commenced my first post in psychiatry in the UK in 1999.
5. I was awarded Membership of the 'Royal College of Psychiatrists' in 2003 and completed my CTT (Certificate of Completion training) following an approved specialist training programme, enabling entry to Specialist Register in 2007.

Background

6. In 1999 I was appointed to the Keele Psychiatry SHO (Senior House Officer) training programme, specialising in psychiatry. This was completed in 2003, and I decided to train as a 'General Adult Psychiatrist'.
7. Between late 2002 until mid-2004 (18 months), I undertook the role of an associate specialist working in general adult psychiatry in Shelton Hospital Shrewsbury, which was a joint in-patient and community post, whilst waiting to be appointed to a training scheme for my registrar training. In 2004 I was successful in enrolling on the Nottingham SPR (Specialist Registrar) training programme and completed this in 2007. All of my training has been based with the Trust. Following completion of my training and becoming eligible to be appointed to a consultant post in general adult psychiatry, I was successful in being appointed to the role of consultant general adult psychiatrist. My first

consultant post was a community role, specifically working with Broxtowe and Hucknall Local Mental health team within the Trust.

8. In 2010 I was approached to consider if I would be interested in an inpatient role at Highbury Hospital. My role therefore changed and included a shared post doing both community and inpatient roles. I continued my community role as half of my role and took on the role as an inpatient psychiatrist at Rowan 1 ward in Highbury Hospital as the other half of my role.
9. In 2016 I ended my role in the community team and took on the full-time inpatient role, as the sole consultant managing 16 beds on Rowan 1, a male only ward at Highbury hospital. This remains my current role.
10. Between 2016 and 2022, whilst keeping my full-time role as an inpatient consultant, I was also appointed to the management role of clinical director for the general adult mental health directorate.
11. During 24 May 2020 and 20 June 2023, the time period that this statement refers to, I had been working at the Trust as a consultant in general adult psychiatry for over 13 years.

Part A

12. I set out in this part of my statement a brief overview of some broad principles in mental health treatment, both generally and within the Trust, to provide background and context to Part B of my statement which covers the care and treatment of VC.

Inpatient mental health services

13. For any patient admitted to the in-patient service at the Trust, whether they are detained under the Mental Health Act 1983 ("**MHA**") or a voluntary patient, they are assessed, managed and cared for with the same standards of care.

14. The process of care for any patient includes making a thorough assessment of the patient's presentation. During the admission, the information from the direct assessments made and all the documented evidence in the medical records is collated and will include all aspects of the patient's life including medical, psychological and social factors. This will also include considering historical presentations and risks. We employ the basic concept of the "biopsychosocial model of management" which involves looking at medication prescribing, psychological interventions and help address any social factors like housing, finances, social inclusion, education, employment etc.

15. In all cases, risk is constantly assessed and reviewed as it will be important that the patient's risks have reduced as compared to when admitted and the patient is now safe to be managed in the community prior to discharge. There will be consideration of risks at all stages, and the risks will be reviewed and addressed during the patient's admission.

Mental Health Act 1983

16. Patients detained under the MHA are usually brought into hospital against their will because they demonstrate poor insight and are not able to understand that they need to be in hospital for the benefit of their mental wellbeing and risks to themselves and / or others. Being detained under the MHA allows the in-patient team to provide care in a safe way with the correct

legal frameworks required to enforce treatment. The patient is also entitled to relevant rights under the MHA including the right to appeal against their detention.

17. Section 2 of the MHA is for assessment and treatment of a patient. The focus is often on assessment, where the treating teem seek to come to an understanding of the patient's presentation. It enables a clinician to formulate a diagnosis which then informs the patient's treatment such as medications and need for psychological interventions. We also seek to address any social issues around accommodation, activities of daily living, and finance that might be arising. There also needs to be a consideration for the provision of care in the community once discharged and therefore appropriate referrals will be made as early as possible to ensure that community care is in place once the patient is ready for discharge.

18. The treatment, care and management of individuals under Section 3 of the MHA is very similar to Section 2, with the difference being that with patients on a Section 3, the focus is predominantly on treatment. Patients detained under Section 3 will tend to be patients who are known to services, have a clear diagnosis and have a treatment plan in place which has failed due to various reasons such as non-concordance to treatment, poor engagement with services, psychosocial stresses and substances misuse. There is a focus during the patient's admissions to try understanding the factors responsible for the relapse of illness which could include problems around insight, poor compliance to medications, poor engagement, illicit substance use, alcohol misuse and social factors. We will then try and address this part of the treatment plan.

19. Medication options for all patients are dictated by the patient's clinical presentation and will be dependent on the patient's insight and compliance with treatment. There are different routes of administration such as oral medication, or injectable medication (depot options, discussed further below) so the choice of medication may also be influenced by the fact that not all medications come in both oral preparations and injectable forms. It may also be that jointly with the community team there could be a discussion around the consideration of a Community Treatment Order ("**CTO**") (discussed further below).

The Inpatient Team

20. On every acute ward there are various roles and responsibilities for clinical professionals within the inpatient services team:

    a. Each ward will have at least one consultant psychiatrist appointed to it. They will be the Responsible Clinician ("**RC**"), who has 'approved clinician' ("**AC**") status to act as the RC and carry out duties related to the MHA. They have overall responsibility for the care and treatment of a patient detained under the MHA.

    b. The Trust is a training centre, therefore consultants will have resident doctors (the term junior doctor is no longer used) 'attached' to them for the purpose of training. The resident doctors attached to the consultant psychiatrist include foundation trainees (doctors who have recently qualified in medicine and are in their first two years of practical training), GP trainees and registrars who have chosen to specialise in psychiatry. When we have vacancies within the training posts, the vacancies will be filled by Locum resident doctors with similar skill level. We do on

occasions have doctors placed on the ward who are out of training like trust grade doctors or staff grade doctors.

c. Each acute in-patient ward will also have a ward manager. The ward manager has line management responsibilities for the non-medical staff (predominantly nurses and healthcare assistants) on the ward. They manage the ward, address any patient complaints or concerns and link in with the consultant to ensure that: Ward Reviews and Multi-Disciplinary Team ("**MDT**") meetings run well; there is good attendance from ward staff in reviews; discussions around performance of staff within the reviews; problem solving; and addressing concerns raised by staff, about staff, patients or family/carers. The ward manager will also ensure that resident doctors complete the required physical health monitoring for all patients.

d. Clinical team leaders are senior nurses who deputise and support the ward manager with day-to-day clinical and administrative matters related to the ward and patient care.

e. Mental health nurses are registered nurses in mental health at various Bands[1] depending on their experience. They will work with patients on the ward to administer medication, attend emergencies, attend Ward Reviews and provide nursing perspectives on the patients during meetings with the clinical team.

f. For every patient admitted to the ward, they are allocated a 'key worker' or 'named nurse' for the purpose of continuity and to ensure that a patient has one main professional to go to. This professional will develop

[1] NHS Agenda For Change sets out different pay band levels

a rapport with the patient, have 1:1 time with them, review their progress jointly with the patient, ask the patient their views on their admission and treatment, and listen to any needs that the patient may identify.

g. As far as I can recall and is my understanding, we do not have associate nurses on the ward.

h. Psychologists on the ward provide a psychological perspective to the patient's care and presentation. This could include psychological formulation, safety planning around risk, work on a patient's insight and identify the need for any specific psychological therapies. Where the psychologist has done some work with a patient, the psychologist will attend the patient's Ward Review to give feedback or offer an opinion on the patient's care and possible next steps including advice for community teams going forward. Psychologists will also attend MDT meetings where decisions are made if there was a role of psychology, what that was and agree on their involvement in a patients management.

i. Pharmacists on the ward help support medication management. They ensure correct medication reconciliation, i.e. making sure the medication the patient was taking before admission is verified, to ensure the patient continues to receive all their necessary medication including physical health medication. They also remind doctors of any drug-to-drug interactions, ensure medications are being prescribed within the guidelines of the British National Formulary ("**BNF**"), and can help to support patients to understand their medication and explain side effects.

j. Occupational therapists ("**OT**") help with the assessment of patients' activities of daily living, i.e. the skills that a patient needs to safely live in

the community. They help to inform the social care provision, inform the relevant professionals whether there are any physical health disability adaptions required to the patients care in hospital or at home, and assist with social inclusion.

k. Health Care Assistants ("**HCA**") and support workers are there to support clinical staff on the ward. They work with the nurses, and they are involved in the day-to-day care of the patient. They support the patients on the ward and assist with escorting them off the ward for leave under Section 17 MHA.

l. The inpatient service at Highbury, which includes all mental health wards, both male and female, has an overarching person who manages the running of the wards: the service manager. They will have close links with the ward managers and help to address any management issues the ward may be facing including staff levels, acuity, level of care on the wards. They will support ward managers with issues with staff management, conduct and capability.

Inpatient Team Meetings

21. On Rowan 1, we have weekly MDT meetings every Monday between 09:30 and 12:00. The MDT is our business meeting of the ward where no patients are seen but the current care and what needs doing relating to each patient is discussed, including discharge planning. The people who are present at the MDT varies depending on people's availability. However, there will always be a senior medic and senior nurse. This meeting for the most part is chaired by the consultant. We will discuss each patient, including their current

presentation, evidence of mental illness, risks, compliance to treatment, any management issues, review of leave (if the patient has any), physical health issues and any barriers to discharge that need to be looked at so that a plan can be agreed to address any issues of concern. We also agree when the Ward Review of the patient is to be planned and who should be invited.

22. Ward Reviews (ward rounds) are held on either Tuesday or Thursday, starting at 09:30, where the patient is physically seen face to face and all aspects of their clinical presentation are reviewed, including risk. Care planning and decisions about treatment are jointly made between the patient and MDT. Where a patient has given consent to allow carer/family involvement, they would be included and their opinions sought. If the patient has a community team, they too will participate.

23. Board Reviews are held on most days of the week, Tuesday to Friday. On Rowan 1, they are held first thing in the morning, from 09:00 to about 09:30. It is a brief and quick daily meeting with key members of the MDT discussing whether actions agreed have been completed, if not why and what now needs to be done to complete. There will also be a brief discussion if there had been any new developments or concerns including risk and plans made to address this. I did not attend the Board Reviews, but my junior doctors were present to address any physical health issues. In the Board Review they would discuss compliance to medication, concerns around risk, maintaining patients' ADL's (activities of daily living), response to section 17 leave off the ward, any incidents of risk, social issues that need addressing and any physical health concerns.

Relationship with Community Teams

24. The services provided by the inpatient teams at Highbury Hospital and other agencies (such as framework, social care, housing associations, drug and alcohol teams etc) which carry out care planning and treatment for patients experiencing acute mental health crisis, as mentioned above, have similar goals in outcomes and care for the patients. The intention and focus is to assess the patient, assess the patient's risks, formulate the problems, decide on the appropriate management plan (with the ultimate goal being working towards the patient becoming well), and ensure the risks are mitigated and patient is back to their level of functioning and are safe to be in the community.
25. The length of time a patient is in in-patient care is for as long as is clinically required. The focus of the admission is to assess and treat. When considering discharge, one would take into account factors such as has the patient recovered in terms of resolution of symptoms; are they engaging with treatment; are they now not exhibiting risks; and are they now safe to be managed in the community.
26. Provision of care in the community is the responsibility of either a Crisis Resolution and Home Treatment ("**CRHT**") team, or a Local Mental Health Team ("**LMHT**"). The main difference between these teams and inpatient teams is that they are delivering care whilst the patient is at home as opposed to on an inpatient ward. The decision as to which team or where the patient should be managed depends on several factors including the severity of the patient's symptoms, the nature of the patient's illness, level of risks (which may include their behaviour, insight, and engagement with services), or carer burnout.

27. The intention for every community service is to try to facilitate treatment and manage patients in the community within their homes, with admission to hospital being the last resort when clinically indicated.

28. CRHT sits in between the in-patient team and LMHT. They provide care to patients who are already involved with the LMHT but are presenting in crisis and are admission vulnerable. They also provide care to patients who are not under an LMHT but are in crisis and have self-referred, have been referred via the GP or other Third-Party agency. The CRHT team also plays a role of supporting and helping with discharge of patients from the ward. There are times when there is a delay in allocating and for the LMHT to take on care of the patient. To avoid delay in discharge, the CRHT team will support facilitating discharge, monitor and support the patient in the community and hand over care to the LMHT when things are in place. Also the CRHT team will agree to provide extra support in the monitoring and review of patients from the ward, joint with the LMHT. Individuals in contact with CRHT will be in crisis and probably acutely unwell, but they are able to be safely managed in the community. The CRHT team have the ability and resources to see patients as often as is required, this could be up to 3 times a day, they can respond to a crisis immediately, they can help with medication compliance and supervise patients taking their medication as they are a 24-hour service, 7 days a week. This cannot be provided by the LMHTs who only work 9 to 5 and weekdays only. The CRHT team are also the gate keepers to the admission beds and are able to make decisions whether they could safely manage the patient in the community, or if this was not possible, admission was required. There will always be a consideration of whether the patient can

be managed in the community, and this will fall to the CRHT team who are best placed to decide whether the patient can or needs admission.

29. The LMHTs provide care to patients in the community experiencing mental health difficulties that are moderate to severe in nature. The teams will consist of various disciplines including psychiatrists, nurses, support workers, occupational therapists, psychologists, employment support workers, social workers, admin staff. They receive referrals from GPs, in-patient wards, CRHT teams, drug and alcohol services and 3rd sector organisations like housing, framework, primary care psychological services.

30. The care provided to patients within secondary care psychiatric services will have regard to the national framework 'Care Programme Approach' ("**CPA**"). CPA is a framework in mental health care used to support patients in their care through a structured process of assessment, care planning, and review. It involves a designated care coordinator who works with the person and other professionals to create a comprehensive care plan that addresses mental, physical, and social needs, such as housing, employment, and medication. The plan is regularly reviewed to ensure it continues to meet the person's goals for recovery. It is my view that the CPA framework is more useful in the provision of care provided in the community but the principles of it are part and parcel of care within in-patient services. This is because a patient in the community who is being cared for the LMHT will be allocated to either care pathway (less need) or CPA pathway (higher need), based on the complexity of their clinical picture, risk, and need. However, all inpatients will be considered as CPA pathway as since they have required admission, they fall in the high category of need. During the inpatient admission the principles of

CPA are followed, and the patient will be designated as CPA pathway. Towards the end of the admission, based on the outcome of our assessment and formulation, this will be informative as to the CPA level as we would have clarified the complexity of the presentation, the risks, the formulation and the need in the community. The inpatient team will determine if the patient needs involvement with the LMHT (there are times when no such need is identified and patients are discharged back to the GP). If so, we will make the referral to the LMHT for their involvement highlighting the assessment we have made, formulation, risk and the required intervention from the LMHT. This information will then guide the LMHT including their own assessments decisions around the level of CPA.

Mental Health Act Assessments

31. When conducting an MHA assessment to consider whether someone is unwell and requires detention, the criteria is very clearly stipulated in MHA and the MHA Code of Practice. Firstly, you need to identify the presence of a mental disorder; the mental disorder needs to be of a degree that warrants admission to hospital. You must also consider whether there are associated risks to the individual's health, to themselves, to others or a combination of both. You must also establish whether the individual is not agreeing to attend hospital as an informal patient and whether they are able to be safely managed in the community. When completing the MHA assessment, I would also consider the individual's engagement with services, compliance with medication, insight into their illness, any carers' views or carer burnout, and any worrying challenging behaviours.

32. To progress with the detention under the MHA on an inpatient ward, the three professionals involved in the MHA assessment, being two doctors and one Approved Mental Health Practitioner ("**AMHP**") (who is usually a registered social worker by background but can also be a nurse, OT or psychologist) has to be in agreement with the decision to detain a patient.

33. The principal criteria for detention as per the MHA when considering detention under Section 2 or Section 3 are very similar. As noted above, Section 2 is for assessment and treatment, whereas Section 3 is for treatment. Therefore, in applying Section 3, one would look for evidence of an established mental illness as per ICD-11 (International Classification of Diseases) (ICD 10 when VC was detained on the first 2 occasions) diagnosis. One would look at whether the current presentation fits in with how they have previously presented when unwell, and would look or be aware of there being an established management plan that the patient did not adhere to or follow and has led to the relapse. In such a situation, the focus of intervention would be on re-establishing the treatment plan. These patients will be known to the service and the clinicians involved in the MHA assessment as hopefully one of the doctors is aware of the patient's history and treatment and if not, the clinicians are satisfied that it was clear that the patient had a formulation and care plan and patient has relapse due to not adhering to the care plan and there is no change in the patient's clinical picture. If there is any doubt or uncertainty or there is a change in presentation to what is known, it would be best to consider Section 2. It is also good practice that an opinion is sought from the patient's nearest relative whether they agree to the detention under Section 3. If a nearest relative disagrees with a Section 3 detention, the

detention cannot proceed unless the AMHP, who believes that the nearest relative's objection was unreasonable, must apply to a County Court to have the nearest relative legally changed and detention can proceed. In case of Section 2, the nearest relative's objection can be overridden and hence Section 2 can be used whilst the nearest relative is being changed.

34. Determining whether an individual is mentally unwell comes from skill, understanding of the MHA, training, and experience. For this determination there is a level of subjectivity, however the key principle will be that there is evidence the patient is suffering from a mental disorder or mental illness. This may include signs and symptoms of mental illness which include;

    a. Mood problems;
    b. Hallucinations;
    c. Delusions;
    d. Thought disorder;
    e. Changed and disordered behaviours;
    f. Doing things out of character;
    g. Poor insight into their mental health;
    h. Appetite and sleep problems;
    i. Any association with levels of risk to self or to others.

35. The presence of the symptoms has either emerged in a short space of time (days to a few weeks) or there has been a more gradual increase in intensity of the symptoms over a period. In addition, one would also want to evaluate if the presence of these symptoms were impacting on the patient's behaviour and risk to a significant level. There will need to be clear evidence of changes

in behaviour particularly around risk and functional impairment related to family life, work hobbies and interests.

Diagnoses

36. When establishing a diagnosis for a mental disorder or illness in a patient with psychosis, it is important to note that psychosis itself is not a diagnostic label as per the ICD manual of classification of diseases. Psychosis is a collective term to denote the presence of one of more symptoms that suggest psychosis which could include the presence of several factors including thought disorder; delusions; hallucinations; passivity phenomenon and misidentification syndromes.

37. For a more specific diagnosis like schizophrenia for a patient experiencing psychotic symptoms, it will be important that the clinical picture meets the criteria for a diagnosis of schizophrenia as per ICD:

    a. At least one specific symptom (thought echo, insertion, withdrawal, broadcasting; delusions of control or passivity; delusional perception; or running commentary/discussing voices) OR

    b. At least two "other" symptoms (hallucinations, thought disorder, catatonic behaviour, negative symptoms) for over one month.

    c. The symptoms must also not be better explained by another condition, such as a mood disorder, substance intoxication, or brain disease).

38. As stated, it is important to rule out all other possibilities such as there being an organic basis of the psychosis, a mood disorder (depression or Mania) or use of illicit substances. Based on the current ICD-11 classification, the key factors that indicate a diagnosis of paranoid Schizophrenia are that for an ICD-11 diagnosis of Schizophrenia (code 6A20) requires symptoms to be

present for at least one month, with at least two symptoms present, including one core symptom such as delusions or hallucinations.

39. There are differences between the ICD-10 (which was used during VC's admission) and the current ICD-11. The ICD-10 uses more of a categorical approach and has subtypes (paranoid, hebephrenic, catatonic etc) whilst the ICD-11 uses a hybrid categorical-dimensional approach. The ICD-11 abandoned all subtypes as were present in the ICD-10 and its emphasis is on the presence and severity of symptom clusters, their longitudinal course, and the individual's functional impairment. In ICD-10 it emphasizes assessing severity across six domains;
    a. Positive;
    b. Negative;
    c. Depressive;
    d. Manic
    e. Psychomotor;
    f. Cognitive symptoms.
40. Clinicians further label symptoms of schizophrenia in two major categories;
    a. '**Positive symptoms'** which may include;
        i. Delusions;
        ii. Hallucinations;
        iii. Experiences of control of passivity
        iv. Disorganised thinking;
    b. **'Negative symptoms'** which may include reductions in;
        i. Effect;
        ii. Speech;

iii. Motivation;

iv. Social interaction.

Treatment, care and management of patients experiencing Psychosis

PICU wards and Seclusion Rooms

41. As noted above, when detained under Section 2 and/or 3 of the MHA, a patient resides on a ward and is allocated an 'inpatient bed'. When determining whether a patient who is detained under Section 2 or Section 3 of the MHA requires more restrictive care than usual, such as seclusion and/or requires a psychiatric intensive care unit ("**PICU**") bed, in my clinical experience, the section in which a patient is detained does not have a bearing on whether the patient is accommodated in seclusion, or they require a PICU bed.

42. A PICU unit is a specialist ward as it has higher levels of security and is better resourced with staff to be able to manage more ill and risky patients, but the patients are not secluded. The Trust has a PICU unit, Willows Ward, situated at the Highbury Hospital site.

43. Seclusion rooms are for patients who are too unwell and pose a risk that cannot be managed safely on the open ward. For a patient to be secluded, they need to be detained either on a Section 2 or Section 3, as it would be against the law to seclude a patient and take away their liberties if they were an informal patient. Within the Trust, we have two sites where the general adult psychiatry wards are located: Sherwood Oaks Hospital site in Mansfield, and Highbury Hospital in Nottingham. Seclusion rooms are attached to the

four general adult wards at Sherwood Oaks, and Highbury Hospital has one seclusion room on the Willows Ward.

44. Based on the Trust 04.08 'Seclusion Policy and Procedure'[WITN0163050], it is recommended that patients should be in seclusion for the shortest possible time and only for a period that it is necessary. Patients in seclusion are reviewed more regularly to ensure high level of care is provided and need for seclusion is reviewed and deemed appropriate if it is to continue. Decisions based on the patient's presentation and risk, can lead to a decision being made to end seclusion.

45. If a patient who is informal but the presentation and risk were such that seclusion was now required as they could no longer be safely managed on the open ward, the patient can be secluded using the Mental Capacity Act 2005 ("**MCA**") and there would be an immediate request for a MHA assessment.

46. The main reasons for placing a patient into seclusion are related to the severity of the patient's condition and the associated risks, such that the risks or the safety of the patient or others cannot be managed on an open general psychiatric ward. The clinicians on the general adult wards who have determined that they could no longer safely manage the patient on the ward will make a referral to the PICU unit outlining clearly the patient's clinical picture, risks and the reasons and rationale for the request for a PICU transfer. The PICU team which consists of their senior staff (nurses, psychologists, medics) will review, discuss and give their decision. This will be a similar process if admitting directly to the PICU ward from the community.

47. When considering risk to self and/or others, the risk that the patient presents with is always a significant factor in determining where the patient can be safely managed. The general principle is that where a patient is presenting with risk to themselves or others that cannot be managed on an open general adult psychiatric ward, they will be considered for either seclusion or admission to a PICU ward. In practice, Seclusion is a rare event and as a last resort and for the shortest period. Admisison to the PICU is more common and the preferred option to manage patients who cannot be safely managed on a general adult ward. There are fewer patients on the PICU ward, there are more staff and the staff have more experience in managing challenging patients.

48. Risk to self may include repeated attempts to self-harm (cutting, headbanging, self-mutilation), ligating, attempted suicide, or repeated attempts to abscond from ward. Risk to others may include repeated physical assaults on staff or patients and has required a number of attempts of rapid tranquilisation treatment and it is no longer possible for the patient to be safely managed on an open ward with the resources available.

49. The risk is in most cases driven by the patient's mental state; hence the severity of the patients' symptoms being considered in the overall decision-making process.

50. The decision to terminate seclusion is a team decision. The patient should have demonstrated a period of stability for 24 to 48 hours and the change needs to be consistent. The factors considered would include;

    a. Has the patient generally been calm;

b. Have there been any incidences of aggression, hostility, intimidation or hurting themselves;
c. What has been the patient's engagement and cooperation with staff;
d. Have they been compliant with treatment;
e. Have they engaged appropriately with assessments;
f. Do the symptoms of illness specifically the psychotic symptoms, manic symptoms still pose a risk of aggression or hostility based on the intensity of the symptoms;
g. Has the patient been able to acknowledge and understand what brought them into seclusion and do they show remorse;
h. Does the patient currently have any thoughts of harm to self or others.

51. Based on the assessment of these factors a decision is collectively made by the seclusion review team that would include the psychiatrist, senior nurse, other nurses and other supporting staff like HCA's. The staff present would have been involved in the patients care. If it is the opinion of the team that based on the facts available can the patient now be safely managed on the open ward, and if this is the case, seclusion is terminated.

Risk information from the Police

52. When considering a patient's risk, it is important to understand their risk history, including any involvement with the police. Therefore, information sharing and obtaining information from professionals regarding a patient's presentation and history is standard practice. Professionals within the psychiatric wards emphasise gathering all relevant information regarding a patient's involvement with the law, particularly when the circumstances of admission involved police or criminal behaviour. This is important to inform

our risk formulation. Risk formulation is a standard heading subject in a psychiatry history taking that one must consider collecting any information where the patient has had any involvement with the police or the law. This can be via probation services, from the patient or the police, whichever is relevant.

53. In situations where the notes or information available suggests police involvement, criminal history, history of risk to others that involved the criminal justice system, there will be a request of a PNC (a check against the Police National Computer) check and this would be in most cases where there is evidence of extensive forensic involvement in the past and recent, information is not known and that this would aid risk assessment. The PNC database used by UK police and other agencies will hopefully give us a real-time information check, which would give us factual information around the patient's criminal behaviour and inform the risk assessment. It is important to make conclusions if the criminal behaviour is related to mental illness or not which will guide interventions.

54. An alternative to seeking this information would be to ask the patient directly and from my practice, patients are forthcoming with such information in most situations. They will inform us of any upcoming or required court appearances, if the patient may have probation and if they have any bail conditions. We would seek to verify this information either from the police or contacting the probation service to ensure we had accurate information. It is also common practice that we would involve probation services in discharge planning, where relevant.

55. It has however been my experience that obtaining police criminal records or information regarding the patient's involvement with the law is not always straight forward and information is not easy to get. It is my experience that the PNC checks take too long and there is a regular need to chase it. Police are not also willing to share information unless through official means like the PNC check or senior intervention. There has been improvement since mental health teams became embedded within the police service, specifically the Liaison and Diversion mental health team (from around 2014, period of national roll out) and the Street Triage Team (around 2014 as well). They both work closely with the police force and as they document using the same Rio medical records system as our inpatient services, we are able to gather accurate information as it happened, and where necessary or if further clarity is required, we would get information directly from the police.

56. The Liaison and Diversion service is a link between the police and mental health services for patients who may be presenting with mental health difficulties, and the police have become involved. Where there were difficulties obtaining information from the police or the PNC check was taking too long, we would have the option to approach a named senior police officer who we had a link with related to mental health who would aid us in gathering the required information. I do not know when this arrangement was set up but know it has been available for a few years.

Observation Levels

57. All patients on inpatient wards are subject to observations at different intervals. At the point of admission, all patients whether detained under the MHA or an informal patient who is voluntarily on the ward, will be nursed on

intermittent observations. This will mean they will be seen every 10 minutes (since 2025 this has been changed to every 15 minutes). This will be maintained until the first senior medical review where this will be discussed, and changes could be made as appropriate. In certain situations and depending on the intensity of the patient's symptoms and behaviours, a patient may be on 1:1 observation. For the most part observation levels are dictated by risk of harm to self or others but on occasions observation levels are dictated by patients' physical health or vulnerability such as risk of falls. This will be reviewed during the first senior medical review and changes made as appropriate.

58. Staff should follow the policy guidelines set out by the Trust, 'Trustwide therapeutic and supportive observation policy and procedure' [WITN0163049] when deciding on what observation levels to be in place for a patient. It is regularly reviewed at each MDT meeting, Ward Review, and Daily Board Reviews and either maintained or changed as needed.

59. The observation level a patient is put on is a joint decision between the nurses and the consultant. We will take into consideration the patient's reason for admission, the patient's behaviour since coming on to the ward, the level of agitation, hostility or aggression, their level of cooperation and engagement, what recent risk and current risk they are presenting with both to themselves or others, their mental state and level of severity of their acute symptoms, the potential risk of absconding from the ward, their level of insight and compliance to treatment. Physical health factors, patient frailty, poor food and fluid intake are also considered.

60. All those present at the review (nursing staff, HCAs at times, medical staff, psychologists and OTs if present) would then jointly agree on the most appropriate observation level, which is subject to review and can be changed as required. The observation level is recorded in the patient's Progress Notes: in the nursing entries, Ward Reviews and MDT reviews. The nursing staff can increase observations as required but to reduce observations this will need to be discussed with the medics. The observation level is to safely manage the patient on the ward and to allow effective assessment of the patient.

61. Generally, as the patient's mental health improves and their risks reduce and their engagement and compliance with treatment gets better, the observation levels will reduce to the lowest level which is general observations, where the patient is checked every hour.

62. The Trust has a service guide "Acute inpatient wards, adult mental health service guide" [NHFT0003175] which details the expectations of an inpatient stay within the adult mental health acute ward. I was and am aware of this policy.

63. Where there is suggestion that there has been criminal behaviour or police involvement, it will be usual to contact the police for more information but this can take time to receive and we make the safest decision based on the information we do have. The observation levels in principle are about the here and now, fluid and subject to change.

