

Witness Name: Dr Anna

Frances Ludvigsen

Statement No.:

WITN0166001

Exhibits: [See Index]

Dated: 13<sup>th</sup> November 2025

## THE NOTTINGHAM INQUIRY

---

### FIRST WITNESS STATEMENT OF

### DR ANNA FRANCES LUDVIGSEN

---

I, Dr Anna Frances Ludvigsen, will say as follows:-

1. I worked for Nottinghamshire Healthcare NHS Foundation Trust (the '**Trust**') between August 2016 and April 2022. 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 8 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.

### **Background**

3. My qualifications are as follows:
  - a) MSc Leadership for Health Professionals, Swansea University, July 2020
  - b) Membership of the Royal College of Psychiatrists, January 2016
  - c) Bachelor Medicine Bachelor Surgery, University of Nottingham, July 2010
4. I graduated from The University of Nottingham medical school in 2010 and completed my Foundation Year 1 and 2 in the NHS East Midlands region. Between August 2012 and August 2013, I worked as a GP trainee and during this time I completed a psychiatric module which facilitated a change in specialism. I therefore completed my 'Core Trainee' years 1 - 3 in the NHS East Midlands region.
5. Between August 2016 and August 2018, I was a Junior Clinical and Leadership Fellow in Mood Disorders at the Trust and NHS Health Education East England. This was a non-training post. Whilst under the supervision of a consultant, I worked in a tertiary referral specialist depression clinic. As part of

- the leadership component of my post I helped to set up a liaison clinic in primary care for patients with longstanding depression. I had the opportunity to become involved in teaching medical students during this time, and this developed into helping to create a simulation-based learning programme in co-production with patients, carers and students.
6. In 2018, at the end of my two-year fellowship, I applied for the post of Simulation Based Learning Lead. As Simulation Lead most of my time involved teaching, but I spent one day a week working clinically. This was initially in the specialist depression service and later in the Psychiatric Intensive Care Unit (PICU). In the year preceding my deployment to Rowan 1, I worked in psychotherapy delivering mindfulness based cognitive behaviour therapy in an outpatient setting.
  7. During 2020-2021, during the Covid-19 pandemic, junior doctors were re-deployed from the Trust, to work in the acute healthcare trusts. Therefore, in early 2020, as no teaching work was being conducted during this time, I was asked to work on Rowan 1 ward at Highbury Hospital to cover for the doctors who had been redeployed to the acute trusts. I worked at Highbury Hospital, exclusively on Rowan 1 ward from 30 March 2020 until 24 July 2020. Prior to this I had only completed one six-month placement on acute wards in my first year as a Core Trainee. I had not completed any other placement during my core training on acute wards other than when I was on call for Derbyshire and Lincolnshire Healthcare between August 2013 and August 2016. As I was not in a training post during my employment at the Trust, I worked on Rowan 1 at the grade of a non-autonomous speciality doctor.

8. I was conscious that most of my recent experience was in non-clinical settings, and I did not have much experience on an acute psychiatric inpatient ward. In this context, I had not progressed past Core Trainee Year 3 level. I therefore sought refresher training and Continuing Professional Development (“CPD”) training and learning to familiarise myself with the necessary skills, however this in itself was difficult to obtain due to the pandemic. I completed as much as I could and what seemed relevant, for example I completed basic life support refresher [WITN01660002]. Other colleagues were also seeking whatever training opportunities they could, due to the fact that a lot of practitioners were going into clinical situations where they had not been before, because of the pandemic.
9. During my time on the acute wards, it was extremely difficult and chaotic. There did not seem to be a robust infection policy and/or infection control was not often being followed in the way it would in an acute hospital trust when staff are more familiar with such procedures. There were no places to wash hands for full infection control and PPE was being placed in incorrect locations on the ward. Nurses and ward staff were terrified during this time, and I was equally as worried as Rowan 1 ward was extremely chaotic. During this time, there were also changes in the ward set up, such as an all-male patient ward turned into a mixed ward due to infection control / quarantining patients and there was not as much medical staff as required with most being seconded to the acute trusts and perhaps because those covering for them on the psychiatric wards such as myself, were not used to working in an acute setting or they were derived from non-clinical roles. It also felt like the volume

and acuity of patients was much higher than I had experienced before and patients coming on to the wards were extremely unwell from a psychiatric and at times a medical perspective. However, I had regular supervision with my consultant and completed a work-based assessment with him which happened to focus on this case. His feedback as to my level of skill and understanding was that I met or exceeded expectations of Good Psychiatric Practice as outlined by the Royal College of Psychiatrists [WITN01660003].

10. It was an extremely difficult time especially with wearing PPE and there was difficulty with speaking to the patients and difficulty in establishing a therapeutic relationship with patients too due to the barriers with masks and PPE.

11. I returned to my role as Simulation Based Learning Lead at the Trust in July 2020.

12. I left the Trust in April 2022 and had a career break until September 2022 when I started working as a Problem Based Learning Facilitator at the University of Nottingham, a role which I had for around 3 years. I relinquished my license to practice medicine in 2022, and at the time of writing this statement, I have only recently applied for reinstatement of my license as a job opportunity abroad has arisen.

## **Part A**

13. In this part of my statement, I address some general points, to provide background and context to Part B of my statement which deals with the care of Valdo Calocane ('VC').

14. I wish to note that these general points are based on my experience and understanding as a junior doctor with limited clinical experience on acute inpatient wards. As set out above, I was providing cover during the COVID-19 pandemic for a period of 4 months. I have been asked what policies I would regularly use and refer to in this role. Due to the passage of time, I cannot remember any particular policies being brought to my attention during mandatory training that would be relevant to this statement, and I do not recall being provided with any policies in the week that I had to prepare to work on Rowan 1.

15. I would also like to add that much of what I set out below is based on my training and/or observations of working as a junior doctor. As junior doctors in any healthcare setting I have been in, the role is generally not to become involved in discussions unless there is objective information to add. Unless I had factual information to add, I would speak if I had a strong opinion about something that seemed to differ to the consultant, but otherwise would not add another medical opinion to the Multi-Disciplinary Team ('MDT'). My role in the team on the ward was to support the medical care of patients and assist the consultant, but not as an autonomous practitioner such as a Registered Nurse or Occupational Therapist, for example.

### **Inpatient Mental Health Services**

#### **The Mental Health Act 1983**

16. For patients that require treatment on an inpatient ward and are detained under the Mental Health Act 1983 ('MHA'), the broad clinical aim of providing

treatment is to alleviate or prevent suffering from the effects of mental health conditions (and sometimes associated or concurrent physical health conditions). Whilst I am not an expert in the MHA, and I have never been granted approval to use it within clinical practice, I know that the MHA provides powers to professionals who are trained and approved to legally detain patients in hospital. The aim of doing so is to provide assessment and/or treatment of patients who are believed to be suffering from a mental health condition, the nature or degree of which suggests they may be a danger to themselves and or others and they cannot be safely treated in the community.

17. When a patient is detained under Section 2 of the MHA for assessment and treatment, this means they will be admitted to hospital. I understand that the professionals involved in detaining them, plus the hospital bed manager, decide where they should be admitted in order to receive the care they require. Part of the care for the patient includes reviewing and treating their physical health and wellbeing in addition to assessing them for signs of mental illness and assessing and managing any risks to themselves or others. Section 2 allows for a patient to be held in a suitable clinical setting for up to 28 days. Although Section 2 is for assessment and treatment of the patient, assessment and treatment often run side by side rather than sequentially. As part of the assessment of their mental health, the response to treatment can be considered and treatment can be given alongside assessment. An analogy in a physical health setting might be when an individual is admitted with a suspected infection, antibiotics might commence as soon as possible,

whilst the assessment of the infection continues. In psychiatry, treatment commences as soon as a patient is admitted, which might be medication, or might be in the form of receiving the support and care from the medical and nursing staff whilst assessment continues.

18. Care, management and treatment for Section 2 and 3 of the MHA is not dissimilar, however as referenced above, each section has a different legal framework. My understanding is that if the nature and degree of the mental illness is known, then a person can be detained under Section 3 of the MHA in order to receive treatment for their mental illness that has already been assessed, in order to safeguard their safety and/or others. As with being detained under Section 2, other aspects of a patient's health and wellbeing must also be addressed. There are other conditions contained within the two sections that differ. For example, the length of time a patient can be detained is 28 days for Section 2. Patients can appeal against detention under Section 2 within 14 days of the detention. A Section 2 cannot be renewed once it has lapsed and a patient who continues to require ongoing detention in an appropriate setting, would need to be detained under another section (for example Section 3). A Section 3 can last for 6 months and then renewed for another 6 months and thereafter annually. Patients can appeal against detention under Section 3 at any time, but only once during the first six months of detention and then once every 12 months thereafter. Following discharge from a Section 3, a patient has certain rights to the provision of service in the community under Section 117 of the MHA.

## The Inpatient Team

19. An inpatient team is comprised of many professionals including the following;

- a. **Responsible Consultant Psychiatrist;** is a clinician with the overall responsibility for the patient's management and treatment whilst under their care on the ward. The Responsible Clinician ('**RC**') is the approved clinician with overall responsibility for a patient's case. Certain decisions (such as renewing a patient's detention or placing a patient on a Community Treatment Order ('**CTO**')) can only be taken by the RC.
- b. **Registrars, Ward Doctors and Junior Doctors who act under the Responsible Consultant Psychiatrist;** are doctors with varying levels of experience who, under the supervision and direction of a consultant, carry out the duties that are required to provide the care which has been decided as necessary for the patient. In practice, junior doctors also tend to focus primarily on ensuring that the physical health needs of the patient are met (in liaison with primary and secondary care colleagues). This is also common in physical hospital settings when a junior doctor on a surgical team may be expected to liaise with the medical team to ensure any medical needs are addressed so the surgeons can focus on surgery;
- c. **Ward Managers;** hold the overview of how the ward is functioning in terms of procedures and staffing to ensure a smooth running of the ward;

- d. **Mental Health Nurses;** are registered nurses who have undergone training in the care of people with mental health problems and are registered with their governing body;
- e. **Key Workers/Named Nurses;** are professionals, usually registered nurses, who have been identified as the main contact for a specific patient on the ward. They are known to the patient and pay particular attention to the patient during their stay in hospital in order to offer them therapeutic relational support and to act as a bridge between the patient and the MDT team.
- f. **Associate Nurses;** are not registered nurses, but bridge the role between a healthcare assistant and a registered nurse. They have undergone formal training and are registered with a governing body;
- g. **Psychologists;** are medical professionals with formal training in psychology, they are part of the MDT and are able to understand the psychological aspects that may be impacting on the patient as well as recommend or carry out psychological interventions as part of the patient's treatment;
- h. **Pharmacists;** are professionals with formal training in pharmacy. They are able to advise on and ensure that medications are prescribed in an appropriate and safe manner for patients;
- i. **Occupational Therapists;** have formal training in occupational therapy. They can look at how a patient interacts with their environment and assess what ways the environment can be altered or utilised better to support the patient;

- j. **Health Care Assistants and Support Workers;** have either no, or less, formal training or qualifications but who often have the most contact with the patients on the ward and are responsible for ensuring day to day activities are carried out and support/interactions with patients take place.
- k. **Service Managers;** have overview of how the service or part of the service under their remit is running in relation to benchmarks and performance outcomes.

### **Community Teams**

20. As well as the inpatient teams at Highbury Hospital, there are other agencies who carry out care planning and treatment for patients who experience acute mental health crisis. Treatment can be provided by the Crisis Resolution Home Treatment ('**CRHT**') teams, Early Intervention in Psychosis ('**EIP**') teams and Local Mental Health Teams ('**LMHT**'). The main difference to the treatment provided by the inpatient team and other teams is the location: CRHT, EIP and LMHT provide their treatment in the community, usually at patients' homes.
21. Care planning in inpatient units, CRHT, EIP and LMHT all aim to provide the patient with care that will optimise their health and wellbeing, as well as considering the safety of the patient and others. In inpatient settings, this would include understanding and addressing factors about where a patient should be discharged to. Typically, the inpatient team would meet with one of the community teams to discuss discharge in order to decide on a plan which

will address their needs once discharged to a community setting. The community team will then continue that plan in the community setting.

22. The framework used to co-ordinate treatment of individuals with severe mental health problems is the 'Care Programme Approach' ('CPA'). At the time I was working on Rowan 1, I would have been familiar with CPA, but I am less familiar with it now, given the passage of time. I also note that I had not been invited to undertake the Trust's training on CPA as part of my annual training requirements until it had been discovered there had been an error in updating my training requirements after I had worked on Rowan 1, but I do not think this fact had any bearing on the care and treatment that was delivered. I understand there were certain requirements within the CPA such as having a care co-ordinator and that certain things were required, such as regular reviews and a plan to ensure that the social and care needs of an individual are assessed and met. The CPA means that a patient who has a severe mental illness is cared for in a way which is compliant with national guidelines, and this should ensure that their needs are met. The inpatient services have a responsibility to ensure this process was initiated and handed over to the relevant teams on discharge of the patient.

### **Assessment of patients – Mental State Examination**

23. For determining whether a patient is acutely unwell, examination and history of the individual are used. In the case of physical healthcare for example, certain body processes would be measured such as heart rate, breathing rate, blood pressure, temperature or certain blood tests and the results compared against commonly agreed ranges. In the case of psychiatric presentations, the

same is done by looking at the way someone's mind is functioning. This would be done whenever an objective assessment of someone's state of mind is required, for example on admission, at Ward Reviews, or if there had been any significant change in presentation. A framework called the 'Mental State Examination' ('**MSE**'), also known as "present state examination" is used to do this. This framework ensures the examination is as objective as possible when assessing the patient's mental state at the time of assessment. It allows assessment of the presence of psychopathology that could indicate a mental illness and provides guidance on what is considered abnormal or normal functioning. It measures the state of mind at the time the assessment is undertaken, and so findings could change from one moment to the next, much like physical examinations of blood pressure or heart rate can change.

24. All that is required for this assessment is for the patient to be in the room with the doctor. Even if a patient chooses not to engage in the assessment, information can be gathered by observation alone from noting the appearance of the patient or their behaviour. By taking into account all the findings of a MSE, it is possible to see patterns of dysfunction emerging which may point towards the presence of a mental illness. The examination is divided into separate sections:

- a. **Appearance**, how someone looks;
  - i. Do they appear physically unwell;
  - ii. Are there any unusual aspects to their clothing;
  - iii. Are they dressed appropriately for the weather or situation
  - iv. Are there any signs of self-neglect, or self-harm

- v. Do they look older or younger than their age.
- b. **Behaviour:** is their behaviour appropriate to the situation;
  - i. Are there any signs in the way they are sitting that might indicate what is going on in their mind for example;
    - 1. Do they find it difficult to sit still, or are they almost motionless (psychomotor agitation / psychomotor retardation);
    - 2. Do they suddenly look around as if they have seen or heard something;
    - 3. How are they interacting with me and others;
    - 4. Are they open to our interaction, or do they seem suspicious, withdrawn, overly familiar or friendly, do they maintain typical eye contact.
- c. **Speech:**
  - i. Do they speak at a rate, rhythm and volume appropriate for the setting?
  - ii. Are they able to express themselves easily, or are they seemingly struggling to find words or using words that make no sense or seem invented?
- d. **Mood:**
  - i. How do they describe their own mood;
  - ii. Is their mood description different from what it appears their mood to be from an observer's perspective;
  - iii. Is their mood appropriate for the circumstances;

- iv. Is it constant throughout or does it change rapidly;
- v. Is the intensity of mood appropriate.

**e. Perceptions:**

- i. Do they appear to be responding to stimuli only they can perceive, for example;
  - 1. Hearing sounds that others cannot (this ties into the observation of behaviour);
  - 2. Do they report when asked that anything unusual is happening in terms of sounds, vision, taste, touch, smell.

**f. Thoughts:**

- i. Are they thinking about any unusual topics;
- ii. Do they believe things that do not have any objective evidence (delusions);
- iii. Are their thoughts constantly returning to a certain topic without them wanting to (obsessions);
- iv. Do they have intrusive thoughts that they have to carry out certain behaviours repeatedly even if they don't want to (compulsions);
- v. Do they have any thoughts of harming themselves or others;
- vi. Do they think their thoughts are being interfered with by outside forces (thought insertion, withdraw, blocking, broadcasting).

**g. Cognition:**

- i. Do they know where they are;
- ii. What time it is, who the people around them are;

iii. What is their attention span like?

h. **Insight:**

i. Do they recognise that there has been a problem in their life which has resulted in the current situation? If they do, do they think that problem was a result of a disturbance of their mind, if so, do they believe they require treatment and help?

25. The findings of the MSE are taken together with other factors, such as behaviour which may be linked to a disturbance of the mind, to determine whether someone is unwell and to some extent how unwell they are. I would use these findings to form a view of the state of someone's mental health. I would record the MSE in the Progress Notes on the Trust's electronic records system, 'RiO' unless there was a requirement to do so elsewhere, such as on the Core Assessment Proforma. It would be discussed with the consultant as a verbal handover or when reviewing the notes in Ward Review.

**Diagnoses**

26. Individuals with certain mental or physical health conditions may experience what is called 'psychosis'. During my time on Rowan 1, I was not qualified or expected to provide a definitive diagnosis without supervision. However, I would have known that psychosis is a term used to describe the phenomena of a patient's mental state where there are symptoms which indicate a mismatch between the individual's perception or experience of reality and consensus reality, i.e. what everyone else is experiencing.

27. An example of this above is disorders of perception, whereby the individual may experience phenomena that appear to be caused by outside influences

but are not. These could include auditory, tactile, gustatory, haptic or visual hallucinations. Further, disorders of the way the mind is thinking are included such as first rank symptoms of schizophrenia (thought insertion, withdrawal, broadcasting), delusions, such as those of persecution, grandiosity etc. It can also affect the person's mood. The term psychosis is simply used to indicate that such symptoms are present, not what is causing them and is therefore not a diagnosis in itself.

28. In people experiencing psychosis, schizophrenia is one of the possible diagnoses. Although schizophrenia is a diagnostic label, a diagnosis is not as straightforward as the factors which may indicate a diagnosis of schizophrenia, and the diagnostic criteria, has continued to change over the years and over the course of different editions of diagnostic manuals. In 2020, the ICD-10 (International Classification of Diseases, 10<sup>th</sup> edition) and DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> edition) were typically used (the ICD manual would more commonly be used in the UK, but some consultants, especially if trained abroad would prefer to use the DSM). DSM-5 amalgamated all subtypes of schizophrenia into just 'schizophrenia' and so did not have a separate diagnostic criterion for 'paranoid schizophrenia'.

29. However, all diagnostic criteria agree that symptoms of psychosis must be present for a diagnosis of schizophrenia, albeit exactly which symptoms and for how long has differed over time. Generally, a time period of 1-6 months is considered necessary for the presence of symptoms. In addition, other illnesses and disorders that could account for these symptoms, such as drug

induced psychosis, which would be a common differential in young people presenting with a first episode of psychosis, must be excluded. This is not to say that you would need to wait to start treatment until a diagnosis is certain, as often the treatment for some of the other causes of psychosis and for schizophrenia are the same.

30. At the time of VC's inpatient stay, ICD-10 was most commonly used in the UK and its criteria for a diagnosis of paranoid schizophrenia states:

*“The schizophrenic disorders are characterised in general by fundamental and characteristic distortions of thinking and perception and affects that are inappropriate or blunted. Clear consciousness and intellectual capacity are usually maintained although certain cognitive deficits may evolve in the course of time. The most important psychopathological phenomena include thought echo; thought insertion or withdrawal; thought broadcasting; delusional perception and delusions of control; influence or passivity; hallucinatory voices commenting or discussing the patient in the third person; thought disorders and negative symptoms.*

*The course of schizophrenic disorders can be either continuous, or episodic with progressive or stable deficit, or there can be one or more episodes with complete or incomplete remission. The diagnosis of schizophrenia should not be made in the presence of extensive depressive or manic symptoms unless it is clear that schizophrenic symptoms antedate the affective disturbance. Nor should schizophrenia be diagnosed in the presence of overt brain disease or*

*during states of drug intoxication or withdrawal. Similar disorders developing in the presence of epilepsy or other brain disease should be classified under F06.2, and those induced by psychoactive substances under F10-F19 with common fourth character.*

*General diagnostic criteria for schizophrenia: Symptoms must be present most of the time for at least one month:*

*one of:*

- a) thought echo, insertion, withdraw, broadcasting or*
- b) delusions of control, influence or passivity*
- c) 3<sup>rd</sup> person auditory hallucinations or*
- d) persistent delusions of other kinds*

*or two of:*

- a. persistent hallucinations in any modality every day for at least 1 month accompanied by delusions.*
- b. neologisms, or breaks in thought leading to incoherence.*
- c. catatonic behaviour*
- d. 'negative symptoms' marked apathy, paucity of speech or incongruity of emotional responses"<sup>1</sup>*

---

<sup>1</sup> ICD-10 classification of mental and behavioural disorders, World Health Organisation

## **Treatment, care and management of patients experiencing psychosis.**

### **PICU and Seclusion**

31. Some patients may pose a risk such that they cannot be safely managed in an acute ward environment, and due to this, it is considered whether a Psychiatric Intensive Care Unit ('**PICU**') bed or seclusion is more appropriate. PICU is a locked ward with a higher staff to patient ratio. Seclusion is an approach to nursing a patient in an environment in which they are not in contact with other people. This can be in a dedicated seclusion suite with two-way mirrors or electronic televisual monitoring, or patients may be nursed in seclusion on the ward by being kept in their room with minimal contact with staff or patients.
32. The question of whether someone requires admission to PICU or seclusion is either raised before admission to hospital, based on the circumstances and details of their detention, or is considered because the MDT, typically the nursing staff, feel that the person can no longer be managed safely in an acute ward environment. I have never been involved in decisions about where to place someone on admission, but I have been party to conversations about where someone should go after they had already been admitted to the ward. As a junior doctor, my role in such discussions was limited to providing factual observations rather than making independent clinical decisions about patient placement.
33. The question of whether a patient needed to be moved from an acute ward to PICU or seclusion, would tend to be raised by the nursing staff if they expressed their opinion that a patient could not be safely cared for on the

ward. Unlike in physical healthcare settings, where a patient is looked after is often guided by the nursing staff, as it is they who manage the risks on a moment-by-moment basis. In such circumstances, the ward manager would approach the medical team and, in my experience, the medical team would tend to support the wishes of the nursing team by either seeking to move the patient, or seeing if there were any other measures that could be taken.

34. During my time and under my roles with the Trust, I have never been in a position where I have been expected to independently determine whether a patient should be held in seclusion or admitted to a PICU ward. I have however been in situations where this question has been posed by the nursing staff, for example when on-call as a Core Trainee, and possibly while working on Rowan 1, though I cannot recall which patient was involved. In such circumstances I would be required to seek guidance and agreement from a more senior clinician. This would also be required for determining that someone is removed from seclusion. There would have been a protocol which is followed concerning the monitoring of patients in seclusion, and to determine whether seclusion should be terminated, though I do not recall whether I read and followed this policy at the Trust, but as above, I would always have deferred to senior colleagues on this point.

35. In regard to seeking information from other agencies such as Police, to assist with the decision of whether to place a patient in seclusion or PICU on admission, I have never been involved in such a decision, as it would be made prior to them reaching the ward. In general, whilst on the ward, I do not believe it was standard practice to seek detailed information where a patient

has been assessed for admission as a result or in connection with an arrest or alleged criminal behaviour, as this information is usually provided by the professionals who carry out the initial assessment.

### **Observation Levels**

36. When a patient is admitted to an inpatient ward, a decision is made as to what the appropriate levels of observation are. As a trainee and ward doctor, the only time I would have made a decision regarding observations would be in conjunction with nursing staff for patients who were newly admitted to the ward or if there had been a change in an individual's behaviour.
37. From memory, determining observation levels would be the result of a discussion with the nurse in charge. There were times when I determined that a newly admitted patient I had clerked would need to be on 1:1 observation because I determined they were a risk to themselves, for example. There can also be a risk in placing someone under too intensive observation, as it is very intrusive and may make them more likely to act violently. Most new patients would be placed on 10-15 minute intermittent observations.
38. For observations, there are policies that are followed by nursing staff. The observation levels are usually then reviewed by the MDT based on feedback from staff about behaviour of the patient on the ward, known or perceived risks to the patient or others, and the degree or nature of their illness.

39. During the initial period of observation following admission, it is important to determine the exact circumstances which led to the patient's admission when determining an initial period of observation following admission. It is important to understand 'who this person is' and 'why' they have been admitted, plus any past psychiatric or medical history. Any risks which have been identified and what risks should be considered would also be relevant to consider.
40. A typical admission clerking by a doctor would cover most of these points including a psychiatric history, MSE, physical examination and risk assessment, formulation, differential diagnosis, working diagnosis and plan. On the ward it is important to make the patient feel as safe as possible whilst closely observing them for signs of mental illness. For example, it is important to know how they interact with staff and other patients, if there are any signs of mental and or physical illness or anything that seems unusual.
41. As referenced above, medical professionals complete multiple assessments before and during an inpatient's stay in hospital. A Core Assessment is a proforma document contained in RiO. It is completed by a doctor when a patient is first admitted and roughly follows a standard psychiatric history and examination format. It would be completed once at the beginning of an admission, so it is a static document.

### **Patient Documentation**

42. The assessment of risk is an ongoing process whilst a patient is in hospital. It is a daily consideration for staff as part of the day-to-day functioning on the ward. At times, these risks are formally documented in the notes in various places. There is a Risk Assessment proforma on RiO, which is a running

document completed by nursing staff. Typically, clinicians would assess risk as part of an examination in addition to the MSE during the admission clerking and at each Ward Review. Following admission, that would be revisited at each Ward Review and documented in the clinical notes. The combination of MSE, reports on how the patient had been since the last review and risk assessments would be considered together to help the RC to formulate a care plan where past, current and future or potential risks are addressed. The risks may not be explicitly documented as "we consider X is a risk, and therefore we will do Y", but are more likely evidenced by the plans made. For example, a patient whose mental health is at risk of deteriorating due to social isolation on discharge might be encouraged to live with family on discharge and thus documented in the notes. It shows this risk is something the team considered.

43. Another proforma document used by the Trust on RiO is a 'Summary and Care Plan'. This contains a summary of the patient's mental and physical health and the treatment strategy for that person. I understand that it is completed by the nursing staff, and the aim is to have a single electronic document where the most important information relating to a patient can easily be seen. I have never completed this document due to this being the remit of the nursing staff. I would read Ward Review notes to see what care plan had been directed by the MDT.

44. There may be times when a patient has more than one admission to an inpatient unit under the MHA. If so, it is often necessary to sit down and work through previous admission notes in order to build a picture of the patient to

ensure any patterns regarding their presentation and condition are captured within ongoing care planning.

45. From my time on the ward however, patterns regarding presentation and condition from previous admissions was not always easy to notice because details may be inaccurate, out of context or missed out of documents all together. How the symptoms are captured depends on the systems used within the care setting. However, as I was familiar with the circumstances of both of VC's admissions, I do not believe this was relevant to the care I provided during those times.

46. Within Mental Health settings, the "Mental Health Clustering Tool" is a needs assessment tool designed to rate the care needs of a patient. It is used to help services track and receive funding for the care they deliver. I have been asked by the Inquiry what the function of this tool is. I understand that this was commissioned by the Department of Health and assigns patients to a cluster within a classification system based on need and likely service utilisation, but not necessarily primarily for their diagnosis.

## **Risks**

### **"Insight"**

47. Insight is a term used within the context of a psychiatric examination. It is a description of the degree to which the patient has self-awareness of the presence of the illness, its effects, and the need for treatment and support. This ability to have self-awareness can be impacted by the presence of mental illness itself. Often, if the illness is treated, then the ability to have the

cognitive objectivity necessary to recognise that they had been ill returns. This then makes it possible to have meaningful discussions concerning matters such as treatment.

48. Whilst I am not an expert in the MHA and not qualified to apply it in clinical settings, I understand that the concept of 'insight' is not one that changes whether someone is detained under the MHA or not.

#### "Masking"

49. An individual may however try to hide some of their symptoms of a mental illness, and this is called 'masking'. A patient may therefore not disclose when asked whether they are hearing voices, or that their thinking is dominated by the conviction they are being spied on or monitored. Individuals may also try to behave normally when being observed. It is difficult to sustain 'masking' and generally there might be outward signs that this is happening. For example, the patient may suddenly turn and look in a direction as if they heard something or they may appear to be talking to themselves when really, they are talking to some agent they perceive as being outside of themselves. They may try to suppress these behaviours; however, this is difficult to do when under close observation such as being an inpatient on a psychiatric ward.

50. When considering what is relevant in regard to the risks that a patient may pose to themselves and/or others in the event they deteriorate or experience a psychotic crisis or become acutely unwell, I was taught during my psychiatry training that past behaviours are strong indicators of future behaviours and

therefore it is important to have full awareness of any risks to self or others that were prominent in the past.

### **Medication**

51. When a patient is experiencing psychosis, clinicians will consider what medication will be appropriate. I have been asked by the Inquiry about the medical differences between the following prescription medications in the treatment and management of psychosis;

- a) **Olanzapine**; is a newer type of antipsychotic medication that acts on certain chemical receptors in the body to reduce the intensity of psychotic symptoms, it has a sedating action and was licensed for the treatment of schizophrenia and to control agitation in schizophrenia.
- b) **Clonazepam**; is a benzodiazepine medication that increases a chemical in the body which helps people to feel less anxious, this therefore promotes relaxation and sleep, it is addictive after a few weeks of continuous use, it has a slow speed of onset and the effects last several days. Although it does not directly treat psychosis, it treats factors that can aggravate psychosis, such as lack of sleep.
- c) **Lorazepam**; is also a benzodiazepine but works more quickly than Clonazepam, the effects also wear off more rapidly, it is often given to patients who are psychotic and agitated.
- d) **Zopiclone**; is a drug used for sleep, it was licensed for short term use in insomnia, it is less sedating than benzodiazepines. Since a

lack of sleep can be a trigger for psychosis zopiclone can be useful to help patients who are experiencing psychosis if they have been having trouble falling asleep.

- e) **Haloperidol;** is an older type of antipsychotic drug that mainly works on one type of receptor in the brain. It is often associated with more side effects than the newer type of antipsychotics because it is less precise about the type of receptors it works on. It was licensed for the treatment of schizophrenia and for the rapid control of acute agitation in psychosis.
- f) **Aripiprazole;** is a newer style antipsychotic medication, licensed for the treatment of schizophrenia and the control of agitation in schizophrenia.

### **Discharge Planning**

### **Discharge Readiness**

52. I have never held a position where I have been expected to decide whether to discharge a patient, however I have witnessed (and scribed) discharge discussions during MDT meetings, and Ward Reviews. For any patient detained under the MHA, discharge planning is considered and often begins before a patient is even fully assessed, to ensure that certain processes can be put into motion early based on any needs which have already been identified. People are often surprised that discharge discussions start at an early stage of a patient's admission, and before the patient is well enough for discharge, but it is important to start the process early. An example of this

from physical healthcare, could be an older patient admitted with a broken hip who is likely to need home modifications before discharge. Since these provisions may take a long time to arrange, discharge planning begins early in the admission - before the patient is well enough for discharge, sometimes even before the operation to fix their hip. The same applies in psychiatry. Early discharge planning is simply to avoid a patient being fit for discharge but discharge being delayed due to not having the right support in place in the community. Plans which are made as part of this process are often changed and adapted depending on the course of treatment and newly identified needs.