Medication

64. When a patient is presenting with psychosis, clinicians will consider what medication will be appropriate. I have been asked by the Inquiry to explain

the medical differences between the following prescription medications in the treatment and management of psychosis:

a. **Olanzapine** is an atypical antipsychotic of second-generation antipsychotics. In the treatment of a psychotic illness, NICE recommends that an atypical antipsychotic is used as first line. It is clinicians' understanding that psychosis is due to an imbalance of the neurotransmitter Dopamine in the brain and the antipsychotic medication works by trying to correct this chemical imbalance. It is also described as a major tranquiliser.

b. **Clonazepam** is a benzodiazepine, also called a minor tranquiliser. It does not treat psychotic symptoms, and its main purpose is to help with addressing the behavioural problems such as agitation, aggression and distress. This medication is sedating and 'quicker' in acting as compared to an antipsychotic. Benzodiazepines are divided into short acting, medium acting and long acting. This is related to their speed of action and duration. Short acting will be quick action, effects within minutes and action for a short period of time, 30 minutes to an hour. Clonazepam is medium acting in that it takes a little while longer to have effect, 15 to 30 minutes and effects last longer for a few hours. It only comes as a oral preparation.

c. **Lorazepam** is also a benzodiazepine, also known as a minor tranquiliser. This works very similar to Clonazepam, but it falls in the category of short acting Benzodiazepine. Short acting will be quick action, effects within minutes and action for a short period of time, 30

minutes to an hour. It comes in two different preparations, oral form and injectable form.

d. **Zopiclone**, is defined as a hypnotic in the BNF. It can be an additive and used for patients who have difficulties with sleep.

e. **Haloperidol** is an antipsychotic medication; it is in the class of typical antipsychotics. These are first-generation antipsychotic medications. It is used in the treatment of psychotic illnesses, but it also has a role in the treatment of acute situations, for purpose of rapid tranquilisation of a patient either by way of oral administration or by injection if the patient is not agreeing to take the medication orally.

f. **Aripiprazole** is similar to Olanzapine and is a second-generation antipsychotic. The difference however between the two is usually in the side effect profile: Olanzapine is sedative and can cause significant weight gain whereas Aripiprazole does not cause significant weight gain and is not as sedative. There is no difference in terms of how they work or how effective they are.

Core Assessment

65. Medical professionals complete multiple assessments before and during a patient's inpatient stay. The "Core Assessment" is completed at the point of admission and the remainder of the patients' records are documented in their Progress Notes (the running record of interactions with, and related to the patient within the Trust's electronical medical records ("**RiO**")). The Core Assessment must be completed for all patients when a patient is admitted to the ward, and it is normally completed by the resident doctors on the ward or nurses working on the ward. The Core Assessment is completed by the

resident doctors as it is their clinical role to clerk all new patients to the ward, and this is documented in the Core Assessment. It is also a training opportunity to enhance their skills in history and Mental State Examination ("**MSE**"). The aim of the assessment is to document the relevant psychiatric history and presentation of a patient, under various headings history of presenting complaint, mental health history, medical history, medications patient is taking, family history, personal history, drug and alcohol history, forensic history, current social circumstances, MSE and physical examination.

66. As per my medical training, we follow a standard format of history taking and MSE to help us collect all the relevant history to allow us to understand the patient and help with the formulation required to guide patient care and management. The Core Assessment document is a standardised format agreed by the Trust and available within Rio to guide and support staff gathering information in a standardised way, which is populated by staff and this is then available to all staff involved in the care of the patient. It can also avoid duplication of information as historical information in terms of past contact with services, risk and treatment is helpful to be placed into the Core Assessment.

Mental State Examination

67. A MSE is the gathering of information such as the symptoms of illness that the patient is experiencing and an examination to elicit any signs of possible illness. Together the information and examination help a doctor understand the patient's problems and assists with a diagnosis.

68. MSE involves the objective assessment by the clinician under the following headings;

    a. Appearance and Behaviour;
    b. Speech in relation to its rate, tone, amount;
    c. Mood including the patients affect;
    d. Thoughts – both form of thoughts and content including risk;
    e. Perception – the assessment of hallucinatory experiences in the 5 major senses;
    f. Cognition;
    g. Insight.

69. Documenting information and findings based on the above provides an objective assessment of the patient's clinical picture which can then inform their risk assessment and formulation.

Summary and Care Plan

70. A Summary and Care Plan is completed by the patient's key worker (named nurse on the ward) and is a summary of the named nurses understanding, assessment and opinions of what the patient's clinical condition is, as well as the risks. With this information they should be in a position to come to an agreed joint position with the patient with regards to the intended management plan, with the goal of getting the patient better, focus on recovery and safely back into the community.

71. The factors which determine the appropriate approach to formulating this document are the patient's history and mental state. The summary and care plan serves as a conclusion that sets out the assessment of the patient's problems and the most appropriate treatment plan to achieve recovery.

72. On an in-patient ward, as the Summary and Care Plan is co-produced with the patient, it is the named nurse who is tasked to complete this jointly with the patient and it is then shared with the patient. This document should be updated during the admission, especially when there have been changes to the patient's circumstances, new information has been made available and if there have been changes to the treatment plan.

73. The Summary and Care Plan should be informed by the nursing assessments that take place, including one to one named nurse (key worker) sessions, psychology and OT if involved, MDT meetings, board reviews and Ward Reviews.

74. As highlighted in the form, there are several areas included. In view that this is a co-produced document with the patient, the named nurse is best placed to complete and update this document and this is meant to be reviewed and discussed in their weekly one to ones. The named nurse will summarise what is known, and will be informed by discussions, opinions and plans from the Ward Reviews which in the most part informs the care planning. The named nurse will offer their summary to the patient of what maybe be going on with the patient and why, factors that may be responsible for the current presentation, raise issues if present around illicit substance misuse including alcohol, any psychosocial factors that may be relevant. It will include consideration of stresses and risks. They then jointly agree the care plan and any differences of opinion will be acknowledged.

75. Within this Summary and Care Plan, there is clarification of the patient's MHA status, CPA, capacity, risk factors and leading to the development of the care

plan/treatment with emphasis that the patient is involved in the process of this document where possible.

76. If a patient has had multiple admissions under the MHA, at the beginning of each admission, the medical notes are reviewed both in relation to the circumstances of the current admission and details of past admissions.

77. There are various pieces of information including, but not limited to, previous Tribunal reports, the patient's Progress Notes and the Core Assessment document. These are reviewed and any patterns highlighted. This could be around patterns of non-compliance, use of illicit substances including alcohol, patterns of similar risks when patient becomes unwell or patients pattern of engagement with services etc.

78. There will also be a joint discussion with community staff who attend reviews, other involved staff in the community from third sector organisations (this could include housing associations, framework, social care, probation, safeguarding etc) and a patient's carers to try and elicit patterns and ensure they are captured within a patient's ongoing care planning.

Care Planning

79. Inpatient care planning is focused on managing acute symptoms with significant risk and ensuring this is completed in a very controlled environment. If a patient is detained it makes it easier to enforce treatment in patients who lack insight.

80. Community care planning however is dependent mostly on patient cooperation. No form of treatment can be enforced in the community. Even with patients on CTO, without their consent or engagement, a CTO only

allows the community team to recall the patient to hospital with patient still at liberty to choose if they accept treatment or not up to that point.

81. For the most part, when a patient known to the community is admitted to an inpatient ward, it will be usual to follow the same care planning as within the community with the aim to re-establish any treatment plan as in most cases the patients have stopped following the agreed care plan in the community. When a patient responds and is well, the care plan is then continued again in the community.

82. If the patient is new to services, if the in-patient team has put in a care plan to which the patient has responded positively, it will usually be continued by the community team and they will try and support ongoing concordance in the community.

83. There is usually a joint decision between the in-patient team and the community team to ensure the best deliverable care plan is put in place with the focus being the patient and their needs.

Mental Health Clustering Tool (was HoNOS PbR)

84. "HoNOS PBR" refers to the Health of the Nation Outcome Scales ("**HoNOS**") used in conjunction with Payment by Results ("**PbR**") in mental health services. I understand that it evolved after the UK Department of Health, in 1993, commissioned the Royal College of Psychiatrist's research unit to develop scales to measure the health and social functioning of people with mental illness. It is an internationally recognised tool. It provides data on patients' health and helps determine how mental health services are planned, funded and evaluated. It allows for standardised, and outcome focused mental health. The HoNOS is a clinical tool that measures the health and

social functioning in patients. Its scores are used to allocate individuals into clusters for planning and funding purposes under the PbR system. It is a standardised tool used by clinicians, it rates 12 areas such as behaviour, symptoms and social factors on a scale 0 (no problem) to 4 (severe problem). It has two broad categories: current ratings (13 items) and historical ratings (5 items). The HoNOS considers the worst problems that have occurred during the previous 2 weeks. It helps practitioners monitor a patients progress over time and guide treatment.

85. The scores from the HoNOS assessments and other information helps assign individuals to a specific cluster which represents their level of need and type of care they require. The HoNOS PbR tool links funding to the complexity and needs of patients and the cluster determines their funding. The tool is used to ensure funding accurately reflects the care required which is especially relevant for in-patient care where costs are higher.

86. The “clusters” are broadly divided into 3 major arms, non-psychotic clusters (1 to *8), psychotic clusters (10 to 17) and organic clusters (18 to 21). This is detailed in the NHS England Mental Health Clustering Booklet [WITN0163051].

Risk Assessment

87. The risks associated with a patient are assessed on a continuum, as risks change with time. The Risk Assessment document is documented on Rio, and risk assessments are in the Progress Notes, both in nursing notes and within the Ward Review and MDT meeting entries. The assessment of risk is a significant aspect of care planning within inpatient services and in the community. The risks a patient poses to themselves, or others underpins

almost all of the decisions we make in terms of patient care. This will include the identification of risk factors (factors that perpetuate risk, precipitate risks and also factors that reduce risk), the actual risks the individual has to self and to others and guide treatment planning, interventions, safety planning and mitigation of risk broadly in the short term and medium to long term.

88. The risk determines the observation levels that a patient is put on (with higher observations where there is higher risk). If the risks are closely linked to the presence of active symptoms of illness, then this will dictate how aggressive treatment is offered and would normally also involve using higher doses of medication and additional 'as required' ("**PRN**") medication.

89. The level of risk will also predict which environment is best to safely manage the patient and may include the 'PICU' or seclusion considerations. The level of risk will also determine if patients are given leave off the ward or not. The level of risk will also determine the level of care a patient will require including whether forensic services need to be involved of any other relevant services and agencies such as safeguarding, MAPPA, probation and police. The level of risk further informs clinicians if a patient is ready to be discharged back into the community and can safely be managed there. This is in keeping with what is described in the Trust's Service Guide: Adult Mental Health Acute Inpatient Wards, at section 7.0 "care and treatment". [CQCM0017192].

90. As with all patients, risk assessment is an important aspect in the assessment, formulation and interventions that are provided to patients. One of the most important factors from a patient's history that predicts future risk is past risk behaviours. It is important to consider early life factors that can predict risk (like childhood adversity, abuse, growing up around domestic

violence, substance misuse in teen years, criminality, cruelty to animals, self-harming behaviour, mental ill health), current co-morbid substance misuse (alcohol or illicit substances), relapse and presence of symptoms that drive risk (psychotic symptoms, elated states of mind etc), personality difficulties (dissocial or antisocial behaviours), poor compliance to medication, poor engagement with services in the community, social factors (like housing issues, finance, social inclusion), current risk behaviours.

91. Insight and masking are also relevant to risk assessments.

    a. "Insight" is related to the patient's understanding and recognition of their illness. The key considerations when assessing insight are around the patients understanding and acceptance of suffering from mental health problems. A patient has insight if they accept that they require treatment to control their illness and has an understanding of the importance to accept the treatment and the need to continue it for as long as is being recommended by health professionals, especially when the treatment has been shown to be effective and has made them well and mitigated risks. In an inpatient situation, a patient with insight is able to recognise and accept why they have been admitted and demonstrate an understanding of the reasons that led to admission, the treatment required to get better, what they need to do to remain well and accept that they needed admission.

    b. "Masking" is where a patient conceals or supresses their symptoms of their mental health condition to appear 'normal'. This act can either be conscious or unconscious. The patient will potentially mimic behaviours to blend in, hide emotions and compensate for symptoms. The reasons

for masking could be to gain social acceptance, avoid stigma, judgment or negative reactions. Can be a coping mechanism to navigate social situations that feel overwhelming or threatening.

Discharge

Readiness for discharge

92. The process of planning discharge starts from the time the patient is admitted to the ward. The intention is to keep the duration of a patient's in-patient stay as short as possible and only for as long as it is required. The intention is to get them back to their premorbid state of functioning and get them back into the community. The treatment or interventions provided will be guided by the formulation, addressing factors impacting on illness (like substance misuse, social factors, debt, housing etc), addressing behaviours including insight that have led to the admission and the risk. When progress has been made, such as improvement or resolution of symptoms of illness and a reduction in risk and improvement in functioning, discharge planning will be formally be talked about. This will be a collective process between the in-patient team and involving the community team, carers, any involved agencies and the patient. To get to this point of formally considering discharge, the in-patient team broadly would have initiated and optimised medical treatment (medications), psychological interventions considered, and social issues addressed. The improvements the patient makes which aid process of discharge planning will include: improvement in the symptoms of their illness (less distressing, not evident, symptoms more in the back ground, symptoms not impacting on individual etc); risk (risks have reduced, not causing management problems,

safe to be in community); and functioning. The improvements will have been consistent and sustained for at least a week and more. The patient will also be tested in terms of their ability to manage and cope in the community by being supported with incremental amounts of leave from the ward from escorted leave by staff, to leave on their own, and could include home leave. There will generally be a consistent view amongst health professionals, the patient's carers and family and the patient that due to the interventions in place, risks have reduced, the patient is back to their premorbid functioning, and the patient can now be safely managed in the community.

93. The principles of discharge planning are based on the broad principal of determining that the patient was back to their premorbid state or as close as was clinically possible and the patient was safe to be back in the community. This will be based on resolution of the patient's symptoms, reduction in risk, improvement in functioning to the point where the patient can be safely managed in the community, compliance with treatment, showing improved insight and demonstrating a willingness to engage with community services.

94. Another factor that is considered in discharge planning is whether this was the first presentation to services or whether this is a repeated pattern of illness. In principle, people with enduring psychotic episodes will require medication in the form of an antipsychotic drug, with first line being atypical antipsychotics. According to evidence-based practice they all have the same efficacy. The specific drug chosen is usually due to clinicians' choice and subtle differences in side effect profiles. When considering discharge, the medications will have been optimised to the right dose and side effects evaluated and addressed.

95. There is also a focus on considering a patient's psychological needs. This could be around psychological formulation, insight into their illness, coping skills, medication compliance, safety planning, specific therapies that may be beneficial that can be delivered in the community. Social needs such as housing, benefits, social care needs, and social inclusion will also be considered.

96. If there has been a change in the patient's clinical picture with resolution or diminishing of their symptoms, in that they are not exhibiting active symptomology that was affecting their ability to function, they have demonstrated better insight, they have been compliant to treatment, opinions of carers/family will be sought in relation to discharge, information will be sought from the community mental teams if they are involved. Further, if a patient has used leave off the ward appropriately with little concerns around their safety and that of others, these are all indicators a patient should be now appropriate to return to the community and be discharged. The intention on a patient's time in an inpatient stay is to get them back to their pre-morbid state.

97. The decision to discharge is a collective approach between all involved parties. This will include the in-patient team, the community team, carers and family, any other involved agencies like framework, housing, probation, social care etc and the patient. Factors that would suggest patient was not ready for discharge would include: where a patient remains actively unwell with evidence of ongoing acute psychotic symptoms; ongoing concerns around risk such that cannot be safely managed in the community; if the patient remains agitated, aggressive, shows poor insight; if there are concerns around the patient's ability to function (poor self-care, challenges to maintain

home etc); where there is poor compliance to medication; where there is evidence of poor engagement; and if family/carers/community team who know him better raise concerns.

Community Teams

98. Where patients are not known to secondary care mental health services, inpatient wards will make a decision about whether they will require mental health support post discharge and specifically input from the LMHT. This decision will be based on the formulation, the treatment the patient has been put on, and needs of the patients, which will predominantly be guided by me as the RC. The nursing staff will make the referral to the LMHT for the need of community mental health support and the LMHT will be informed of what support was being asked which would include specific pathway like the EIP team, out-patient reviews with a psychiatrist, community nurse, psychological considerations, social interventions.

99. In some situations in-patient teams will involve the CRHT team to help facilitate discharge. For new patients to the service who will require community follow up, there is often a delay in the LMHT picking up patients referred to them by the in-patient team. It has been my experience that due to capacity challenges LMHT's face, there is a delay in picking up these patients. In such incidences where patient who is ready for discharge and will require a robust community follow up plan, the CRHT team will provide this until the LMHT is able to take over care. The CRHT team will work and liaise with the respective LMHT to ensure this transition of care to them is done smoothly. The CRHT team can also be involved as an addition to the LMHT, working with the LMHT to provide more intensive support where this has been

identified. The CRHT team can provide support out of hours and weekends which LMHTs can't do and CRHT can also make more frequent visits to patients.

Discharge planning

100. In my experience, discharge planning within an in-patient setting broadly does not differ between detained and informal patients. Admitting a patient under the MHA involves restricting an individual's liberties and the law requires us to ensure that this period of restriction is as short as is clinically required and relevant.

101. When planning the process of discharge, this will involve the whole MDT including the community team, carers/family and the patient.

102. In addition, in situations where there are repeated concerns around compliance with medication, patients repeatedly being admitted due to non-compliance to treatment and the patient is detained on a Section 3, there will be a consideration of depot medication and the need for the use of the legal framework, CTO. In the first instance this will be discussed and will need to be agreed with the community team. This is because the community team will be responsible for the care of the patient in the community and will also be responsible for all the legal aspects of the CTO, and will require an approved clinician who will be the community consultant psychiatrist.

103. The health professionals involved in the discharge planning includes the in-patient team and the community team as when planning discharge, the intention is of transferring care from an in-patient setting back to the community. The community team will either be the LMHT or the CRHT team ,and in some cases both. In specific cases there may also be involvement of

third sector providers and other agencies like framework, social care, probation, police, housing providers, drug and alcohol teams etc. LMHTs and CRHT teams decide who they send to the Ward Review meetings, but most commonly they are from a nursing background.

104. The needs of the patient and the care required will determine who would be responsible for ensuring the discharge plan is followed. This is why it is important and essential for the intended community providers of care in the community to be involved in discharge planning. For most patients admitted to the in-patient wards, this responsibility will fall to the LMHT. However, there can be situations where if the primary concern was around substance misuse the responsibility of the patient's care will fall with the drug and alcohol team. Where, in rare situations, there was no evidence of mental health issues, the patient will be discharged back to the GP.

105. NHFT's Service Guide for Adult Mental Health Inpatient Wards outlines that it is the responsibility of the ward MDT "*to carry out an extensive assessment of the individual [patient's] needs resulting in either a robust community package of care or the identification of longer-term needs and referral to facilitate these*" [NHFT0000130 at p.7]. The service guide does not go into detail as to what processes need to be followed as this is left to the clinicians to determine. In terms of 'extensive assessment', this will include a thorough assessment of the patient's clinical picture, precipitating, perpetuating and predisposing factors that could be responsible for driving the current illness. It will include a biopsychosocial assessment which includes consideration of genetics, drugs, psychological and social factors. It will involve obtaining collaborative information from the patient's medical records (if already known

to services), family/carers, community teams and any involved agencies. It will include repeated assessments of the patient mental state and risk, and the analysis of the observations and behaviours observed during the admission of the patient.

106. In terms of the risk of harm to self and others, this will include an understanding and recognition of any past risk that has been documented or expressed, looking for factors that are precipitating or perpetuating risk (symptoms of mental illness, past history of risk, current history of risk, psychosocial factors etc) and also factors that maybe protective of risk (family, religion, no past risk etc).

107. A 'robust community package' could include the in-patient team making a referral to the community team for involvement post discharge and this is done as soon as the need is identified. There should be a good transfer of care from in-patient to community services highlighting the opinions of the in-patient team around diagnosis, treatment, assessment of risk and monitoring required in the community. There is usually an agreement of care to be provided in the community with the community team, as the planning is done collaboratively including the patient and their carers when patient is considered to be safe to go back in the community. It should include all aspects of care, namely medical treatments, psychological and social aspects of care. There will also be an important consideration in terms of risk and its management, early warning signs of relapse, medication concordance and advice on the need to intervene if there is evidence of relapse. The information is available to the community teams via the Rio medical records as well. If the patient is known to services, the care coordinator will track

events on the ward vis the medical notes and also attend Ward Reviews to offer their input and views of the community team.

Post-discharge

108. During the process of discharge, it is agreed as to what is going to be the follow up plan and this is known to the patient and his family/carers. It is the expectation that once the patient is discharged, the responsibility of the care of the patient will fall to the community service. The community team will be aware of the community package of care, it will have been agreed with them and hence it is their responsibility to ensure the care is implemented when the patient is in the community.

109. The ward has the responsibility to look after the patients on the ward. The resources and staffing is based on this delivery of care, and it would not be practical nor safe for in-patient teams to be following up the patients they discharge. There is a clear demarcation of roles between in-patient and community teams, this will reduce risk of overlap and remove any uncertainty for patients in terms of responsibility of care. There is a handover and clear expectation that once patient is discharged, the responsibility of care from that point onwards falls with the community team.

Community Treatment Orders

110. It is my understanding and view that any patient with an enduring mental illness that is subject to Section 3 MHA can be considered for a CTO as part of their discharge plan. Any patient on Section 2 or a patient who is an informal patient not considered to be detainable on section 3, cannot be considered for CTO.

111. To be considered for CTO, the patient needs to meet certain criteria or characteristics. The CTO is usually considered for revolving door patients (repeated admissions to hospital most commonly due to non-compliance, and therefore the intention is to reduce repeat admissions to hospital). The CTO aids in encouraging patients to abide by the conditions set which could include taking their medication and if not, there was the potential consequence of recall back to hospital. In these situations, the power of recall available in a CTO is beneficial in cases where a patient's deterioration and risk escalate very quickly requiring speed of action.

112. Where the patient has repeated admissions and presents with risks that are very closely linked to poor or non-compliance to treatment, a CTO will be strongly considered. The CTO's main benefit is the ability to recall the patient into hospital if conditions are not followed and hence lead to early intervention which mitigates risk.

113. When considering CTO for a patient, consideration of risk that is linked to mental disorder is one of the required criteria for the application of a CTO. The MHA focuses the risk on risk to mental health, risk to self and risk to others. I am not aware that either the MHA or the MHA Code of Practice give any specific consideration to criteria for patients with specific histories (such as violence or aggression) for CTOs. I am not aware of there being any special criteria as it is my understanding all risk needs to be considered that falls within the risk of risk to mental health, risk to self or risk to others. Where the risk is concerning and significant, the risk is driven by the presence of mental illness with treatment demonstrating evidence of mitigating the risk

and there is evidence of poor compliance/engagement with services leading to repeated admissions, CTO needs to be considered.

114. It is my understanding that the CTO must continue to fulfil the same criteria for detention on Section 3. The CTO is an extension in principle of a Section 3, into the community. The risks, which mean that the patient continues to be under Section 3, cannot be seen in isolation and there must be evidence that the risks are driven or influenced by symptoms of their mental illness. The control of symptoms, which is dependent on compliance to treatment is the main factor that leads to deterioration and increase in the respective risk and to address this, the CTO could be beneficial as a tool to enhance compliance with medication, predominantly given as depot form.

115. The key factors that I would be looking out for would be evidence of non-concordance to medication in the community, reluctance to take medication on the ward and needs regular prompting, history of repeated admissions to hospital precipitated by non-concordance to medication, patients who show partial to poor insight, patients who misuse illicit drugs/alcohol, patients who show and have demonstrated a history of masking of symptoms and the patient who shows poor engagement.

116. The situations in which I would insist that the patient will need to be discharged on depot and there was no other option would be in situations where there were significant concerns around risk, repeated admissions leading to impact on quality of life, to maintain stability of the patient's mental health so that services in the community can safely manage them in the community. It will also be in situations where the community team managing the patient are of the strong opinion, which will be based on the above factors,

that patient can only be safely managed in the community and avoid readmissions if the patient is on depot.

117. In all these situations it is important that there is support and agreement from the community teams as they will be tasked with the responsibility to ensure the treatment plan is adhered to in the community. The community team needs to put plans in place of how to deliver this.

118. In terms of considering depot medication and its relationship to risk, it is my view that all risks and all of the patient's history need to be considered in the decision making around a CTO and depot medication. Where it is clear that the risks are driven by the patient's mental disorder and there is evidence that medication compliance addresses or mitigates the risk, if there are patterns of repeated non-compliance, depot medication should seriously be considered and this may also include using the legal framework of the CTO to ensure the patient adheres to the depot.

Staffing Levels

119. Staffing levels are usually managed by the ward manager. In my experience, staffing on wards can vary widely from positions of well-staffed to times when staff shortages are present and attempts are made to plug the gaps with agency staff. To my knowledge and confining myself to the time when VC was admitted under my care (this was during the period of COVID pandemic), and to Rowan 1, overall, I do not recall that I was made aware that there were significant staffing shortages on the ward. Based on this it was my understanding that in terms of the day to day running of the ward, there was safe staffing on the ward and if there were gaps these would have

been covered by agency staff. I was aware that there were no gaps in terms of the medical support for the team on the ward.

Part B

1. VC's First Admission (under Section 2 MHA) – Rowan 1, Highbury Hospital, ("First Admission") Relevant Dates: 25 May 2020 – 17 June 2020 (23 days)

Initial observations, assessments, and care plan

120. VC had been detained on a Section 2 of the MHA after having been assessed on 25 May 2020. VC was transferred from the Cassidy Suite and arrived on Rowan 1 ward of Highbury Hospital at 23:30 on 25 May 2020. It was noted by nursing staff that since he had arrived, VC presented as suspicious, was responding to unseen stimuli, was reluctant to engage, refused to be clerked by the on-call doctor or engage with physical examination, presented as unsettled, had been kicking doors and had required PRN medication, Lorazepam to help him calm down [NHFT0000168 p5].

First Review by MDT

121. I first became aware of VC on 26 May 2020. This was a Tuesday which is one of my Ward Review days. Prior to the start of my Ward Reviews planned for the day, the nurses informed me that we had a new admission who would need to be seen for their 72-hour senior review. We agreed that I would see him later that afternoon, after the planned Ward Reviews. Having looked at the records, I finished my planned Ward Reviews with other patients at 15:30 and then we started to discuss VC with the view to doing his 72-hour senior

review. The record on Rio of this discussion is titled: "*MDT Discussion […] Patient Review – MULTI DISCIPLINARY TEAM*" [NHFT0000168 p7]. With those present: my junior doctors, the ward nurse and myself, we reviewed what was recoded in VC's Rio records with regards to reasons for his admission and his section status, and the nurse gave an update of how VC had been on the ward to that point. VC was described as changeable and chaotic, he was not happy to be on the ward and we agreed that we needed a period of observation and assessment on the ward and would delay the 72 hour senior review for 48 hours and plan to see him on Thursday of that week (28 May 2020). This was the next day in the week that I had Ward Reviews.

122. When discussed by the MDT on the afternoon of 26 May 2020, VC had been on the ward for around 15 hours. It was determined in the MDT discussion that VC: "*Requires a period of observation on the ward to do an assessment of his metnal [sic] state and hence we will defer the 72 hour review until Thursday as he is in a state that is too chaotic for this now*" *[NHFT0000168, p7]*. VC had a plan in place to start Olanzapine, atypical antipsychotic and having reviewed the notes I made the decision that he would also benefit from a regular benzodiazepine, specifically Clonazepam to manage his distress. Both these were prescribed during the MDT review. Based on the view that he had just been admitted to the ward, he was clearly unsettled as stated above and there was a preliminary treatment plan in place, I made the clinical decision that the senior medical review could be planned after allowing him time to settle on the ward and to allow nurses to make observations of his presentation. This would also allow the effects of the Clonazepam to start to work to calm him down. This would allow a better assessment, and the 72-

hour senior medical review went ahead on 28 May 2020 (within 72 hours of his arrival). Interviewing him on the day he was admitted and having understood that he was presenting as challenging, would have been challenging and would have achieved little based on how he was presenting on the ward, for example on the day he was admitted, he kicked a glass door, was agitated, he wanted to leave the ward, the nursing staff had to pull the ward alarm, he had to be restrained with the help of the response team, and he required PRN Lorazepam. [NHFT0000168, p8].

Summary and Care Plan – 26 May 2020

123. At 05:02 on 26 May 2020, a "Summary and Care Plan" was completed by Campbell Mtetwa, who is a nurse and VC's "Key Worker" [NHFT0000207]. This is a Summary and Care Plan that the key nurse makes in conjunction and agreement where possible with the patient they are key working. This is meant to be a fluid document which should be updated when things change, and new information becomes available. It is my understanding that this Summary and Care Plan related to the initial admission period which would then be changed to account for the progress that has been made over time. I believe that this document was based on information available to the nurse in the Rio records and the time he had been on the ward, which was about 5 hours.

124. I did not have any input in drawing up the Summary and Care Plan. This is a document that the named nurse and the patient agree on and co-produce. The document can be informed by the MDT and Ward Reviews that I lead on

the ward, and it is for the key worker and the patient to raise any concerns or issues related to the care plan that they have agreed on.

125. It is my view that with the available information that was known and recorded in the Rio notes, and the short amount of time he had been on the ward, the nurse did accurately reflect all the key information that was known to inform the Summary and Care Plan. However, I do acknowledge that the document should then have been reviewed and changed as time passed, as further assessment and management did take place in the course of the admission.

126. It is my view that this document should have been updated as the admission progressed, taking into account new information, new observations and assessments made, taking into account discussions within the MDT meetings and Ward Reviews.

127. The document asks, "*has the patient participated in the development of the care plan*" and the answer is given as "*does not have capacity*." The principle of capacity, as per the MCA, operates on the principle that capacity is presumed and there is an obligation to act in the person's best interests with the least restrictive option. One will need to consider the formal assessment of capacity where a person is unable to make a particular decision at a particular time because their mind or brain is affected by illness or disability. A person can have capacity for one decision and not for another. Lack of capacity may not be a permanent condition. Where there is evidence of disability of mind or concerns around a patient's decision making, capacity will need to be formally assessed, and it is a legal requirement that I have incorporated in my practice to follow the MCA guidance and principles.