53. There are therefore no pre-requisites to commencing discharge planning, which can commence at any time during a patient's admission.
54. Determining whether a patient is ready for discharge would be decided by the RC, as I am not qualified to hold this status. I have therefore not been in a position where I have been expected to make a decision regarding a patient based on their risk profile for discharge planning, however, I would be present at MDT discussions which would inform the RC's decision.
55. In my experience from witnessing these discussions, things determining the types of behaviours and/or observations that would lead the MDT to consider that a patient remains at risk to himself and/or others, would be any signs that the patient is unwell and that the degree or nature of their illness may pose such a risk. For example, ongoing suicidal ideation in a depressed patient, or persecutory delusions that a psychotic patient cannot resist, or an absence of

insight on the part of the individual which could increase the risk of non-adherence to treatment.

56. In terms of the actual planning for discharge, it is important to highlight that I have never held a position where I am responsible for formulating a discharge plan and was not qualified in my roles when on the inpatient ward to apply the MHA. In my experience such a plan is made by the RC after considering the views of the patient, family and members of the MDT, as well as the team who will be receiving the patient in the community. My experience is therefore based on discussions observed during MDT meetings.

#### Community Care Planning

57. The Trust's "Service Guide: Adult Mental Health Acute Inpatient Wards" outlines that *"the named nurse & the ward MDT aim to carry out an extensive assessment of the individual patients needs resulting in either: a robust community package of care or the identification of longer-term needs and referral to facilitate these"* [NHFT0000130, p7]. I do not think that I was aware of this document during my time on Rowan 1. It may have formed part of ward inductions, but my re-deployment due to Covid was an unusual situation and I do not think I had a ward induction. My understanding of how such an assessment should be conducted as a trainee or ward doctor, is that this is an extensive assessment of a patient's needs where each professional would be present at the MDT, adding information about the patient from their perspective, plus input from the patient, their family or any carers. In this way

a holistic picture of the physical, social and psychological needs of the patient can be constructed.

58. When carrying out this assessment or formulating treatment or discharge plans, the assessment of risk, which is an ongoing process whilst in hospital, is central. Paragraphs 42, 55, 63, 64, 100 detail further how risk of harm to self or others is assessed.

59. When considering a 'robust community package of care' I would anticipate this would be one where a patient's care needs have been identified following assessment. These needs would then be taken into consideration when deciding on how they can be addressed by the community teams.

#### Post-discharge responsibility and follow-up

60. When a patient is discharged, decisions about ongoing treatment are the prerogative and responsibility of the consultant in charge of the patient's care. This means that when a patient is discharged to another team and the RC changes, the new consultant is responsible for the patient's care plan. A discharging clinician might decide to follow up with the receiving team if they have new information to share. The inpatient consultant is responsible for formulating the plan, usually in conjunction with any team the patient is being referred to, and the receiving team is responsible for carrying out that plan.

61. When a patient has been discharged, it is my understanding that if the discharging team on the inpatient unit are satisfied that the receiving community team have all of the information they require, there is no requirement to follow up the implementation of a community package of care

or any other discharge plan after a patient has been discharged, unless new information comes to light which is relevant to the patient's care and/or treatment.

### **Community Treatment Orders**

62. When a patient is discharged from an inpatient setting, it can be on the basis that their discharge is subject to conditions which form part of a CTO. The mechanism for this is within the MHA and I am not qualified to apply the MHA in clinical settings, therefore I have not had to make these decisions. My understanding however, is that there is no directive within the Trust or under the MHA which states that a patient must be discharged on a CTO. A CTO discharge is at the discretion and judgment of the RC and can only be used if certain legal criteria are met. As I am unable to apply the MHA, I am not qualified to make a decision or judgment regarding a patient being discharged on a CTO including any risks to self and/or others.

### **Non concordance with medication and Depot medication**

63. When considering a patient's risk profile, professionals would consider whether the patient is at risk of not taking their medication upon discharge. The most obvious signs of this would be if the patient states they did not want to take medication. Another example is a patient may agree to take medication but then avoids doing so, either because they had no intention of taking it in the first place or because they changed their mind.

64. There can be many reasons and risk factors for non-concordance with medication which would need to be considered in order to determine the risks.

These include, forgetfulness, intentional decisions to omit doses, lack of information, emotional factors, and cognitive or physical disabilities that hinder self-administration, fear of side effects, difficulties accessing medication and having a lack of trust in the clinician who prescribed it.

65. I have been asked to explain the circumstances in which I would consider that a patient cannot be discharged from inpatient treatment unless they agree to accept their medication through depot. I was not qualified to make decisions regarding whether a patient could be discharged or what medication they should be prescribed and how they should be prescribed it. There is nothing that can compel the RC to prescribe a particular medication. They may decide to do so having weighed up the risks and benefits if they feel it is clinically justified, and the patient is in agreement. If the patient did not agree then it would be a bit like discharging them knowing they would not be taking any medication once in the community, as there would be no legal power available to the community team to compel them to take it. Essentially, they would have to wait for the patient's mental health to deteriorate to the point the MHA could be reappplied. The only way a depot could be prescribed to a patient who refused to take it, is as a condition of a CTO under the MHA. For this to happen, the criteria for a CTO would have to be in place e.g. the patient must have been detained under a Section 3 and this is converted to a CTO before discharge, which was not the case during VC's first admission.

66. Although I was also not qualified to make decisions regarding the types of risks to self and/or others relevant to non-concordance that would indicate the need for prescribing depot medication, my understanding would be that the

clinician making such a decision would need to consider the risk of harm to self and others if the medication was not taken and consider all possible, least restrictive and legal alternatives for the patient. The risks of harm to self or others may include factors such as history of aggression in the community and inpatient settings, risk of violence in the absence of treatment, history of violence, non-concordance with medication, social isolation, disengagement from treatment and potential masking of psychotic symptoms. The risks would have to be balanced with the risk of harm that would come from administering an injection to a patient against their wishes. Especially of a drug which carries risks itself, such as the potential for serious adverse effects. The clinician would also explain the pros and cons of the medication with the patient, to try to obtain their consent, because once discharged and not under section, there would be no way to force someone to have the depot (unless on a CTO).

### **Staffing**

67. During the period that VC received treatment under the care of the Trust's inpatient mental health services, the ward personnel would have comprised of the team identified earlier in this statement. I have been asked by the Inquiry whether I considered during this time the hospital was safely staffed. I can however only comment on the period between 30 March 2020 to 24 July 2020 when I was re-deployed from my usual role to cover Rowan 1 ward at Highbury Hospital.

68. It is important to also note, that my time on the ward was an unusual time, as it was during the first phase of the COVID-19 lockdown. The only reason I was working in an acute setting, was due to junior medical staff having been redeployed to the physical healthcare hospitals and my consultant requested that I temporarily leave the medical education department in order to work on the ward.

69. I understand other people within the Trust were in similar positions of having been redeployed during those times. I do not know what the prescribed levels of staffing or skill mix were set at during my time on Rowan 1. From my experience of medical staffing, there would typically have been a non-specialist junior doctor, a Core Trainee, a registrar and a consultant on a ward such as this. We only had a non-specialist junior doctor in their first clinical year, plus me and the consultant. In addition, it seemed that many of the staff who were working may have been drafted in from other areas of the Trust too, due to COVID-19. I believe there was also an understandably high level of sickness due to the pandemic during this time as well. I do not know however, if the ward was safely staffed, but because of the pandemic, nothing about that period of time felt safe due to the challenges set out in the introduction to this statement.

**Part B**

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

**Initial observations, assessments and care plan**

**Core Assessment – First admission [NHFT0000188].**

70. VC had been admitted to Rowan 1 under Section 2 of the MHA at around 23:30 on 25 May 2020. He was discussed at the MDT on 26 May 2020, at which I was present, and on 27 May 2020 I completed a 'Core Assessment' for VC.

71. The admitting doctor on the ward would usually complete a Core Assessment, however on the day VC was admitted, the on-call doctor was unable to engage in his initial assessment due to VC being too unsettled.

72. I do not recall if I had completed a Core Assessment document at the Trust prior to being redeployed to Rowan 1. However, my understanding of this assessment was to establish a relationship with VC, to be able to assess him thoroughly. It was to also enable other colleagues to have a 'snapshot' and understanding of him. Essentially, it was similar to an admission clerking document. I wanted to ensure I had completed a MSE as well as a physical assessment and Electrocardiogram ("ECG"), as without this we could not safely start VC on any medication. It was usual for an ECG to be carried out at the same time as the Core Assessment, as there can be limits as to how much tolerance a patient has in your presence, so the aim is to do as much

observation and seek as much information as possible whilst also carrying out a physical examination and ECG.

73. At the time, my understanding of the circumstances of VC's admission was that he had attempted to break down a door to gain access into someone's flat because he believed his mother was in danger, and his intentions were that he was trying to help, not that he was trying to harm anyone else.

74. The Advanced Mental Health Practitioner ('AMHP') Referral and Assessment which led to VC's admission recorded that the person whose flat VC broke into on 24 May 2020 was so terrified when VC broke into her flat that "*she jumped out of the first floor window*" [NHFT0000008, p2]. Given the passage of time, I cannot recall whether I knew this information before doing the Core Assessment with VC, however I note that I have not included this detail in the Core Assessment document, and consider that it is the kind of thing I would have noted during the clerking in of a patient, if I had known about it. I would typically have looked at the MHA papers, Risk Assessment, the Summary and Care Plan documents, and the Progress Notes to understand the circumstances leading to admission if they were not already known to me. The information about the neighbour was absent from the Risk Assessment and Summary and Care Plan, but present in some early entries in the Progress Notes. I now wonder whether because the Core Assessment (27 May 2020) came after the first time VC was discussed in the MDT meeting (26 May 2020), I relied too much on the information contained within the Risk Assessments and the MDT notes without going back and reading every entry in the Progress Notes to double check the information when I completed the

Core Assessment. However, I do know that the fact that his neighbour sustained injuries as a result of jumping from a first floor window, was fully known to the MDT during this admission, as it is noted in his discharge summary from the first admission, together with the fact that he had tried to enter the flat in order to confront the individual who he thought was responsible for spying on him, as noted in Ward Review documentation. Although with the passage of time it is difficult to remember, I think that Dr Seedat also told VC about what happened to the neighbour, as I think this may have been what prompted VC to describe himself as a *“lunatic banging on people’s doors”* and that people were right to be scared (see paragraph 106 below).

75. As with all patients who experience psychosis, I believe there is an implicit potential risk to others as their actions are often unpredictable. This is something medical professionals who work with such patients think about whenever they interact with them, especially if not much is known about them. At the time I assessed VC, I had no evidence that he had been intent on harming anyone else, but I was alert to the possibility and so did consider that he may be a risk to others.

76. I did not feel any sense that my own safety was being threatened at the time of VC’s assessment, but I was aware he could potentially behave in an unpredictable manner. From memory, I felt that the experience was frightening to VC as he seemed confused and perplexed as his reality was not congruent with what others were experiencing, so it was impossible to predict his behaviour.

77. The assessment included two other colleagues being in the room with me, a junior doctor and a nurse. This was from a therapeutic and safety aspect. I believe that it is good practice to see a new patient who is mentally unwell with another person present, as it reduces the chance of any incidents. With any new admission we would always try to ensure a nurse was present, and at times a Foundation Year 1 doctor may be present as well as part of their training.

78. My main focus during this first meeting would have been on trying to engage with VC in order to establish a therapeutic relationship, to examine his current mental state, obtain an ECG and complete other physical examinations necessary for his safe immediate care. It is likely that I tried to keep the focus of this first meeting on those issues and as brief as possible. I believe this is likely, as he had declined to engage on the first occasion a doctor had tried to assess him on the ward (when the night doctor attempted to see him), and he was still considered to be too unwell to attend Ward Review shortly afterwards, and had to be restrained when trying to leave the ward the day before.

79. I do not remember how long the Core Assessment took; however, this would have been as quick as possible, as I did not wish to keep him there any longer than absolutely necessary. The clinic room was a small room and with three staff there it felt quite confined which I felt may have caused further stress to VC. In my own typical practice, I would see a patient and take brief written notes and then transcribe these onto the proformas on RiO, together with information I may have obtained from other sources. This being more akin to

the clerking that had not been possible for other doctors to carry out earlier. I did obtain some information from what was already available, and from observations, and VC himself. The information within the assessment for VC would therefore be from various sources, such as other colleagues and the RiO records, not just taken directly from him.

80. On this day, VC was not well, was very suspicious and guarded. During the Core Assessment there was very little eye contact or interaction, it was very difficult to elicit information from him, and his answers were very brief. VC also appeared to be responding to unseen stimuli in the room.

81. Key observations recorded by me on this assessment include the following:

- a. **“Consent and Capacity”**: *“implied consent to examination and history”*
- b. **“History of Presenting Complaint”**: *“was apparently knocking on neighbour's door, trying to get in [...] he believes he was not in his right mind at the time but cannot say in what way regrets his actions now, during the MHA the following was documented: [...] [VC] revealed he hear [sic] his mother screaming and people were screaming telling him that his mother was being raped and she was in pain [...] his brother and sister told their mother that they have been worried about [VC] for the past few weeks, messages he sent them appeared to become more odd and he did not seem himself.”*
- c. **“Views of Carer/Family”**: *“not sought – his mother came to the ward today to drop off some things – says there is no past psych Hx, no drug use, Valdo is usually a quiet and reserved, polite.”*

82. I have considered why; in completing the Core Assessment, I did not seek further information from VC's family about the behaviours they had observed prior to VC's admission. During the course of the admission, it would be important to obtain collateral information from the family and to engage with them as much as they and the patient wanted. Typically, I would see a patient first and would need to obtain their informed consent before giving any information to any third parties. In my experience it would be unusual to have spoken to the family before speaking to the patient. From the perspective of clerking and obtaining a history, it is the information the family can provide about the patient which is important, and I knew that nursing staff had already spoken to VC's mother earlier that day and so I knew that we had some collateral history available. From the perspective of working in a way which is person centred and fosters a good therapeutic rapport with the patient and their carers/family, I would say that in my experience having those discussions happens mainly with the consultant in Ward Review or separate meetings, rather than as a result of the admission clerking.

83. The Core Assessment I completed included a MSE and recorded key information surrounding:

*“bruising to the right hand, poor eye contact and rapport, guarded and suspicious, long pauses before replying to questions at times, mood blunted and incongruous affect (says ‘I feel great – but in flat monotone), frequently pausing mid-sentence and looking around distracted and pre-occupied, when questions about this says he is having ‘an internal dialogue,’ but reluctant to talk about who with or*

*what about [...] hearing faint voices, male, does not believe he has a mental health problem or that he should be in hospital.”.*  
[NHFT0000188, at p.3].

84. During assessments, typically I would ask and would conduct an examination of any injuries evident or reported. If I did not, then I suspect this was due to my clinical judgement not to do so and on reflection, I believe I did not pursue a line of questioning surrounding the bruises, as I did not wish to agitate him by reminding him of what just happened, due to his responses, identifying it was making him more suspicious and uneasy when being asked questions surrounding this. I therefore may have concluded that the bruising came from when VC was banging on the door trying to get into his neighbour's flat. Asking about this at that time may also have increased VC's agitation levels making it more difficult to complete other aspects of the examination, and for him to feel more settled on the ward. During the assessment, I tried to keep the focus on his interaction on the information that seemed most important at the time as it was very difficult to obtain any information from VC during his assessment due to being guarded and there being a PPE barrier. I would however have made a note to conduct an examination at a more appropriate time if I had noted an abnormality and so, on balance, I think I probably did examine his hand and found nothing of concern and had my suspicions confirmed that VC injured it by banging on the door, but failed to document these facts.