128. What is recorded in the Summary and Care Plan therefore is that the nurse was of the view that VC did not have the capacity to engage, contribute and make informed decisions regarding his care plan at that time. I cannot offer an opinion as to how the nurse in question made the capacity assessment as I do not know what questions were asked and how the nurse came to their opinion. It was also my view that at the time of admission, VC lacked capacity as his decision making was clearly compromised by the acute psychotic symptoms he was experiencing (see my email correspondence with the police at paragraphs 226-233 below). It is my view that the nurse made this view likely based on VC's presentation where it is documented by nursing staff that on arrival, he was responding to unseen stimuli, not engaging and he appeared suspicious. It was thus obvious that VC was presenting with a disability of mind, and this was impacting on his decision making and likely to be impacting his capacity.

129. Within a few days of VC' admission to the ward and after his Ward Review with me on 28 May 2020, there is consistent nursing documentation which describes VC as being settled, no longer agitated, engaging with staff, interacting with his peers, eating and sleeping (observed sleeping for 7 hours on average), taking medication prescribed, improved focus and attention and observed playing chess with other patients. His MHA section rights were read to him which he understood, and he also agreed to read the information leaflet. He engaged appropriately in Ward Reviews, he was articulate, and he participated in discussions around his mental health and also decision making. As the admission progressed it was my opinion that VC did demonstrate capacity to make decisions around his care and was able to

participate in his care plan. He participated in making decisions for example around his medication, discussions around his formulation, section 17 leave, and activities on the ward.

130. The Summary and Care Plan should have been updated by his key nurse on the ward, but based on the documentation I have seen, this did not happen. I am unable to give a reason as to why this did not happen, but the key nurse should have been responsible for this.

131. Having looked at the records, the only other updated Summary and Care Plan for this admission is dated 3 June 2020 [NHFT0000206] completed by the nursing student, probably at the supervision of the key worker. This was 8 days into VC's First Admission.

132. It is my view that the two documents are almost identical. The second document should in all circumstances have reflected what had happened and changed in the 8 days since the first document was completed. Based on this, it is my view that the second document did not take into account any of the assessments that had taken place since in admission, the change in his presentation and the plans that had been put in place. From review of the notes, changes noted include his observation levels had been changed on 2 June 2020 to general observations from intermittent observations, he had been sleeping better, he was already prescribed Zopiclone to help with sleep as required, he was given section 17 leave which was escorted to grounds granted on 2 June 2020, and he was to be referred to the EIP service for community care.

133. I confirm that it would be good practice to update the document to capture accurately the most current Summary and Care Plan, however I would note

the difference between its use in the community and inpatient wards. In a ward setting, it is my view that the Summary and Care Plan related to the patient is better captured in the documentation within the Progress Notes and specifically the care plan agreed at the end of each Ward Review. What should have then happened is that the Summary and Care Plan document is updated based on this and this is then jointly co-produced with the patient and their key nurse. It is my view that the document updated on 3 June 2020 did not accurately reflect all the key information, but the Ward Review care plan within the Progress Notes did.

134. The Summary and Care Plan document in Rio, in my opinion is not a very user-friendly document within an in-patient setting as compared to the community setting because the situation in the inpatient service is more fluid and rapidly changing and it is not practical to be regularly updating the Summary and Care Plan. This is in contrast to what happens in the community where there is more stability and less change over time. It is my opinion that the Summary and Care Plan is more helpful in community care provision where care plans are more static and stable. However, I can assure the Inquiry that patients are made aware of the changes that do take place in their management during Ward Reviews and it is then expected that this will be reinforced in the Summary and Care Plan document that is co-produced with the named nurse and the patient.

Risk and Safety Assessment – 24 May 2020

135. On 24 May 2020, after VC had been arrested by the police and taken to Bridewell police station, he was assessed under the MHA as his behaviours

whilst in custody suggested he was not mentally well. The outcome of the assessment was that VC was not detained at that time but instead a plan was made to manage him in the community. This was prior to my involvement with VC.

136. A Risk and Safety Assessment was completed by Annette Palmer (Clinical Lead Nurse) on 24 May 2020 [NHFT0000197]. I am not entirely certain but taking into consideration what I understand usually happens, I would expect that this document was completed based on the Rio medical records. She most likely took into consideration information documented in the Progress Notes (the entry made on 24th May 2020 by the Liaison and Diversion Service) [NHFT0000168 p1] and her own attendance at the first MHA assessment that took place on 24th May 2020 when VC was not detained. This Risk and Safety Assessment document was present in VC's electronic medical records however I did not review this document when VC was admitted to the ward. This document is completed by the professional based on information that is documented in the medical notes, the professional's own assessment and any other relevant information such as from family, carers, police, other agencies. VC was a new patient to the service, and it was my understanding that all the information was available in VC's Progress Notes, including what was contained in this risk and safety assessment document, and that is what I concentrated on. Upon review now, I note that its contents were evident in the Progress Notes and nothing important was missed. It was my view at the time that all the information was in the Progress Notes, VC had not had any assessments completed by health professionals other than by the street triage team and by health professionals when seen

for his MHA assessment. Annette Palmer had populated the document based on the information contained in the Progress Notes and her presence at one of the mental health act assessments that took place.

137. I cannot comment if Annette Palmer was aware of the Royal College of Psychiatrists Good Practice Guide and it would not be expected as she is a nurse and hence would not be expected to follow this guide as the college is for psychiatrists.

138. Having said that, it is my view that broadly, based on the information gathered around the events of his arrest and the subsequent assessment that took place at the MHA assessment, the risk and safety assessment done by her, appropriately captured the key risk issues to himself and others. The document showed that there had been no risk to self, there was no known risk from others, and she did tick Yes for the risk to others, as there was clear risk of aggression.

Summary / overview of developments in VC's presentation during the First Admission

139. Patients admitted to the ward are constantly assessed in a number of ways. This includes direct objective assessments by staff on the ward, 1:1 sessions with their key nurse, interactions and engagement with OT, behaviours exhibited on the ward, risks and incidents, use or need of any rapid tranquilisation treatment, rapport and levels of engagement, participation with activities on the ward or off the ward and in Ward Reviews. Staff then make summary notes of their interactions in the patient's Progress Notes on Rio. This starts from the time they are admitted. These interactions and observations are recorded daily by all staff involved in the patient's care.

During each MDT meeting and Ward Review, the nurse will give a summary of the assessments relevant and will include clinical symptoms, important behavioural observations, any risks, ADLs (activities of daily living), levels of engagement, and utilisation of leave. The aim of gathering this information is being able to start to formulate an opinion with regards to how unwell they still are, improvements they have made or are making, what risks are evident if any, if there has been mitigation of risk, functioning, compliance to treatment.

140. The notes show that in the first two days of admission, VC was not engaging with staff, he was agitated and pacing, he had kicked the doors (though there were no incidents of violence towards staff or other patients), he appeared distant, long stares and he had on one occasion attempted to leave the ward, required restraint and required rapid tranquilisation medication to help manage the challenging behaviours. By the evening of 27 May 2020, the nursing entry records that *"Valdo has presented as a lot more settled that was previously. He has been engaging with staff and was spent time in communal area interacting with peers"* [NHFT0000168 p9].

141. The first Ward Review (ward round) that a newly admitted patient has is the 72-hour senior medical review. He engaged well at his 72-hour senior medical review on 28 May 2020. He was calm and there was no evidence of aggression, intimidation, or hostility. He demonstrated an understanding that he was in a psychiatric hospital. He was able to reflect on the incident that involved the police attendance at his flat, he said this behaviour was out of character for him and described his symptoms of illness including hearing voices [NHFT0000168 p11].

142. There was consistent nursing documentation that he was settled, there had been no evidence of aggression/hostility/threatening behaviour and he was described as polite and pleasant on interaction.

143. In his second Ward Review, on 2 June 2020, nursing staff reported that he was quiet on the ward, predominantly room based, would come out during mealtimes, appropriately interacting with staff good and peers when he did, his sleep was good but he was "perhaps somewhat guarded". This meant that he was not openly willing to discuss his underlying mental health difficulties and deflecting by saying all was okay. His interaction in the Ward Review itself was better: he did respond to questions, and he left me with the impression that he was able to recognise that he may have a mental health problem, it will require treatment, and he agreed to accept help and support. In view that he was settled, there had not been any risk concerns since the last Ward Review, it was jointly agreed with the nurse that his observation levels could be changed to from intermittent observations (where VC was checked every 10 minutes) to general observations (where he was now checked once every hour, at least). These observations could be changed at the discretion of the nurses if circumstances change where the observations need to be increased. He was given escorted leave with staff to the hospital grounds (section 17 form completed) and we would also make provisions for him for his family to visit him in hospital bearing in mind that there were social distancing rules due to COVID. At this point he was not on any regular treatment. It was also agreed that the nursing staff will make referral to the community mental health team, (Early Intervention in Psychosis team) that

covers his locality to ensure he had community follow up upon discharge from hospital [NHFT0000168 p17].

144. However, subsequently after this Ward Review, there was a change in his presentation. The nursing staff recorded that VC in the early hours of the morning on 5 June 2020 informed staff that he could hear a voice (a woman's voice who was in distress) and felt it was coming from the linen cupboard but there was only linen in the cupboard when he asked the staff to open the linen cupboard. VC was noted to be pacing the ward, and his engagement had reduced [NHFT0000168 p23]. In the course of the day on 5 June 2020 I was informed of this by the nurses and I reviewed VC with his family present on the same day. I explained to VC that based on all the information I had and the event that night, it was confirmation that VC was experiencing an acute psychotic illness. VC was not pleased with this opinion but was able to acknowledge that he had not been right. His father who was present also revealed that there was a possibility that his own father may have had mental health difficulties, but no specific diagnosis and he never got treatment. This may point to some genetic component to VC's illness. I explained to VC that he will need to start medication, and I recommended as per NICE guidelines an atypical antipsychotic to be considered as first line medication. There are a number of medications within this class and the choice of which one comes down to clinician familiarity and differences in side effect profile. Aripiprazole is generally a good choice in patients who have never taken an antipsychotic because it is not as sedative as the others, does not cause problematic sexual side effects, the efficacy is the same as the others and it is generally better tolerated. On this basis I decided on Aripiprazole, 5mg once a day

[NHFT0000168 p24]. It is generally advised that one start with low doses and increase as clinically needed. Aripiprazole maximum within the BNF is 30mg once a day.

145. In the MDT meeting on 8 June 2020, nursing staff reported that VC was mainly bedroom bound, he was pleasant and polite on approach but not proactive in engagement and seemed withdrawn and not eating as well. Discussion was had if he could be masking symptoms (this is explored further below) [NHFT0000168 p26].

146. During Ward Review on 9 June 2020, VC had been taking the Aripiprazole for about four days. The response effects of these medications can be seen from as early as two days but could be delayed for 10 to 14 days. VC had trimmed his beard and moustache, he engaged well in the review, he had been taking his medication and said he had found it helpful. This was in keeping with my experience of other patients describing feeling better within a few days of taking medication especially when never having taken antipsychotic medications before. He denied experiencing any current psychotic symptoms when directly asked. He explained that he was not very good at interpersonal relationships and liked to keep to himself. He said he was still disappointed about the news that he had an illness and having to take medication, which was supervised by the nurses on the ward, but this was different to denying that he had illness at the start of his contact with services. This was positive and indication of some insight. He denied having any thoughts of wanting to hurt himself or others. He was keen to live in Nottingham and not go and live with parents in Wales. He was able to understand his formulation and his treatment [NHFT0000168 p28].

147. It was my view at this stage that VC understood what I meant by the term psychosis and the types of symptoms this condition presents with, using his own symptoms as examples. He was able to understand why an antipsychotic was being suggested and how it would work. Positively we had no difficulties on the ward with his compliance and his need to take treatment. It was my view that this was a demonstration of a level of insight. There had not been any incidents of risk to self or others on the ward.

148. He seemed to have taken some of the discussion in the Ward Review on board. The next day, on 10 June 2020, he went off the ward to the allotment on the hospital site with the occupational therapist who summarised that VC engaged well in conversation, behaved appropriately, he was not observed responding to unseen stimuli or distressed [NHFT0000168 p31]. Later the same day when seen by the nurse on the ward, it is documented that VC was bright in mood and pleasant. He talked about what he would do when discharged and also his plans around his studies with a desire to complete his studies [NHFT0000168 p32].

149. At his Ward Review on 11 June 2020, VC engaged well, he had gone off the ward on leave to the grounds which he found pleasant, he was able to discuss plans regarding his accommodation and his studies. It was stressed to him the importance of taking his medication which he acknowledged and gave assurances that he would take them. He did not describe any acute psychotic symptoms and there had not been any behaviour whilst detained that posed a risk to himself or others [NHFT0000168 p35].

150. Over the next few days, there was consistent documentation from nursing staff that VC had been settled, he was being nursed on general observations,

polite in manner, no behavioural problems, mood was brighter, he was compliant with his treatment, spending time in communal areas and utilising the agreed grounds leave which was escorted with staff, one to one.

151. On 17 June 2020, I saw VC with his mother. This was the day he was discharged from hospital. This was planned and VC and his family were made aware of this. The plans for his follow up in the community were also agreed and put in place. At the review, VC was pleasant, he was able to take on information that we discussed, he demonstrated understanding of this information including the discharge plans which were explained to him again. I once again stressed to him the importance to continue taking his medication, he needs to sort out and ensure he has stable accommodation, he should engage with the crisis team to start with plan for him to be managed by the appropriate community mental health team and he should ensure that he requests repeat prescriptions of his medication from his GP [NHFT0000168 p49].

152. In terms of the assessment of risk, it was clear to me that his risks were driven by the presence of active psychotic symptoms. During his stay on the ward there had not been any evidence of risk of harm to others. Even when he was unsettled in the first two days on the ward, he did not harm anyone, and his frustration was directed to furniture (kicked a glass door and restrained as he was attempting to leave the ward). For the most part, excluding the first two days of his admission, VC had not shown any evidence of aggression, intimidation or hostility to staff or peers. On direct questioning he denied any thoughts or intention to hurt anyone. His mother also confirmed that he was not a violent person by nature. There had not been anything in

his past where he had acted in a violent manner towards another individual and confirmed by his mother. His presentation, behaviour and actions were closely monitored, and they did not indicate any risk of harm to self or others at that time. He was often described as polite and pleasant in manner. The risk of relapse was also low as he was taking medication (to which he had shown response) and his medication was supervised.

153. As VC's admission progressed and we were able to get a better understanding as to what was going on, this guided our decision making. We made every effort to try and rule out any alternative explanations of his presentation like the possibilities of illicit substances being involved, any mood symptoms or any overt organic conditions. He was given a period of no medication from when I first reviewed him on 28 May 2022 until 5 June 2020, when I started him on Aripiprazole. When the evidence of overt psychotic symptoms became evident, he was started on antipsychotic medication to which he responded. This helpfully also proved valuable in convincing VC that his experiences were not in keeping with reality and helped with insight. VC was informed that it was my conclusion that he was suffering with a mental health illness, and he will require treatment. He accepted to start medication, and he responded well. This, and his risks being low on the ward, guided us in his observations being reduced from intermittent (every 10 minutes) to general (every hour), he was given escorted leave off the ward to the grounds, and he was supported with family visits. We also started to talk about discharge and the care he will need in the community. He was compliant with treatment and there had not been any risk incidents to self or to others since

28 May 2020. It was clear that control of his symptoms would lead to mitigation of the risk.

Clinical Reviews

N.B. the sub-headings stating the date of reviews are to assist with navigation of the document, but do not mean that the entirety of that section relates directly to that review, as various of he reviews pick up on themes for further, more general discussion.

72 Hour Review – 28 May 2020

154. On 28 May 2020 we reviewed VC for his 72-hour senior medical review, during his first Ward Review. The people present were Dr Ludvigsen (ward doctor), Dr Ibrahim Hakam (F1), Amanda Smille (senior ward nurse), Helena Samila (student nurse), VC's mother who attended via phone, VC, and me. The 72-hour review is required by the admission policy of the trust [NHFT0001243]. The record is titled 'Ward Review but should have been titled '72-hour senior review'. It is the understanding and principle that for all new patients admitted to the ward, their first Ward Review is the 72-hour senior medical review. The purpose was to review the circumstances of his admission, understand the patient, gather information in the context of their history, mental state examination, analysis of the information available, formulation/impression and decide on a management plan. This also includes assessment of risk.

155. The process of making decisions around a patient's mental health and formulating risks involves collecting information, collateral history, observations, assessment of behaviours directly (which was possible as VC

had been admitted to the in-patient service) and to include mental state examination. We would consider the evidence of any historical risks, current risks and determine if there are any protective factors which will then inform the risk assessment.

156. Within "Feedback / Ward round discussion" of the review, there is a section from the nursing staff which noted that VC was still "*very unwell*" but was "*less chaotic, less aggressive.*" Under "Family/carer involvement" it states that VC's brother told the MDT team that VC informed him that there were voices telling VC that "*some people are coming after his family*" and under "MDT discussion, it states that Dr. Ludvigsen "*believes that VC is responding to unseen stimuli*" and when asked what he was thinking about he said, "*capital punishment*." [NHFT0000168, p11]. VC was asked to explain what he meant by his comments about capital punishment. VC did not elaborate, and it was difficult to fully understand what he meant. I did focus on finding different ways to assess his risk to self and others by way of his behaviours, his thoughts when he did engage. He did not again express this thought.

157. There was clear evidence from information gathered prior to his admission, information from the family, our own assessments of VC that he was presenting with a first episode psychosis, and this was shared with VC and his family. The above all factored into our analysis and conclusion of his risk.

158. It was clear that the risk of potential harm to others was dependent on the presence of acute psychotic symptoms. That was the only consistent factor driving the risk.

159. In terms of historical risk, from the assessments and information we gathered including collateral from the family, there was no suggestion or

reports of a history of historical trauma, there was no past history of abuse, there was no past history of violence, VC was described as polite and pleasant and kind by his family, the recent behaviours were completely out of character, he did not indulge in illicit substances or alcohol. From VC and his family, particularly his mother, I was able to ascertain that VC had not had any involvement with the police in the past. I had no reason to doubt that his mother was a reliable person in providing collateral history.

160. We were aware of the two recent separate incidents within 24 hours that led to his eventual detention to hospital, and it was evident from the documentation that these incidents were driven by his psychotic beliefs with the intention being to save a woman who was in distress who he believed to be his mother. It was our view that his risk of aggression was high at the time of the events, but his risk of violence was low as he had not assaulted anyone. It does not necessarily follow that a person who is aggressive will necessarily proceed to violence. The understanding is that people who are aggressive or have aggressive tendencies will have a higher risk of violence. Hence there is a level of association.

161. During the First Admission, other than in the first two days when he was aggressive, kicked doors and required rapid tranquilisation, there had been no further incidents of aggression, hostility, or harm to others or to self. The view of the nursing staff who witnessed and managed this incident was that it had been because VC was unhappy being on the ward, he did not feel he needed to be in the hospital and did not understand why he was brought to hospital. He was clearly agitated, and he told the staff that he wanted to leave the ward. Thereafter, he was described a lot of the time by nursing staff as

being calm, polite, and pleasant. The staff reported no incidents of intimidation or antisocial behaviours. On the first Ward Review on 28 May 2020, it is my recollection that VC was polite and respectful, there was no intimidation, he engaged well, and a good rapport was established. There was no aggression, and he did not seem irritable.

162. In my own interactions with him, he was respectful, he was polite, he engaged well, there was good rapport established and at no time did I feel intimidated or threatened.

163. Based on our assessment, we concluded that the risk of aggression he posed and the potential risk of harm to others was closely linked to the presence of active psychotic symptoms which were drivers of his recent aggressive behaviours. It was my view that if his symptoms could be treated using antipsychotic medication that he responded to, the future risk of aggression and potential risk of violence to others would also be mitigated. This is why there was a significant emphasis made to help him recognise this and ensure compliance to treatment when this was started. By the end of the admission, it was my view that he had been on an adequate dose of the medication and for an adequate time to judge that the medication had been effective, controlled his symptoms, and mitigated the risk.

164. At every point when medication had been initiated and established, the message was reinforced to VC as to how important it was going to be for him that he continued these in the community and there was going to be community follow up that will monitor and support his compliance and mental wellbeing.

165. It was clear in the nursing documentation that VC was not very interactive with them and his engagement was poor. This was more evident from the time he was admitted to when medication was started on 5 June 2020, as there was a noticeable change reported by staff on the ward after being on medication for a few days. He was not very vocal with the staff on the ward. However, from the beginning, his attitude and interaction in Ward Reviews was very different where I was able to establish rapport, get him to answer questions and have discussions around his mental health.

166. During the first Ward Review on 28 May 2020, it was my general opinion that VC demonstrated a level of insight in that he acknowledged that he had not been himself, he had some odd experiences, his mind was not clear (VC said "*my mind has become clearer since my admission*") and his actions were out of character. This was a change to what he had said a few days previously when assessed under the MHA and when he arrived on the ward.

167. In subsequent Ward Reviews, including the discharge meeting where his mother was present, there is evidence documented where VC acknowledged that things had not been right, that his behaviours were out of character, that the symptoms he had including hearing voices were not normal occurrence and he understood that it was our expert opinion that this was suggestive of mental health difficulties and specifically that this was suggestive of psychosis.

168. At the start of the admission, he had not wanted to take medication as he felt his difficulties were probably due to not sleeping and stress and felt his difficulties would remit. I agreed to follow this request from him, and it would also allow me to make a medication free assessment. However, it became

evident within a week of his admission that he was experiencing acute psychotic symptoms despite now sleeping better and his stress levels had reduced. This gave evidence that his symptoms were more indicative of illness, most likely a functional psychotic illness. This was discussed with VC, he accepted that this would suggest mental health difficulties and that he needed medication to treat his psychosis which he agreed to do. He was compliant with his medication throughout his stay on the ward from when it was started. It was positive to see the good response to medication he showed on the ward.

169. In summary, VC acknowledged that things were not right, he admitted that his recent behaviours were out of character, he accepted that his symptoms of illness were suggestive of mental health problems and specifically psychosis, he agreed to take medication which he understood was to help treat the psychosis and he showed a positive response to medication. This analysis suggested to me that he did have insight in that he knew that something was not right which he now understood to be his mental health and that he needed to take treatment.

Ward Review – 2 June 2020

170. VC's next Ward Review was on 2 June 2020. Under "Patient Diagnosis/ICD10 Code" VC is recorded as experiencing "*psychosis*." [NHFT0000168 p17]. Psychosis is a general term to describe the presence of experiences that are not in keeping with reality. They include positive symptoms such as delusions, hallucinations, thought disorder, passivity phenomenon. They also involve negative symptoms like lack of motivation,

diminished emotional experience, reduced or paucity of speech, social withdrawal, and decreased ability to feel pleasure.

171. Psychosis or psychotic symptoms are not only evident in schizophrenia but can also be present in other forms, such as organic conditions, mood conditions, or substance related.

172. This was VC's first presentation to services, and one needs to ensure that all possible causes of psychosis are explored before a definitive diagnosis is made. This is standard medical practice. There tends to be diagnostic uncertainty in relation to the possible aetiology of a psychotic illness and it is only with time that one is able to get this certainty from information regarding the progression of the illness, its course, symptom consistency and exclusion of other potential differentials like mood disorders. Studies on the natural course of psychotic illness have shown that there is a 20 percent chance that the psychosis would not recur [NHSE0002453].

173. It would be poor practice to jump into a diagnostic label so early in the evolution of an illness. In principle, whether the label of psychosis is used or schizophrenia, it does not have a significant bearing on the treatment. It does not delay treatment, and treatment will not differ significantly. It is accepted practice that people presenting with a psychotic illness for the first time are more accurately labelled as experiencing a first episode psychosis until there is clarity of symptom stability and consistency, with the nature of the illness and other possibilities ruled out. First episode psychosis, which excludes aetiology, also ensures that the patient has the correct community treatment pathway via the early intervention in psychosis team. A wrong diagnosis of

schizophrenia has also implications on outcomes (schizophrenia has a poorer outcome as compared to mood disorders) and stigma.

174. Under the risk assessment within this Ward Review, the risk to others is recorded as: "*He believed others were trying to spy on him/torment his mind and tried to enter a neighbour[s] flat to confront them, there have been no incidents of violence yet but this would be a potential concern if acutely unwell*." [NHFT0000168 p17].

175. At the time of the First Admission, I was aware of the facts that VC had on two occasions attempted to damage the door of a neighbour's flat which I believe was clearly driven by experiencing a psychotic breakdown at the time. I knew that on the first occasion he had damaged the neighbour's door, and police were called and the second time he had done the same but on this occasion the occupant, out of fear, jumped out of the window for safety and hurt themselves. This was recorded in the documentation made by the city Liaison and Diversion mental health team based at the police station as VC was arrested for the second time and seen by them [NHFT0000168 p3-4].

176. From the information available it was fortunate that on both occasions VC did not gain entry into the flat. VC was clearly seeking to gain entry as it was his intention to investigate his conviction that a woman, his mother, was being raped and he wanted to go and rescue her [NHFT0000168 p2-4]. There had not been any assault or violence towards another. It was my opinion based on the information I had that VC was clearly a risk of aggression, but his risk of violence was low. It is my understanding that the two can be linked (aggression with violence) but it has been my experience that not all patients who show aggression will necessarily go on to be violent. Hence the two risks

need to be seen and assessed separately. It is my recollection that I questioned VC during one of my Ward Reviews early on in his First Admission about what he would have done if he indeed had gained entry, and he responded that he wanted to save the woman and had no intention to hurt anyone.

177. It was clear from the documentation and the collateral history obtained from the family that VC was experiencing an acute psychotic breakdown, and he was hearing voices and delusional beliefs that a woman was in danger, he believed this woman to be his mother he had to go and save her. He made the opinion that the noise was coming from the neighbour whose door he damaged.

178. It was clear, based on what had happened and VC's actions, that VC demonstrated a high risk of aggression, but his risk of violence was low. There was no evidence or suggestion that VC had assaulted anyone.

179. However, through my experience of having managed patients with similar clinical presentations and when patients have the conviction to act as VC did, I made the impression that VC posed the likelihood of repeating his behaviours (approaching his neighbour's door, banging on the door an there being a potentially different outcome if the neighbour did open the door) when ill, could then potentially lead to a risk of violence to others. It is my experience that it is usually past behaviours and acts that predict risk going forward. It was my opinion that VC's current risk of violence from the facts available was low but there was the possibility of violence if he acts on the conviction of his psychotic beliefs and confronts those who he believes are the perpetrators. Based on his description of what happened and his actions, it was clear that

for VC the beliefs and experiences he had were real to him and drove him to act.

180. It is my usual practice that where we have a patient who has a history of crime/antisocial behaviours or has been admitted due to recent concerns of criminal behaviour, we as ward will contact the police and attempt to gather information around any recent alleged crimes, any court appearances, bail and bail conditions, probation and also request a PNC check.

181. On this occasion, in relation to VC, the incident around the two arrests by the police that took place prior to his First Admission to hospital were clearly documented in his Rio medical notes within the Progress Notes: a record made by City Liaison and Diversion team on 24 May 2020 at 09:54 [[NHFT0000168 p1], Street Triage Tam, Nurse David Todd on 24 May 2020 at 21:13 [[NHFT0000168 p3]; City Liaison and Diversion team on 25 May 2020 at 09:09 [NHFT0000168 p3-4]; and the two MHA assessments that took place on 24 May 2020 and 25 May 2020. This information was available and accessible to all of us on the ward. I can confirm that I reviewed all his Progress Notes prior to the first review and made myself familiar with his case and what was known. The information contained the context of VC's arrest, the allegations, and how he had presented in the police station. The MHA assessments took place at the police station, and the context of the arrests were known to the panel doing the MHA assessment.

182. It was also my conclusion that it was the preferred police option that they had decided to follow the mental health diversion route rather than prosecute. This was because the police had involved mental health services, they were of the view that VC was not well mentally, the custody sergeant made

enquiries as to when the MHA assessment was going to take place (this information was conveyed by the city Liaison and Diversion team to the crisis team and documented on Rio on 25 May 2020 at 11:50 [NHFT0000168 p4]) which suggested that it was also their thinking that VC needed mental health support. This led me to believe that they were not going to prosecute. Later on during the admission I was approached by a police officer by email requesting an opinion if VC had capacity at the time of the incidents in question and I responded informing the police officer by email that it was my opinion that I did not think that he had capacity (see below at paragraph 226-233). I did not hear back from the police officer which suggested they were not going to take any further action. Records show that I responded to the police officer 7 days later. I do not remember as to the reason for the delay but it would probably have been due to clinical work commitments, management responsibilities and written communication to respond to (mostly via emails as there was more communication via this due to the COVID pandemic and the need to reduce face to face contact).

183. I obtained collateral history from VC's family which clearly indicated no history of violence or involvement with the police.

184. Based on all of the above, I did not feel that contacting the police would have added to what was already known. It was clear what the risks were.

185. By 2 June 2020, having understood the circumstances of VC's admission, taking into consideration what had happened on the two incidents when the police arrested him, collateral information from his family and the assessments we made on the ward, it was my opinion that the risk of violence VC posed was low.

186. I recollect that VC did not realise that on the second occasion when he banged on the neighbour's door the neighbour had jumped out of the room which was on the first floor and injured themselves. VC was clearly surprised and saddened by this news. Factoring what symptoms he had been experiencing and the actions he had taken to date, I discussed and informed VC my assessment and concerns around risk. I shared with VC that it was my opinion that there was a likelihood of the risk of violence to others, especially when he was acutely unwell. Based on his presentation and his behaviours, I formed the opinion that VC was a high risk of aggression when he was acutely unwell. This was based on evidence of the circumstances of his admission, the incidents for which he was arrested on the two occasions and VC's behaviours of unsettled and aggressive behaviour during the first 2 days of the admission to Rowan 1.

187. By the end of his First Admission, it was my opinion that both his risk of aggression and violence were low. After the first two days on the ward, there had been no incidents of aggression/hostility, intimidation, or violence on the ward. It is also my view that when he required restraint on one occasion, during the first two days of his admission, this was not due to him being violent but was to stop him from absconding from the ward. His family described VC as not a violent person by nature and there was no known past history of violence or involvement with the police. VC did not use illicit substances or alcohol. Both his family and VC described his recent aggressive behaviours as out of character for him.

188. He consistently denied any thoughts of harm to others. There had been no violent or aggressive behaviours for most of his admission. He was described for the most part on the ward as pleasant, polite, respectful, and calm.

189. It was my opinion that VC was clearly a risk of aggression when acutely unwell. It was my view that based on the information I had that VC's risk of violence was low. It was also my opinion that there was the potential risk of violence to others when unwell due to the assessment that VC can be driven by his acute psychotic symptoms to act as he did prior to his admission.

190. VC had a stable family upbringing, he was raised in a loving family, he did not have any childhood factors that would be predictors of future violence (such as physical abuse, witnessing domestic violence, being in care, using of substances in early years, truanting from school, bullying, involvement with the police, criminal behaviour, persistent antisocial behaviour) and to this point he had not assaulted or be violent to any person.

191. His recent behaviours were clearly out of character, verified by his family and it was evident that they had been as a result of the acute psychotic symptoms he had been experiencing. There were some associated factors including poor sleep, social isolation and stress that were most likely contributory factors to his psychosis.

192. I also formed the view that with active treatment this risk could be mitigated.

193. These risks were reflected at every point during VC's admission and care planning. The purpose of his care plan focused on stabilising his mental health which would then lead to mitigation of the potential risks mentioned. The purpose of starting him on treatment, reinforcing the message of being concordant with his treatment, to remain engaged with community services,

to develop and understanding of his illness and the risks associated were all for the sole purpose to keep him well, have regular monitoring which would mitigate the risk he posed. This was discussed and planned for at each review and at the discharge meeting.

194. The assessment and management of patient risks is the MDT's responsibility. This is done collectively with the consultant taking the lead. The assessment and management of risk ultimately sits with the RC. The RC, in this case me, will gather views and opinions from the staff, review medical notes, particularly noting any incidents of risk. The RC will then make their own assessment by reviewing the patient and come to a conclusion around the risk the patient presents and consider plans to mitigate the risk. It is good practice that all staff continue to assess and review risk on a daily basis to help inform the patient's risk assessment. It was my opinion as the RC, based on the information available and the assessments made, that the risk VC posed was closely linked to his psychotic illness. VC had not shown any risk to himself, and the main risk identified was the risk to others which, as stated, was closely linked to the presence of acute psychotic symptoms of his psychotic illness. There was an emphasis on this in the management of VC's risk, and it was evident to me that control of his symptoms would lead to mitigation of the risks he posed. Formally during MDT's and more specifically the Ward Reviews, risk was discussed, clinicians involved shared their views and opinions and a review of the risk was made and also the key mitigating factors. Risk is fluid and changes with time. Thus, review and analysis of risk is a continuum.

195. Under the heading “Discharge Planning,” within the 2 June Ward Review, the following plan is recorded: “*What needs to happen prior to discharge? more clarity around his mental health and insight, safety planning*.” [NHFT0000168 p18]. This is because it was clear from VC’s interactions on the ward that he was not someone who was very vocal or open. He was not very talkative, and he did spend a lot of time in his room, but this got better when he was started on medication. It was normal practice that in such situations we needed to be more proactive to ensure we gathered all the relevant information to be clear and convinced that VC was better and that his symptoms had improved, that he was showing better insight, and that he would be safe in the community. I thought that clarity around his mental health could be obtained through more proactive time with VC with his key nurse and nurses or staff he had a good rapport with. This could include more active interactions and closer observations of his behaviour, which would help give a better objective picture of his mental health. I wanted the nursing staff and specifically his key nurse to discuss VC’s views of his illness and for him to understand his presentation and what was required to stay well, which if consistent would aid his insight. In terms of safety planning, this was to discuss with VC, to ensure he took his treatment, engaged with the community team, his ability to recognise when he was unwell and what actions would he take to seek help or be safe in terms of risk to self or others. This would be done by the key nurse and at times we would seek the expertise of the psychologist. At this time on the ward, we did not have psychology support and from the notes I am not able to confirm if the key nurse completed this. However, I can confirm that in my interactions with him

I did cover these issues including the need to take medication, link of his symptoms to his risk, social isolation, good sleep and to seek help from his community team/supports.

196. Overall, it was clear that the risk of potential harm to others was dependent on the presence of acute psychotic symptoms. That was the only consistent factor driving the risk.

197. In terms of historical risk, from the assessments and information we gathered including collateral from the family, there was no suggestion or reports of a history of historical trauma, there was no past history of abuse, there was no past history of violence, VC was described as polite and pleasant and kind by his family, the recent behaviours were completely out of character, he did not indulge in illicit substances or alcohol. From VC and his family, particularly his mother, I was able to ascertain that VC had not had any involvement with the police in the past. I had no reason to doubt that his mother was a reliable person in providing collateral history.

198. We were aware of the two recent separate incidents within 24 hours that led to his eventual detention to hospital, and it was evident from the documentation that these incidents were driven by his psychotic beliefs with the intention being to save a woman who was in distress who he believed to be his mother. It was our view that his risk of aggression was high at the time of the events, but his risk of violence was low as he had not assaulted anyone. It does not necessarily follow that a person who is aggressive will necessarily proceed to violence. The understanding is that people who are aggressive or have aggressive tendencies will have a higher risk of violence. Hence there is a level of association.

Observed incidents and information relating to aggression during First Admission

26 May 2020

199. On 26 May 2020, it is recorded by nurse Aisha Yusuf during the "long day" observations:

> *"[VC] walked to the end to the corridor and started to kick a glass door. Staff asked him spot [sic], he would not. Verbal de-escalation was used to no avail. The alarm was triggered at 12:15, the response team arrived and restrained Valdo in prone position. He was administered 2mg Lorazepam on the right gluteal muscle. Staff established dialogue with him, said he wanted to leave the ward. Valdo appeared to have no insight of being detained under Sec 2 of MHA. Part of the restraint team disengaged, and he was escorted to his bed are [sic] in passive hold. Vlado then ran from his room heading for the door, he as [sic] restrained and sat on a chair on passive holds. Valdo went to the main door and started budging it. He was retrained on the flow [sic] and escorted to his bed area once he as[sic] settled*." [NHFT0000168 p8].

200. This incident was reported and given an incident response number IR1 334434 [NHFT0007520]. There is a record of the incident report which is present under the section of VC's records on Rio and heading IR1's. There was only one IR1 completed during his admission to Rowan 1. I was aware of this incident as I had read the Rio notes prior to assessing him in the Ward

Review that took place on 28 May 2020 and the nurse in that review also recounted the incident as part of the nursing report.

201. In understanding this incident, it is important to consider the context of his admission. In-patient psychiatric wards can be quite daunting environments and can be unsettling and scary, and VC had no previous contact with mental health services, community, or in-patient. This was his First Admission, he had been brought to hospital against his will (detained on Section 2). He had not had any involvement or understanding of mental health services let alone an inpatient psychiatric ward.

202. I made the impression that VC was very unhappy to be admitted to a psychiatric ward. He did not understand the reason for his admission, he did not accept the opinion that he was unwell, and he did not see the need to be in hospital against his will. It is also likely that he was agitated due the effects of his acute psychotic symptoms that he had been experiencing and probably was still experiencing. Particularly at the start of the admission, this situation was clearly unstable. In my experience it is not that unusual that detained patients who lack insight and understanding, do not see the reason they need to be on the ward.

203. VC acted out his frustration and also attempted to leave the ward. The situation was appropriately managed by staff, and the acute administration of medication seemed to have the desired effect. VC was very different after this. He was settled and there were no other such incidents.

204. It is my view that VC clearly demonstrated a risk of aggression. This was based on the fact that he was kicking doors, not engaging with staff, and forcefully making at attempt to leave the ward. The restraint was for his safety

and during this event he did not assault anyone, and he did not show any intent to harm others. Based on this it was my view that his risk of violence was low.

1 June 2020

205. On 1 June 2020 at 05:18 it is recorded by Nurse Tafadzwa Matosi during the "night shift" observations:

> *"[VC] went to patient RN bedroom toilet and hiding there, wake up around 03:30hrs [and came in] communal area and fall asleep while he was sat on the sofa, no management issues report at time of this entry*." [NHFT0000168, p15],

206. I was not aware of this until I became aware of it when I decided to review VC to start medication on the 5 of June 2025. This was 4 days later. I had reviewed the notes as per standard practice and became aware of this event and my interpretation at the time was that this further added to evidence of him being unwell, indicating his state of mind, most likely hiding for his safety and most likely driven by underlying psychotic symptoms. It would have been helpful if the nurse who witnessed this had asked VC what he was doing to get more clarity. Based on what I knew and taking into account the symptoms that VC had been experiencing it was my view that this behaviour was driven by active psychotic symptoms and the most likely intention of his behaviour was that he was feeling scared, probably fearing something and decided to hide.

207. There was little to suggest that this indicated that VC was posing a risk of violence to others. There would have been an entry if VC had made any

attempt to hurt the nurse who found him, as might have been expected when the nurse found him, if indeed it was his intention to attack. The nurse was safe and there was no documentation of violence.

4 - 5 June 2020

208. On 4 June 2020 at 17:21, it is recorded by ward doctor Dr. Anna Ludvigsen:

> *"Reports that Valdo was assaulted by peer AO as he was trying to leave the ward. I asked Valdo about this and he assured me that they were just 'playfighting', that this helped to release tension for them both and they both enjoyed it. He thought it was funny that this had been misconstrued as an assault. Despite the fact it took a couple of staff members to pull AO off Valdo when they were both lying on the floor. Another staff member who was there for the duration of the event confirms that he did not think there was anything other than play fighting taking place e.g. there was no aggression.*" [NHFT0000168, p22]

209. The same event is noted by nurse Robin Mame in their long day entry:

    a. *"This afternoon Valdo had Ward Review. Prior to going there he was seen [wr]lestling with another patient and staff had to intervene, however, when spoken to patient stated that they were just playfighting. No management concerns on the ward*" [NHFT0000168, p22]

210. I was contacted by phone on 5 June 2020 by a member of staff (not documented on Rio) that there was a change in VC's presentation. VC had been observed to be pacing on the ward, had stated that he was hearing voices the previous night, and he knew where on the ward they were coming

from (the nurse's entry of this interaction is at NHFT0000168 p23). Based on this information, I decided to review VC the same day, so I reviewed him with his mother in the afternoon, as documented in the Rio notes on 5 June 2020 at 16:04 [NHFT0000168 p24]. I now had enough information (hiding in the toilet, pacing, isolated, hearing voices now) to consider starting medication. As per my practice, as I prepared to review VC, I skimmed through the notes to review and note what patients were presenting as since I last reviewed them, looking for symptoms of illness, risk incidents, improvements. It was then that I became aware of this incident of "wrestling with a fellow peer," as well as the incident around hearing voices which I had been contacted about. The wrestling incident was raised with Dr Ludvigsen, who then spoke to VC about it and made a record of the incident. Dr Ludvigsen also sought the opinion of the staff member who had witnessed the incident and their views on the incident. It is my experience that events of this nature where there are altercations or banter amongst peers was not uncommon on psychiatric wards. My impression at the time of reading this in VC's medical records was that it was a fellow peer who was alleged to have assaulted VC. This incident was witnessed by a member of staff who was present for the duration of the event. It was clear from witness reports that it was the peer who was alleged to have attacked VC and VC did not react in a violent way and made light fun and described it as playfighting, it helped release tension and he felt it was funny that the incident could be misconstrued as assault towards him. I noted that it took two members of staff to pull the other peer off VC, but this was to separate them and prevent anything potentially escalating. In view that VC did not retaliate to what was described as assault towards him, this suggested

that VC's risk of violence was low. Nobody had been injured or hurt. This was in my view an isolated incident (there were no other such incidents) and it was my view that this incident did not suggest or contribute to risk of aggression or violence. Instead, VC's actions to being assaulted and not retaliating suggested low risk.

Text messages between VC and his brother

211. On 3 June 2020 at 18:00 I made an entry in the records, summarising text messages between VC and his brother. Having looked through my records, these were provided to me in an email by VC's mother [WITN0163036]. I printed the email and summarised the contents of the email into the Progress Notes. The text messages as per my entry in VC's medical records were from late March to late May 2020. Included in my summary is the following information:

    i. VC moved flats because "*he believed that he was being monitored and he also heard voices but he believed that some of the people had followed him to the new flat*."

    ii. VC was hearing voices and he could hear them "*speak about him in real time […] (possible 3rd person)" telling VC's thoughts to someone else.*"

    iii. VC is noted to have "*made some remark to wanting to hurt these people he was hearing*."

    iv. VC "*believed that they rented the apartment next to him to keep an eye on him […] [h]e felt people were mocking him and he was having periods where he would start crying*."

v. VC "*comments that the things that were happening to him were beyond what one could think […] something extraordinary or he was losing his mind […] He goes on to say that he confronted these people next door, they denied it and acted to be innocent. He believed they used some type of technology which was quite advanced*" [NHFT0000168 p21].

212. I concluded as a result of this information that these messages:

> "*Clearly shows psychotic symptoms starting and developing over time with associated behaviours around increased religious pre-occupation, crying. Clear evidence of auditory hallucinations third person, passivity, and persecutory delusional beliefs. This suggest[sic] more of a functional illness rather than it being precipitated by stress or isolation.*" [NHFT0000168 p21].

213. The information provided by his brother was extremely important and useful. It helped me understand how long VC's difficulties had been going on. The length of time was important as it helped me understand how long VC's period of untreated psychosis was as this had a particular emphasis on the implications on prognosis. There are lots of studies which have shown that the longer the period of untreated psychosis, the poorer the long-term prognosis [WITN0163052; WITN0163053; and WITN0320008]. The information from his brother gave us a clear picture of VC's symptoms of illness, likely duration, the extent of his psychotic symptoms and the contents of his beliefs, as VC was not forthcoming with all his experiences. This information validated and supported the clinical opinions being considered. It was factored into VC's diagnostic formulation, informed the assessment of

his risk, and guided the planning of his treatment and care. Even though at this point he met the clinical criteria for a diagnosis of schizophrenia, it was more favourable to use the diagnosis of first episode psychosis as all possible differentials (mood related, organic pathology, substance use) had not yet been completely ruled out. It terms of treatment and management of risk, this made no difference as the treatment pathway was similar. The information from his brother confirmed that VC was suffering with a psychotic illness. It was clear that VC at this point had been untreated for possibly over 6 months, and it was now crucial that he was treated, resolve the psychotic symptoms to improve long term prognosis.

In terms of the risk, VC had only mentioned once that he wanted to hurt the people responsible. This was an important insight and was factored in the risk assessment and risk analysis. Up to this point he had not hurt or assaulted anyone or acted on his beliefs and based on this it was my view that his current risk of violence was low. One important predictor of risk is past risk. Apart from the message to his brother ("made some remark to wanting to hurt these people he was hearing"), he was consistent during the period he was on the ward that he had no intentions of wanting to hurt anyone when asked directly.

214. It is our clinical understanding that people who experience or present with psychotic symptoms for the first time, are vulnerable to re-emergence of psychotic symptoms. Studies have shown that people are more likely to experience psychotic symptoms if they have a genetic vulnerability to psychosis [WITN0163054]. His father stated that there was family history of

mental illness and although, there was no detail or diagnosis, this suggested a possibility of genetic vulnerability.

215. Under certain conditions, this vulnerability is more likely to show itself. In the case of VC, taking into account what we knew based on the assessments that had taken place, the information from his brother, it was more likely suggestive of a functional illness. With the possibility of genetic vulnerability, it was my view that the lack of sleep, social isolation and stress had a contributory factor to his acute clinical presentation.

216. Having observed VC on the ward, taken into account the reasons for admission, the associated incidents, the account of VC's mind set, beliefs and experiences as recounted by his brother, the duration of his symptoms, there was ample evidence to conclude that this clinical presentation was consistent with a functional psychotic illness. It clearly met the criteria for a psychotic illness as per the ICD 10 classification of diseases (this was the classification of diseases in use, it has been recently updated to ICD11, implemented in member states in January 2022 but it was not as yet fully implemented across the entire UK). In addition, some of the symptoms that VC was experiencing were clearly consistent with symptoms labelled as first rank symptoms of schizophrenia (also labelled as "Schneiderian first rank symptoms") namely passivity phenomenon, third person auditory hallucination and thought broadcast. This is referenced in all reference psychiatry textbooks. It was also clear that there was no suggestion or evidence that VC could have been taking illicit substances from what he said and confirmed by his family. It is documented by nurse Godwin Gonde on 28 May 2020 that VC had given a

urine sample and came back negative for everything except benzodiazepines.

Ward Review - 9 June 2020

217. On 9 June 2020, at a Ward Review at 10:22, under the heading "Patient Comments", VC is recorded as saying that "*he has not had thoughts about hurting himself or others*." [NHFT0000168, p28]

218. When VC was seen on 9 June 2020 in Ward Review, this was after he had been started on antipsychotic medication which he had been taking for 5 days. The information shared by VC's brother was from prior to medication. Risk is fluid and changes with time. In the brother's account there is a comment that I have summarised as "*made some remark that he wanted to hurt these people he was hearing*." To this point, despite having made this statement, VC had not assaulted anyone. He also made it clear to me at this same review, but I note that this part was not captured in the Ward Review notes, that if he had gained entry to the flat, he had no intention to harm the occupant but to save the woman. Based on this, it was my view that his current risk of violence was low but going forward if he did relapse, his risk of aggression and violence could potentially increase. His brothers account suggested that VC had been unwell for many months and over this period to the point he was admitted, VC had not directly harmed another.

219. The comment from VC about not having had thoughts of harm to self or others was whilst he had been on the ward. The purpose of the review was to assess for any current risk. After settling on the ward, there had been no

further reports or incidents of risk on the ward to himself or others. This was in keeping with what he said.

220. I am therefore not of the opinion that the comment about VC denying whether he had any thoughts of harm to himself or others was contradictory to what his brother reported, simply a reflection of the different presentations: pre and post medication.

221. I had no reason to believe that VC was not telling me the truth during this review. It is important to ask questions directly to patients. I hope that patients will be open and honest, as it was a safe space where they can talk about issues. It is my practice to look at both subjective and objective assessments and any collateral information. If I suspected that a patient was misleading me, it would be because what the patient was saying was contradicted views, opinions, or information from others. In such case I would discuss this openly with the patient to see their reaction. At the time of this assessment, it is my view that what he was saying was consistent with his presentation on the ward.

222. We do not know as to when in the community VC started to experience psychotic symptoms and it is only based on family accounts that give an indication as to when they possibly started. Prior to the events leading to the admission, it is likely that if he was having psychotic symptoms, they were not impacting on his behaviour or action to bring him in contact or scrutiny of services. I formed the opinion that the aggressive behaviours VC had exhibited prior to his admission were clearly driven by his psychosis. It was clear that VC had not physically assaulted anyone. I recollected that when I asked VC what would have happened if he had gained entry to the flat, he

said he would not have harmed anyone but wanted to merely to save his mother. It is difficult to say with certainty what the outcome would have actually been if he did gain entry. On the ward he believed the voices were coming from a place on the ward, he pointed to the linen cupboard and when it was opened, he was surprised that his mother was not there. He did not act out. As stated above this event was discussed with VC in my Ward Review on 9 June 2020 but this discussion was not captured in the Ward Review entry made by the junior doctor. This is from my recollection of events and there is only a brief summarised note to say VC did not have any thoughts about hurting himself or others.

223. VC was repeatedly asked during his admission if he had any current thoughts to hurt anyone, if he had thoughts of harm towards people who he thought maybe behind his experiences and he consistently denied any thoughts or intent.

224. When we started to consider discharge, the factors that contributed to our decisions were the assessment of the improvement in his symptoms, insight, compliance and response to treatment, his functioning, and the mitigation of risk. It was also important to have a clear plan of follow up in the community.

225. There was a huge emphasis on compliance with treatment and engagement with community services. It was our opinion that for VC to remain well and mitigate against the risk, there needed to be effective control of his psychosis. This was because it was clear that the predominant driver of his risk and poor mental wellbeing was the presence or absence of his active psychotic symptoms. Even though VC was not very vocal with what was going on in terms of his thoughts and experiences and there was the concern of possible

masking of symptoms, it was my objective opinion based on reports from nursing staff (reduced observations, increased presence in communal areas, brighter in mood, going out on section 17 leave, not pacing or agitated, no behaviours to suggest he may be responding to unseen stimuli, no vacancy in responses) and my own assessment from the Ward Reviews, that there was an improvement in his mental state, there were no overt psychotic symptoms, better insight, and family comments that he was better. It was my view that his symptoms had subsided due to a positive response to medication. It is difficult to say if the symptoms were irradicated but if there were any residual symptoms present, they were most likely in the background and not affecting his functioning or behaviour. Effective compliance to treatment with antipsychotic medication was important to stay well, mitigate risk and enhance his quality of life.

Email exchange with Police

226. On 31 May 2020, PC Marsden emailed me [NGPF0000082 p15] asking whether or not VC had capacity at the time of the incident which took place on 25 May 2020.

227. The usual interaction we have with the police would generally be for one of two reasons. One would be to answer the question of whether a patient had capacity at the time of an incident and the other reason would be to see if the patient was fit for interview.

228. On this occasion it was my understanding that the police were asking this question as they wanted it to assist their decision of whether to prosecute VC for the recent incidents with his neighbour.

229. I responded to PC Marsden's query on 8 June 2020 as follows:

Dear Richard

I can confirm that Mr Valdo Calcocane, DOB: 04/09/1991, who is a university student at Nottingham university was admitted to Rowan 1, Highbury hospital on a Section 2 of the MHA on the 25 May 2020. He currently remains an in-patient.

I can confirm that he presented with clear symptoms and signs suggestive of an acuter psychotic illness. He needed rapid tranquilisation at the very beginning of his stay but he has now settled and his mental health was somewhat improved.

He had no recollection of the events prior to his admission and it will be my view that he was not in touch with reality around the time of his admission nor around the time of the incident of causing damage to someone's door.

It was clear that his judgement and also awareness of his environment and actions was impaired due to experiencing an acute psychotic breakdown which was likely to have been precipitated by a combination of stress, sleep deprivation and social isolation. It will be my view that it was more than likely that he did not have the capacity to be responsible for his actions as this was not done in a clear conscious state.

Thank you.

[NGPF0000082 p16]

230. I understood that my response would likely be used as part of the police gathering information around VC's capacity, to decide if VC should be prosecuted for the recent incidents when he was arrested by the police.

231. I did not make a specific record of this request from the police in VC's medical records but in hindsight I accept that I should have. I should have made an entry documenting the request from the police and a summary of the opinion I offered. There was an email record of this, but I appreciate that not everyone would have had access to the email. Due to patient data confidentiality, it is our priority to ensure all patient related information was documented in the patients Rio notes. In hindsight I should have recorded this correspondence in VC's Rio notes. I do not feel this omission of not including the email in his Progress Notes had a significant bearing on his care. From my experience, I had also made the assumption that the police were unlikely to prosecute as he had been diverted to health, detained under the MHA and lacked capacity, which I confirmed in the email to the police. It has been my general experience that where a patient is exhibiting evidence of mental illness and under the MHA, there is a tendency not to prosecute.

232. The rationale behind my decision making around his capacity at the time of the incident was based on the information available in his medical records. This was based on details of the incidents in question, his mental state in the police station, assessments made by the Street Triage Team and the two MHA assessments that took place as they gave a picture of VC's state of

mind closest to the two incidents. It was obvious to me that VC was unwell, his behaviours were driven by psychotic symptoms and based on this it is likely that his decision making had been compromised.

233. There was clear evidence that VC was experiencing a psychotic illness. It was also clear that during both incidents, his actions were driven by the psychotic experiences he had been having, which led to him wanting to gain access to the neighbours flat with the intention to save a woman in trouble who he believed to be his mother. His capacity for rational thinking would have clearly been compromised. He was clearly experiencing a disorder of mind. His behaviours were clearly out of character as described by him and his family who knew him best.

Discharge discussions

234. On 10 June 2020 at 20:41, Campbell Mtetwa (Staff Nurse and VC's Key Worker) records that VC's mother called to "*express concerns about Valdo's discharge plans and was hoping to speak to his RC tomorrow over the phone as she felt discharge was too early*" [NHFT0000168, p32].

235. It is my consistent practice to involve significant carers and family in the care and management of patients on the ward. I would invite them to Ward Reviews; I would have telephone contact and meet them outside Ward Reviews if required or requested.

236. At various points VC's mother was invited and attended reviews jointly with VC. At all these reviews and during conversations and interactions out of the reviews, her views and opinions about her son were considered and valued. I would overall encourage patients to allow their loved ones in their care as I know that they have valuable collateral information, they can offer opinions

as to how their loved one was doing, notice improvements and make an important contribution to planning discharges. The involvement and information from VC's mother was helpful and contributed to the formulation and management plan of VC's condition including decisions around accommodation and his university studies.

237. VC's mother lived in Wales, it was at the time of COVID when there were social distancing rules in place, and I would like to commend her for the time and effort she made to be involved in his care and treatment. We did involve her at all levels of VC's care, including discharge. Her views were always taken into considering and valued.

238. VC's mother had not had any previous contact with mental health services, let alone an in-patient environment. I understood she had raised concerns around the possibility of too early discharge. It is not uncommon for carers/family to question if discharge was progressing too quickly. Family would generally be anxious about their loved one being back in society especially in situations where their loved one has acted out of character. They would clearly not want a repeat on the situation and want their loved one to be well and be able to get on with life. I clearly acknowledged her concerns and took the opportunity to discuss this with her. During the course of VC's admission, through ward reviews where VC's mother was present (28 May 2-2020 and 5 June 2020) and via telephone conversations (1 June 2020 and June 2020) I explained to her the purpose of an admission (the main focus was to assess a patient's mental health, come to a decision about their formulation, assess and address risk, consider appropriate treatment and ensure there was a community plan if this was required. Ultimately, the

purpose is to ensure that patient was safe in the community at point of discharge) , the role of in-patient care (admissions to hospital are meant to be for the least amount of time, to support community treatment, to address the acute situation including risk, and as a continuum to community care) and how we come to decisions around discharge (if the patient was well, shows good functioning, insight, medication compliance, reduced risk, safety in the community). During the discharge meeting on 17 June 2020, I gave her assurances that VC had responded well to treatment, he had shown better insight, there had been no risks of concern, and there was a treatment plan being put in place to support him in the community. We were at a point where VC was able to take responsibility, adhere to the treatment plan and keep himself well. He was at a point where he could be safely managed in the community and VC also was keen to get on with his university studies.

239. VC's mother confirmed and acknowledged the improvement VC had made, she said communication with the family was also better and I had also given her information on the formulation, diagnosis, and potential course of VC's illness. I told her in the presence of VC that it was my opinion that VC had experienced a psychotic illness. I was not going to give any specific labels. If he continued with treatment and stayed well his prognosis was good and there was a 20 percent chance that his symptoms would not recur but there was also the 80 percent risk that it would recur as part of the natural course of the illness. It was vital that VC took his medications and engaged with mental health services in the community. I also met with her and VC on the day he was discharged [NHFT0000168 p49] and reassured her and answered any questions she may still have. Other than revisiting what we had

already discussed, she did not have any new questions and took VC to his accommodation. At this review we acknowledged the improvement VC had made, the need to ensure compliance, that treatment will continue with community support, and that there was no longer requirement for VC to remain as an inpatient. We noted that he had his studies to continue, and it was time to progress with discharge.

Discharge Summary – 16 June 2020

240. On 16 June 2020 I was listed as the Discharging Consultant on VC's Discharge Summary [NHFT0000223]. Under "Risk Factors and Safety Planning," the following was noted in terms of risk to others:

a. "*Others - he believed others were trying to spy on him/torment his mind and tried to enter a neighbour flat to confront them. He kicked the door, damaged it, and scared the person inside who had to jump out of the window from her first floor flat and injured her back and needed treatment. There were no further incidents whilst on the ward. There was clear remorse for his actions***."**

241. In the Ward Review on 28 May 2020, when reminded of his aggressive behaviours, VC described himself as some lunatic banging on people's door and people were right to be scared. This showed he understood the implications of his actions [NHFT0000168 p11]. In addition, on 2 June 2020 during a Ward Review, he said that he did not want to experience anything similar in relation to banging doors or cause distress to others [NHFT0000168 p17]. This did suggest a level of remorse of his actions and not wanting to repeat it.

242. There is unfortunately no record of this in his Rio notes but during my Ward Review on 28 May 2020, I recall informing VC that during the incident where he banged on the door, the occupant got so scared that she jumped out of the window and she did hurt herself and needed to go to hospital. He was surprised at this news. His mood clearly changed, appearing sad and said he was not a violent person, his actions were out of character, and he had no intentions of hurting anyone. This did demonstrate a level of remorse.

Risk of aggression – nursing entries

243. Various observation logs by nurses state "*aggression*," or "*history of aggression*" or "*no new risks identified*" under the heading "Risk." Nursing documentation of the observations they make and events they document uses the acronym MONITOR.