85. In addition, I noted that he did not want to discuss his social history and did not want to engage in those types of questions. I expect that I made a

judgement that this first encounter was not a good time to ask him if I could speak to his family. Despite trying to understand who VC was, family history was also not marked as discussed, and this would also have been due to a judgement call on the day and it not being the right time to ask him about family.

86. In retrospect, perhaps this first clinical encounter was not the best time to complete the Core Assessment, and it may have been better to have delayed completing the form until VC was better able to take part in all aspects of the assessment. Instead, I could have made a standard admission clerking entry in the Progress Notes, but I think the protocol was to try to complete the Core Assessment Proforma as soon as possible following admission.

87. At the time of the Core Assessment, I did not believe that VC had insight into his condition as he told me he did not believe he was suffering from a mental health problem.

88. As a general note, any assessment documentation completed and entered into a computer, unless it is the Ward Review, is generally done without the patient. During assessments I would hand write my notes with the patient in the room, and I would then complete the electronic record once the patient had left, to enable me to input a full psychiatric history, mental state examination (MSE) and risk of the patient as part of the MSE. Once I had transferred my handwritten notes onto the assessment form on the Trust computer I would then dispose of my notes into the confidential waste. On reflection and reviewing my Core Assessment of VC, there is a possibility that I had recorded my examination findings of the bruising in my handwritten

notes of my record of interaction with VC, but may not have transferred them onto the electronic assessment form.

### **Summary and Care Plan – First Admission**

89. On 26 May 2020, a 'Summary and Care Plan' was completed by Campbell Mtetwa who was a nurse and VC's 'Key worker' [NHFT0000207]. I was not present or involved in writing this document and I do not recall if I saw it at the time, although it would have been my usual practice to review as much information as possible before seeing a new patient for the purposes of admission clerking
90. VC had only been admitted to the ward some hours earlier to the Summary and Care Plan being formed, therefore this would have formed the basis of his care whilst on the ward until any changes to his treatment were made during the course of his stay, or new information became available.
91. Within the plan, some of the sections are incomplete such as the CPA status, advance directive, capacity, personal wellbeing and medication. The Care Plan outline reads as a nursing plan and appears to be in keeping with similar plans for patients newly admitted to the ward, about whom not much is known yet and who require a period of assessment. Some of the details of the circumstances surrounding his detention under the MHA are missing, for example, the fact that he appeared to be suffering from psychosis and that the neighbour whose flat he tried to get into had come to harm while jumping out of a window.

92. I had no input into the plan, and this was completed before I was on shift and before I had met VC. I understand that it is the responsibility of nursing staff to update Care Plans, so do not have direct experience, but I believe that the intention is that they are updated as the Care Plan evolves. I understand that the treatment plan would be decided by the consultant and if necessary, the nurses would adjust their Care Plan to take that into account.
93. The Summary and Care Plan recorded that VC was viewed as not having capacity to participate in formulating his Care Plan at that stage. Capacity is time and decision specific, so a person detained under the MHA can still have capacity to make specific decisions. I do not know how VC's capacity was assessed at the time the Care Plan was formulated as I was not present.
94. Capacity assessments fall under the Mental Capacity Act 2005, and they are a two-stage process. At the time of these events, the law determined that everyone is believed to have capacity unless there are grounds to believe this may be impaired. Firstly, it must be believed that someone may be suffering from an impairment of functioning of the mind or brain which could affect their ability to make decisions. If it is believed that this is the case, then their capacity is assessed on the basis of their ability to make a specific decision at a specific point in time. It is a requirement that capacity is assessed once any practicable measures have been taken to optimise their ability to participate in the process, as this can fluctuate.
95. In order to assess a patient's capacity about a specific decision, they must be able to understand the information relating to the decision. If they understand the information, they must then be able to retain the information long enough

- to be able to weigh up the 'pros' and 'cons' of making a decision. Finally, they must be able to communicate their decision. If a person is capacitous to decide about, for example, a specific treatment plan, then it is necessary that they consent to that plan unless detained under certain Sections of the MHA.
96. In the case of VC, a few hours after admission, it may have been possible to firstly ascertain that VC was suffering from a mental illness by virtue of the fact that he had been detained under the MHA for that precise reason. It would also appear that since it was documented in the MHA Assessment that he did not believe he was suffering from a mental illness and that he was unable to understand the information required to make a capacitous decision about any treatment, the writer may have used that information.
97. If a person is detained under the MHA, it is not necessary for them to consent to treatment for their mental disorder. In some cases, they can be treated without their consent, even if they may have capacity to withhold their consent. However, to establish a therapeutic relationship and foster trust between the patient and the mental health professionals trying to help them, it is always best to try to involve them in decisions about their treatment and try to treat with consent if possible.
98. Although the Summary and Care Plan records that VC did not have capacity to take part in the creation of the Summary and Care Plan at the time of his admission, there were times when VC was deemed to have capacity to make decisions about specific elements of his care and treatment, such as participation in Ward Reviews. This is documented in Ward Review reviews dated 2 June 2020 which I documented, 9 June 2020 for which I was present,

and 11 June 2020 for which I was not present. These entries state that VC had capacity to make particular decisions while in the Ward Reviews because he: i) understood the information required to make decisions about his treatment and care, ii) could retain the information long enough to iii) weigh up the pros and cons of different options and iv) was able to communicate his decision. For example, on 2 June 2020, I recorded that he *“never wants to experience anything similar again or cause distress to others”*, he acknowledged that there was something wrong and that the problem *“is somehow located within him rather than external to him e.g. there may be a problem with his perception of reality”* but felt ashamed so had not asked for help, and *“[he] now realises that in order to safeguard his own safety and wellbeing and that of others he must ask for help if he finds he is hearing voices, becoming paranoid etc”* [NHFT0000168, p17]. It therefore appeared that he was able to understand the information relevant to making decisions about his treatment, including that he had been mentally ill and posed a risk to others, and demonstrated that he could use this information to weigh up the advantages of engaging with treatment or not, and he was able to communicate his views on the matter. Therefore at this point in time it appeared that VC had capacity to understand the information relevant to decisions about his admission and treatment that were being discussed in the Ward Reviews, and therefore capacity to participate in his care and treatment plan.

99. Although the Summary and Care Plan was updated by a student nurse on 3 June 2020 [NHFT0000206], many of the fields are not populated and it does

not capture aspects of the plan that were decided during Ward Reviews. I was not present or involved in writing this document and I do not recall if I saw the updated version at the time.

100. Any changes in presentation and/or mental state would have been assessed by staff on an ongoing basis, and nursing staff would record their observations daily in the Progress Notes. Following the initial Core Assessment, the RC would review and formally assess VC's presentation during Ward Reviews, also documented in the Progress Notes. In response to new information surrounding changes and developments in the level and nature of VC's risk, entries would be made in the Progress Notes. Any significant interactions with the patient would also be recorded by the individual making them, again in the Progress Notes. I cannot comment on guidelines others may have followed. I documented and thought about risk in the format that I was taught was appropriate for use as part of a standard psychiatric history. I believe that the way I was taught, and conducted my reviews followed standard teaching for risk as part of MSE. In my notes I focused on the positive findings, rather than mentioning negatives, much as with the rest of the MSE, for the sake of clarity and brevity.

#### **Risk and Safety Assessment – First Admission**

101. A Risk and Safety Assessment was completed by Annette Palmer (Clinical Lead Nurse) on 24 May 2020 [NHFT0000197]. I believe that I would have read this as part of completing the Core Assessment. I have been asked by the Inquiry to comment upon this document, with reference to the 'Royal College of Psychiatrists' Good Practice Guide for the Assessment and

Management of Risk to Others'. Although I do not believe I was familiar with this guidance, upon review now, I note that the Risk and Safety Assessment proforma does not follow the same format or use the same language as the guidance, however I would note that the guidance is primarily aimed at psychiatrists, and this is a nursing document. I would also note that the guidelines are far more nuanced and in-depth than I have seen in acute settings and take a form I have only seen in forensic or high intensity settings. The guidance emphasises the need to capture vital information about any history of risk or violence to others. The Risk Assessment form completed states that there is a risk to others but fails to mention that VC's neighbour jumped from the window and injured herself because she was scared of him when he was trying to break into her flat. It mentions that his intention in breaking in was not to harm anyone. There are several aspects of the guidance which do not easily map onto the proforma. Particularly with respect to thinking about risk in terms of a dynamic phenomenon, how the risks might change in different environments and the need for a safety plan. In my experience, I have seen the approach to risk formulation described in the guidance be taken in certain settings such as a locked rehabilitation ward with patients detained under court orders and at times on PICU. I have not seen it used in inpatient acute wards, and I don't think the Risk Assessment proforma lends itself to this more detailed and nuanced approach.

## Clinical Reviews

102. On an acute psychiatric ward, management of a patient's care includes MDT meetings and Ward Reviews. The purpose of an MDT meeting is an opportunity for the medical team of different healthcare professionals involved in the care of a patient to come together and share information. It is usually chaired by the consultant. In psychiatry, MDT meetings are conducted in a separate room and many discussions take place without the patient present. The consultant may decide to review the patient alone at a separate time to this meeting, which would be more akin to a Ward Review. The weekly MDT meeting is where the consultant decides on the treatment plan, unless they decide to modify it in response to new developments in the interim. It may or may not involve the patient. Usually, there would be a minimum attendance of a senior doctor and a representative from the nursing team. Each of the healthcare professionals and the patient or carers share important information or issues that have arisen in the course of the previous week. This is so there can be clarity and understanding amongst all concerned about the issues, goals of treatment and next steps required. By the end of the MDT there should be a clear plan that everyone is aware of.
103. The weekly Ward Review is when the MDT review the patient and make decisions about future treatment approaches. Often it is the only time the consultant would see the patient. The term "Ward Round" is probably a bit misleading as it derives from physical healthcare settings when a patient's team, led by the consultant, would physically walk around the hospital ward seeing each patient in turn by the bedside. A Ward Round or Ward Review is

usually when the consultant together with other members of the MDT see the patient. The review is held in a conference style room with everyone sitting around a table. Often the members of the MDT present first discuss the patient and then the patient and relatives are brought in.

104. On 28 May 2020 at 11:57am, a 72-hour Ward Review took place for VC, which I attended [NHFT0000168, p11]. It is noted under the section detailing feedback from 'Nursing' that VC was still *"very unwell"* but was *"less chaotic, less aggressive"*. There are also notes which record the following information about VC's presentation:

a. *"Family/carer involvement": "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."*

b. *"MDT discussion": "Dr. Ludvigsen "believes that VC is responding to unseen stimuli" and when asked what he was thinking about he said "capital punishment."*

105. It was my understanding that these factors, coupled with VC's history of aggression, could mean that when he was acutely unwell, he could pose a danger to others. To the best of my recollection, that was my belief after I first met him when I completed his Core Assessment and remained so throughout the two admissions during which I had contact with him.

106. Under "Mental State Examination" it states *"Has insight into current condition"*. It is possible that the Foundation Year 1 doctor scribing this review asked the MDT what he should write in this section although I have no recollection of this now. From the entry I can see that during Dr Seedat's

discussion with VC, VC is documented as acknowledging that the behaviour that led up to his detention was out of character for him and described himself as being *“a lunatic and banging on people’s doors and frightening people”* and that people were right to be scared. It is recorded that VC stated that he was aware that lack of sleep and anxiety in the past caused him to hear voices that other people could not hear, he knew that he was in a mental health hospital because of this. VC therefore acknowledged that he was suffering from some sort of mental health problem, which Dr Seedat told him was psychotic in nature. VC also agreed to seek help by speaking to the nurses if he felt unwell again. My understanding therefore is that VC acknowledged that there was a need to seek help.

107. On 02 June 2020, there is a record of a Ward Review in relation to VC at 16:44. I attended this Ward Review and scribed the record of it. I have recorded under the risk assessment and risk to others that *“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, p.17]

108. I would have been aware of the circumstances described by the professionals involved in the MHA assessment as documented in the Progress Notes. There appeared to be clear consensus around the circumstances of the admission, and I was not asked to contact the police for further information. It would have been very unusual for me to encounter

information directly from the police regarding admissions to acute mental health wards where they have been involved. Unless I happened to be there when the police brought in a patient and talked to them to ask what happened, I would not have direct communication with them and I do not believe that it was common practice to try to contact the police for information, as it is expected that the individuals carrying out the MHA assessment had all the relevant information and would use it in order to make their recommendations.

109. At this point, I understood that when unwell, VC wanted to find the people he thought were responsible for spying on him or to try save his family from coming to harm, but that it had not been his intention to harm others directly in the process. Due to the inherent risk of these thoughts tipping over into action during a psychotic episode, I did therefore think that he could pose a risk to others if he became acutely unwell. I believed, based on the Ward Review of 28 May 2020 where VC's mother reported that VC "*has not told his brother that the voices [he was hearing] have told him to harm himself or anyone else*" that it had not been VC's intention to cause harm to others directly [NHFT0000168, p11]. During the Ward Review dated 2 June 2020, VC explained that he had had in fact gone to the neighbours flat when he was unwell because he wanted to 'get to the people' he thought were spying on him [NHFT0000168, p17]. I therefore believed that VC was a risk to others if he became acutely unwell, as the nature of psychosis is unpredictable and may therefore drive an individual to become violent. I believe that it was my view at the time that he posed a risk to others when he was unwell, as had

already been demonstrated by the incident when a woman jumped from a window because she was understandably afraid as he was trying to break into her home.

110. Although I was not in a position to make decisions in regard to VC's care planning, as that was the responsibility of the RC, I felt that a number of strategies were in place to address the fluctuating levels of risk towards others. For example, towards the start of his admission when VC was acutely unwell, the levels of nursing observation were such that he was under closer observation in order to proactively manage any signs of an increase in the levels of risk. As his presentation improved, the level of observation decreased. He was also started on antipsychotic medication at the beginning of admission. The medication was briefly stopped (apart from "PRN" (as needed) medication) as a drug free trial and this was recommenced when it became apparent that psychotic symptoms were returning.
111. The changing risks were also considered when thinking about his discharge. The main factor leading to an increase in risk would be if he discontinued his medication. That is why he was not discharged until it was felt that he had sufficient insight into his condition and the need for treatment, which consisted of regular contact with the mental health team and taking his medication regularly.
112. Ultimately, it would be the RC's responsibility to ensure that care planning considered the risk of violence to others.
113. On 2 June 2020, under "Discharge Planning", I have recorded: *"What needs to happen prior to discharge? more clarity around his mental health*

*and insight, safety planning.*" [NHFT0000168, p18]. When this Ward Review took place, VC had not been on the ward for long enough for us to fully assess and understand his mental health, including his response to treatment. This is what is meant by more clarity being required around his mental health. In other words, we may have drawn some preliminary conclusions at this time, but we needed longer to better understand what VC was experiencing. In terms of requiring more clarity around insight, I meant that we needed to ascertain the degree of insight VC had and if the insight he appeared to show during that Ward Review was reliable, or if it was subject to fluctuation. These two factors were still in question and therefore it would not have been possible to formulate a plan to ensure his safety and that of others upon discharge at this point. He was not ready for discharge until these issues were resolved, and plans had been made to address the chances of an escalation of risks when discharged.

114. On 03 June 2020, at a Board Review meeting at 16:48 one of the action points that was listed for VC was '*prepare for discharge, refer to crisis on discharge*' [NHFT0000168, p.19]. It is usual to consider discharge from a very early stage in a patient's admission but is not a marker of the patient's readiness for discharge at that time. This is because for any discharge, it can take several weeks to put into place the necessary requirements to enable a safe discharge. This is especially the case if there are issues around accommodation, which seemed likely to be the case for VC. If a person's MHA Section ran out and they were fit for discharge, but the safety netting was not in place, it is not possible to force a patient to remain in hospital until

the practical arrangements are sorted: you would need their agreement to stay until arrangements were ready to implement, or you would need to have a legal basis to detain them further (by converting a Section 2 to a Section 3, or extend a Section 3). The intended date of discharge was set to be the 22 June 2020 (when VC's Section 2 was due to expire, i.e. 28 days after detention) during the Ward Review on the previous day. However, that does not mean that is the date in which VC would be discharged if he was not deemed well enough. During the Ward Review on the previous day, I understand from VC's records that he did seem to have greater insight into his condition and understood that in order to feel well and prevent a similar incident from occurring, he needed to continue to engage with mental health services and treatment.

115. I have been asked by the Inquiry to what extent did information shared during Board Reviews, MDT's and Ward Review team meetings, impact into VC's inpatient care planning during his first admission. The 'Care Plan' would have been devised by the RC during the Ward Review or MDT meeting, and information from Board Reviews would be fed into these meetings. What happened in a typical Ward Review or MDT is that each person representing a different profession is given the opportunity to speak and share any information they feel is relevant from the perspective of their profession. So occupational therapists would talk about occupational engagement, physiotherapists would talk about physical health or mobility issues, and nursing staff would talk about how the patient had been on the ward. My contributions would largely be to document the discussions, taking turns with

any other junior doctors who may be present or to speak about the patient's physical healthcare. For example, I remember referring one patient under the 2 week wait protocol for some worrying respiratory system findings or another for advice on management of their diabetes. I would update the MDT on progress on such matters. In addition, anyone would be free to raise any other topics or express their opinion. The RC would take into account these different streams of information, see the patient if it was a Ward Review, conduct their interview and then decide on a treatment plan.

116. Nursing staff have much more contact with patients than the doctors, and they record their observations into the Progress Notes. There was no expectation for the doctors to read the daily nursing observation log during Ward Reviews, due to time pressures. However, convention was that the nursing representative would feedback any important observations to the MDT team so there could be a shared understanding of the patient's presentation. Every member of the MDT could review entries in the patient record in RiO, and I would often try to review as many entries as possible if I was not the person documenting the Ward Reviews, but that was mainly due to my own clinical curiosity and to avoid anything being missed.

117. The information recorded by nursing staff through daily observation logs would have been considered when deciding on a clinical plan during the Ward Review. Information presented during Ward Review seemed to be taken into account by the RC when deciding on a clinical plan during the Ward Review or MDT meetings as he would often ask clarifying questions and if he considered it relevant, he would adjust the plan accordingly.

**Observed incidents and information relating to aggression during First Admission**

118. On 26 May 2020 at 17:35 Nurse Aisha Yusuf recorded during the “long day” observations:

*“VC walked to the end to the corridor and started to kick a glass door. Staff asked him to stop, 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 in passive hold. Valdo then ran from his room heading for the door, he was restrained and sat on a chair in passive holds. Valdo went to the main door and started budging it. He was retrained on the floor and escorted to his bed area once he as settled.”* [NHFT0000168, at p.7-8], This incident was reported and given an incident response number IR1 334434.

119. This describes when VC tried to leave the ward and had to be restrained on the day he had been admitted. He therefore was still very unwell and did not understand why he was in hospital. The risks of violence and aggression were still high, as is commensurate with his level of psychosis at this point. It is common for patients in this frame of mind to try to leave. From a management perspective this means that measures are in place to reduce the chance that he would want to leave or that he could succeed in doing so.

For example, by administering medication which could alleviate his mental health symptoms. Additionally, by increasing nursing observations and by making sure the ward environment limited the possibilities for him wanting to abscond, such as allowing him to be in his room and away from what was often a noisy and chaotic situation with other unwell patients, and by locking the doors to the ward.

120. On 1 June 2020 at 5:18 Nurse Tafadzwa Matosi recorded 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, at p.15].

121. This incident occurred later in VC’s admission when his behaviour and symptoms appeared to be settling. The context of why he entered the other patient’s bedroom and was found in the toilet is not clear from the notes. However, I understand the nurse documents in the same entry that VC had been ‘settled and pleasant’ and that he ‘posed no management issues’. It therefore seems the nurse was not concerned by his behaviour that night. I do not know if this information was flagged to the day shift nursing staff during handover and I cannot recall if I saw it. Clinically it is not possible to determine the significance of it without knowing why he was in the other patient’s room. It is however not uncommon for patients to become disorientated on the ward and end up in the wrong room. On the other hand, unusual behaviour could also be a sign of disordered mental processes. It is not clear from the entry what the reason for him being there was. I note that this incident is not

highlighted in the nursing comments of the Ward Review which took place on the 02 June 2020 and as we rely on the information that nursing colleagues highlight to us, I would assume that they did not consider the incident to be significant.

122. I cannot however recall if I saw either of these entries at the time, and to understand their clinical significance, we would have viewed them within the context when they occurred.

123. On 04 June at 17:21 I recorded an observation on VC;  
*"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 eg there was no aggression."* [NHFT0000168, at p.22]

124. I remember this occurring and I sought to clarify exactly what happened in case it represented an assault by another patient in which we would have to involve the police or was the result of a deterioration in the mental health of either party involved. I therefore spoke to VC about it. VC explained he understood it to be playfighting instigated by the other patient. A staff member who witnessed the whole incident agreed this was the case. I

therefore took the information from VC and the staff member at face value. If anything, I believed that VC had reacted with a level of sociability in this situation which he would likely not have been able to do earlier during his admission when he was acutely psychotic. I also note that the nursing entry at 19:38 records *“he was seen lesling [sic] 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, at p.23].

125. On 03 June 2020 at 18:00 Dr Seedat has recorded a summary of text messages between VC and his brother, including the following information:

- a. 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.”*
- b. 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.”
- c. VC is noted to have *“made some remark to wanting to hurt these people he was hearing.”*
- d. 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.”*
- e. 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, at p.21]

126. Dr. Seedat 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 etc. Clear evidence of auditory hallucinations 3rd person, passivity and persecutory delusional beliefs. This suggest more of a functional illness rather than it being precipitated by stress or isolation."*

[NHFT0000168, at p.21]

127. Although I was not present at this meeting and did not see the messages, only the record of them on RiO, this information provided by VC's brother was useful as it gave weight to the thoughts professionals already had that VC was likely experiencing a functional psychotic illness. This meant that we were treating him as someone who was likely to be in the early stages of a psychotic illness such as schizophrenia. This analysis meant that VC would require ongoing treatment and contact and care with mental health professionals in order to minimise the risk he would pose to himself, or others should he become severely unwell again. Since a treatment approach which seemed to address these issues had already been implemented in the previous Ward Review, I do not think it significantly altered our treatment plan. It just provided more evidence that we were on the right track for VC and what support he needed. I do not think the information significantly altered the discharge plans for VC as we were already aware that VC was experiencing

these symptoms noted above when unwell and at those times his behaviours could pose a risk to others.

128. On 16 June 2020 VC's discharge summary noted the following under risk factors and safety planning';

*"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 incidences whilst on the ward. there was clear remorse for his actions."* [NHFT0000223, p3]

129. In the Ward Review on 2 June 2020, which I was present for, VC expressed that *'he never wants to cause distress to others (again)'* [NHFT000168, p17] as a result of becoming unwell. Therefore, identifying his actions. Although I do not recall the detail of this conversation, I do recall that in general, Dr Seedat's style was to be blunt with patients, and hold them accountable for their actions. I therefore expect that as part of this approach, he had mentioned to VC the effects on the neighbour, which had caused VC to state that he did not want to cause distress to others again. To that extent, VC had expressed remorse, but I believe I had only had one or two other interactions with VC where I was not part of the Ward Reviews or other joint meetings, so I was not often in direct conversation with him.

130. Various observations recorded by nurses in respect of VC between 26 May 2020 and 17 June 2020 [NHFT000168, p5 to p49], note under the heading "Risk", "aggression", or "history of aggression" or "no new risks

identified". I expect that the view of nursing staff would have been due to their knowledge of the inherent risks of those suffering from persecutory beliefs when they are unwell, and knowledge from the notes of the details of VC's admission. VC had also required physical restraint on one occasion when first admitted to the ward as he tried to leave. VC's history of breaking down a door and trying to enter his neighbours flat indicated a level of physical arousal that may lead to acting out other thoughts whilst unwell which could be directed at individuals. It became apparent during VC's admission when his family shared his text messages with the team, that he had previously had thoughts of hurting those he thought were responsible for spying on him.

131. It had been known that VC had acted in a violent and aggressive way when unwell and that he had tried to gain entry to his neighbour's property. He had also been violent and aggressive when trying to break down the door to leave the ward as referenced above. The Ward Review notes capture the possibility of this violence and aggression, which I note had only been directed towards property at this stage, but may be directed towards others should he become unwell. I further believe there was a shared understanding amongst the nursing and clinical team that VC could pose a risk of violence and aggression when unwell and that this had been directed towards property but could escalate and be directed towards individuals. We do make a distinction between risk of violence/aggression towards others and risk of violence/aggression towards property. VC had a risk of both but had a history, at that stage of only acting violently or aggressively in a manner that was directed at inanimate objects.

132. I also considered that VC did pose a risk of aggression to others for the reasons outlined above, as he had already demonstrated aggressive behaviour directed towards property on two occasions and had required restraining. In addition, I personally understood that whilst unwell, VC wanted to find the people he thought were responsible for spying on him, or save his family from coming to harm but that, when questioned about this afterwards, he believed it had not been his intention to cause harm to others directly in the process. Due to the inherent risk of these thoughts tipping over into action during a psychotic episode I did therefore think that he did pose a risk to others if he became acutely unwell. In his psychotic state, VC wanted to find the perpetrators he believed were spying on him, but when he was well, VC realised that those he previously thought were causing him distress were actually innocent people.

133. The Risk and Safety Assessment [NHFT0000197], usually updated by nursing staff, does not help to clarify this, as it does not capture the fact that restraint and rapid tranquillisation were necessary to prevent VC from leaving the ward shortly after he was admitted, referred to above.

134. On 3 June 2020, the Summary and Care Plan was updated by a student nurse [NHFT0000206]. I was not present or involved in creating this document and as it is a nursing document I cannot say what it should have contained.

### **Pattern of non-concordance with medication – First Admission**

135. On 4 June 2020, VC is recorded as expressing that he does not want to be on any medication, during a discussion between Dr Seedat for which I was present [NHFT0000168, p.22]. On 5 June 2020 he agrees to start medication [NHFT0000168, p.24] during a discussion with Dr Seedat and his parents for which I was not present, but on 9 June 2020 it is noted that VC is “disappointed” by having to take it during a discussion in Ward Review with Dr Seedat for which I was present [NHFT0000168, p.28].
136. By 9 June 2020 it was evident that VC was suffering from a psychotic illness which was likely functional in nature. There had been evidence that when acutely unwell he experienced, amongst other things, third person auditory hallucinations, delusional beliefs about being spied on or his family being in danger. These beliefs caused him to confront former neighbours, move addresses and then attempt to break into the flat of a new neighbour who sustained injuries as a result of trying escape. While on the ward he required restraint to stop him from breaking down another door and absconding. He was initially treated with antipsychotic medication whilst on the ward and his symptoms appeared to disappear. They returned during a drug free trial and again disappeared when treatment was resumed. It was therefore believed that without regular medication, VC was likely to start suffering from psychotic symptoms again and that when he was unwell, he may pose a risk of harm towards others or property. In addition, there was a risk of harm to himself in terms of likely self-neglect and a worsening of his mental health and accidental harm to himself due to misadventures.

137. It was understood that VC's level of insight into his illness and his acceptance of the importance of taking medication and engaging with the community teams were central to managing his risks, should he be discharged. His care while on the ward involved discussions and treatment aimed at increasing his insight into his condition. We aimed to ensure that he understood and that his family understood this. We made sure the CRHT understood his presentation and the fact that he had to continue to take medication in order to prevent relapse and escalation of risks.

138. Discharge was not considered until VC showed insight into the need to take medication and agreed to engage with ongoing contact with mental health services. These topics were discussed with him and his family, starting on the 5 June 2020 once the clinical picture had become clearer [NHFT000168, p24]. VC demonstrated that despite being disappointed that he would have to take medication, he accepted the need for it and found it helpful, as mentioned during Ward Reviews on 9 June 2020 [NHFT000168, p28], 15 June 2020 [NHFT000168, p46], and I understand from the records that the plan was discussed during a discharge meeting between Dr Seedat, VC and his mother on 17 June 2020 (although I was not present for this, as I believe I was not on the ward that day) [NHFT000168, p49].

139. There were also firm plans for close follow up by the community team once he was discharged. The importance of this was explained to VC and his family and arrangements shared with them. A meeting was held with a representative of the CRHT on the 15 June 2020 in order to facilitate an

effective handover and it was agreed that he would be seen the day following discharge by the team [NHFT000168, p46].

### **Masking, insight and isolation – First Admission**

140. During his first admission, VC was noted to have started to acknowledge his illness, for example in the Ward Review on 2 June 2020 at which I was present and which I documented in the Progress Notes [NHFT0000168, p.17]. However, questions were also raised about whether VC's presentation as withdrawn could indicate that he was 'masking psychosis' [NHFT0000168, p.26]. I believe it was me who raised the point in the MDT meeting on 8 June 2020 of masking as a possible reason why VC appeared more withdrawn as reported by the nursing team. What I meant with '*masking psychosis*' was that VC could be avoiding contact with staff and patients in an attempt to hide that he was again suffering from troubling symptoms of psychosis. I also wondered if it could be a sign of depression which could be associated with side effects from the medication or a manifestation of mental illness. It was also my understanding that it was possible there could be other reasons, for example, to do with the ward environment as acute psychiatric wards can also be stressful places if patients are unwell or disturbed, so it is also not uncommon for patients to keep to themselves. It could also have been to facilitate social distancing since we were in the middle of the pandemic. Another possibility was this was to do with the fact it had only recently been concluded he was likely suffering from a functional psychotic illness, which would require ongoing treatment.

This was news that VC may have been taking some time to process. I am not sure anyone felt strongly that the withdrawal noted at the time was very likely to be because VC was trying to mask psychosis, but it aroused my clinical curiosity, and I wanted to understand why this was happening.

141. In the MDT note for 8 June 2020, which I scribed, under the heading "Plan", the following is recorded: "*all members of the MDT please try to dig deeper when [VC] declines an activity -, if anything is really behind the refusal?*" [NHFT0000168, p.26]. To test any concerns that VC was masking psychosis, staff were asked to explore with VC his reasons for not wanting to participate in certain activities at the time the refusal arose. This was because if he was masking psychotic symptoms, he would find it more difficult to continue to do so in the moment and staff may have noticed any objective evidence of such symptoms or any other reasons. Dr Seedat asked VC about his more withdrawn behaviour during his Ward Review on the 09 June 2020, and VC explained that it was because he had never been a particularly social person [NHFT0000168, p.28]. This description of not being very sociable correlated with VC's mother's description of his pre-morbid personality.

142. I had no planned interactions with VC at the time when I could have asked this as part of that interaction. My suggestion that staff dig deeper was about exploring the behaviour in the moment it was happening. I could have questioned VC, but felt this would not be helpful since nothing had been uncovered by Dr Seedat's extensive questioning on this matter during Ward Review the following day. I would have been vigilant for any signs whilst VC did not feel he was being observed when I was on the ward.