244. Within this the "R" stands for risk. The risks that the nurses document is not divided into what is historical risk and what is current risk. It is my understanding and belief that there is a culture that when nurses document in this way using MONITOR, there is a lot of copy and paste. It is my view that where there has not been any change in risk or there has not been any incidents, the same information will be carried forward particularly in relation to R in MONITOR. In the case of VC there were no new incidents or increase in risk and so the known risk was carried forward for each entry. There were also entries from early June made by nurses which stated that there was "no new risk identified" (entries on 4, 5, 6, 9, 10 June and other subsequent entries)

245. When he was admitted and based on his actions in the first two days of the admission, the risk assessment the nurses made was clear that he was a risk of aggression to others but subsequent to that there had not been any incidents of aggression or violence. There were several entries that did reflect this by the comment that there were “no new risks”. In some entries for example, 7 June 2020 and 11 to 17 June 2020, the nurses under R stated that there was “history of violence and aggression” but they do not state that it was a current risk.

246. The purpose of the admission was to assess, formulate, treat, and mitigate risk. The risk was mitigated with treatment and psychoeducation, and this should have been captured in the nursing risk assessment, putting emphasis on what was historical and what was current.

247. This would be my explanation of the rationale of documentation of risk by nursing staff, and it is different to the risk assessment made in Ward Reviews which was more in keeping with what the risk was at the time.

248. As commented earlier, it was my consistent view that VC was not aggressive or violent by nature/personality. There were no factors in his early life to suggest a violent upbringing or acts that would lead him to act in this way. His family described him as a gentle, pleasant, and polite person and he came across as such in Ward Reviews. It was also known via history from VC and his family that he had not been convicted of any criminal offence, and the Liaison and Diversion team did not highlight any such matters.

249. His risk of aggression was closely linked to the presence of acute psychotic symptoms. If these were managed, his risk of aggression would also reduce.

Therefore, it was my view that there was a potential risk of aggression when VC was experiencing active acute psychotic symptoms.

250. It is my view that the risk and safety assessment that was originally completed by Annette Palmer (Clinical Lead Nurse) on 24 May 2020 [NHFT0000197] (see above at paragraph 135-138) should have been reviewed and updated after any incident. The document commented on the incidents of risk prior to admission, and I feel the incidents in the first two days of admission should have been included as there was clear evidence of aggression. In addition, I feel the nursing observations of concerns around potential masking of symptoms and social isolation should have also been added. Subsequently, during the course of the admission there were no new events that inferred risk or increase in risk in terms of aggression or violence. The incident where he was hiding in the bathroom and the wrestling with a peer in my opinion were not indicators of risk. The document update should also have included the actions and effects of the interventions we gave to VC that helped to mitigate the risk as at the time of his discharge, his risk of both aggression and violence was low and so was his risk to himself.

Pattern of non-concordance with medication – First Admission

251. I had made the conclusion that VC was indeed suffering from an acute psychotic illness. The description of it being “acute” is to stress that he was experiencing active symptoms which were impacting on his behaviour and were not related to long illness i.e. chronic illness. I felt there was a probable genetic vulnerability with evidence of family history of mental illness and that the recent episode was probably precipitated by stress, social isolation (COVID), and lack of sleep.

252. It was also my conclusion that the risks that he had posed, specifically the events where he knocked and banged at the neighbour's door on two separate occasions was clearly driven by acute psychotic symptoms. He had not shown any tendencies to violence in his early life, and this behaviour was noted to be out of character for him both by himself and his family.

253. VC is recorded as expressing that he did not want to be on any medication [4 June 2020, NHFT0000168 p22]. On 5 June 2020, he agreed to start medication [5 June 2020, NHFT0000168 p24], but is noted to be “disappointed” by having to take medication [10 June 2020, NHFT0000020].

254. When he was informed of my opinion on his diagnosis and the need to take medication, he was disappointed, and it was my belief that he did not want to be associated with the stigma of mental illness and the impact this would have on his future. He would have preferred a natural resolution of his symptoms and prayer.

255. I was of the opinion that control of his psychotic symptoms would mitigate against the risk that he had posed. There was a positive response to treatment, and he was repeatedly educated and encouraged to take medication even upon discharge for his own mental wellbeing and mitigation of risk. It was my belief that he understood this and had capacity to decide to take medication.

256. It was clearly stated to him that if he did not take his medication, there was a high likelihood of his symptoms remerging and this would potentially increase his risks. This risk could be to himself or others. It would have a significant impact on his studies. It was my view at the time that VC understood this and believed it.

257. From what was known, we had stressed the importance of medication compliance which VC had to take responsibility for. His family were aware of this and the consequence of not being compliant. There was an agreed community plan with the CRHT team to monitor his compliance and mental health in the community.

258. It was clear that non-compliance would lead to a high risk of relapse and hence the importance of close monitoring and action as required.

259. When VC was initially admitted to the ward in May 2020, he was meant to have been started on an antipsychotic medication after the first MHA assessment on 24 May 2020. The decision was made not to detain him and instead he was home treated with the support of the CRHT team. However, before the CRHT team could deliver the prescribed medication (Olanzapine 2.5mg and Zopiclone 7.5mg), VC had been arrested for the second time. After the second MHA assessment and subsequent detention, he was written up to continue the antipsychotic.

260. When I saw him for his 72-hour senior review on 28 May 2020, VC wanted to see if his symptoms would abate without medication:

> "*Valdo explained that he would want to seek a period of being medication free so that he could better understand who he is. Dr Seedat explained that he will stop regular medication; however, PRN medication will remain prescribed*" [NHFT0000168 p12].

261. It is not unusual to give patients a period on the ward, usually up to a week, of being not on any treatment as this can aid assessment, help give a clear understanding of the patient's presentation and not clouded by the effects of medication. The subsequent presence of active symptoms and his past

history of symptoms was helpful in convincing VC in regard to diagnosis and the need for treatment.

262. It is well known from research that in relation to the natural history of the course of functional psychotic illnesses, an episode of illness would last for a period of 6 to 9 months. During this time, the patient's vulnerability to relapse is at the highest and hence it is evidence-based practice that after a first episode of psychosis patients should be encouraged to take medication for this specified period of 6 to 9 months to prevent relapse illness.

263. Even though VC was disappointed about the potential diagnosis of a psychotic illness and the need to take medication, it was my belief that he understood that he had mental health difficulties, and he also understood the rationale for medication. When medication was started, VC did not show reluctance to take medication, he did not express any specific concerning side effects, and he also commented on feeling better and stated that the medication has been helping him during his Ward Review on 9 June 2020 [NHFT0000168 p28].

264. This was VC's first presentation to services. It was clear that remaining well for VC was going to be dependent on VC remain concordant with his treatment. This was repeatedly highlighted to him and his family and the providers of care in the community, in this case the crisis team.

265. The risk and concerns around non concordance or poor concordance is a common occurrence with psychiatric patients and being a common reason for readmissions to hospital.

266. The concerns of non-concordance were adequately considered at the time of discharge, VC had a responsibility in this role and had capacity, and it was

on VC with support and monitoring from the crisis team to ensure he remained compliant. The risks and effects of non-concordance were clearly explained to VC.

Masking, insight, and isolation – First Admission

Masking

267. During an MDT on 8 June 2020, it is recorded that:

> *"Has mainly remained in bed space, unclear why this is, has declined all OT input, posing no management problems but seems increasingly withdrawn, need to uncover why this may be e.g. is he masking psychosis or low mood or are there other reasons. Was reported to have been hearing a woman's voice screaming which staff could not hear"* [NHFT0000168 p26]

268. Masking is when patients are not willingly to openly discuss or reveal symptoms of their illness, consciously or unconsciously. This means that the patient is experiencing psychotic symptoms but would find ways not to reveal these or talk about them. The patient will usually deflect by denying the presence of any symptoms even when evident. This is not an uncommon occurrence on psychiatric wards and it something we are always on the lookout for.

269. In my experience, the purpose of masking would be to conceal or not reveal symptoms or experiences that would lead to be labelled with a mental illness, prove that one is well and not get put on treatment or interventions, do not need to be in hospital or do not want to be involved with the stigma of mental

health services. The likely intention is to give the impression that there was nothing wrong with them.

270. The behaviours associated with Masking include social isolation, limited interaction with staff, could be withdrawn, limit periods when they can be observed or scrutinised. In the MDT meeting on 8 June 2020, the nursing feedback was that in view of the limited engagement with staff, spending a lot of his time on the ward, not getting involved in any activities on the ward, withdrawn, they were concerned that could there be the possibility of VC masking symptoms.

271. It is impossible to make a patient tell you about their experiences, if it is their position they do not want to do this. We would do our best to try get around this by focusing on behavioural observations, more probing to encourage patient to be free to talk about their difficulties, develop therapeutic relationships, use information from family during their interactions, ask staff with whom the patient may have developed a rapport to make an assessment.

272. It was obvious and clearly documented by staff about VC being quiet on the ward, appearing withdrawn but this was not throughout his admission. The documentation showed changes when he was started on medication and less evidence of being withdrawn during the latter part of his admission.

273. During my Ward Reviews, his engagement was different in contrast to what was reported by staff in terms of his engagement with them. This is not unusual in my experience, possibly more open to speak to someone making decisions but I was also mindful whether in any way it reflected on VC's mental state. He was more vocal, he engaged well, there was good rapport established, and I was left with the impression that he was being open and

honest with me. He admitted to being unwell, he acknowledged that he was not right, and he may have mental health problems, he did admit to experiencing active psychotic symptoms prior to his admission to hospital. He was able to recognise and accept that his actions which were out of character were driven by his beliefs which were not in keeping with reality. To me this did not suggest masking, but I did recognise that he was probably not 100 percent open.

274. It was clear to me having received feedback from the nurses and reading the documentation that there was only a superficial assessment taking place. There were observations made but the staff were not challenging or probing as to why he was not engaging in things, why he spent a lot of time in his room, whether staff had focused time on him to encourage him to talk as it is not uncommon that quite patients tend to draw less attention. I did not have any specific concern. It is always helpful to get other clinicians' perspective as to how a patient was doing. It was my intention that that information would contribute to my own assessments to give a more accurate picture. It was my intention to make sure we were making an accurate assessment of his mental state and that the time on the ward was utilised effectively.

275. Therefore, in the plan from this MDT, it is recorded:

> *"Monitor mental state and continue current medication - all members of the MDT* ***please try to dig deeper when he declines an activity - if anything, is really behind the refusal?"*** [emphasis per original, NHFT0000168 p26]

276. The intention was to see if we could get a better understanding of what could have been going on with him, aid in assessment of his behaviours and

mental state that was objectively evident and in turn would help inform the treatment plan, the risk assessment and discharge planning.

277. I did note that staff did try to engage him more with some success. Towards the end of the admission, he did go off the ward on leave, he was more visible in the communal areas, and his mood was also brighter. VC could not be forced to talk and in general he was not a very talkative individual. In terms of his premorbid state, at the Ward Review on 28 May 2020 VC said that since coming to England aged 16, due to language barriers, he had struggled to fit in, he did not make friends and got too comfortable being alone. His mother informed staff on the ward, documented in an entry on 26 May 2020, that VC was quiet and preferred to keep to himself.

278. As stated earlier, I did not automatically conclude that VC was masking his psychosis. The staff on the ward suggested that it could be a possibility as he was withdrawn and isolating in his room. During the Ward Reviews he was definitely more engaging and communicative and did not give the impression of masking. If he was masking, he would have avoided questions around his symptoms, tried to change the subject, responded with short answers, denied any observations made by staff and suggested staff fabricating things, or come up with clever explanations about observations made on his behaviour which do not add up: the objective picture differs markedly from the subjective picture This was not evident with VC during my reviews.

279. VC also described himself as not a very good communicator, he had become isolated, and he liked being on his own. There are behaviours that are usually accompanied and seen with patients who present with psychosis like responding, muttering under their breath, heard talking behind closed

doors. These were not evident in VC's assessments. I acknowledged the concerns raised by the staff about the possibility of masking and suggested options to consider trying to address this. My own view during interactions with him, I was not of the impression that he was masking symptoms.

280. Masking of symptoms would impact on care planning if we were not getting enough information or a true picture of the patient. This was factored into VC's care (see direction to the MDT above) but it was my view that in the case of VC, there was significant information available that allowed an accurate assessment of his condition, aid in diagnostic formulation, risk assessment and care planning.

281. Again, masking of symptoms would impact on the discharge planning process, but it was my assessment that I had the required information to make judgments of VC's mental state and risk at the point of discharge and be able to safely make plans around discharge back in the community.

282. Discharging him back in the community did not suggest that all was well and that was the end of treatment. The decision to discharge was predicated on the understanding that VC no longer needed to be on an acute psychiatric ward, he could be managed in the community and being on the ward was no longer therapeutic. At this point his presentation would not continue to meet the statutory criteria for continued detention,

Short-term risk formulation;

283. In terms of the short-term risk formulation, it was clear that at this point we had made a clear diagnosis of VC suffering with a psychotic illness, and his risk was directly linked to acute psychotic symptoms. We did start him on

treatment, which was effective, there was noticeable improvement and also agreed by his family. In the short term it was clear that concordance to medication would control his symptoms and this in turn would mitigate against the risk he was identified with. The concerns around possible masking of symptoms was considered, we did agree on using a proactive approach to engage him and it was our view that with treatment this was less of a concern.

Long-term risk formulation.

284. In terms of the long-term risk formulation, this was VC's first contact with services and diagnosed with first episode psychosis. The long-term risk formulation at this point was very similar to the short-term risk formulation as we were at the start of his contact with mental health services. It is difficult to predict the long-term course of the illness at this time. It was important that VC continued with his treatment for at least 6 to 9 months, engage effectively with community services and seek help when required. Going back into the community has its own stresses, and stress has been considered a risk factor for relapse of symptoms, which can impact on the course of the illness and sometimes medication on its own maybe insufficient even if he was concordant. It was my view that the issue of masking or VC not being very open or upfront with his symptoms of illness was acknowledged and the plan of involving the crisis team to monitor and support him was to ensure he was regularly reviewed. It was due to this concern that I sent an email to the crisis team consultant insisting that VC should be seen face to face, rather than the phone contact that I had seen in his records due to the COVID situation, as

this will give them a better assessment of his mental state (see para [x] below).

Insight

285. It was my view that there was a clear positive shift in terms of VC's views on his experiences. Looking at the Ward Reviews that took place and my discussions with him when seen with his family, there was ample evidence where VC accepts that his behaviours were out of character, things were not right, that he has mental health problems, he needs help and support and agreed to take medication with which he was compliant in hospital.

286. The presence of insight is a significant factor which can predict the patient's compliance to treatment, engagement with services and help seeking behaviour.

287. VC in my view developed insight into his illness and treatment required and with his agreement that he would take his medication, he would engage with services, and his risks were low at time of discharge, helped support safe discharge back into the community.

Social Isolation

288. Throughout VC's First Admission, he was observed to be withdrawn and isolated from his peers. VC was a new patient to us, and we were trying to get to know him. It is not uncommon to have patients on the ward who do not interact with their peers and spend a lot of their time in their room. This can be for various reasons that are specific to the patient. Some patients would say they do not like the high intensity environments, want to avoid

confrontations, some will say they are not like other patients on the ward, some liked their own space.

289. It was well known that social isolation can be a risk factor for perpetuating and precipitating psychotic relapses. Based on this it was my intention to gather from VC why this was the situation with him that he did not engage with his peers as he had been observed to spend a lot of time in his room. On 9 June 2020, during Ward Review, raised with VC my concerns about VC not going on leave, not engaging with patients or on the ward. VC explained that he was a quite person, he was not good at interpersonal relationships, he liked his own space, he had become a loner, and he was not going to change. I communicated to VC that I was "*concerned with how [VC] will be able to manage on his own when he is discharged from what [I was] seeing on the ward…. [I] explained that [I] wants Valdo to continue to engage with OT. In addition to go out on leave.*" [NHFT0000168, p28].

290. My intention was to see if this observation could be part of his illness, what we call negative symptoms. I noted from the records that after we had started treatment, VC spent a bit more time in the communal areas, interacted at times with peers, utilised leave and also attended a yoga class. VC informed the OT during their interactions that he was able to look after himself, he had his own coping skills like breathing exercises and mediation he used when feeling stressed and he was very busy with university work as there was lot to do.

291. VC was encouraged to spend more time in communal areas, attempts were made to engage him with OT, but he refused any offers of support, and we had discussions about the importance of social inclusion activities.

292. The concern around social isolation was discussed with his family, specifically his mother. At the discharge meeting on 17 June 2020, when his mother was also present, I again in some detail answered their questions around diagnosis and treatment. In addition, I also emphasised the importance of social inclusion activities [NHFT0000168 p49], how this was a risk factor for relapse and VC was aware that he needed to explore this and he could also ask services to support him with this if he so wishes.

293. A CTO has compulsory powers that the patient must follow and there are additional conditions that could be added. The process is that if the patient on the CTO does not follow these conditions, then consideration is given to recall the patient.

294. The additional conditions are at the discretion of the clinicians; it is jointly agreed with the community team who will be managing the CTO. The additional conditions need to be reasonable and practical.

295. It would be highly unusual in my experience to have a CTO condition where someone is required to engage with anyone other than a mental health professional. Requirement to engage with services in particular a patient's care coordinator and community consultant is usually added as a condition. There is not a provision within the CTO to require patients to engage with family. The family can be involved as much as they want, working together with their loved one, support them and advocate for them. One does not require a legal framework to do this. However, it is imperative that patient confidentiality is maintained. It is difficult to think what the condition would be for the patient to engage with the family and would be impractical. It would be difficult to enforce a condition such as - the patient must send an email or

make a phone call to their parent on specified days or times a week. If they did not, would one recall them to hospital? At this point, VC had no objection to sharing information with his family and was also in support of family attending his Ward Reviews and being involved in his care. There were no issues around breaching patient confidentiality when it came to his family as VC gave valid consent to share information with them.

Recording and sharing of observations and assessments

296. There are various ways in which information is shared about a patient. In the case of VC, the main areas of information gathering and discussion which influenced decision making with regards to care planning was during the MDT meetings and Ward Reviews.

297. In the MDT meetings regarding VC, the focus of the discussion was how he was progressing, had there been any symptoms of illness, any risks of concern, his attitude to his treatment and interaction with staff and his ADL (activities of daily living) skills. This information guided decisions around his care planning and discharge planning. We made decisions around his observations levels and if they were appropriate, whether leave was safe and if there were any issues. Decisions were made as to how to have closer supervision to determine symptoms of illness or how he was progressing due to concerns around masking and not really engaging with staff and how to get around these difficulties.

298. In VC's Ward Reviews, decisions were made around his formulation, his risk and how this was understood including mitigating factors, his observation changes during his admission, his treatment and review of it, review of any

physical health concerns (there were none), section 17 leave, his university education and accommodation issues, social isolation and discharge planning. VC's family were involved in various of his Ward Reviews as he had given his consent. Community teams were not involved in Ward Reviews for his First Admission, until the crisis team were involved at the time of discharge planning.

299. As VC was a compliant patient on the ward, he did not exhibit any management problems, there were no risk incidents, he was eating and drinking well, his physical health was good, and he did not have social issues that needed addressing, there was little that was addressed via the Board Reviews, but they ensured that things were on track.

300. The assessment and management of patients on an in-patient psychiatric ward is a collective effort. For obvious reasons, patients will have more contact with staff whose position is to work on the ward throughout their shift. They will have more opportunities to make regular observations. In the case of VC, I had the opportunity to assess and review his care in Ward Reviews, and I also had discussions with him with his family present around his mental health and was able to make my own assessments during these interactions. The observations and assessments made by nursing staff on the ward were informative and recorded in the Progress Notes. In addition, the nursing staff would give an update of the patient's presentation, incidents of any risk, concerns and progress at each MDT and Ward Review.

I can confirm that as common practice the information recorded by nursing staff on a daily basis and their feedback was reviewed by me and included in my decision making. There was valuable information around VC's mental health

and presence of any active psychotic symptoms, any risks or incidents of concern, his interactions and behaviour, what he did all day, food intake and sleep, compliance to medication.

301. The entries were made by either nursing staff or health care assistants and at times students. Junior medical staff would also document any health issues that may have been addressed by them but in VC's case he was fit and healthy in terms of his physical health. He did have his ECG and routine bloods done. The purpose of these entries is to share with all involved in his care what was going on with VC every day. The contents and observations were reviewed and considered in VC's care. It is not possible to read every entry, but it is my practice to skim through the entries in the period since last Ward Review or MDT. In the case of all patients on the ward including VC, the focus will be on observations around his mental health clinical picture (mood, psychotic symptoms, lack of symptoms), functioning, any risk issues, general behaviour and interactions, looking out for indicators of improvement, concerns. Information relating to VC was also shared during the weekly MDT and Ward Review as part of the nursing feedback report. There will be feedback on medication compliance, how section 17 has progressed and if any issues, engagement with OT and how referrals to community teams have been progressing. We would also discuss nursing views on discharge readiness and planning.

302. I can confirm that the daily observations regarding VC, including my own assessments of his presentation were taken into consideration and aided decision making around assessment, formulation, risk assessment and treatment/care planning.

Clinical conclusions from First Admission

Core Assessment - 27 May 2020

303. The core assessment completed by Dr Ludvigsen on 27 May 2020 [NHFT0000188] was the standard clerking documentation of VC as an inpatient. This would have been completed on 26 May 2020 but VC declined to engage with the duty doctor on call and so it was left to the day doctors of the ward to complete at the earliest opportunity.

304. I was aware of the contents of the document. It summarised the events leading to the admission and it also contained valuable personal history and some collateral from his mother. The information in it was accurate and it was a summary of her assessment that she had made when she met with VC.

305. The contents of this document were also evident in the Progress Notes; there had been further developments and more information gathered and at the time of discharge. The information in the document was relevant and considered as part of the planning process especially around the events leading to admission but in itself the document was no longer current and due to this it was not considered significant as part of the discharge planning process. The Core Assessment document is not a running record but a document that contains the summary events of contact, assessment formulations and risk. It is not expected that the Core Assessment document needs to be updated in the course of the admission. The more current information will be in the Progress Notes, the Discharge Summary and Care Planning document.

306. The section titled “Views of Carer/Family” states that their view was not sought, but there was information in the records that VC’s mother had been

to the ward and informed staff that there was no known past psychiatric history, no drug use and VC was quiet, reserved and polite. At the time of the clerking Dr Ludvigsen had not spoken to family and she was not able to add more information. It was also not expected that this document is updated as the admission process as clinicians would look at the Progress Notes where updates are recorded. Information from family was available in the Progress Notes. This is not meant to be a rolling document during the course of the admission. However, the delusional beliefs were recorded in the running records, and they are available to any clinician who becomes involved in his care.

307. The section titled “Other Agencies involved” was left blank. This section is usually related to other agencies actively involved in the care of a patient at the time of their stay in hospital. VC had been directed towards mental health services, diverted from the criminal justice system and hence the police were not actually involved in his care. At the time of filling this document there were no agencies actively involved in VC’s care. I accept that the police had been involved in attending to the incidents in question and made the arrests. However, it was clear to the police from the documentation that, the attention was to address his mental health which had a significant bearing on the incidents. It was clearly stated in the history of the presenting complaint section of the Core Assessment that he was arrested by the police, which would inform clinicians of the involvement of the police. Hence the addition of the police to this section would not have added anything.

308. As stated above, the involvement of the police during the two incidents was highlighted in the core assessment. Dr Ludvigsen in the Core assessment

document recorded in the 'history of presenting complaint' section: "*VC arrested twice by police on 24 May 2020"*. The details of the events were clearly available in the Progress Notes which are the running records that we predominantly focus on. I can confirm that the incidents were integral in the risk assessment we made and even though the details of the information of police involvement was not populated under the other agencies section, it had not affect or have a bearing on the risk formulation with respect to discharge planning.

Referral to CRHT

309. On 5 June 2020 I communicated to VC and his family that "*it was [my] clinical opinion that he was suffering with a psychotic picture, first episode, and that this will require treatment*" [NHFT0000168, p24]. In psychiatry we tend to take a holistic approach to management of a patient. The principle that we follow when planning treatment is to look at their mental health, physical health, and day to day aspects of their life. These can either be impacted by the illness they have, or they could have an impact on their illness. So, when planning treatment we follow the biopsychosocial model. The "bio" is in relation to medications, "psycho" is psychological interventions that may be appropriate and "social" is their day-to-day life activities like housing, employment/education, and social activities. For each patient this will be different depending on the need. In case of VC the treatment focused on medication to control his psychotic symptoms, specifically an antipsychotic medication, psychological work around insight, medication compliance, understanding of his illness, and social needs around social inclusion, support

around accommodation, his university studies, registration with GP. To ensure this was addressed even when in the community, a robust community follow up plan was also planned for.

310. On 12 June 2020 I made a referral for VC to CRHT [NHFT0000021] and on 15 June 2020 I was present at an MDT meeting with the CRHT team [NHFT0000168, p45]. Patients admitted to the ward will fall into one of two categories: they will be involved with a community team on discharge or not. It is our standard practice that a patient admitted to the ward who has not had contact with mental health services or was not currently in contact with community team and it is our view that they will need follow up in the community, we would make referral to the appropriate sector mental health team, which is linked to the patient's GP.

311. In case of VC, it was clear in my view that he was presenting with a first episode psychosis and based on this the appropriate team would be the early intervention psychosis (EIP) team and referral to them was made. The EIP teams came into existence as part of the national service framework introduced in 1999. They were set up so that people experiencing a first episode psychosis had access to timely specialised care. The team's purpose is to reduce the duration of untreated psychosis, manage symptoms, support recovery and also support family and carers. They work as a multidisciplinary team composed of psychiatrist, psychologist, nurses, social workers, employment support workers, other support workers. VC's presentation was consistent with requiring this pathway of care.

312. There was a lack of clarity as to where VC was going to reside. He had a few weeks left at his current address, and he had talked about moving to

Birmingham. It was also suggested to him that he should consider going back to Wales and live with parents, but he was not keen to do that.

313. Due this lack of clarity and to ensure there was a robust plan of community follow up, it was one of the roles of the CRHT team to help facilitate discharge and also provide care in the short term until community care with the EIP team was put in place.

314. The CRHT team is better resourced as compared to LMHTs. They have the facility to see patients more often and even daily as per need. However their involvement is short term, and the goal is to hand over care to the LMHT as soon as this was possible, in this case the sector EIP team.

315. In view that we now had a plan for discharge, it was also agreed that he will need follow up in the community and due to the uncertainty of where he was going to be living, it was my view that the CRHT team supporting him in the community whilst VC was deciding as to where he was going to reside in the long term was the best alternative and would ensure that VC was followed up and supported in the community.

316. On 22 June 2020 I contacted the CRHT team after VC had been discharged to highlight that VC should be followed-up face to face "*as he is likely to downplay any symptoms/problems*" [NHFT0000168, p51]. My intention of contacting the CRHT team was not because I had concerns that VC maybe at risk of non-compliance with medication. This was a time of COVID and in order to maintain social distancing as per government guidelines, community contact with patients had moved from face to face to more telephone contact.

317. After his discharge, this was not unusual for me to do, as I wanted to see how VC was getting on since being discharged: did he stick to his word, was

he engaging with services. I perused his notes and became aware that VC's contact with the CRHT team up to that point had been via telephone contact only. There had not been any face-to-face contact, and this was 5 days into his discharge. It was my view that assessments with VC were more informative when seen face to face. VC was not very vocal and kept his conversations to the minimum. But if seen face to face, in addition to what he said, people can make objective assessments of his presentation and behaviour which would give a more accurate assessment of his clinical picture and be more informative in case he maybe be masking symptoms.

318. It was also my view that VC needed to build trust, and this is better achieved with face-to-face contact. It was my experience that his interactions and conversations with me were more open, and he was clearly more engaging.

319. The face-to-face contact would also allow the CRHT team to check if he had been compliant with his medication with objective evidence.

320. It was important that VC remained well and there was no return of his psychotic symptoms. It was made very clear in his risk assessment and the information given to the CRHT team that relapse of his illness would lead to the presence of risk.

321. To mitigate this risk, there was psychoeducation provided to VC about his condition, his medication and how his risk was related to his illness. He was remined to ensure he remained compliant to medication and the crisis team were informed to closely monitor this.

322. Although I did follow up when I saw reference to a telephone contact, and provided my advice that face-to-face would be preferable, my responsibility of care and management of a patient admitted to my ward stops when the

patient is discharge. I have to maintain my focus and attention to the patients under my care on the ward. Once in the community, the responsibility falls to the respective community teams involved in the patients care including the patient's community consultant.

Risk planning

323. It is my view that the risks or aggression, violence, masking, and lack of insight were adequately addressed and planned for as per the guidance from the Royal College of Psychiatrists' Good Practice Guide for the Assessment and Management of risk.

324. In terms of violence, it was my opinion that his risk of violence was low, but the potential of this risk to increase was related to the presence of active psychotic symptoms. Compliance to medication and engagement with services would mitigate this risk. In the case of VC there were no early life experiences, past events, violent tendencies, drug history that would have had a bearing on the risk.

325. In terms of aggression, it was our view that his risk of aggression was high at the time of the incidents and was clearly linked to being actively unwell and influenced by psychotic symptoms. Protective factors were that he did not use drugs, no past history of aggression, this was out of character for him, no early life stigmata (like abuse, domestic violence, trouble at school, fighting, crime). After treatment it was clear to note that his risk of aggression had reduced and was low at the time of discharge. It was emphasized that this was linked to active symptoms and would be mitigated with treatment as was

the case. Hence remaining compliant with medications was going to be important.

326. The concerns around masking were raised and efforts were made to address this. It was my opinion that the masking was not significant and did not impact in my assessment, formulation, risk assessment and management. However, it was something that needed to be kept under review and hence the plan that he should be seen face to face in the community rather than telephone contact.

327. As noted in the progression of his care on the ward, his insight improved. He was able to recognise that there were problems with his mental health, and he also acknowledged improvement with medication. It was emphasised the importance of medication concordance. This was part of his management plan when he was back in the community to ensure medication concordance.