143. VC did go on leave and talk to the occupational therapist the next day (10 June 2020) when he engaged well in conversation and behaved appropriately [NHFT0000168, p.31]. Ward Review is also a relatively stressful situation for most patients and this would make it harder to hide or obscure any symptoms and act as a test. Patients often report that they find sitting in a Ward Review surrounded by numerous healthcare professionals while being questioned or asked to speak about matters that are very personal a stressful experience.
144. I did not believe there was any evidence to support my clinical hypothesis that a potential cause of VC being more withdrawn could be because he was masking psychosis at this stage in his admission. I was aware that during discussion with Dr Seedat in the Ward Review, he often tried to downplay his symptoms, especially in at the beginning of his admission, but it was obvious this is what he was doing and prompted Dr Seedat to probe further which resulted in VC answering more openly.
145. Whilst on the ward, VC was encouraged to participate in activities on offer on the ward. Both his named nurse and the occupational therapist had discussions with him about this, and VC appeared to engage with them and participated in some activities following this. The importance of speaking to mental health staff. should he experience any symptoms, was also discussed with VC who agreed to this. Dr Seedat explained to VC and his mother the importance of not becoming socially isolated again e.g. entry in Progress Notes dated 17 June 2020 for which I was not present, but which is documented in the Progress Notes [NHFT0000168, p.49].

146. The question of discharge destination was raised with VC. He was encouraged to return to his parents' house in Wales partly, I believe, so he would not be alone. The Progress Notes show that Dr Seedat also had a meeting with the CRHT on the 15 June 2020 to brief them on VCs presentation. There was some ambiguity about where VC would live once his tenancy in Nottingham expired, as he stated he wanted to move to Birmingham. Dr Seedat documented that he had discussed with VC, his mother and the CRHT the need to ensure he would receive follow up from and referral to, the EIP team wherever he chose to live [NHFT0000168, p.46]. Dr Seedat also spoke to one of the CRHT consultants following discharge to request VC be seen face to face as he may try to downplay his symptoms [NHFT0000168, p.51].

147. On the ward, the short-term risks of VC masking through social isolation and withdrawal were addressed by encouraging him to become more engaged with staff and ward activities, which he did. In the longer-term the risks of masking psychosis through social isolation were addressed through the discharge planning process by requesting close follow up with the CRHTT. In my experience, the three day follow up would have been face to face, and the record of the MDT meeting with the crisis team on 15 June 2020, which I was present for, state "*Crisis team will visit him on Thursday at 2/3pm*" [NHFT0000168, p.45].

148. Developing insight was one of the aspects of VC's Care Plan. The only time I personally directly assessed VC's insight was during the Core Assessment I carried out on the 27 May 2020, shortly after he was first

admitted. At that time, I found that he failed to understand what had been happening to him and he failed to understand that the symptoms he was experiencing were a sign of mental illness for which he required treatment. My conclusion was that, due to the psychotic symptoms he was experiencing preventing him from understanding what was happening to him, VC lacked insight at that time. Once treatment was commenced VC appeared to rapidly recover from these psychotic symptoms.

149. On the 28 May 2020, during Ward Review at which I was present, it is documented that VC understood his behaviour:

*“Valdo is aware that he is here, as he has been banging on doors and breaking them down. Valdo claims this is out of character. Described himself as ‘some lunatic banging on people’s door’ and people were right to be scared. Valdo says that isn’t normally him and his behaviour was out of character.”* And *“Valdo says he wants to become a better person”*. [NHFT0000168, p11]

150. It is also recorded that *“Valdo explained that he would want to seek a period of being on medication so that he could better understand who he is”* [NHFT0000168 p11]. No clear reason for his psychosis had been identified at that point by the clinical team which is perhaps also reflected in VC’s minimal level of understanding of his condition at this point.

151. Once the clinical team had good evidence that VC was suffering from a functional psychotic illness and VC’s treatment had commenced in accordance with this, it became possible to explain to him the nature of his condition. By the Ward Review that I scribed on 2 June 2020, VC accepted

that there was a problem located within himself that had caused his psychosis, and which resulted in the events leading up to this admission. He explained that previously he had believed this was a problem with his soul rather than ascribing it to mental illness, but that he now understood that it was due to mental illness. VC acknowledged the need to ask for and accept help, support and treatment from mental health staff. [NHFT0000168, p17]. At this point it appears that VC's level of insight into his condition was more concrete.

152. On 3 June 2020, information from VC's brother which revealed more detail about the nature and duration of his symptoms was added to the notes [NHFT0000168, p21]. I recall that I was eager to understand what was in these text messages and therefore read them in the notes. I was not present at the discussion on 5 June 2020, between Dr Seedat, VC, and his family, when Dr Seedat explained to VC that his opinion was that he was suffering from a functional psychotic illness rather than a psychotic episode due to stress and sleep deprivation and that he would likely require ongoing care and treatment in the longer term [NHFT0000168, p24]. However, this was referred to during the Ward Review I attended on 9 June 2020 when VC said that he was disappointed by what Dr Seedat had told him. However, despite this disappointment VC spoke about trying to embrace the illness and the fact that the medication he had been started on, had been useful and necessary [NHFT0000168, p28]. By 9 June 2020 therefore, VC's insight into his condition had appeared to develop further. Since his mental state had been stable and the treatment approach appeared to be working, a provisional

discharge date was set for 16 June 2020 and referrals to community teams were made [NHFT0000168, p29].

153. I was not present at the Ward Review on 11 June 2020, but I would typically review the notes of any Ward Reviews and MDTs that I might have missed, and therefore would have seen that it is recorded that VC continued to agree that there may be difficulties with his mental health and that he needed to take medication and accept help and support [NHFT0000168 p36]. VC's level of insight therefore changed throughout the course of his first admission. To begin with he did not understand that he had been suffering from mental illness. However, during the course of the admission and treatment VC showed that he understood he was suffering from a mental illness and accepted that he required ongoing treatment for this. He is documented as having a degree of insight into his mental health condition as part of the MSE recorded in Ward Reviews on the 28 May 2020, [NHFT0000168 p12], 2 June 2020 [NHFT0000168 p17], 9 June 2020 [NHFT0000168 p28], and 11 June 2020 [NHFT0000168 p36]. Discharge was not considered in earnest until this had occurred.

154. The possibility that VC would be non-concordant with treatment, resulting in a likely relapse of psychotic symptoms, a decrease in his level of insight, and a serious increase in the risk of harm coming to himself and others was addressed by ensuring that VC, his family and the community teams who would take over his care were aware of these possibilities, so strategies could be implemented to reduce the risks of this occurring.

155. There are various observations of VC being withdrawn and isolated from his peers on the ward. On 9 June 2020, Dr Seedat communicated to VC that he was concerned with how VC will be able to manage on his own when he is discharged during a Ward Review for which I was present [NHFT0000168, p28].

156. For patients who have been diagnosed with first episode psychosis, social isolation increases the risk of a worsening in psychotic experiences, as there is no one to 'sense check' reality with, it also increases the risk of discontinuing treatment. Both factors would increase the risk of relapse. Furthermore, it would make it more difficult for anyone else to notice if a person was becoming unwell again, thus further increasing all the risks that would be present for a particular individual should they relapse.

157. Risks associated with patterns of isolation can be mitigated through the involvement of family, carers and people with lived experience of mental illness such as peer support workers. Whilst I am not an expert or qualified to apply the MHA clinically, my understanding is that Clinicians do have the power to require patients engage with family and/or community support and this could form part of a CTO condition for the patient, but that such an order can only be applied if a patient has been detained under Section 3 of the MHA, which VC had not.

#### **Clinical conclusions from First Admission**

158. On 5 June 2020, Dr Seedat communicated to VC and his family that *'it was [his] clinician opinion he was suffering with a psychotic picture, first*

*episode, and that this will require treatment* [NHFT0000168, p.24]'. I was not present at this discussion but read so in the Progress Notes Dr Seedat made. Treatment for first episode psychosis typically follows a bio-psycho-social approach: including ruling out or addressing any physical causes or contributing factors and prescribing antipsychotic medication, understanding and addressing any psychological factors and the patient engaging with psychological treatment and considering any social factors that could have precipitated the episode and addressing these once the patient is stable enough to meaningfully participate in this process. In keeping with a standard approach to psychiatric treatment in the UK, it was my understanding that this bio-psycho-social approach would be continued by the specialist Early Psychosis team on discharge.

159. In terms of triggers for VC's first episode of psychosis, early in the admission, VC explained that the stress of university work and a disrupted sleep schedule were a likely trigger. Illicit drug use is a very common trigger and so we screened for this by asking VC to provide a urine sample which was tested for common illicit substances on the 28<sup>th</sup> May [NHFT0000168, p10]. It came back negative for all drugs except benzodiazepines (which had been prescribed). After conversations with his parents for which I was not present but which are documented in the Progress Notes, it transpired that VCs paternal grandfather may have suffered from a mental illness so a genetic predisposition may have been present [NHFT0000168, p10]. VC denied that the COVID-19 pandemic or the isolation caused by lockdown were contributing factors [NHFT0000168, p24], and there was no specific

evidence that COVID-19 had adversely affected VC, other than deepening his social isolation (although there is evidence<sup>2</sup> that the lockdowns and events around that time affected many people more than we might realise, even now).

160. On 22 June 2020, Dr Seedat contacted the CRHT to highlight that VC should be *followed up face to face as he was likely to downplay his symptoms/problems* " [NHFT0000168, p.51]. I was not aware of this at the time, but it is documented in the Progress Notes so would have likely read about it during his next admission. VC was often evasive about how he was feeling and could be reluctant to open up to others about his problems. He spoke about often feeling like he had to solve things by himself. With further exploration and prompting VC would reveal what was troubling him. When I observed him being examined by Dr Seedat during Ward Reviews, at times when he was no longer thought to be psychotic (in contrast with my first examination of him), it did seem to be more of a personality trait that he was reluctant to share too much information about himself, which correlated with the collateral history we had of his pre-morbid personality being quiet and keeping to himself. It often took a concerted effort to obtain this information and to not just accept his first response if it seemed dismissive and not the full story. I believe this is what Dr Seedat meant when he spoke to the CRHT. I would however make a distinction between a patient downplaying symptoms and someone masking symptoms, as the latter would be a deliberate attempt

---

<sup>2</sup> Dhensa-Kahlon RK, Wan ST, Coyle-Shapiro JA, Teoh KR. The mental health impact of repeated COVID-19 enforced lockdowns in England: evidence from the UK Household Longitudinal Study. *BJPsych Open*. 2025 Jan 13;11(1):e16. doi: 10.1192/bjo.2024.803. PMID: 39801010; PMCID: PMC11733484. **WITN0166005**

to not engage with a person, avoid contact or cover up signs that they were responding to unseen stimuli or similar. Even though I raised the question at one stage during this admission if VC could be trying to mask symptoms of psychosis because he was socially withdrawing, there appeared to be no evidence of this and this was not something that was highlighted as an ongoing concern.

161. Both times that I remember speaking with VC during his first admission to probe his mental state independently (the Core Assessment at the start of the admission, and the “playfighting” incident on 4 June 2020) I needed to encourage him to expand on his initial answers as these would often be very brief. This is an approach I was taught during medical school and in my training, as it is common that patients need to be encouraged and supported to be open when you are asking about troubling symptoms. The risk of not doing so would be that important symptoms of mental illness could be missed.

162. From my level of experience and training, I believed that the risks of aggression, violence, masking and lack of insight had been adequately addressed and planned for VC, and they were in a manner that was congruous with plans I had seen for patients presenting in similar ways throughout my training. The immediate risks of the above were considered to be low at the time of discharge as VC was no longer experiencing psychosis and appeared to demonstrate insight into the need to continue with medication and treatment, agreeing to take medication and engage with the community team.

163. We were cognisant of the fact that, regardless of what VC said, he may decide to stop taking medication or stop engaging with treatment once no longer on the ward. Likewise, we were aware of the fact that any discontinuation of treatment or engagement was likely to lead to relapse, in which case all known risks would escalate and could potentially exceed risk levels previously reached. However, it was determined that, providing the right support was in place, it was possible to safely care for VC while in the community to ensure that this did not happen. A meeting with CRHTT was arranged for the 15 June 2020, prior to discharge to discuss VC and his presentation of risks.

164. I have been asked by the Inquiry to consider the 'Royal College of Psychiatrists' Good Practice Guide for the Assessment and Management of Risk'. I do not recall if I was familiar with this guidance prior to writing this statement but had encountered similar guidance in high intensity and forensic settings. As noted above, this document appears to be more focussed on forensic and high intensity settings. When considering the document, in the light of VC's first admission, I would say that the risks of aggression, violence masking, lack of insight, were adequately addressed and planned for in the short term, but are not necessarily presented in the way that the guide suggests to make it obvious that we had done so. This is akin to when I scribe MSEs, where I would only tend to highlight positive findings and omit negative findings (where I had considered and assessed something, but it was not present) for the sake of brevity.

**VC's Second Admission (under ss.136 and then Section 3 MHA) – Cassidy Suite and Rowan 1, Highbury Hospital (“Second Admission”): 13 July 2020 – 31 July 2020**

**Initial observations, assessments and care plan**

165. On 14 July 2020, VC was assessed and re-admitted to Highbury Hospital for treatment under Section 3 of MHA [NHFT0000168, p.58 and NHFT000037, p.5-7]. This was his second admission under the MHA.

166. I was still working as a ward doctor on Rowan 1 at this time; however I may have reduced the number of days I was working in order to deliver teaching, but I am not sure. I finished working on the ward on 24 July 2020, a week before VC's discharge from this admission.

167. On 15 July 2020, Dr Rupert Ackroyd completed a 'Core Assessment' which recorded that recorded VC was detained under the MHA due to "*prominent concerns regarding insight, medication concordance, risks to others when unwell and risk of further deterioration without intervention*" [NHFT0000187]. Unfortunately, I cannot recall whether I referred to this document or reviewed this document, however it would have been my typical practice to do so.

168. During this admission to hospital, the treatment VC needed to address the issues and risks identified in this assessment were: admission to hospital, recommencement of medication and assessment of his circumstances leading to failed discharge and relapse, with a focus on exploration of why

medication had been discontinued and what should be done to prevent this in happening again.

169. In considering what observations, behavioural changes and indicators are key indicators that, following a period of treatment, a patient has made progress in respect of concordance and insight, I would say that a patient who has insight is one who: firstly, accepts that there have been difficulties in their life; secondly, agrees that these problems are the result of a mental illness; and thirdly, accepts the need to seek help and support for the mental illness, and then engages with that help. This means that a person really knows these things to be true. I would judge this based on discussion with them on the topic with exploration and testing of their conviction.

170. On 14 July 2020 Busayo Ajewole, Clinical Lead Nurse updated VC's Risk Assessment [NHFT0000196] and Sarah Rivers, Nurse, updated this on 15 July [NHFT0000195] I was not present for or involved in either of these updates.

171. Upon review, I can see that 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 [...]"*

172. I can also see that 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."*

173. I unfortunately do not recall if I saw these documents at the time, however it would have been my typical practice to do so, if it had not been reviewed already by another member of the clinical team upon admission, as they would be gathering information to understand the reasons for admission and risks. Although the Risk and Safety Assessment would be one such document, I find that the most helpful source of information about the circumstances which led to admission usually come from the senior doctors and the AMHP who do the MHA assessment. In VC's case, one of those doctors was Dr Seedat, so we would have been confident that we had good information about why VC had been detained.