2. VC's Second Admission (under Section 136 and then Section 3 MHA) – Cassidy Suite and Rowan 1, Highbury Hospital ("Second Admission") ***Relevant dates:*** **13 July 2020 – 31 July 2020 (18 days)**

Admission under Section 3 of MHA

328. On 14 July 2020, I undertook a MHA Assessment of VC, where it was decided that VC should be re-admitted to Highbury Hospital for treatment under Section 3 of the MHA [NHFT0000168, p58 and NHFT0000037 p5-7.] I am a full-time in-patient consultant, and all my work is within my in-patient ward looking after the patients admitted there. However, VC had been detained on Section 136 of MHA and brought to the Cassidy Suite by the police. The Cassidy Suite called the AMHP to arrange a MHA assessment

and the staff felt it would be good practice if one of the doctors required to do the assessment had knowledge of VC. I was contacted as I am based at Highbury hospital, and they asked if I was available to come and do the assessment. In view that I knew VC and his history, I agreed to do the assessment.

329. Prior to going to do the MHA assessment, I familiarised myself with what had gone on since his discharge from hospital, and I had also read in it is entirety the entry in the Progress Notes by the Street Triage Team that that:

> *"Valdo had been banging on the door and when someone opened it, he immediately forced his way in, attempting to push past the resident. He was restrained on the floor by a number of residents until Police arrived*" [NHFT0000168, p56].

330. My handwritten documentation is at NHFT0000037.

331. My assessment records note that VC was arrested for breaking into a neighbour's flat and "barging in" but do not specifically refer to the restraint. To not repeat in my documentation what was already there, my focus in the entry was the summary of the assessment we made when we interviewed VC during the MHA assessment. This did not in any way mean that the events as recorded by the Street Triage Team were ignored or not taken into consideration. To summarise, during the MHA assessment I took into consideration how he had been in the community since discharge, the information recorded by the Street Triage Team, including the incident where he was restrained by a number of residents, his presentation on the Cassidy Suite since his arrival and the face to face assessment we made during the

MHA assessment. In hindsight for clarity, I should have made a note of the types of information I relied upon in my assessment.

332. I acknowledged in my assessment that it concerned me that VC minimised the potential risk to others and he could not fully acknowledge the risk of his actions and led to his admission to hospital.

333. As stated, that at the time of the MHA assessment I was aware that VC had to be restrained by fellow residents up to the point the police arrived. This was factored in my assessment and was a significant factor, in addition to the presence of acute psychotic symptoms suggestive of relapse of his illness that led to his detention under the MHA.

334. The event that transpired at this time of barging into a neighbour's flat was similar to events that transpired just prior to his first detention. His behaviour of confronting his neighbour was clearly driven by the reemergence of acute psychotic symptoms and most likely this was due to non-compliance to his medication, which he confirmed. His actions were clearly aggressive but from what was known, VC had not assaulted anyone and had not been physically violent. I acknowledge from the record of events that VC had to be restrained until police arrived and this could be suggestive of violence. What was concerning to me was the fact that he was minimising the aggression he had shown and showing little foresight as what could have transpired if he had not been restrained. He was unable to appreciate that he had to be restrained and if not, what may have been. There could have been the potential risk of violence.

335. It is a legal requirement that clinicians are able to demonstrate the presence of certain conditions in order to legally detain a person in hospital. Detention

is a significant act that takes away the individuals liberty. Hence it is important that legal processes are followed. These include for Section 3, presence of mental illness, the condition is of a degree and /or nature, there are risks and patient was not willing to come into hospital and patient cannot be safely managed in the community.

336. VC met all these criteria. VC had stated that he had stopped taking his medications two weeks previously, he did not feel he was as ill as when he was first admitted, the incident of going to his neighbour was minimised and he was not fully able to appreciate the potential risk of violence due to his actions. The time frame to reemergence of symptoms (relapse) when stopping medication can vary greatly. It is difficult to say for certain after one period of relapse whether this will be the course, but it was obvious that his symptoms would remerge within a short period of time based on this period of relapse. The stopping of medication highlighted poor insight and poor compliance of treatment. Both these factors were a significant consideration in the decision to detain him on a Section 3 and considered in his management, both current and future.

337. Lack of insight includes where individuals do not believe they have an illness. They do not believe that they need treatment and do not feel they need contact with mental health services. Where the overwhelming evidence suggests, contrary to the views of the individual, that the individual is clinically mentally unwell and needs treatment, the safest place and option of managing such individuals will be within an inpatient setting and under the legal framework of the MHA. The interventions the patient requires including medical treatment will need to be provided against the person's wishes. This

was the case with VC at this time of his detention. The intention is to enhance the mental wellbeing of the patient, address their acute psychotic symptoms and mitigate risks. This is reflected in my assessment that "*Community Treatment is not an option due to his poor insight and poor concordance to meds. He is clearly a risk to others and to himself*" [NHFT0000037 p6].

338. I also noted my assessment within the Progress Notes. My record includes that that VC "*minimised potential risk to others*" and that it was "*concerning that Valdo was unmoved or unfaced [sic] regarding his actions and did not appreciate the danger he put others in due to his actions based on what he felt to be happening and true but this was not happening in true reality*." [NHFT0000168 p58]. The purpose of the MHA assessment focuses predominantly on the question that does the patient meet the criteria for detention and what was the least restrictive pathway to address the concerns.

339. What concerned me was that VC was minimising what had happened in terms of his action and did not see the potential seriousness of his actions. He could not appreciate that his actions were driven by illness and given the impression that his actions were justifiable based on the feeling he had as he described it. He seemed unfazed by the fact that he had to be restrained by other residents. His family described him as polite and gentle, and he did not seem upset or distressed by his actions which would have been expected.

340. This made it more likely to consider detention as this was a significant concern and it was clear that he required treatment, there was the potential of risk of violence and this needed to be mitigated before he went back into the community and this could only be safely done within an inpatient setting.

341. At the time it was difficult to determine if VC was consciously minimising his actions. From the assessment it was my opinion that VC was not able to clearly appreciate the gravity of his actions and the potential consequences and this could be understood in the context the impact of the acute relapse of illness and poor insight he was now exhibiting. He believed that his experiences were real in terms of what he felt and experienced and this was driving his behaviour. This suggested to me that it was not deliberate and there was no specific personal gain for him. Without addressing the symptoms of illness, he would remain a risk to others. This was something that happened around his First Admission.

342. It was fortunate that I was involved in the detention of VC, and he was subsequently admitted once again to Rowan 1 under my care. He had been on the ward just over 3 weeks previously. This did ensure some level of continuity of care and the ward staff, and I did have familiarity of his clinical condition and care plan.

343. I viewed the Second Admission as part and parcel of the First Admission. Even if this was a Second Admission, in view of the proximity of the admissions, it was my view that the current period of illness was the same episode of illness. I had made it clear to VC that he remained vulnerable to relapse, and it was important for him to take his medication for 6 to 9 months. When considering whether VC had been discharged too early, it was my opinion that VC had responded well to treatment, he had developed better insight, there had not been any incidents of risk, he no longer met the criteria for detention and keeping him longer would not achieve any therapeutic advantage to him being in the community where he could still be closely

monitored, reviewed and supported back in his own environment. A readmission does not necessarily equate to the patient requiring a longer admission, decisions are made on clinical and risk grounds.

344. I want to confirm that based on this thinking, I saw the two admissions as one and hence took all the information from the First Admission to inform me in understanding the clinical presentation, the risk and management planning.

345. It helped me to recognise patterns of clinical presentation, factors driving relapse, VC's insight and commitment to treatment and importantly risk to others.

346. The MHA assessment which I undertook on VC concluded that he needed work on concordance and insight. It has been my experience that patients who have a good understating, recognition and insight into their illness will engage better with services, adhere to care plans and take treatment.

347. When a patient begins to demonstrate a willingness to engage, speak openly about their difficulties, seek help when in distress, able to recognise and accept that they suffer from a mental illness, believe clinicians opinions around diagnosis and treatment, able to relate their risk being linked to episodes of illness, understand and recognise the importance of medication in their symptom control and compliance and recognise the risks they can pose, what drives the risk and able to accept and work with interventions that will mitigate the risk. The patient will show a willingness and understanding of this. The patient shows a willingness to take medication and no evidence of reluctancy. These will all be factors considered when assessing insight.

348. At the start of the assessment, between the health professionals present for the assessment (Dr Manzar, the AMHP and me) it was the opinion that if we

did progress to detention, we would be considering detention under Section 3 of the MHA. This is not unusual when the clinicians involved in the assessment have knowledge of the patient. In this case I did have knowledge of VC, and it was clear to me that this was a relapse of a condition that had already been assessed, and the focus and goal was treatment. It was evident to us all that prior to this MHA assessment, VC had recently been admitted to hospital, his mental health had been assessed, and conclusions were made with regards to his formulation and treatment. It was clear that VC suffered with a first episode psychosis and there were associated risks, and these will be mitigated with treatment and will include follow up in the community. VC had a diagnosis and a treatment plan to keep him well and mitigate the risks.

349. Section 2 is for assessment and treatment, whereas Section 3 is for treatment. VC's presentation on this occasion was very similar to his First Admission, the acute psychotic symptoms were similar, his associated behaviours were the same but, on this occasion, he did get access into the occupant's flat. His risks were again linked to his psychotic symptoms, and he had confirmed that he had stopped taking medication. Based on this, it was clear that the focus of his care was not assessment which would suggest assessment under Section 2 but the main focus at the point was that VC needed to get back onto his treatment, follow the care plan and the appropriate section was Section 3. All clinicians present at the MHA assessment were in agreement. There was clarity in terms of the mental disorder, which was first episode psychosis, there had not been a change in the symptoms of the illness he was presenting with, and it did not necessarily

require a specific diagnostic label as per the ICD 10. He met all the other criteria for detention under Section 3.

Initial observations, assessments, and care plan

Risk and Safety Assessment – 14 July 2020

350. On 14 July 2020 Busayo Ajewole, Clinical lead nurse updated VC's Risk and Safety Assessment [NHFT0000196] and Sarah Rivers, nurse, updated this on 15 July [NHFT0000195].

351. Under the heading of 'risk to others details' the following information was recorded:

> *"Arrested for attempting to gain entry into random neighbours flat as he felt that someone is in trouble. Valdo did not gain entry or harm anyone but he was kicking the door. Prior to previous admission Valdo was involved in a similar incident whereby he entered into another resident's flat whilst experiencing distressing auditory hallucinations [...]"*

352. Under the heading 'risk formulation the following was recorded':

> *"[VC] experiencing early psychosis [...] VC was arrested by the police for criminal damage (kicked a door in of another flat). No history of violence or aggression. Has been hearing voices and believed his mother was in the flat that he was trying to get in to, had a lack of sleep during the past week and has been feeling the pressure from his studies. Not eating and drinking well from his own admission. Valdo has been admitted to Rowan 1 again on*

14/07/20 on Section 3 of the MHA via the Cassidy Suite. He is being nursed on 10-minute intermittent observations."

353. During the period of his admission, I had not looked at this document. Having reviewed this document now to respond to the Inquiry, it is evident to me that the contents of this document contained information from the First Admission and hence they are confusing. This document appears to have been updated by nurse Ajewole adding in some additional information, in particular the circumstances and events around his detention on a Section 136 by the police to a document that had information related to the First Admission.

354. The comment of no history or aggression was, in my understanding, carried forward from when the document was initially completed in his First Admission where VC had not managed to gain entry to the neighbours flat. There was a tick to confirm that there was risk to others, but this new risk should have more clearly reflected in the document and a comment to indicate that there was risk of aggression and potential violence to others.

355. I accept that the document lacks clarity, it should have been captured that VC forced entry into the neighbours flat and also required restraint until the police arrived. It just so happened that during the two occasions around his First Admission he did not manage to get into the flat as the occupant did not open the door but the second time he did. Based on this it is my view that the risk was the same, but the outcomes were different.

<u>Police Report – 13 July 2020</u>

356. At the time of my MHA assessment of VC, I was aware that the police had become involved, they were called, attended, and then detained VC in their vehicle and later under Section 136 MHA transported VC to the Cassidy Suite. When I was contacted by the Cassidy Suite requesting my availability to do the MHA assessment, I reviewed his notes and was aware of what had been documented by the Street Triage Team, including the police involvement.

357. The information regarding police contact and the incident in question was clearly documented in the VC's Progress Notes which was available to me. I did not myself directly contact the police or the Street Triage Team as the information was already there. It was clear what had happened: he had been detained by police, assessed by street triage team whilst he was in the police vehicle and decision made to detin him on a 136 and brought to the Cassidy Suite.

358. The information was included and considered in the risk assessment which led to the decision to detain VC on a Section 3 as he was requiring hospital admission. It was clear that he could not be safely managed in the community and appropriate treatment and mitigation of risk needed to take place before he can be allowed back in the community.

359. The Police report from 13 July 2020 recorded that VC "*broke into the property and assaulted someone, they have him detained on the floor, he is kicking off though"[*NGPF0000049]. I was not aware of this police document and hence was not aware of the contents of this document. At the time, I relied on the information documented by the Street Triage Team (entry made in the Progress Notes for VC on 14th July 2020 [NHFT0000168 p56]) who

were there with the police. It appeared to me that the police had updated them of what had happened, they interviewed VC in the police car and hence made the conclusion that the information was correct. The Street Triage Team entry dated 14th July 2020 made no comment that VC had assaulted anyone. It stated VC attempted to push past the resident and he was restrained with support from other residents until the police arrived.

360. Risk assessment is the responsibility of everyone looking after patients on the ward. The risk should be captured and updated under the core assessment documentation, and under the risk and safety assessment. This should be updated by the patient's key nurse when an in-patient and his community nurse or lead clinician in the community. In view that there was continuity of care, I was well aware of his mental health difficulties and the risks VC posed from his First Admission and was also now aware of the circumstances around his Second Admission. The documentation, risk and safety assessment may not show this, but I can provide my assurance that the risk of aggression and hostility, issues around compliance to treatment, insight, VC's understating of how his illness plays a significant role in his risks were all part of his risk formulation, and efforts were made to address this.

Core Assessment – 15 July 2020

361. On 15 July 2020, Dr. Rupert Ackroyd (Locum Assistant Psychiatrist) completed a "Core Assessment" for VC [NHFT0000187]. Under "History of Presenting Complaint," it states:

"Valdo had gone to a neighbours flat who was staying with him as he had heard voices […] he barged into the persons flat and wanted the

person to admit what he was doing and other neighbours came to the rescue and called the police […] Assessed and detained under Section 3 MHA – prominent concerns regarding insight, medication concordance, risks to others when unwell and risk of further deterioration without intervention […] Valdo recalls events and understands why he has been detained into hospital […] Valdo denies that he has discontinued aripiprazole 5mg OD, but did say he stopped a different antipsychotic after leaving hospital. He identifies this as an error as he can see that the medication had some effect given his deterioration now."

362. Having read the accounts documented by the Street Triage Team and what was known to me at the time, I was not aware that VC had physically aggressive or harmed anyone. The entry from the Street Triage Team documented that VC was banging on the door, someone behind the door opened it, VC immediately forced his way in, attempting to push past the resident and he was restrained to the floor by a number of residents. There is no mention that VC had assaulted anyone.

363. Dr Ackroyd, in the 'History of Presenting Complaint', documented that VC barged into the persons flat and other neighbours came to the rescue which suggests that an intervention had taken place. I accept that the documentation could have been more accurate with the exact details, but it is my view that in assessing the risk it was clear that VC had forced himself into someone's flat and an intervention took place for the safety of the flat occupant. This suggested a significant level of risk which would need to be addressed in his management plan.

364. As I have stated, I was aware and knew that VC had required restraint by neighbours and that there was a serious potential risk of violence. But the documentation did not say that he had physically assaulted someone. If there was an actual physical assault, one would need to have considered how serious this assault was, what was the context, what was his intent at the time, and any police actions. It was known to me at the time that the police had no intention to arrest him and opted for a mental health disposal by detaining him on a Section 136. This suggested that if a physical assault had taken place, it was not deemed to be serious. The police never contacted the ward to interview the patient or request a capacity statement to suggest VC was fit for interview as would be the case if the police were following up on any criminal activity they intend to prosecute for.

365. In the planning of care on the ward, I am not solely reliant on what is in the Core Assessment document. There is more detailed information in the Progress Notes. The Core Assessment document, in my opinion, is a more helpful and useful document when a new clinician is trying to get familiar with the patient, as they can refer to this document to get a clear picture of the patient's mental health, risk and all the other information. The Core Assessment document on is historical information about the patient and summarises past presentations, mental health symptoms, interventions, past history, personal and family life, substance use history, forensic history, and risk. Useful aspects of the Core Assessment document, the details in the Progress Notes, assessments done on the ward, and my own review of VC's care during MDT's and Ward Reviews collectively contributed to the care planning. During his early contact with services, related to the first two

admissions, I would say that I was the clinician who had the most knowledge and understanding of his presentation at that time, as I was his RC during both admissions.

366. It was my assessment that VC did pose a potential risk of harm to others of both aggression and violence. It was also evident from the risk events that the risk was closely linked to the presence of acute symptoms of illness. This would need to be factored in his risk assessment, plans for mitigation and that guided our care planning.

Summary and Care Plan – 15 July 2020

367. On 15 July 2020 Robin Mame, a staff nurse, completed a Summary and Care Plan [NHFT0000204]. It records details of VC's care plan including;

Summary formulation p1;

- Under "Reason for Transfer:" "[P]rominent concerns regarding insight, medication concordance, risks to others when unwell and risk of further deterioration without intervention."

• Under "Valdo's View of Recovery": "Valdo appears to lack insight into his current presentation. Therefore, it is unlikely that he understands the need for recovery. Staff will need to support him so that he can be compliant with treatment to enhance recovery."

Care plan details;

i. *Under "Safety": the Summary and Care Plan refers to the incident wherein VC "barged into his neighbour's flat."*

368. This document is a fluid document. It is completed at the start of the admission and meant to be updated by the patient's key nurse to reflect changes in care planning and risk. This document is mostly guided by discussions in the MDT and Ward Reviews and views from the patient, as this is for the patient.

369. Having read what Nurse Robin had written in this document, under “safety”, after the comment that VC had barged into the neighbours flat, Nurse Robin did add that neighbours came to the rescue which suggest that there was an intervention that took place by the neighbours. For this document, Nurse Robin should have been more explicit about the specifics of the events that took place including the fact that VC had to be restrained by the neighbours.

370. This document was completed as per the Trust admission policy [NHFT0001243] by Nurse Robin prior to any MDT or Ward Reviews having taken place. The document summarised what was fact and evident in his Progress Notes.

371. It is my view that Nurse Robin included all the relevant aspects of care planning, importantly the assessment of his mental health, his risk and contingencies as to how risk should be managed if evident, his compliance to treatment, observation levels and his general wellbeing, having just been admitted to the ward. This was not for the entirety of the admission, and this should be updated as the admission progresses as required.

Clinical Reviews

N.B. the sub-headings stating the date of reviews are to assist with navigation of the document, but do not mean that the entirety of that section relates directly to that

review, as various of he reviews pick up on themes for further, more general discussion.

72 hour Review – 16 July 2020

372. On 16 July 2020 there was a ward/72-hour review where it is recorded that:

> *"[VC] Seems non-plussed when confronted with the effects of his behaviour with the neighbour during this incident and also the previous admission. No signs of remorse or insight into how his actions have affected others. Just says 'there will not be a next time'. Dr Seedat observed that there seems to be no insight or remorse and that the danger is that this will happen again and perhaps Valdo will end up killing someone. Valdo simply responds by saying 'it will not happen again'. Police are not intending to press charges.*
>
> *Dr Seedat explored Valdo's insight into his mental state and possible serious mental illness. Very frank discussion. Valdo does not accept that he may have an enduring mental illness."*
>
> "He is hoping it will go away 'that [he] can use [his] will to power through it."
>
> [NHFT0000168 p.64]

373. It was a fortunate situation that VC was admitted under my care, having looked after him in the First Admission. There was some level of continuity of care. This was purely by chance, and it so happened that there was a bed available for him on my ward. It was also not very long since he was discharged, just under four weeks.

374. I refreshed my memory in relation to his recent First Admission and I was involved in his MHA assessment which led to his detention on Section 3 for this Second Admission. I would confidently say that I was aware of his clinical picture, the circumstances of his admission, his circumstances, his symptoms of illness, his risks. I was aware of the two separate incidents of banging at a neighbour's door which subsequently led to his First Admission and now the incident that led to his current admission. It was difficult to say if this behaviour leading to the Second Admission was an escalation. What in my view was different was that the occupant of the flat on this occasion opened the door. This allowed VC to make and attempt to complete what his thoughts and feelings were telling him which was to go and save this woman. It was clear that VC was unable to resist the impact of his beliefs which were clearly driving his behaviours.

375. With regards to the statement that "*perhaps Valdo will end up killing someone*", it is my clear recollection that I did say those words but the documentation lacks the context in which it was said which was said, which was to impress on VC about the potential risk of his behaviours, including unintended consequences.

376. The context is that I was discussing his risk and how this was closely linked to the symptoms of his illness. It was my intention to psycho educate and impress upon VC the seriousness of his illness and the potential impact on risk. I reminded him that before his previous admission, a neighbour on whose door he was banging had jumped out of the flat and hurt their back and required surgery. I was saying that if he continued to do this, it could be more serious where the neighbour would not be so lucky and could die if they

jumped out of the building: he could end up killing someone by unintended consequences of his action, banging on their door. Up to this point, VC had not voiced any thoughts of harm to others, he had not expressed any intent during the admissions to the ward, he did not use illicit substances, there was no suggestion of antisocial behaviour or any past trauma of violence. There was no evidence of violence to others that I was aware of and he did not present with any of the stigmata that would increase the risk of violence (including history of abuse, growing up in a home with domestic violence, substance abuse at a young age, fighting and problems at school, cruelty to animals, criminal behaviour, gang affiliation). Based on this, it could not be my opinion nor my conclusion that VC would kill someone as I had no evidence or basis on which to make this assessment. There was nothing in my assessments to date to suggest that.

377. My opinion at the time was that VC, when unwell, was a risk of aggression and violence. Being compliant with his medication and having insight would mitigate against the risk. It was my concern at the time that if he was unwell, the behaviours he had been engaged in of, approaching neighbours who he felt were harming someone, would be repeated, and if they took a similar action to jump off the window, they may not be so lucky and could end up dying. This would be attributed to VC's actions.

378. In hindsight, I should have checked the accuracy of this record and corrected it to include both the context and what I said and what my intentions were of saying that. My goal was to clearly impress on VC the potential dangerousness of his actions and potential consequences especially when

he was unwell, and how important it was for him to accept that he has an illness, that he needs to regularly take his medication and stay well.

379. It was my impression that the police were not going to press charges. It has been my experience that if there was going to be police involvement, the police would have arrested him and taken him to the police station to follow the usual procedure. On this occasion, it was my belief that the police were suggesting that VC required mental health input, probably due to his presentation at the time and hence it was my view that VC would be progressed towards the mental health services rather than towards the criminal justice system. This was based on the fact that the police had detained him on a Section 136 and taken him to a place of safety, the Cassidy Suite at Highbury Hospital to be formally assessed under the MHA. Street triage also made a note at the bottom of their entry dated 14 July 2020 that custody did not appear to be an appropriate place based on the likelihood that the presentation was mental health driven [NHFT0000168 p56].

380. I have been asked about this entry in other investigations, and I have been consistent in my views related to this and gave a similar view and opinion when interviewed for the Trust's internal report and the NHS England investigation.

381. During the Review on 16 July 2020, it is also stated:

> "*Discussed depot: Valdo takes medication while on the ward but then stops once discharged. Dr Seedat explained pros and cons of depot. Valdo will think about it."* [NHFT0000168 p64]

382. In my opinion, this relapse was most likely due to VC stopping medication. Therefore, I introduced the option of having a depot version of the medication he was on as it would ensure compliance, and it would be advantageous in that he would not need to remember to take tablets everyday but a monthly injection. It must be remembered that VC was not non-compliant with medication: he did take them for a time after discharge and made a conscious decision to stop as he was feeling better and he talked about reading that it could “slow the mind” and later on, when asked, expressed he had experienced side effects [NHFT0000168 p64].

383. The medication, how it worked, what it was, and potential side effects were discussed with him during his First Admission and so he did have some awareness of it. I informed him in this Second Admission that to ensure ease of taking medication (not having to remember to take a tablet each day) and people caring for him having certainty that he was taking medication there was an option he could consider which was an injectable form of the medication and the injection would be a monthly one. I explained to him that it will be the same chemical as his oral medication he had been taking and where the depot is administered (in the arm). I explained how the depot is given, how it would be introduced, the frequency of the depot, how it would be continued in the community and reminded him of what the medication was, how the chemicals inside his body worked, explained side effects, pain of the injection, the medications efficacy and monitoring.

384. It was my opinion at the time that VC was able to understand the information I had given him regarding his illness and the need for medication. He was able to demonstrate to me that the experiences he had been having were not

in keeping with reality, he accepted and understood that when he took the medications the experiences were not there, he recognised that he had come back into hospital as his symptoms had re-emerged and one reason for that was that he had stopped taking his medication, he acknowledged that he felt better on the medication, he did not want his symptoms to re-emerge, he understood that his risks were driven by his psychotic beliefs, and he confirmed that he would take medication as he wanted to stay well. I was assured by him that he understood that the medication will have to be taken for an extended period of time. Specifically, about the depot medication, he was able to appreciate how this would help with compliance as this would be given to him by health professionals and there would be record that he had been taking his medication. He was able to retain most of the key points raised, he was able to weigh up the information and decide. On this occasion, equipped with the information I had given him, he said he would ponder over it and will let me know. It was on this basis that I made the conclusion that he did have the capacity to understand the pros and cons of depot medication. If it had been my assessment that he lacked capacity, I would have certainly considered enforcing depot medication and used the CTO framework to ensure he continued the medication in the community. I understood that in order to stay well, being compliant with his treatment was important as it also mitigated his risk. Therefore, it would be crucial that he remained compliant with treatment. It is my practice that all my capacity assessments are done in line with the principles of the MCA and the supporting Code of Practice. Capacity decisions are time specific and decision specific. The premise is that everyone is presumed to have capacity and the requirement that any decision

made for someone lacking capacity must be in their best interest and least restrictive.

385. The basis upon which a patient who is diagnosed with first episode psychosis and has a history of aggressive behaviours is considered a risk to others needs to be considered on a case-by-case basis because formulation of risk is not an exact science and can be unpredictable. There are many factors that come into play, including patients' past and current situation and events that allow us to make some level of prediction. One of the consistent factors that predicts potential future risk is past risk.

386. In terms of the past, factors such as violent past, early use of substances, involvement in criminal behaviour, school truancy, challenging behaviours, Trauma including abuse are relevant.

387. In terms of the illness itself, the presence of acute psychotic symptoms, the content of the experiences and the related behaviours, concomitant use of substances, underlying personality problems (antisocial or dissocial), criminal behaviour, past risks, medication compliance and stresses could be important factors. If the patient has command hallucinations telling the person to harm others, delusional beliefs or passivity phenomenon that compels the patient to harm others, they will be considered higher risk than those who did not have these features in their illness.

388. Where the risk is closely linked to the mental illness, effective treatment with compliance can help mitigate risk and enhance mental wellbeing. Hence the importance of medication concordance and engagement with services to help mitigate risk.

389. In case of VC, I was clear in my opinion and risk assessment that his clinical picture and risk had not significantly changed as compared to the First Admission. It was clear that the risk remained linked to active symptoms which drive his risk behaviour. His risk of aggression was evident, but his risk of violence remained low but as in the First Admission, there was the potential risk of violence to others. What had become clear was that VC would force entry into a dwelling where he suspected that a woman was in danger, driven by his psychotic beliefs. This action put himself at risk and others. It was evident that risks were linked to when he was ill with acute symptoms, as all the incidents to date were driven by his acute psychotic symptoms. Positively he did not have antisocial tendencies, he did not have a criminal past, he did not use substances, and he had not verbally expressed any intent to harm others. Where the perpetrator behind the psychotic beliefs is a known identifiable individual, the risk can be more imminent, and this was not the case with VC.

<u>Discharge Summary – 31 July 2020</u>

390. A Discharge Summary dated 31 July 2020 was completed at the end of VC's Second Admission. Under "Ongoing Risks" it states

> "*Others: he believed others were trying to control him/spy on him/torment his mind and has broken into his neighbours' flats multiple times to confront them, there have been no incidents of violence yet but this would be a potential concern if acutely unwell. One of his neighbours jumped out of her window as a result of fear and severely injured her back*. [NHFT0000222 p3]."

391. The Discharge Summary was completed by the Foundation Year 1 doctor on the ward. At the start of the doctor's rotation, I would explain how and what should be included in the document. VC was discharged on a Friday and hence the document was finalised on the Friday after he left the hospital. In view that the Discharge Summary must be completed with a target of 24 hours, this had to be validated on the Friday, I did not see this summary at the time, and I did not review all discharge summaries before they are validated. I would only do so if the junior medics needed support with it. Having now looked at the Discharge Summary, it is my view that there should have been more detail included, and the risks appropriately emphasised. It is my view that in terms of risk to self, there had been no specific risk to self like self-harm or suicide and hence I do not feel that accidental injury was a risk. There was also no suggestion of self-neglect.

392. In terms of risk to others, it would have been helpful and more informative if the three incidents (from both the First Admission and Second Admission) were mentioned, that there had been aggression and violence (and so it was not correct as that there had not been incidents of violence).

393. There should also have been mention of the risk of non-compliance to medication or risk of stopping medication and the relationship of doing this to his risk.

Insight – Second Admission

394. It was my opinion early in the admission that VC's level of insight was poor. Insight is assessed based on a patient's understanding of the illness, recognition that they have an illness and what that is, being able to link their

symptoms to their behaviours and the potential risk if that is the case and an understanding that they will need treatment and where this treatment is best provided.

395. The Street Triage Team had noted their discussion with VC about his illness on 14 July 2020:

> *"I asked Valdo if he could recall the previous incident prior to his admission. He stated that he could and recognised he was unwell. He denied feeling unwell at present and thought this evening's events were "mild" in comparison. The longer I spoke to Valdo he seemed to lose his composure somewhat; sighing at times and then smiling inappropriately. I got the impression that Valdo was attempting to conceal his symptoms*" [NHFT0000168 p56].

396. He did not seem to understand or recognise the seriousness of what had happened with the neighbour, what had driven it as a symptom of illness (believed someone was in danger and confronted the neighbour, admitted to hearing voices), he had to be restrained, and police involved. He minimised what had happened, and he did not feel he required admission to hospital.

397. I was clear that VC lacked insight, he could not be safely managed in the community and needed to come into hospital and due to his poor insight, and this would have to be by using the powers of detention under MHA as he was not willing to be admitted as a voluntary patient.

398. VC had been re-admitted due to a relapse of his illness. It was my opinion that VC did not connect that his symptoms had re-emerged as he had stopped taking his medication, and he did not appreciate that his symptoms of illness had led to his actions of going to confront the neighbour and was unable to

appreciate the potential seriousness of his actions. I was clear that VC showed poor insight. However, when it came to discussion around his treatment VC was able to tell me that he now believed that stopping medication was wrong, he understood that he will need to take medication and was in agreement from the beginning to go back on his medication and even agreed to take a higher dose. despite the poor insight, I was of the opinion that when it came to specifically about medication, he was able to make decisions, and the insight did not have a significant impact. If it did, VC would have refused to take medication, and we would have had to find assertive ways to treat him. It was my opinion that his poor level of insight had a bearing on his capacity particularly around his diagnosis. I was of the view that his capacity to make decisions around his mental illness, its management, and his ability to understand the potential risks was affected.

399. Insight has a close association with capacity. Based on this, Insight can impact on capacity around decision making related to treatment, engagement with services and recognition of illness. So, if a patient was presenting with poor insight, it will have an implication for treatment, understanding and recognition of illness and ongoing engagement with services. This will also have impact on risk and its mitigation.

MDT meeting - 20 July 2020

400. On 20 July 2020, during an MDT meeting at 14:10, I noted that VC "*requires work on insight*" [NHFT0000168, p74]. It was clear very early on that VC lacked insight. It was also importantly recognised that his risk to others and

to some extent to himself around self-neglect, was linked to the presence or absence of acute psychotic symptoms.

401. The changes that I would have been looking for to demonstrate if VC had developed insight would be his ability to able to understand and recognise that the symptoms he has been experiencing were an indication of a mental illness and specifically psychosis. I would have been looking at whether: he was able to realise that his experiences were not reality; he was able to appreciate and recognise that his symptoms were the driver of his behaviour and actions of harm towards others; he was able to understand the potential outcomes of his risk to others when he was unwell; he was able to agree that medications control his symptoms and ongoing compliance was going to be important to stay well and mitigate the risk; he understands the need to engage with mental health services to monitor and support him when in the community; and he demonstrates an openness and willingness to discuss his condition and treatment.

Ward Review – 21 July 2020

402. A at a Ward Review on 21 July 2020 it was noted that according to the APIP (Acute Psychological Interventions Practitioner) Nurse, Angela Purdue, VC "***appears*** *to understand the importance of continuing to take medication when he is discharged.* ***Appears*** *to have developed good insight into his condition*" [NHFT0000168 p79] (emphasis added). From review of the notes, this appears to have been discussed during a planned 1:1 between the APIP and VC, lasting 25 mins on 20 July 2020 [NHFT0000168 p75]. The Ward Review of 21 July 2020 states under "Patient comments" that:

"*Valdo says his discussion with Angela yesterday was very informative and he recognises the importance of continuing medication after discharge more. Valdo believes he took things out of context prior to his admission and he was wrong to break into his neighbours flat. Valdo understands that the situation could have been much worse for the neighbour and himself. Valdo acknowledges this is the second incident."* [NHFT0000168 p79].

403. It was clear that improvement in insight would lead to better compliance with treatment and engagement with services, especially in the community. I accept that when this comment was made, he had been on the ward for 5 days. I feel it was correct to use the term "appears" as that is what was directly observed by the APIP nurse and reported directly by VC. However, considering the presentation during his First Admission, the concerns around potential masking of symptoms, my own view during the MHA assessment that he was saying the right things that he thought we wanted to hear and the events leading to the Second Admission due to non-compliance needed to be factored in when commenting on his insight. At this point in his admission, I would not have made the conclusion that VC had appeared to have developed good insight. I would have taken a more cautious approach and suggested that this was a beginning to working towards insight. I would like to clarify that the understanding of his insight during the course of the admission was not solely predicated by the assessment made by nurse Angela Purdue.

404. During a Ward Review, individual clinicians would give feedback about their involvement with the patient. In this case APIP Angela was not present in the

review, but the Ward Review nurse was relaying feedback she had received from Angela and Angela had also made an entry of her interaction with VC around insight into the notes [NHFT0000168 p75]. I could not therefore challenge her view at that time and it would not be fair of me to challenge a colleague in front of a patient but to respect their views and opinion. I would have instead had a discussion and used gentle persuasion to consider the alternative, if appropriate. If she was present, I would have sought clarity on her views around whether VC had been masking symptoms. I did not challenge her views outside this meeting which, in hindsight I should have. I would like to confirm that within the Ward Review, clinicians giving feedback may have varying opinions and I feel this is healthy as it provokes further inquiry and assessment. On this occasion I recognised this as an opinion she made, and I remained cautious about VC's insight at this point and would see how things progress.

405. The conclusions I drew was that it was positive that VC was able to demonstrate better understanding of his illness and symptoms and the need to remain compliant with his medication. I recognised that the work on insight needed to continue during his time on the ward and when he was back in the community. The views he was expressing about his illness and need for medication was evident in subsequent interactions he had with nurses on the ward and HCA staff. There were further discussions with VC with me, interactions he had with nurses on the ward and HCA staff around insight. This included discussions about his illness, the need for medication, relationship between risk and his illness and a discussion around early warning sign recognition, family support and how to seek help.

406. It was my impression that this was a good start, there was consistent comments from VC during this session and other 1:1 times with his key nurse where he had been consistent to recognise that he had mental health problems, his symptoms were suggestive of illness, his behaviours were related to his illness and the need to take medication.

407. On face value, I feel that one could not conclude that at this stage that he had developed insight within the period 14 – 20 July. It is my opinion that VC did start to develop a better understanding of his illness and treatment. I feel the recognition that he was back in hospital, he was detained on a Section 3, the rationale for the detention and the concerns, the ability to recognise on reflection that his symptoms increased after stopping medication, helped him to start the process towards developing insight but I would not have concluded that he had developed meaningful insight within 4 days of admission. It was my belief it was beginning to dawn on VC that he had a mental illness and will need to take medication otherwise there are going to be consequences for him. It was the plan to ensure work on his insight continued whilst he was on the ward and also a plan for this to continue when he was back in the community. Insight is not something you have, or you do not, it can chop and change and thus can vary with time. The degree of insight can also vary from being poor, to partial, to good insight. It is thus important that there is on-going assessment and evaluation of insight. I feel it would be a fair summary to say that he had a better understanding and recognition of illness, was beginning to develop insight and recognising the need to take medication to control the symptoms and this would have a positive effect on his risks.

408. As above, the possibility of depot medication had been raised with VC during the 72-hour Ward Review on 16 July 2020, where it is recorded that "*Discussed depot - Valdo takes medication while on the ward but then stops once discharged. Dr Seedat explained pros and cons of depot. Valdo will think about it - ward staff to provide information. Also, brief discussion about mechanisms of action of anti-psychotics*" [NHFT0000168 p64].

409. During the Ward Review on 21 July 2020, VC's mother queried whether VC should be started on depot medication, and VC stated that he did not think that he needed to make that decision now. It is recorded that "*Valdo was informed by Dr Seedat that he has time to think about whether he wants to take a depot on discharge or would prefer to stay on oral tablets (ensuring his concordance)*" [NHFT0000168 p79].

410. During this discussion I did not mean to infer that it was going to be solely VC's decision to decide if he took depot or not. I introduced the option of an alternative to oral medication to inform VC that this option was available to help with compliance to medication. VC was not keen from the outset, and I told him that he had the time to think this over and we would discuss it again. It is important to discuss therapeutic options that a patient has and see if you can do things with their consent in the first instance.

411. It was clear in the case of VC that he had an established mental illness for which he required treatment, especially medication treatment to control the symptoms of illness. Doing so would enhance his mental wellbeing and mitigate the risks. Some of the antipsychotic medications have the option of oral medication and parenteral administration (injectable). The Aripiprazole

he was on, in addition to the oral option, also had the injectable depot option if required.

412. Some of the factors that one will consider to determine if someone would benefit from depot injection would include patient choice, where there is a pattern of repeated non-compliance, revolving door patients where the patients main reason for readmission was due to poor compliance to medication, where patient has significant use of illicit substance with a comorbid psychotic illness and medication has been noted to control psychotic symptoms but patient too unreliable to take oral medication and in situations where risks are closely linked to relapses of illness with relapse commonly being due to poor compliance to treatment.

413. Patients who take depot medication are not all subject to CTO. In my experience the majority of patients who are on depot are not subject to CTO and they are on depot through their own choice. There will be situations where it is obvious that to safely discharge patients back into the community they will need to be put on depot and due to the patient's poor commitment to this, such patients will strongly be considered for CTO. In these situations, it is evident that compliance to medication has shown to keep patient well and hence avoid admission or compliance to treatment helps mitigate the risks. This also helps engagement with community services and mental wellbeing.

414. In terms of capacity assessment, I follow the principles and practice of the MCA. Whether a patient is detained under the MHA, lacking insight or is deemed to be lacking capacity at the time, it will still be my practice and intention to discuss the depot option and seek the patient's agreement. The

intention is always to gain agreement or understanding as this will encourage compliance.

415. Capacity decisions are time specific and decision specific. The premise is that everyone is presumed to have capacity and the requirement that any decision made for someone lacking capacity must be in their best interest and least restrictive.

416. The consultant will provide information to the patient about medication and the formulary versions, oral or depot. The consultant will explain the importance of medication and compliance, how medication worked, what it was, potential side effects, how long it needs to be taken, what will be monitored, benefits of taking it and risks of not taking medication.

417. The patient will be told that there are options for both oral and depot medication. There will also be an emphasis in some patients to push the agenda for depot medication if this was appropriate as per the conditions in which depot would be beneficial, as listed above. The consultant would explain what depot medication was, the frequency of administration, how this will be administered in the community, the required monitoring, and the benefits of taking depot over oral medication. Also, the draw backs of taking depot as compared to oral would be explained. The consultant will then determine if patient was able to understand the information they had been given, able to retain most of the key points, able to weigh up the information and make an informed decision. Patient will also be given written/printed information on the medication and have the opportunity to ask any questions or seek clarification. Carers or family may also be involved if patient agrees.

418. In situations where it is clear and the community team feel it was the only safe way to manage the patient in the community, even if patient is demonstrating capacity, a decision could still be made to give depot and in such situations, CTO will strongly be considered.

419. It was my view that VC had demonstrated good insight at this time. This was his Second Admission, VC was clear he was not keen to take injection, and the community team were in agreement at this time to manage VC on oral medication. It was my opinion at this time that there was not a compelling reason to force VC to take depot against his wishes. All I could do was to encourage and convince him to take the depot as it would be an easy way to ensure compliance, and the community team would be able to confirm that he had been compliant as he would have had his injections. On the basis of this I was left with the option that it was going to be VC's decision to make if he wanted to take the alternative option of the depot. At this point, as the admission had progressed, I had come to the opinion that VC did have capacity specifically in relation to his medication treatment.

420. At the time of admission, he was immediately started back on his medication and was given double the dose he was supposed to have been taking. In his first senior medical review on 16 July 2020, he told me that stopping medication had made him more paranoid [NHFT0000168 p64]. In his session with Angela Purdue on the 20 of July 2020, he stated that he now understood that he needed to take medication to stay well [NHFT0000168 p75].

421. In my interaction with him at the Ward Review on 21 July 2020, in view that VC had been admitted due to stopping his medication, I raised with him the option of taking the depot version of the medication. It was my belief that VC

understood what a depot medication was, he understood what it involved, I informed him of the process that would be involved when he was in the community, and I explained to him the benefits of the depot versus oral medications and also the pit falls, particularly that he will need to accept an injection. The main decision was oral versus depot injection. It was my view that he had now understood how important medication was in controlling his symptoms and his risk. He said he was not fond of needles, and it was his preferred option to continue with oral medication, and he would continue taking it in the community. During the course of the admission, he did not give any concern around medication compliance, and he consistently recognised the need to take medication, the benefits of doing this and preferring oral medication. At this point it was my view that we needed to follow a conservative approach and build on a therapeutic relationship as he had been compliant with medication, he had shown better insight, and so I wanted to give VC a chance to take responsibility for staying well. It was my conclusion at the end of the admission period that he had the capacity to make a choice if he continued oral medication or took the depot. I did not feel that the depot could be forced onto VC.

422. It is my opinion that we had a very clear view about VC's mental health, the symptoms of his illness, the associated behaviours, and the risks to date.

423. It was my view that the presence of insight was going to be a significant factor in having some prediction about compliance going forward and we placed extra emphasis on this during this Second Admission.

424. It was clear from our assessment that VC was suffering from a psychotic illness, this was a first episode psychosis, and I was now of the opinion that

his psychosis was most likely in keeping with a diagnosis of paranoid schizophrenia. His risks of aggression and violence were closely linked to his acute psychotic symptoms and medication compliance was going to be important to mitigate risk and enhance his mental wellbeing.

425. I felt we had made progress with regards to his insight during this admission. He had been more vocal and open to the suggestions and discussions around how medication compliance was important in the control of his symptoms and risk. The re-admission, I believe, also gave him a wakeup call as he was more acknowledging of the risk and remorseful of his actions and I formed the opinion in agreement with his community team specifically his community nurse (care coordinator, CCO) that we would continue with oral medication. We were in agreement that he had the capacity to make the decision whether he took medication in the oral form or depot. He was clear he did not want the injection. If he was to be prescribed depot, this would have to be given against his wishes, and we would have to use CTO. It was thought proportionate no to take the CTO route given the level of insight, evaluation of risk and its mitigation. Therefore, VC would remain on the oral medication.

426. VC had no mental health problems until now, he was clearly struggling to come to terms with his illness, despite in my view recognising that he was not right, having to navigate the stigma of mental health involvement and to this point he had only relapsed on one occasion, it was unjustified to put him on a CTO.

427. It was my opinion that giving him another opportunity to take responsibility of his illness and treatment, on this occasion having demonstrated more understanding of his treatment and illness, continue to work on his insight in

the community and medication compliance would mitigate the risks. With a robust community plan, this could be safely done without the CTO.

428. It is my view that if VC's Summary and Care Plan as well as his Risk Assessment had acknowledged that he had not merely broken into a neighbours flat but was alleged to have assaulted the individuals in that flat and was therefore restrained by them, it would have not changed the decision to enforce depot or CTO. It is not a given that because there has been an incidence of violence that this was a reason to enforce depot or put them on a CTO. One needs to consider all aspects of the patient's presentation including evidence of factors such as it being a repeated pattern of non-compliance, there was evidence of poor insight consistently, poor engagement with services, evidence of substance misuse. It was clearly evident to me that VC's risk was dependent on the presence or absence of active psychotic symptoms. When his symptoms were present his risks would increase.

429. The main factor and determinant for VC was to ensure his psychotic symptoms were controlled and the mitigating factor was VC being compliant with his antipsychotic medication, as it was positive that he had shown good response. I accept that the enforcement of medication (as would have been the case of the depot and CTO) would have reliably achieved this but at this time it would not have been the least restrictive option and hence would not have been in the spirit of the MHA. I was of the opinion that VC had gained better insight during this admission, he had not as yet shown repeated non-compliance and with better understanding, should be given the chance to make the choice he had made, which was to take oral medication. The key

outcome was VC to remain compliant with his medication as this would control his symptoms and mitigate against the risk.

430. I can understand that he implied the same after his First Admission and then stopped his medication. However, it was my view that the re-emergence of his symptoms on stopping medication and then coming into hospital for a second time gave him improved clarity of the benefits of medication and would enhance his compliance to control his symptoms and risk. He was more open and engaging with conversations around his treatment. I believed that he was now more aware that not taking medication would lead to further admissions to hospital and engaging in behaviours that were out of character for him. This gave some hope that VC would take his medication in the community and be compliant. This was the least restrictive process. At this point it would have been too heavy handed to force him onto a depot and CTO. To monitor medication compliance, for the short term when discharged, plan was put in place for the involvement of the CRHT team to jointly work with the EIP team, to provide added support to ensure compliance by regular visits and checking he had been taking medications and in the medium to long term this would be followed up by the EIP team who were also responsible for providing VC his repeat medication which they would deliver to him.

431. It was clear that if we improved his insight, we would be able to improve his compliance to treatment. On this admission, being detained on a Section 3 with the focus being treatment (as an assessment had already taken place during his First Admission) it is my view that through the interventions on the ward and psychoeducation (including work on insight and medication

compliance), VC demonstrated a better understanding of his illness, recognition of the importance of his medication and the link between his symptoms and his risk. He was compliant with his treatment on the ward, and he was not reporting any side effects especially the side effects he had said were the reason he stopped taking the medication after the First Admission. On a number of occasions, he said he was not experiencing any of the side effects he said had made him stop taking his medication. He said he was happy with his medication and would continue taking it.

432. This was also his first readmission which I believe gave him a better perspective and evidence as to what would happen if he did not take medication and I had also planned for a robust community plan through his EIP team, supported by the crisis team.

433. He also did not have the other factors of substance misuse, antisocial personality factors or inherent criminal behaviour and the traumatic experiences in early life that have links to violence and aggression in later life.

434. During this Ward Review on 21 July 2020, under the heading "Risk Assessment", VC's risks to others is recorded as:

> "*believed others were trying to spy on him/torment his mind and tried to enter a neighbour flat to confront them, there have been no incidents of violence yet but this would be a potential concern if acutely unwell." [NHFT0000168, p80*],

435. This was not accurate as there was evidence of aggression and violence that also required restraint from neighbours of VC. The team was also aware

of the incidents that had taken place during his First Admission. This information was recalled in the MDT and VC had been discharged under four weeks previously after his First Admission and most staff on the ward remembered him and would have refreshed their memory of his presentation. There would not have been any changes in staff in that short period.

436. This documentation was completed by the junior doctor making the record in the patient's medical records. The care planning of VC's care was not reliant on this statement as it was already documented, and the team were aware of, the risks of aggression and violence, and it was with respect to this risk the care planning took place and interventions put in place to mitigate these.

Ward Review – 28 July 2020

437. On 28 July 2020, at a Ward Review, under MDT discussion, it is noted in respect of VC's treatment:

> *"Dr. Seedat explained that we have called the Crisis Team as we feel as though Valdo may need more support when he is discharged. Explained we have doen [sic] some work on insight, concordance and it seems as though he is saying the right things. Though we want Crisis team follow-up to ensure this is the case."*
> [NHFT0000168 p106]

438. As already stated, from the beginning of the Second Admission the goal was to ensure VC had better understanding of his illness, the links between his symptoms and risk and the importance of medication compliance.

439. I was also aware that based on the First Admission and there being some evidence early during the Second Admission, that VC would say the right things that he believed people wanted to hear.

440. I believe we made progress during the admission, VC showed better motivation and engagement, he was stable on the ward, his medication had been optimised, there was no evidence of any acute psychotic symptoms expressed or observed, and he did not require ongoing in-patient care.

441. It must be understood that management of patients is a continuum. The treatment and interventions must continue when transitioning from in-patient and community. It was my view that VC had shown improvement in his mental health, there had not been any objective or subjective psychotic symptoms, he was more engaging and interactive, there had not been any risk concerns, he no longer required in-patient care, and he could now be safely managed in the community with adequate community provision.

442. The work around insight and concordance could continue and be safely done in the community. It will be a good test as to how he would now cope and engage when he is back in his environment as compared to being on an in-patient ward and compulsory powers. It is well known that the in-patient environment cannot replicate the real-life situation in the community. Patients' experience of how they will cope can only be realised if and when they are back in the community.

Pattern of non-concordance with medication – Second Admission

443. VC's Second Admission was precipitated by him stopping his medication "*two weeks after discharge from his last admission because he read that it could 'slow the mind'*" [NHFT0000168 p64]. From his description, it was clear

to me that he did not actually experience any specific side effects. He was clear that he had read about it and made a decision on information he obtained. It was consistently clear that remaining well was highly dependent on VC remaining compliant with his medication. It was obvious that we needed to try and understand why he stopped medication, which we understand was the most likely reason for his readmission to admission in less than 4 weeks. I am also aware that one of the reasons patients stop medication or prefer not to take medication is due to side effects.

444. This was explored and addressed with VC. Antipsychotic medications are major tranquilisers. Hence the slowing of the mind is to be expected and suggest efficacy: this is how they have their effect. He did not describe any of these side effects at the time of his first discharge from hospital. It could be possible that he felt the side effects after leaving hospital as there could be delay in emergence of certain side effects. At the start of his Second Admission, VC was started on the double the dose of Aripiprazole, specifically 10mg as compared to the dose he was started and discharged on during his First Admission. Aripiprazole was less sedating as compared to other drugs of the same group of atypical antipsychotics.

445. I was aware that he had stopped medication giving two reasons, he felt well and did not think he needed it and the second reason that he felt his mind slowing and it made him feel depressed. I explicitly asked him during this Second Admission when he was taking 10 mg of Aripiprazole, if he was experiencing any side effects, including mental slowing. He was clear that he was tolerating the medication well, he did not feel any mental slowing despite

the increase in dose. He was happy to continue taking it and said he will also continue it in the community and did not have a reason to stop.

446. On 20 July 2020, VC told Angela Purdue (APIP Nurse) the reason he stopped his medication:

> *"[he felt] lethargic with low motivation. He was unable to deliver his academic workload as he had little motivation. Therefore, Valdo stopped taking his medication as he felt so low" However, "he now understands that he needs his medication to stay well at this time and that he would not stop taking his medication in the future without consulting his GP first as he realises that this was what was keeping him well [...] Valdo stated that he fully understands the need for ongoing medication for a time after discharge*." " [NHFT0000168, p.75].

447. A nursing 1:1 on 27 July 2020 records that:

> *"He said that he felt ready to go home and that he had 'learnt his lesson'. He said he liked the staff and they were very nice but that he had no intention of returning to hospital again… Valdo said that he felt fine and that despite his medication having increased he felt normal, like he did before he came into hospital the first time'. He said he had no side effects and denied feeling like he was slowed down in any way. He said this meant he was happy to keep taking the medication in future*". [NHFT0000168 p100]

448. I was aware of both these entries. It was my practice to review the notes of the patient before each MDT and Ward Review. Objectively from the assessments we made, from the interactions we had with him, and

observation of sleep and his behaviour, there was no suggestion of evidence of over sedation or inability to focus or concentrate. Subjectively I must rely on what the patient tells me. Objectively, from the entries in his medical notes, VC seemed more active, he engaged in more activities than he did during his First Admission, did not appear sedated and was more visible.

449. Based on this I had no reason to query what VC was saying that he was not experiencing those side effects as what he said was consistent with what was objectively evident.

450. I acknowledge that during his First Admission, VC had remarked to his clinical MDT team that he was not experiencing any side effects from the aripiprazole [NHFT0000168, p28], but later said that the 5mg of aripiprazole (daily) was making him feel slow and that was one of the reasons for stopping it. Experience of side effects can be quite subjective and individual. Aripiprazole is the atypical antipsychotic with the least side effects as it causes less sedation and weight gain. It is commonly chosen as the first antipsychotic to prescribe.

451. We rely on patients to express and discuss any side effects they may be experiencing so we can adequately address this if possible or give assurance if the benefits of taking medication outweigh the risks. There is the option to trial alternatives as well.

452. Physical side effects of medication can be objectively visible/evident like vomiting, sedation, movement problems, weight gain. Internal side effects like concentration, focus, internal restlessness can be more difficult to pick up and we would usually rely on the patient to raise this with us. In VC's case, he did not volunteer the side effects he had been experiencing to any of the health

professionals seeing him in the community and instead took the decision to stop taking medication due to that. However, going forward through ongoing psychoeducation and building therapeutic relationships we could attempt to build trust for VC to be more open. He was encouraged that going forward he should discuss concerns with his community team. It was explained to him that if he had raised the concerns, this would have been reviewed, analysed and solution identified and jointly addressed with him.

453. It was clear that Aripiprazole was effective medication for VC in controlling his symptoms. If indeed it caused him side effects to the extent that he was unable to tolerate it or was causing functional impairment, alternatives to Aripiprazole would have been discussed.

454. I also felt that revisiting psychoeducation as to how these medications work and the effects they have on the brain would help in improving his understanding and developing ways to manage. In the First Admission I did discuss in some detail, and this was revisited during the Second Admission. VC was an intelligent individual, and he was also encouraged to read the information leaflet on his medication and on his condition.

455. I did not see reason to discuss alternatives as he responded well to the medication and on this occasion was clear that he was not experiencing the same side effects that gave him reason to not take it.

456. Prior to VC's discharge from his Second Admission, I highlighted to him that he would need to remain on medication for at least 2 years in the future [NHFT0000168 p106]. It is my view this was accounted for in my documentation of his care plan in my Ward Review. It was known to the community team who would be monitoring him in the community, and I had

also informed VC that this was going to be minimum duration of time he would need to take the medication, and he was able to understand this.

457. I feel as an in-patient team we adequately addressed the issues of non-concordance to treatment and planned for a robust community follow up plan including the crisis team to review and monitor this very closely.

458. As I have explained, I did not form the opinion that perhaps VC would go on to kill somebody, as set out at paragraph 372-380 above. However, I was clear that medication concordance was important and vital in both controlling his symptoms to enhance his mental wellbeing and quality of life and to mitigate the potential risk associated of aggression and violence.

Accommodation upon discharge

459. On 30 July 2020, Geoff Culpin (AMHP) forwarded to me an email that he had received from Eleanor Taylor at the University of Nottingham, in which she expressed concerns about VC being discharged to the same address as where the incidents had occurred. I replied to say:

> *"I cannot dictate where people go and live, he has a paid up tenancy, the landlords will not give him his money back and he has no income. Maybe that is the work Elanor needs to do is to work with landlords and see how they support their students in such situations.*
>
> *On both occasions the incidence happened in in his other flat and not in the one he is returning to.*
>
> *He is well, he is taking his meds, he will have close follow up and not sure what else she wants. You can [sic] just tell people where they should go, he is an adult*."

[WITN0163007]

460. Mr Culpin queried "*It's the well bit that important is he on a depot? oral meds? Will he have a team following him up ?or crisis*?", to which I replied "*He is on meds, oral meds, he has demonstrated good insight. He is going to be followed up by crisis team and also his LMHT, city south ,he has CCO Claudia Birtles*".

461. It was my belief that VC was well enough for discharge with input from the community teams. Once a patient is well enough to be discharged, it is not possible to compel them to remain as an inpatient without their consent to stay as a voluntary patient. This is one of the reasons why we start planning for discharge at an early stage of the admission, to ensure that there are no external factors which would be a barrier to discharge once the patient is ready. VC was renting private accommodation through a private third party: he was not in university accommodation, or social housing. During Ward Review on 21 July 2020, VC stated that his tenancy was due to end that week [NHFT0000168 p79]. VC's mother contacted me after the Ward Review and I have recorded that "*She informed me that as things stand Valdo was paying rent until mid September at his first flat and he only moved out due to his psychotic symptoms believing that his neighbours were following him. if he is well he may not think that and he could go back to the flat, she was clear that they will not force him to go there but hopefully he can agree. This will save him money paying for another place*" [NHFT0000168 p82].

462. I therefore spoke to VC later on 21 July 2020 to remind him that he still had the tenancy to his first flat, and that rent was paid up until September. We came up with a plan for him to visit this accommodation, to see if it would be ok for him to live there whilst he did his exams. [NHFT0000168 p82]. This

visit took place on 22 July 2020, when nurse Dominic Matiru accompanied VC to his flat [NHFT0000168 p86]. VC would not therefore be returning to the Brook Court address at which the incidents took place, which is why I stated in my response to Mr Culpin that "*On both occasions the incidence happened in in his other flat and not in the one he is returning to"*.

463. VC had the capacity to decide where he lived upon discharge and I had no legal basis to dictate where he should live. He was well enough for discharge, with the community support that had been arranged, and in any event, he was to be returning to a different address to where the incidents had occurred.

Trust's Level 2 Comprehensive Report

464. I understand that the Trust produced a "Level 2 Comprehensive Report" [NHFT0000451], which states the following:

> *"In summary, VC appeared to recover quickly from each episode/relapse of psychosis when an inpatient, resuming work or attendance at university on discharge. In our view, discharge planning reflected an inpatient focus on VC s presentation in the present as a snapshot view of someone with a recent relapse and relatively quick short-term recovery, rather than taking a longer-term view of VC's pattern of behaviour, risks and needs with consideration of what might be required for successful community management." [page 11, at para.29]*

465. It is my understanding that that this report conclusion is based on the entire care that VC received from his first contact with mental health services which

happened to be his First Admission to a psychiatric hospital and up to the point of the incident in question.

466. I was only involved for the first two months of his contact with mental health services, both whilst he was an in-patient. The clinical knowledge I have of VC's involvement and care is only for this period. I have not read his medical notes beyond my involvement in his care during the first two admissions.