174. I can see that the information recorded within the Risk Assessment does not appear to reflect the information and risks of violence and aggression detailed in the mental health assessments that led to VC's

admission [NHFT0000168, p.58 and NHFT0000037, p.5-7]. However, I do not believe that this discrepancy would have impacted his care and treatment by the team because those risks were also outlined in the Core Assessment which would have been reviewed. Dr Seedat completed the MHA assessment for VC and made the entries referenced above. The information was therefore known to the clinical team as it was led by Dr Seedat at the time. It was the responsibility of the entire team to understand VC's risk formulation, and this would have been incorporated into the Ward Review discussions. As Dr Seedat was involved in VC's MHA assessment, he would have ensured that the clinical thinking took into account the circumstances of VC's admission, his mental health assessment, and changing risk profile as he understood it. The Risk Assessment proforma was typically completed by the nursing staff and although it would be available to me, as above, I would tend to also refer to information from other sources such as MHA assessment documents and the Progress Notes (including the description of a patient made by a doctor party to the MHA assessment).

175. I do not recall reading the Community Mental Health Street Triage Team notes [NHFT0000168, p.56] during VC's second admission, however Dr Seedat was the person who completed the mental health assessment, so it was felt by the clinical team there was a good understanding of the reasons for VC's admission. Upon review of those notes now, I am not sure whether I knew at the time of the admission that VC had been restrained on the floor by a number of residents until the police arrived, as recorded by the Street Triage Team.

176. The sources of information I relied on to understand the extent of aggression and/or violence which led to VC's admission were the Risk Assessment proforma on RiO, as well as information provided by Dr Seedat.

177. 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]. Considering that document for the purpose of this statement, I consider that it is significant that VC is described as having "assaulted" someone and was "kicking off". I do not know however if we knew this at the time, as it is not referenced within the Core Assessment, Risk Assessment or Dr Seedat's mental health assessment. The information from those sources is framed as VC having 'barged past someone'. Observations from the Street Triage Notes (although as above, I do not recall whether I saw these at the time) were that although he had been restrained by a number of residents, he appeared calm and not agitated when he was assessed in the back of the police car shortly before being detained. I am not sure that we had any information that he had been behaving with a level of aggression or agitation that could be described as "kicking off". It would have impacted my assessment of risk to others that VC posed at this time and I would have included this fact in the Risk Assessment I documented on the Ward Review / 72 hour review of 16 July 2020 [NHFT0000168, p65], to note that his risk to others had escalated. Without that knowledge, I recorded that his risk to others were that *"he 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, p65]. I therefore believe that it was already my view that VC posed a risk of aggression or violence to others as this is the risk formulation I had in my head from VC's previous admission and I already believed that he could be a risk to others when unwell. This incident sadly confirmed the case and showed that his risks had possibly escalated, and the knowledge that he had been "kicking off" would have added to that belief.

178. On 15 July 2020 Robin Mame a Staff Nurse completed a Summary and Care Plan [NHFT0000204]. I was not present or involved in creating this document. It records details of VC's care plan, including;

*Summary formulation at p.1;*

*- 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".*

*[NHFT0000204]*

179. The Care Plan does not mention that VC assaulted anyone in the lead up to admission and does not include the fact that VC was restrained. The

document does reference, under the heading “Safety” that VC knocked on a neighbour’s door “*to confront him as to why he was discussing him as he had heard voices to that effect [...]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*”. It also includes a plan for how to deal with any escalation of risk on the ward, such as de-escalation techniques as the primary method, followed by Lorazepam medication, and then physical restraint of those methods had failed, and VC displayed physical violence. I would suggest that the document appears to address the most immediate concerns for the management and care of a patient who has just been transferred to the unit. Some aspects are incomplete such as the need for psychoeducation around why VC stopped medication and VC’s views on admission but it does include most of the aspects of the plan as outlined by Dr Seedat on the 14 July 2020 during his MHA assessment (re-start Aripiprazole) [NHFT0000168, p58] and the clerking doctor who saw VC in the early hours and completed the Core Assessment.

### **Clinical Reviews**

180. On 16 July 2020 I was present at VC’s Ward/72-hour Review [NHFT0000168, p.64] and scribed the meeting. The following is a record of the conversation between Dr Seedat and VC in which Dr Seedat was trying to impress upon Valdo the seriousness of the circumstances which had led to VC’s readmission and test his insight into the need to continue to take medication. I recorded that:

*“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]*

181. I typed this contemporaneously during the review and it includes both verbatim remarks (indicated by speech marks) and paraphrasing. I regret that I did not better explain the context surrounding my note that Dr Seedat said that the danger is that this will happen again and perhaps VC will end up killing someone. I do however recall the conversation, and what my thoughts were at the time, because it was quite a shocking thing to hear.

182. My understanding of *‘this would happen again’* was VC relapsing into an acute psychosis as a result of him discontinuing treatment and that as a result harm could come to him as well as others, such as had happened to the neighbour from the first admission who jumped from the window. I did not believe that Dr Seedat’s words *‘VC would perhaps end up killing someone’*

was meant by Dr Seedat as a reflection of concerns he had. I thought that he was testing VC's insight and was trying to shock him into taking his situation seriously, as he had been dismissive and evasive with some of his responses earlier in the conversation. The possibility that VC was deliberately going to kill anyone had not been flagged. I believe that the consensus understanding among the team was that we considered VC's behaviour as being of low risk to others when well and of a high risk when unwell (albeit not necessarily any higher than for many other patients we looked after who presented with acute psychosis and paranoid delusions).

183. When writing these words by Dr Seedat, I found them surprising, and I specifically remember that Dr Seedat appeared to say this as a way of making VC realise how serious his condition could be if he stopped treatment again. I realised Dr Seedat was doing this with VC to try and allow him to realise how serious the potential outcomes of his behaviours were. I felt that Dr Seedat was trying to understand VC, and how he would react to this comment, to see if he understood how serious he needed to take his behaviour, especially in VC's response '*there would not be a next time*' as it did not seem VC was engaging with what was being said to him about his illness and the need for treatment. Dr Seedat seemed to be challenging VC and trying to shock him, trying to enable VC to understand and realise the seriousness of his condition and the potential consequences of what could happen when he is unwell and stopped taking his medication. It was my belief that this was a way of testing VC's insight. I remember this because I was taken aback by Dr Seedat's very direct approach. VC was often dismissive when questioned about symptoms

and I think Dr Seedat was trying to elicit a response. I noted that they had a “very frank discussion”.

184. During VC’s admission, I did not consider at any point that the tragic events that occurred would happen when treating VC. It was never in the forefront of my mind that there was any intention from VC, nor that he would act as he did on 13 June 2023. However, we do know that risks such as these can be a possibility in individuals experiencing severe psychosis. I felt that the risks were however managed by him being on the ward and receiving appropriate treatment.

185. I have been asked by the Inquiry whether I contributed to the conclusions reached by Dr Seedat. It was not the case that my views would be sought by Dr Seedat (or the majority of consultants I had worked for) in order to inform their opinion. Given my junior position, my role was to document information, carry out assessments and ensure the physical healthcare needs of patients were safely managed. What I knew about the various incidents of aggression and violence was based on what was documented in the notes and what Dr Seedat may have said when discussing the reasons for VC’s most recent admission. I am not certain that any of us knew about the Police Report that VC had assaulted anyone.

186. Had I felt any concern that such a risk was not being managed appropriately, I would have questioned it and or spoken to another senior consultant, such as my former clinical supervisor who was accessible in the same building. I also discussed this case with Dr Seedat during a case discussion assessment [WITN01660003, as above].

187. There is a small but inherent danger that anyone who experiences psychosis may act in violent or aggressive ways while unwell. If part of the manifestation of the illness is the presence of psychotic symptoms with persecutory or derogatory content, such as it did for VC, then that would increase the risk. In VC's case there had also been a history of violence and aggression which had escalated with each incident (to my knowledge, this was: first trying to kick a door down but failing to gain entry; and second barging past someone and confronting them), further increasing the risks should there be any subsequent incidents.

188. A Discharge Summary dated 31 July 2020 was completed at the end of VC's Second Admission. Within the "Summary of Admission & Treatment (e.g. circumstances surrounding admission, progress & treatment) it states that:

*"Mr Calocane was admitted under similar circumstances as his previous admission, posing an increasing risk to both himself and others. Mr Calocane had gone to a neighbour's flat who was staying above him, knocked at his door to confront him as to why he was discussing him as he had heard voices to that effect and he was certain that it was this person living above his flat responsible. He barged into the neighbour's flat and wanted the person to admit what he was doing and other neighbours came to the rescue and called the police". [NHFT0000222, p2]."*

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].*

189. This document therefore includes some information about the circumstances of the second admission being under similar circumstances as the first and that he poses *“an increasing risk to himself and others”*. However, it appears that these risks had not been added to the section concerning ongoing risks, which had not been updated since his previous discharge. I had left the ward the week prior to this document being produced, so cannot comment on how it was compiled, and did not see it at the time.

190. As noted above, Dr Seedat was, in my view, trying to explore and develop VC's insight. At this time, VC was refusing to accept that he may have an enduring mental illness. Capacity and insight are closely linked. Insight requires a patient to accept and believe that there has been a problem in their life, that this problem is the result of a mental health difficulty or illness and that they are in agreement that they require help and support to address this. As set out in part A of this statement, at the time of these events, the assessment of capacity was a two-stage process and capacity is considered to be present unless there are grounds to believe there may be a disturbance of the person's mind. In VC's case this was accepted as he was known to be suffering from psychosis, likely the result of schizophrenia. Capacity with

regard to certain decisions could therefore not be presumed to be present so had to be assessed in more detail. I did not have any direct conversations with VC about insight during this admission. I scribed the 72 hour review / Ward Review conducted by Dr Seedat on 16 July 2020 which recorded that VC had no insight into illness as he did not believe he was unwell and that he therefore also lacked capacity at the time to make decisions about his admission and treatment [NHFT0000168, p65].

191. During the Ward Review on 16 July 2020, I also scribed "*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]. I do not believe that I spoke to VC regarding depot medication. I was scribing at the time, so it is unlikely that I contributed to this discussion.

192. On 20 July 2020, during an MDT at 14:10 that I was present at, it was noted that VC "*requires work on insight*" [NHFT0000168, p.74]. During his previous admission VC appeared to arrive at an understanding that he was suffering from a mental illness which required treatment in order to keep him well and prevent incidents of violence and aggression. However, once he was at home, a point came at which he no longer believed this, and he therefore stopped taking medication. Dr Seedat's MHA assessment note on RiO dated 14 July states that VC stopped taking medication because "*he believed he was well, he would be fine*" [NHFT0000168, p58] and in the 72-hour review of 16 July, VC explains that he stopped taking medication because he read it could 'slow the mind' [NHFT0000168, p64]. This resulted in a relapse of his

psychotic symptoms and the incident with his neighbours that followed. During this admission he would therefore have to demonstrate that he was convinced of the fact he had a mental illness, that he understood that when he felt well he may decide he no longer had that illness and may think about stopping medication but that this would likely lead to a relapse causing him to be a risk to himself and others and that he therefore accepted the need to take medication and engage with treatment, even if he felt well.

193. I was also at a Ward Review on 21 July at 13:15 where it was noted that according to the Acute Psychological Interventions Practitioner ('APIP') 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]. The Ward Review notes from 21 July 2020 also state under "Patient comments" that VC had told the MDT team, led by Dr Seedat:

*"Valdo spoke to Angela (APIP) yesterday and reports that he understands his condition well [...] 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]

194. Under “Ward Review discussion: Mental State Examination” it states:  
*“He agrees that there are difficulties with his mental health and acknowledges the importance of taking his medication when he is discharged”* [NHFT0000168, p80]
195. I note however that under the section on mental capacity, it is recorded that VC does not accept that he has a mental illness, which does not match with the various narrative descriptions of VC’s and the team’s comments about his understanding and insight. I did not scribe this entry, so am unable to comment further.
196. From my limited experience, I have not seen many patients where this shift is so quick and dramatic once treatment is recommenced. A similar thing happened during his first admission. I have observed a similar pattern in patients experiencing drug induced psychosis, brief psychotic episodes or mania with psychotic features. In these cases, the degree of insight the patient has seems to depend on how quickly and to what extent the psychotic symptoms which interfere with a clear perception of reality, resolve. I have seen such a rapid shift happen only a handful of times before. I would have had faith in the assessments of these two senior clinicians who on my reading of the documentation appear to judge that VC had developed a degree of insight into his condition at this stage.
197. During the same Ward Review on 21 July 2020, VC’s mother queried whether VC should be started on depot medication. The medical record notes that VC was told that he had *“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, p.79]. I was not considered qualified to make independent decisions about what long-term medication a patient should receive. Patients should always be involved in making decisions about their medication, even if they lack capacity to do so. Their preferences to not receive a certain form of treatment are important factors to take into account and should be accommodated as far as possible. Technically, I believe that as VC had been detained under a Section 3 of the MHA for less than three months it was the decision of the RC what medication to prescribe even if VC had capacity and refused to consent. Nonetheless it would have been best practice for the clinician to seek to understand and take into account the patients views on medication, as was done here.

198. The assessment of capacity to consent to depot medication follows the same format as outlined in the MCA regardless of who is conducting the assessment, and what the decision is: all practicable steps should be taken to help a patient to make a capacitous decision. At the time of these events, my understanding was that first, the relevant information would need to be provided to the patient and any questions answered. The assessor would then have to consider whether the patient was suffering from a disturbance of the mind or brain. If yes, they would move on to establish whether the patient understood the information required to make a specific decision, could retain this information long enough in order to weigh up the pros and cons of a decision and then communicate that decision. If the patient could not do this, they would then ask whether the reason for this was the disturbance of the patient’s mind or brain was.

199. It is not clear to me that the clinical team did determine that it would be VC's decision whether to take depot medication. Dr Seedat is documented as saying VC had some time to think about taking a depot or not during the review on the 21 July 2020. Since VC was detained under Section 3 of the MHA he could have received treatment even if he had capacity to refuse such treatment, so it was not the case that the MDT needed to make conclusions about his capacity in this regard. It would however be important to nonetheless try to obtain his agreement for such treatment. Although it appeared that there had been a remission of the psychotic symptoms, it was documented in the Ward Review notes that VC did not have capacity to make decisions about his treatment during the Ward Review of 21 July 2020 [NHFT0000168, p80]. This is confusing as I would expect to see that VC was considered to have capacity to make decisions about his admission and treatment at the time of this Ward Review based on the fact that his insight had improved. I did not scribe this or any of the RiO entries where insight and capacity are recorded after the 16 July 2020 so do not feel I can comment on why this discrepancy exists.

200. I was not qualified to make decisions about the application of the MHA at this time, so cannot comment on whether the clinical team had enough information about the potential risks he posed to himself and others to put in place a CTO with a condition of depot medication.

201. The decision about prescribing lay with the RC. I understood that VC's care co-ordinator was in agreement with the plan from the perspective of outpatient care.

202. During VC's second admission, I attended a number of Board Reviews in respect of VC [see, for example NHFT0000168, p.68, p.85 and p.91]. Board Reviews were an opportunity for nursing staff to update the clinical team on any jobs that they were required to carry out for patients which may have arisen since the last Ward Review, or vice versa, to ensure any important new information was shared between the nursing and clinical teams and that the care plan was being completed. They typically took place in the nurses' office at the start of a day shift, often while participants were standing so were not intended to be in depth discussions. As doctors it helped us plan our tasks for the day. The meetings were led by a nurse. Each patient was briefly discussed, under the headings: summary of last 24 hours; review of observation levels; physical healthcare needs; activities / OT input; plan and jobs to be completed.

203. Information from any source could be included in Board Reviews. It could be something like a patient complaining to a nurse overnight that they had been feeling unwell and wanted to see a doctor in the morning, or that the lab had called and said that a blood test sample was insufficient and needed repeating. Prior to having board rounds there had been a 'Doctors Jobs book' in the nursing office and we would look in that to see if there were any messages for us about jobs that had to be done. The book sometimes went missing or the messages were unclear. This system seemed a safer and more efficient way of aiding communication between the clinical and nursing teams on a day to day basis. The Board Review for a patient would be entered by the ward clerk (a non-clinical role) onto RiO, and would therefore

appear within the daily Progress Notes. From review of the notes, I can see that VC is mainly described as being in his bed space and being compliant with medication. This is in keeping with his previous admission and the fact the ward could be noisy and chaotic, and he was someone who pre morbidly preferred peace and quiet. I would also note that not all aspects of the treatment plan are included in the “plan” section of the Board Review, but I would not expect the full plan to be there as only specific jobs that had to be completed that day would be listed. It was understood that the treatment plan from Ward Review was what was the guiding principle in a patient’s treatment and that nursing staff would follow their usual policies and procedures.

204. Comparing the daily observations recorded by nursing staff and comments from other healthcare professionals with what is recorded in Ward Reviews I can see that information does track across to the Ward Review notes. It therefore would have been taken into account in his treatment plan.

#### **Pattern of non-concordance with medication – Second Admission**

205. 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, p.64]. At this stage of VC’s treatment, exploring and addressing VC’s pattern of non-concordance was central to his future care planning.

206. 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" [NHFT0000168, p.75]. 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."*

207. I had finished working on the ward on 24 July 2020, but I can see from the notes that during a 1:1 meeting between VC and a peer support worker on 27 July 2020, VC confirmed that he would take his medication on discharge and addressed questions about any impact that the higher dose of Aripiprazole was having on him:

*"[VC] 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, p.100]*

208. These statements were made when it was considered that VC was no longer experiencing troubling psychotic symptoms. I was not present at this Ward Review as I had already finished working on Rowan 1, and I do not recall if I thought he was being open and honest on previous Ward Reviews or simply telling staff what he thought they wanted to hear. This is a common phenomenon with patients who have some familiarity with the mental health

system so I tended to view such interactions with a certain degree of reservation and would still consider the possibility of it being inaccurate.

209. I have been provided with a copy of the "Level 2 Comprehensive Report" [NHFT0000451] produced by the Trust. I have been asked by the inquiry to consider the following paragraph:

*"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, para 29]

210. I think that this conclusion is talking about VC's entire history of care under the Trust, as described in the chapter that this paragraph is summarising. I am not familiar with VC's care during all of his admissions, but only from the time of his first and part way through his second admission. I believe the care he received during the time as an inpatient during the first and second admissions was aimed treating his illness, at addressing his social and psychological needs and at understanding and reducing the risk of harm he might pose to himself and others on discharge. Certain factors such as social isolation, accommodation choices, the possibility of lack of non-concordance with medication and the lack of engagement with community

teams were considered as being risk factors on discharge and the attempts that were made to address them appeared proportionate to me at the time as well as being in keeping with similar cases I had seen. A pattern of non-concordance had not been established by the second admission.

### **Clinical conclusions from Second Admission**

211. I have been asked to consider a screenshot of VC's electronic patient record [NHFT0000169]. The Inquiry has noted to me that under the section titled "Alerts" there is no note of the incident which led to VC's Second Admission, and I have been asked to comment on the significance of this being missed from the frontpage "Alerts". I would say that this is significant because this is where healthcare professionals would look to quickly understand significant risks or other information about a patient. I do not however believe it impacted on the risk formulation for his second admission as the circumstances leading to his second admission were known to the team, aside from the Police Report of assault and "kicking off" as discussed in paragraph [177] above.

212. For the purposes of this statement, I have reviewed the Discharge Summary that was sent to VC's GP practice at the end of his second admission, which includes the following conclusions:

*"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.” [CHCA0000028]*

213. I was not qualified to make decisions about revoking Sections of the MHA or to discharge patients at this time. I had also stopped working on the ward the week before VC was discharged from his second admission so cannot take into account anything that happened while I was not there. However, as mentioned previously, I was present in a Ward Review where Dr Seedat discussed the matter of insight with VC and VC appeared to answer questions in such a way that it was concluded that he had insight into his illness. I note that after I had left the ward, there was another Ward Review which again stated that VC appeared to have insight into his illness. I believe that if I had any reason not to believe him, beyond the level of caution mental health professionals tend to have towards patients who may be motivated to tell them the answers they know professionals want to hear, I would have questioned this conclusion at the time.

214. Although I was not present for the last week of VCs second admission, as with his first admission and from my level of experience and training, I believed that the risks of aggression, violence, masking, and lack of insight had been adequately addressed and planned for in a manner that was congruous with plans I had seen for patients presenting in similar ways throughout my training. Non-concordance with medication was also addressed and planned for. The possibility that, regardless of what VC said, he may decide to stop taking medication or engaging with treatment once no

longer on the ward was appreciated by the inpatient team. As was the fact that any discontinuation of treatment or engagement was likely to lead to relapse in which case all known risks would significantly increase and could potentially exceed previously reached levels as they had done during the incident which led to this second admission. These risks were managed by ensuring that VC understood the risks of stopping medication and testing his insight (for example, his discussion with the APIP on 20 July 2020 [NHFT0000168, p76], the Ward Review on 21 July 2020 [NHFT0000168, p78], his Key Worker 1:1 on 25 July 2020 [NHFT0000168, p93], his 1:1 with Peer Support Worker on 27 July 2020 [NHFT0000168, p100]). Discussions were also had with those who would be supporting him in the community including his Care Co-ordinator, the CRHTT and his family so they too would be aware of the importance of continuing treatment and the risks of discontinuing it, for example the Ward Review on 21 July 2020 [NHFT0000168, p78]. There was also a telephone discussion between Dr Seedat and VC's mother about the importance of continuing medication and that she should contact the LMHT if she felt he was becoming symptomatic [NHFT0000168, p79]. His Care Coordinator from the EIP team was present for this discussion via MS Teams. The university was also informed of the circumstances leading to this admission on the 23 July 2020. It appears that it was arranged for the CRHTT to provide intensive input on discharge, rather than just the EIP team, as documented in the Ward Review of 28 July 2020 [NHFT0000168, p106], although this was after I had left the ward.

215. In the Ward Review on the 16 July 2020, VC's diagnosis was recorded in as 'Schizophrenia like illness'. [NHFT0000168, p.63]. This meant we were treating VC as if he had schizophrenia, which had been a provisional diagnosis during his previous admission. The treatment approach was therefore not significantly different from that of the previous admission with the addition of particular focus on psycho education around the issue of the importance of concordance with medication and exploration of insight.

216. I have been provided with NHS England's independent investigation into the care and treatment provided to VC by NHS services prior to the tragic events of 13 June 2023 [NHFT0000530]. On page xv, two of the key findings are summarised.

Firstly, the Report finds that VC's insight into his condition "*did not appear to increase*" and "*he did not demonstrate retrospective insight.*"

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.*"

217. I have been asked by the Inquiry whether I agree with this conclusion. I have further been asked to explain the extent to which my view in VC's assessment of capacity informed his care, treatment and engagement throughout VC's first and second admissions.

218. I cannot comment on VC's mental state at any times other than during his first and second admissions. I can say with some clinical confidence that when I assessed VC's insight at the beginning of his first admission and documented the 72-hour review at the beginning of his second admission, he had only at best partial insight into his condition. It becomes more difficult for me to give my opinion beyond these points, as I had not directly assessed him myself and any documentation made regarding insight or capacity was made by people other than me. However, other senior clinicians such as Dr Seedat, who was also the medical director at the time, and an APIP who was an experienced psychiatric nurse, appear to have concluded that he did develop insight during the course of his treatment. This was the important factor in determining if he would be concordant with treatment once discharged and therefore informed the risk management strategy alongside the knowledge that his insight may fluctuate, and he would therefore require close follow up in the community. I had no reason at the time to doubt the opinions of senior mental health professionals when they determined that VC, at times, possessed a level of insight into his illness during those two early admissions. Since VC was detained under the MHA during both admissions, whether or not he had capacity to make decisions about his admission and treatment would not have affected the treatment he received. However, it is still important to note in Ward Review documents whether or not a patient has capacity at the time of the Ward Review to make decisions about their admission and treatment and participate in the Ward Review. This was recorded in the RiO entries as part of documenting such meetings. I do

however note that some Ward Review entries regarding capacity in particular seem not to correlate with assessments of insight documented in the same meeting and so appear to be unclear, which is perhaps reflected in the NHS England report.

219. The Inquiry have also asked me to what extent did I feel able to challenge any of the clinical conclusions reached by more senior colleagues during the period in which I was involved in VC's care and treatment at Highbury Hospital and to what extent did I feel able to raise issues or concerns I had in respect of patient care and treatment with senior members of my team during the periods relevant to VC's first and second admission. I felt able to question clinical conclusions and did so during supervision. Dr Seedat also carried out a formal case-based assessment with me, which focused on this case [WITN01660003, as above]. At no point did I feel the need to challenge any of the clinical conclusions reached but if I had, I would have spoken to Dr Seedat directly. My former clinical supervisor and appraiser who was a senior psychiatrist was also working in the same building, and I would have spoken to her if I felt I could not speak to Dr Seedat.

220. My most enduring memories of the time on the ward were how chaotic and loud it seemed, especially with regard to trying to manage the COVID risks, infection control, turnover, severity of illness of some of the patients admitted, change from male only to mixed gender ward and back again and feeling completely responsible for the physical healthcare of patients who at times had quite complex problems, when this was something I had not had to

do for several years. In terms of clinical leadership, I felt that Dr Seedat, who could be direct at times, led in a way that was decisive yet open to input from any team member, patient, relative or outside agency.

221. To my knowledge, I have not been involved in the care of another mental health patient who, following discharge or whilst under the care of the community mental health team killed or seriously injured a member of the public.

### **Recommendations**

222. I have been asked by the Inquiry what recommendations do I think the Chair of the Inquiry should make to ensure lessons are learned and prevent similar attacks in the future. I am not familiar with what happened with regard to VC's care and treatment after his first and second admissions, so am limited in my ability to comment specifically.

223. One thing that has struck me when preparing this statement and reviewing documents is there seems to be confusion about what information was available or where and how important information should be documented and found. It would help if there was a consistent national approach to recording and sharing important clinical and risk information. In a similar manner and although I do not believe it would have significantly changed our management during his first and second admissions, it would nonetheless have been important to have access to the police description of the events that occurred during VCs detentions in a timely and consistent manner.

Perhaps a formalised system whereby that type of information is easily shared between those involved in the care of patients should be considered.

224. Prior to working on Rowan 1, most of my clinical experience had been in areas where time pressures on clinical staff were not so great. It was therefore possible to create and review notes and information in greater detail in those settings. The circumstances on Rowan 1 at the time I was there, were unusual in that it was during the first COVID19 lockdown. It felt like we were under considerable time and resource pressures. However, I do not know what, if anything, could have been done to address this or prevent it from happening again.

225. Speaking from my experience of working in mental healthcare services in general, I would like to highlight that, the patients and carers I worked with in co-producing training programmes often talked about their difficulties in accessing help for their mental health and there often not being continuity of care when that help was provided. The ability to care for and safeguard those with mental health problems (and therefore the community at large) often relies on the ability of patients, carers and professionals to form therapeutic relationships based on familiarity, trust and consistency. Any changes to the provision of mental healthcare should consider the importance of these factors and seek input from patients, relatives, third sector and voluntary organisations as well as the various professionals working with them.

226. I referred to this case during my annual appraisal in August 2020 [WITN01660004, page 22], reflecting on the Case Based Discussion I had with Dr Seedat. I reflected that I had:

*“suggested some options for management on discharge that were second guessing the fact that community services may not be able to provide the level of care the patient may need. He pointed out that it was not my responsibility to decide this is what was required simply because I thought the LMHT may not be able to manage but rather I needed to be clear on what my role as an in-patient clinician was and allow the LMHT to do their job. We talked about the importance of being boundaried, realistic and pragmatic while still working towards improving services on a systemic level whenever possible. I found this immensely helpful as I realised I tend to become frustrated when I think my ideal of service provision is not met and overcompensate in ways which would ultimately be harmful and unhelpful.” [WITN01660004, page 22].*

227. This was written before the events of June 2023. The concerns I expressed were in relation to the system of psychiatric care in the UK as a whole, rather than specific concerns about the local LMHT or this particular patient's discharge. During my training, I had become very interested in Open Dialogue, a Finnish approach to psychiatric care that involves intensive social input and broader societal involvement, supported by higher financial investment in the welfare state than exists in the UK. I was reflecting on why our patients do not benefit from the same standard of care as patients in Scandinavian countries. In very broad, structural and even societal terms, I was wondering why, in my experience, patients often relapse when based in the community, even with the best will in the world and irrespective of the skill

of practitioners involved, and whether anything could be done about it. Dr Seedat's feedback about being more pragmatic reflect the fact that I was thinking out of the box on a much broader level than the scope of psychiatry, as I have a tendency to do. I have often felt that there were things about psychiatry in general that could be improved, which is largely why I spent so long working in a non-training role as Simulation Lead, where I had an opportunity to work with patients and carers to improve the way doctors communicate with mental health patients. This tendency to think about how things can be improved on a wider scale is what I was doing when talking to Dr Seedat. I do not recall having specific concerns about this discharge, and I believe I would remember if I had. My comments reflected my experience of the system of psychiatry in general, not the readiness for discharge of this specific patient or the skills and abilities of the LMHT.

228. I have been further asked by the inquiry what improvements could be made locally and nationally to multi agency working to increase effectiveness in preventing similar outcomes in the future. Whatever changes are made, they should be developed as a result of co-production involving ordinary professionals, at all levels, who will be affected as well as patients and carers. Ideas and solutions no one had thought about can emerge when individuals from different agencies share and discuss their experiences, difficulties and possible solutions together. In particular, I would warn against introducing any new electronic documentation systems without extensive end user input and evaluation.

### **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: 13/11/2025

**Index to the first witness statement of Anna Ludvigsen**

<b><u>No</u></b>	<b><u>URN/ reference</u></b>	<b><u>Document Description</u></b>
1.	WITN01660002	CPD record (comprising 3 documents: provided "CPD-Activity", plus the two training records dated 17 September 2025
2.	WITN01660003	Work based discussion (CBDDrS)
3.	WITN01660004	Appraisal
4.	NHFT0000130	Service Guide: Adult Mental Health Acute Inpatient Wards
5.	<u>NHFT0000188</u>	Core Assessment
6.	NHFT0000008	AMHP Referral and Assessment 25.05.2025
7.	NHFT0000207	Summary and Care Plan 26.05.2020
8.	NHFT0000206	Summary and Care Plan' 03.06.2020

9.	NHFT0000197	Risk and Safety Assessment 24.05.2020
10.	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary ("PRS")
11.	NHFT0000223	Discharge Summary – 16.06.2020
12.	NGPF0000049	Police report 13.07.2020
13.	NHFT0000204	Summary and Care Plan' 15.07.2020
14.	NHFT0000451	Level 2 Comprehensive Report
15.	NHFT0000169	Electronic Patient Record
16.	CHCA0000028	Discharge Summary 31.07.2020
17.	NHFT0000530	NHS England's independent investigation into the care and treatment provided to VC by NHS services prior to the tragic events of 13 June 2023
17.	NHFT0000222	Discharge Summary 31.07.2020
18.	NHFT0000037	Scrutiny of MHA Section Papers 10.07.2020
19.	NHFT0000195	Risk and Safety Assessment 15.07.2020
20.	<b>NHFT0000196</b>	Risk and Safety Assessment 26.05.2020
21.	NHFT0000187	Core Assessment 15.07.2020

<b>22</b>	<b>WITN0166005</b>	Article by Dhensa-Kahlon RK, Wan ST, Coyle-Shapiro JA, Teoh KR, 2025
-----------	--------------------	--