467. Based on this I am unable to offer a view on this conclusion that the report made, and I was not involved in the majority period of his involvement with mental health services. In relation to the short contact with services at the time of my involvement, I do not agree that the report's summary could be applied to this period of his care. I acknowledge that he made quick recovery and responded well to medication which was a positive. I would like to stress that there was a focus on risk, insight, medication concordance and follow up in the community during both admissions. This included the requirements of monitoring in the community going forward and the important link between acute symptoms and risk. This was indicative that long term view was taken be it that he was at the beginning of his illness course.

Clinical conclusions from Second Admission

Rio Alert

468. I have been shown a screenshot of VC's electronic patient record [NHFT0000169]. Under the section titled "Alerts" there is no note of the incident of aggression which led to VC's Second Admission. I agree that the electronic medical record has an ALERT section for a reason. It allows any clinician accessing the records a quick snapshot of the risks that the person

has, in the past or current. It is my view that the ALERT section should have been updated to reflect the incident that led to his Second Admission as it was an important risk event. However, it is my view that the incident in question is highlighted in various documents and Progress Notes of VC's records. It was considered in the assessment and management of his illness and his risk.

469. Based on this I would find it hard to believe that any clinician involved in VC's care would not have reviewed his notes and his risks including this incident. Hence it is my view that even though it was not put in the ALERT section, the risk would have been known and would have formed part of his risk assessment and treatment. This incident was clearly important as it demonstrated the consistency of what would happen (this incident having similarities to the first two incidents with just different outcomes due to the context that during the first two the occupant did not open the door and in the most recent incident the occupant did) if VC started to experience a relapse of his illness. This recurring pattern would guide emphasis on the focus on medication concordance and being able to predict what could happen going forward when VC relapsed. This would guide care planning to include what actions should be taken if there was suggestion of relapse of illness so that the potential risks are mitigated.

Discharge Summary – Second Admission

470. In the Discharge Summary that was sent to VC's GP Practice at the end of his Second Admission [CHCA0000028] the following is stated:

"During his admission, Mr Calocane was started on Aripiprazole 10mg OD. Mr. Calocane presented as much more settled on the ward. He no longer presented with the same symptoms as he had on admission. In addition, Mr Calocane worked with the APIP on the ward to improve his insight of his medication and emphasise the importance of continuing his medication. Mr Calocane assures us that he fully understands the importance of taking medication and he has developed greater insight into his illness."

471. This Discharge Summary was completed by the FY1 doctor working on the ward. I did not review this document at the time it was completed. I can say that I would make it clear what relevant information needed to be included in the document, and the junior doctors are responsible for completing it. Having reviewed the medical records for the purposes of this statement, there is consistent documentation around his views on his mental health and medication. There was compliance with his treatment particularly his medication from the start of his admission. For example:

a. When seen by Angela Purdue on 20 July 2020, she documented that VC acknowledged he stop medication and gave reason for doing it, he acknowledged that he now needed medication to stay well, he would not stop taking medication unless after consultation with medics [NHFT0000168 p75].

b. In Ward Review on 21 July 2020, he acknowledged feeling better since restarting the medication, he found discussion with Mrs Purdue informative and improved his understanding of his condition, recognised the importance of taking medication, it was wrong to break into

neighbours flat appreciated the seriousness of his behaviour, must take his medications regularly and recognised that he has difficulties with his mental health. [NHFT0000168 p79].

c. On 22 July 2020, he visited his flat with HCA Dominic Matiru and he documented that VC wanted to go and apologise face to face what he had done to his neighbour, but the neighbour was not present. He appeared to understand the importance of treatment and understood consequences of his actions if police get involved and how this would impact on his future job prospects. [NHFT0000168 p86].

d. On 25 July 2020, during 1:1 time with nurse Mtetwa, Nurse Mtetwa documented that VC appears to understand importance of medication and VC regretted his actions and expressed remorse. [NHFT0000168 p93].

e. On 27 July 2020, Miss Thwaites, HCA, documented that VC had said he had learnt his lesson, he was happy to keep taking medication, he was happy to engage with community services, he was now more aware of his mental health and he would also consider seeking help. [NHFT0000168 p100].

f. On 28 July 2020, nurse Mtetwa documented in a 1:1 session that VC will continue to take his medication, he will not make mistake of stopping medication and understood negative impact of stopping medication. [NHFT0000168 p102].

g. On 28 July 2020, in Ward Review he said he had no reason to stop taking medication as he was tolerating it well and no side effects. He promised to continue to take his medication, realised that he does things he does

not want to do when unwell and medication help to keep him well. [NHFT0000168 p106].

h. On 30 July 2020, it was documented by assistant psychologist, George Jackson but the session was conducted my clinical psychologist Gareth Foote that VC understood that it was right for him to come into hospital, it was not safe for him to be outside, coming to hospital has helped him unwind and reflect. He said he was paranoid and unsafe in the community. He was complying with medical advice to take his medication. He was able to reflect and express the progress he had made in the understanding of his mental health. He was able to state that he was able to recognise early warning signs and described these as feeling paranoid, lack of control, thinking people were following him, being irritable and commented that he would seek help. [NHFT0000168 p115].

472. I was of the view that based on the various discussions around insight and my own assessment of this, that VC had demonstrated insight into his illness and treatment. This was the view I held at the time of his discharge from hospital on the second occasion.

473. The Discharge Summary contains a formal diagnosis of Paranoid Schizophrenia, IDC10: F200. However, the referral to CRHT dated 29 July 2020 does not include this diagnosis under the relevant section [NHFT0000030], and in the "Mental Health Clustering Tool (HoNOS PbR)" that was completed on 31 July 2020 [NHFT0000181 p4], VC is clustered into "*Ongoing recurrent psychosis (Low symptoms)*." Taking into consideration the clinical presentation over the two admissions, the symptoms he exhibited,

the lack of mood symptoms and no history of substance misuse, it was more than likely that his presentation was suggestive of Paranoid schizophrenia.

474. I had shared my opinion with VC, and I had also put it in my impression in my Ward Reviews. This was then included in the Discharge Summary.

475. The referral to the CRHT team was made by nursing staff and I see that they had included a diagnosis of psychosis. I am not able to comment as to why the nurses did not include the diagnosis of schizophrenia. This was formulated and documented in the Ward Reviews dated 21 and 28 of July 2020 where a member of the nursing staff was present, and it was also mentioned in the e-discharge summary which is validated by nursing staff [CHCA0000028]. Having said that, schizophrenia is a form of psychosis, and I do not feel that the nursing staff having not included the diagnostic label of schizophrenia would have significantly impacted long term care planning. The community team including the CRHT team had access to the Rio notes and would most likely been aware of my formulation. The core principals of treatment do not differ significantly.

476. The CRHT team and any other mental health professionals would have access to the Rio notes and the Discharge Summary. It is likely that the staff involved including the consultants within the CRHT team would have read the Rio notes and been aware that a diagnosis of schizophrenia was made during this admission. This was clearly stated on the Discharge Summary and his illness was also coded as per the ICD 10 diagnostic manual as F200. The long-term care planning would not have been compromised with the label of psychosis rather than schizophrenia being put in the referral to crisis team and the treatment pathway tends to be the same.

477. During the Ward Review on 28 July 2020 a senior nurse from the crisis team was present and I shared my clinical opinion, and this was captured in the review notes:

> "*Impression: acute relapse due to non-concordance with medication, seems calmer in general and no management problems on the ward, Likely schizophrenia. Now ready for discharge*" [NHFT0000168 p108]

478. The mental health clustering tool completed at the point of discharge was to reflect VC's clinical presentation in the previous 2 weeks. Based on the observations that VC had been settled during this period, he had not exhibited any active psychotic symptoms, there had not been any risk whilst on the ward, it was correct that VC's presentation was suggestive of psychosis, and it was evident that he had an ongoing recurrent psychosis with low symptoms falling in Cluster 11.

479. It is my view that based on this explanation there was no discrepancy, all conveyed the consistent message that VC was suffering from a psychotic illness.

Conclusions from Second Admission

480. In considering the assessment and management of VC's risks of aggression, violence, masking, lack of insight, and non-concordance with medication, I would say that we had a better understanding at the time of his second discharge as it was my view that VC was more interactive and engaging and willing to communicate. There was continuity of care between the two admissions as he was cared for on the same ward and mostly the

same staff. This most likely helped with the therapeutic relationship and familiarity which has shown to aid engagement.

481. There was less concern on this occasion that VC was masking psychotic symptoms. At the time of discharge his subjective views were consistent with the objective assessments we made that indicated his psychotic symptoms were in control and he was also on a higher dose of medication.

482. We did a lot of work on insight as described elsewhere in this report and at the time of discharge I was of the view that VC demonstrated good insight into his treatment and condition.

483. We put a huge emphasis on medication concordance. We made attempts to ensure he was not experiencing any side effects which would have given him cause to stop these going forward. We reinforced the message how his symptoms were drivers of his risk and based on this how important it was for him to continue taking medication. I was of the view that he had understood this link and was able to recognise it.

484. The risks of violence and aggression were assessed and addressed. There was a clear association between these risks and presence of active psychotic symptoms. It is my view that VC was able to appreciate this and recognised the importance of controlling his symptoms. He was remorseful of his actions and also wanted to apologise to his neighbours for his actions.

485. Overall it is my view that we adequately addressed and planned for the risks mentioned in the short term and long term when VC was discharged with emphasis that the work and monitoring needed to continue in the community.

NHSE investigation

486. I understand that NHS England Commissioned an independent investigation into the care and treatment provided to VC by NHS services prior to the tragic events of 13 June 2023. I was interviewed by representatives of Theemis Consulting (the company conducting this investigation) on 27 June 2024 [TCLT0000754] and 5 September 2024 [TCLT0000758]. I have been provided with copies of the transcript of these interviews and whilst I broadly agree with the contents, I wish to correct some points of detail.

487. In relation to the discussion of 27 June 2024 [TCLT0000754]:

a. The transcript states "And hence, you will see from my notes that I obviously started him on an Omeprazole depot, and Omeprazole tablets, which is my go-to first-time treatment, particularly in young men" [page 10]. I do not believe that I referred to "Omeprazole" or "depot". I started VC on Aripiprazole tablets, which is my first line treatment for psychotic presentations, particularly in young men presenting for the first time.

b. The transcript also refer to "Omeprazole" at page 11, which again should read "Aripiprazole"

c. There is a section which is redacted at page 25, which I believe involved discussion about the possibility of some family history of mental illness (as referred to at paragraphs 214 and 251, above).

d. The transcript stated "I didn't think depot was indicated in the time that he was involved in care" (page 29). This should read "I didn't think depot was indicated in the time that he was involved in care under me".

488. In relation to the discussion of 5 September 2024 [TCLT0000758], which focusses on the entry of 16 July 2020 (as discussed at paragraphs 372 - 380 above):

a. The interviewer states “My understanding is it's documented by a student nurse, is that correct…” and my response is recorded as “It was recorded by – [blank space]” (page 3). As set out in the paragraphs above dealing with this entry, it was documented by the junior doctor working with me at the time.

b. Where I am recorded as saying “It's also been standard policy, in view of the many patients that I needed to see, that documentation of the ward reviews tend to be done by my junior doctor colleagues” (page 4), it should read “It's also been standard **practice rather than** policy, in view of the many patients that I needed to see, that documentation of the ward reviews tend to be done by my junior doctor colleagues.”. Later in that paragraph where I say “I'm hoping that they would capture accurately what has been said within the ward review”, I am referring to the junior doctor making the notes.

c. Where I am recorded as saying “So my intention was to try to, I guess in some ways, help him truly understand to what extent such difficulties could go to and what could end up. One of those possibilities could be that he could end up killing someone” (page 6), this should be read in the context that I describe at paragraphs 372- 380 above, in that I was meaning that he could end up killing someone as an unintended consequence of his action of knocking on people’s doors and if the person behind the door took the same action of jumping out of the

window, they may not be so lucky as the lady who hurt herself, and it could result in someone dying.

d. The transcript states “The other revolving door scenario is using of substances and that is always difficult, that is not easy to manage because it is not something that the Mental Health Act will allow you to use to manage that in a, if you want to call it a cohesive way” (page 12). This should read “coercive way”.

489. I have been directed to page xv of the investigation report [NHFT0000530], which contains two of the key findings:

b. Firstly, the Report finds that VC’s insight into his condition “*did not appear to increase” and he “did not demonstrate retrospective insight*.”

c. Secondly, the Report found that:

> “*VC’s ability to fully understand the implications of his mental health condition were limited by his lack of insight. This may have meant he lacked full capacity to make decisions in relation to his care and treatment and engagement […] the question of capacity does not appear to inform all assessments of risk across the different care settings.”*

490. I have been asked whether I agree with this conclusion. Based on my assessment and opinions I made with regards to his insight, during the period I was involved in his care, I do not agree with this statement in its entirety. Especially during the Second Admission, we made a concerted effort around this and at the end of the admission it was my opinion based on the evidence (see para [under question 48], that VC did demonstrate insight into his condition and treatment. It is my understanding that these conclusions were

made in relation to an overall view of his care and hence in view that I do not have knowledge of what transpired after the first two admission I am unable to comment as to whether I agree or not.

3. VC's Second Period in Community Care (CRHT and LMHT City South EIP) ("Second Period in Community Care") *Relevant dates:* 31 July 2020 - 3 September 2021 (399 days)

5 November 2020

491. On 5 November 2020, VC contacted my PA, asking me to call him back. I called VC and recorded the following in his medical records:

> *"I told him that I was not able to discuss his care as I was not currently involved in his care and it was not right for me to be involved. […] I said to him that he needed to contact his community team. He understood this and I then asked who his team was and if he had contacted them. He seemed a bit cagey about this and unsure.*
>
> *He said I should look into his records and let him know who his team was and his nurse, which I did. I told him I was going to contact the LMHT to let them know about this contact.*
>
> *I told him that I will urge the LMHT to visit him face to face, assess his mental state and make sure he is okay. I feel based on the interaction that he needs more close monitoring and regular visits otherwise will end up in hospital.*
>
> *I also reminded him that he should call the LMHT for any help or support he requires and he assured me that he had the numbers to do so.*
>
> [NHFT0000168, p136]

492. My role is solely as an inpatient consultant. My responsibility of care is to the 16 patients on my ward. My involvement in their care starts from when they are admitted and ends when they are discharged.

493. In this situation, VC contacted my PA, and I could have told my PA that she should tell VC that he should contact his community team as I was no longer involved in his care. I knew VC, I had established good rapport with him, and I decided to call him to see what is that he wanted.

494. VC was seeking advice, and I told him very early on that I could not and was not the right person to contact. I reminded him that he had a community team, he will have a nurse and a community consultant. He should contact them as they will be best placed to help him. During this call VC did not mention anything worrying that required immediate attention. I told him information about his team as per his request and I also told him that I was going to inform his community team that he had contacted me and ask them to support him. I immediately called the treating community team, relayed my contact with VC and I note the members of the team visited him the next day.

495. The next note in the records is from Gary Carter in the community team, stating, "*Following on from Dr Seedat's communication I visited Valdo with a colleague Community Psychiatric Nurse Abi Parsonage*" [NHFT0000168 p136]. Once VC was in the community, it was the responsibility of the community team to ensure he was monitored and to manage any concerns around his mental health or risk.

496. The assessment and plans put in place when VC was discharged from hospital were shared with the community team and the crisis team. These teams also had access to the Progress Notes. My opinions and suggestions

of care planning were shared with the community teams at the point of discharge.

497. Once the patient is discharged, my involvement in their care stops. My attention shifts to the 16 patients on the ward as admission beds are never empty. It is not practical nor safe that the in-patient consultant can continue to remain involved in the patient's care once discharged from the ward. The Trust policy is also clear that it will be against the rules and data protection, to be accessing patient records when you are not involved in a patients care. Two months had passed since his discharge from my care. I had no knowledge of what care VC was receiving. VC had the EIP team looking after him and this included his community nurse, his community consultant, and the community EIP team, whose responsibility it was to decide on monitoring and management.

498. I did not feel based on the short conversation I had with VC I had enough information or make an informed assessment to consider referral to the CRHT team. Other than the action I took, having no knowledge as to what had transpired in his care for over 2 months, taking into account the lines of clinical responsibility, respecting patient confidentiality and not stepping on other clinician's care of patients, I do not feel there was anything else I could have done.

16 August 2021

499. On 16 August 2021, VC attended Highbury Hospital and went to Rowan 1 Ward. It is recorded by Ward Manager Amanda Smillie that:

> "*Valdo reported he could remember WM A.Smillie. He spoke about whether he could speak to Dr Seedat- reported that I could maybe help*

in the first instance. Valdo reported that Dr Seedat had said that he Valdo was hearing voices during his admission and wondered whether this was correct or if there was an alternative explanation. I asked Valdo whether he thought he was and he then went onto ask whether staff hear voices on the ward, and whether they communicate with Artificial Intelligence, he continued to ask whether Dr Seedat could confirm this. Reported that I was not of the opinion this happened on the ward and Dr Seedat would not be able to help with this matter. Valdo appeared to accept this. Valdo went on to say that the police had information about services" [NHFT0000168, at p 160].

500. It is my vague recollection that nurse Smille who was the ward manager on Rowan 1 at the time, had mentioned this in passing (I am not sure when), that VC had turned up on the ward asking for me, but they managed to deal with it and no action was required of me. It was clear in VC's formulation that he suffered with a psychotic illness. From the interaction described and what was documented specifically asking if staff heard voices, whether they communicate with AI, police had information about services, it would be my opinion that this would have suggested to me that VC was experiencing both auditory hallucinations and delusional thinking which would be highly indicative of the presence of acute psychotic symptoms. This would have suggested that he was showing signs of relapse. Based on his history and risk that I was aware of, the link between active symptoms and risk, this clearly required urgent further assessment and attention.

501. The date of this event is at the beginning of the working week, a Monday. The entry was made on the Progress Notes at 13:01. VC was able to

remember nurse Smille. Almost a year had passed since VC was a patient on the ward. Nurse Smille agreed to speak to VC jointly with her ward nurse colleague. It was their intention to hear VC out and see if they could be of any help. They gave him the space to express what was on his mind and to try and understand why he had come to the ward rather than his community team.

502. This interaction was not only recorded in VC's Rio medical notes, but the nurses also immediately directly contacted the respective community team, EIP that was responsible for his care in the community, via a phone call [NHFT0000168 p160]. The telephone contact with the EIP team was during working hours. The ward nurses were told that VC's usual nurse, the care coordinator was on leave but there was a nurse covering who they spoke to. The issues and concerns observed were relayed to the covering nurse the responsibility was devolved to the EIP team. It was now up to the EIP team to decide on what action they were going to take based on the information given to them by the Rowan 1 nurse.

503. VC was not an in-patient. He was a community patient and his support, and care related to his mental health was the responsibility of the EIP team he was under. The ward nurses did not believe that VC was presenting in an immediate crisis or presenting with concerning risk, and it is my view that the ward nurses correctly undertook their responsibility to both contact the EIP team by phone and put an entry on the Progress Notes. They were clearly concerned how VC had presented to them and felt it was important he received help and support from his community team. It is my opinion that the information relayed to the community team by the ward nurse was indicative

of acute psychotic symptoms which would be suggestive of signs of relapse of his illness. The ward nurses had not identified, and there was no documentation, that there were any concerns that indicated any imminent risk.

504. It is my view that the nurses discharged their duty to VC by relating their concerns via telephone appropriately to his treating EIP team who held the responsibility of care towards VC at the time. The nursing staff had also documented the interaction in VC's running records. I note from the records that the community team contacted VC the next day by telephone.

505. I understand that VC relapsed shortly after this. I am advised that on 31 August 2021 his CPA Care Co-ordinator referred him for a MHA Assessment and a s.135 warrant was used by police to enter his address so that he could be assessed. On this occasion, VC assaulted three police officers and had to be tasered twice. I only become aware of this event since I have been asked by the Inquiry to respond to questions about the care provided to VC. This incident took place almost a year after he had been discharged from my ward the second time. As I have stated earlier, I would only access a patients record if I was clinically involved or there was a clinical reason for me to do. This would be only for the purpose of the task at hand. Based on this, there would have been no way that I would have known about this incident, and I never got involved in VC's care and was not involved in VC's care at the time of the tragic incident.

506. I have been asked by the Inquiry, based on the information known to various healthcare services at this time, what steps could have been taken to avoid this relapse. It was evident that it was important that VC remains concordant

with medication, he needs monitoring in the community and presence of acute symptoms have a bearing on risk.

507. Relapse of illness is not necessarily a reflection of failure of care or monitoring. There can be factors that cause relapse that can be unpredictable. Life stresses can be such factors.

508. I have not looked at his medical records to scrutinise what was the understanding to explain the relapse in August 2021. Understanding of the factors that led to the relapse, one can then analyse whether any of these factors responsible could have been addressed or managed. It is only on this basis that I can make comment what steps could have been taken to avoid the relapse.

509. To my knowledge, I have not been involved in the care of any other mental health patient who, following discharge or while under the care of a community mental health team has killed or seriously injured a member of the public.

Recommendations

510. I have been asked by the Inquiry about any recommendations the Chair should make to ensure that lessons are learned to prevent similar attacks in the future, and also what improvements could be made to multi-agency working to increase effectiveness in preventing similar outcomes in the future. Since June 2023, and more recently in the process of providing this statement, I have reflected at length about my contact with VC in 2020 of June 2023 at length. In this statement, I have mentioned issues relating to documentation: a) the fullness of notes made during Ward Reviews and b) the pro-forma documents used for both inpatient and community care. There

could be more support for clinicians in documenting clinical encounters, and more clarity on the role of proforma documents within inpatient services, as compared to community services. I have also mentioned access to police information, as there could be better systems in place to allow quick access to information. However, I do not feel that any of these points would have altered my care and treatment of VC. There may of course be wider recommendations that the Chair wishes to make, but I do not have the detailed knowledge of the matter beyond my own involvement to be able to comment on these at this stage.

Statement of Truth

I believe that the facts stated in this witness statement are 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: 03/02/2026

Index to the first witness statement of Dr Faizal Yusuf Seedat

No	Inquiry URN	Document Description
1.	CHCA0000028	Discharge Summary dated 31.07.2020
2.	WITN0163002	Application form for access to information re VC
3.	WITN0163003	Memo: Access to Information request dated: 09.08.2022
4.	WITN0163004	Email from Faizal Seedat to Celeste Mendes dated: 03.06.2020
5.	WITN0163005	Email from Faizal Seedat to [Celeste Mendes] dated: 02.06.2020
6.	WITN0163006	Email from Seedat Faizal to Harbey Kelly dated: 05.11.2020
7.	WITN0163007	Email from Seedat Faizal to Geoff Culpin dated: 30/07/2020
8.	WITN0163008	Email from Seedat Faizal to Smillie Amanda dated 30.07.2020
9.	WITN0163009	Email from Seedat Faizal to Lloyd Tuhina dated:09.11.2020
10.	UNIN0001527	Email from Seedat Faizal to Eleanor Turner (dated: 03.06.2020
11.	WITN0163011	Email from Faizal Seedat to [Celeste Mendes] dated: 22.10.2020
12.	WITN0163012	Email from Marsden, Richard, PC3525 to Seedat Faizal dated 01.06.2020
13.	WITN0163013	Email from Seedat Faizal to Marsden, Richard, PC3525 dated: 02.06.2020
14.	WITN0163014	Email from Marsden, Richard, PC3525 to Seedat Faizal dated: 02.06.2020
15.		

	WITN0163015	Email from Faizal Seedat to [Celeste Mendes]
16.	WITN0163016	Email from Seedat Faizal to Smillie Amanda dated 04.06.2020
17.	WITN0163017	Email from Gibson Jonathan to Seedat Faizal dated: 23.02.2022
18.	WITN0163018	Email from Seedat Faizal to Ibrahim Hakam dated: 17.06.2020
19.	WITN0163019	Email from Seedat Faizal to Ryder Esmee dated: 01.06.2020
20.	WITN0163020	Email from Seedat Faizal to Rivers Sarah dated: 02.06.2020
21.	WITN0163021	Email from Seedat Faizal to Birtles Claudia dated: 24.07.2020
22.	WITN0163022	Email from Seedat Faizal to Birtles Claudia dated: 24.07.2020
23.	WITN0163023	Email from Seedat Faizal to Eleanor Turner dated: 02.06.2020
24.	WITN0163024	Email from Marsden, Richard, PC3525 to Seedat Faizal dated:31.05.2020
25.	WITN0163025	Email from Smillie Amanda to Student Services dated: 28.05.2020
26.	WITN0163026	Email from Gonde Godwin to Seedat Faizal dated: 09.06.2020
27.	WITN0163027	Email from [Celeste Mendes] to Faizal Seedat dated: 14.06.2020
28.	WITN0163028	Board review spreadsheet dated: 02/06/2020
29.	WITN0163029	Email from [Celeste Mendes] to Faizal Seedat dated: 19.06.2020
30.	WITN0163030	Email from Katie Price to Faizal Seedat dated: 30.08.2022

31.	WITN0163031	Email from Purdue Angela to Smillie Amanda and others dated: 02/06/2020
32.	WITN0163032	Email from Seedat Faizal - Consultant/ Clinical Director to Di-Mambro Ben dated: 22/06/2020
33.	WITN0163033	Email from Seedat Faizal to Smillie Amanda dated: 30/07/2020
34.	WITN0163034	Letter from Dr F Seedat dated: 03/06/2020
35.	WITN0163035	Letter from Dr F Seedat dated: 03/06/2020
36.	WITN0163036	Email from Celeste Mendes to Seedat Faizal dated: 28.05.2020
37.	WITN0163037	Email from [Celeste Mendes] to Seedat Faizal dated: 01.06.2020
38.	WITN0163038	Email from [Celeste Mendes] to Seedat Faizal dated: 03.06.2020
39.	WITN0163039	Email from Seedat Faizal to Harbey Kelly dated: 03/06/2020
40.	WITN0163040	Email from Seedat Faizal to Oldham Jan dated: 21.07.2020
41.	WITN0163041	Email from Seedat Faizal to [Celeste Mendes] dated: 16.06.2020
42.	WITN0163042	Email from Seedat Faizal to [Celeste Mendes] dated: 15.06.2020
43.	WITN0163043	Email from [Celeste Mendes] to Seedat Faizal dated: 16.06.2020
44.	WITN0163044	Email from Seedat Faizal to Ndlovu Sindisiwe dated: 23.07.2020
45.	WITN0163045	Email from Seedat Faizal to Smillie Amanda dated: 30.07.2020
46.	WITN0163046	Email from Seedat Faizal to Harrison Alison dated: 22.06.2020

47.	WITN0163047	Email from Seedat Faizal to Ibrahim Hakam dated: 30.07.2020
48.	WITN0163048	Email from Ibrahim Hakam to Seedat Faizal dated: 10.06.2020
49.	NGPF0000049	Incident Details dated 13.07.2020
50.	NGPF0000082	Occurrence Details dated 24.05.2020
51.	NHFT0000020	Summary of what led to admission
52.	NHFT0000021	Bassetlaw Crisis Resolution Home Treatment Internal Referral dated 12.06.2020
53.	NHFT0000030	City Crisis Resolution Home Treatment Internal Referral dated 29.07.2020
54.	NHFT0000037	Medical Scrutiny of MHA Section Papers dated 14.07.2020
55.	NHFT0000130	Service Guide for Adult Mental Health Inpatient Wards
56.	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary ("PRS")
57.	NHFT0000169	Electronic Patient Record
58.	NHFT0000181	Mental Health Clustering Tool 31.07.2020
59.	NHFT0000187	Core Assessment dated 15.07.2020
60.	NHFT0000188	Core Assessment dated 27.05.2025
61.	NHFT0000195	Risk and Safety Assessment dated 15.07.2020
62.	NHFT0000196	Risk and Safety Assessment dated 26.05.2020
63.	NHFT0000197	Risk and Safety Assessment dated 24.05.2020
64.	NHFT0000204	Summary and Care Plan dated 15.07.2020

65.	NHFT0000206	Summary and Care Plan dated 03.06.2020
66.	NHFT0000207	Summary and Care Plan dated 26.05.2020
67.	NHFT0000222	Discharge Summary dated 31.07.2020
68.	NHFT0000223	Discharge Summary dated 16.06.2020
69.	NHFT0000451	Level 2 Comprehensive Investigation Report dated 15.03.2024
70.	NHFT0000530	Independent investigation into the care and treatment provided to VC by NHS services dated January 2025
71.	NHFT0007520	IR1 334434
72.	WITN0163049	04.03 (Issue 7) Trustwide therapeutic and supportive observation policy and procedure
73.	WITN0163050	04.04 (Issue 7) Seclusion Longer Term Segregation
74.	NHFT0003175	Acute inpatient wards, adult mental health service guide
75.	NHFT0001243	Trust Inpatient Admission Procedure/ Policy
76.	CQCM0017192	Trust's Service Guide: Adult Mental Health Acute Inpatient Wards 2021
77.	WITN0163051	NHS England Mental Health Clustering Booklet
78.	NHSE0002453	The prognosis of schizophrenia: A systematic review and meta-analysis with meta-regression of 20-year follow-up studies
79.	WITN0163052	Systematic review in the archives of general adult psychiatry, 2005 (Marshall, Lewis, Lockwood et al)
80.	WITN0163053	Duration of untreated psychosis and clinical outcomes of first-episode schizophrenia: a 4-year follow-up study – Shanghai Arch Psychiatry, 2014 Feb

81.	WITN0320008	The clinical significance of duration of untreated psychosis: an umbrella review and random-effects meta-analysis – world Psychiatry, 2021, Jan 12
82.	WITN0163054	Schizophrenia: a classic battle ground of nature versus nurture debate - David St Clair, Bing Lang – Science Bulletin
83.	TCLT0000754	Transcript of interview with Dr Faizal Seedat, dated 14.07.2024
84.	TCLT0000758	Transcript of interview with Dr Faizal Seedat, dated 05.09.2024