Witness Name: Amanda Frost

Statement No: WITN0196001

Dated: 12 November 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF AMANDA FROST

I, Amanda Frost (nee Smillie), will say as follows:

Introduction

1. I am Practice Development Lead for Adult Mental Health at Nottingham (Band 7) Healthcare NHS Foundation Trust (NHFT).

2. I make this statement in response to a request made under Rule 9 of the Inquiry Rules 2006, dated 22 September 2025, and a further request made under Rule 9(2) of the Inquiry Rules 2006, dated 02 October 2025. In this statement, I discuss my career and role, my training and system of work, and my interactions with Valdo Calocane (VC).

3. This witness statement was drafted with assistance from 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.

Career and Role

4. I qualified in 2014 from the University of Nottingham with a Master of Nursing Science qualification with honors, specialising in Mental Health Nursing.

5. Upon qualifying in July 2014, I was employed at Nottingham University Hospitals as a Staff Nurse (Band 5) in Spinal Surgery as a mental health nurse, supporting patients with both physical and mental health care.

6. In August 2015, I joined NHFT as a Staff Nurse (Band 5) at the Wells Road Centre, a low secure mental health forensic unit. I initially worked on the male admission ward and then rotated around the site to work on the female ward, and finally the long-term rehabilitation ward.

7. In March 2018 I became a Clinical Team Leader (Band 6) for Children and Adolescent Mental Health Services (CAMHS), working on the Psychiatric Intensive Care Unit, and General Adolescent Unit.

8. In December 2019, I became a Staff Nurse (Band 5) in Adult Mental Health, on Rowan 1 ward. Rowan 1 is a male acute mental health ward.

9. In January 2020, I became a Clinical Team Leader on Rowan 1 (Band 6). It was while I was working in this role that I met VC for the first time during his First Admission.

10. In July 2020, I became the Acting Ward Manager (Band 7 as a secondment) of

Rowan 1. While working in this role, I met VC for the second time, during his Second Admission.

11. I applied for the substantive post as Ward Manager (Band 7) for Rowan 1 in November 2020 and was successful at interview.

12. In February 2022 I became Practice Development Lead for Adult Mental Health (Band 7) at NHFT which is the position I hold today.

13. I am a Registered Mental Health Nurse and have an active registration with the Nursing and Midwifery Council. I am a member of the Royal College of Nursing.

Training and System of Work

14. Whilst at University, we would have covered the assessment of risk for mental health patients of violence towards others by learning how to ask questions in a professionally curious manner. We learned this both on placements and in lectures; it is fundamental skill of mental health nursing, so it was referred to at several points throughout our training. I also learned how to undertake a risk assessment, which included how to communicate, how to document things correctly, and how to complete the risk assessment itself by using your observations, the patient's history, and so on.

15. I have worked with patients who have been considered a risk to others throughout my nursing career, particularly in a low secure forensic unit. In my previous roles in low secure forensic settings, I would have completed training

around risk assessment tools such as HCR 20 (20-item Historical, Clinical, Risk Management-20 tool for assessing the risk of future violence in forensic psychiatric settings). This risk assessment tool is not something commonly used in Adult Mental Health settings due to requiring lots of detailed information around the crime committed. I understand that the HCR 20 tool has provided as part of the Trust's disclosure to the Inquiry so I have not exhibited the same to this statement.

16. I also complete mandatory training, which includes a clinical risk e-learning package. Within this, I complete the training on Clinical Risk and Safety every three years, and I teach on that course as well (although I did not teach on the course at the time of my interactions with VC). In addition, I complete annual training on Managing Violence and Aggression (MVA), which includes training on both restraint and breakaway. Lots of the other training that I do also includes discussion of risk.

17. When a patient first arrived on Rowan 1, we usually received a handover from the Bed Management Team. The information typically shared with us would be the patient's name, RiO number (similar to a NHS number, a way to identify patients within the RiO system), Mental Health Act (MHA) status, presenting mental health signs and symptoms, physical health issues and risk presenting at this time (including risk to self, risk to others and risk from others). This would be done as a verbal handover, but also written information would be in the patient's record in the progress notes, care plan and risk assessment. The

nurse in charge would review those documents prior to the patient arriving on the ward.

18. I have access to RiO, and to my knowledge, this access is unrestricted. I did not have access to SystmOne as this is not a system required as mental health nurses in NHFT. I discuss how I record and share information by providing specific examples about how this was done for VC below.

19. In terms of raising concerns that I had about the risks posed to others by patients I was involved with, the first port of call would have been the nurse in charge of that shift. During VC's First Admission, I was a Clinical Team Leader, so I would often have been the nurse in charge; in terms of my next escalation, this would have been my ward manager, and/or the wider multi-disciplinary team (MDT). The exact route of escalation depended on the risk at the time: if it was a risk to physical health, for example, that would be escalated to the physical health team.

20. At the time of VC's Second Admission, I was the acting ward manager, so my first port of call for any concerns about patients would be to the responsible clinician, and/or the wider MDT. I did also have other escalation routes too, such as to the service manager, or the matron. I always felt comfortable in raising any concerns that I had about risk.

21. To the best of my knowledge, I have been involved in the care of one other mental health patient who, following discharge or when in the community, has killed or seriously injured a member of the public. This happened in 2021.

Interactions with VC

I. VC's First Admission (under s.2 MHA 1983) – Rowan 1, Highbury Hospital, NHFT ("First Admission")

22. At the start of VC's First Admission to Rowan 1, I was a Clinical Team Leader (Band 6).

(a) Arrival at Rowan 1

23. At this point, very limited information was held on the RiO, as this was VC's first contact with mental health services both at NHFT and nationwide.

24. I was not on duty the day that VC was admitted to Rowan 1, but I would expect that the usual handover described above at paragraph 17 took place, and that this was received from the Bed Management Team, who would have been communicating with Liaison and Diversion team at Bridewell Custody Suite.

25. This handover would also have included details about VC breaking into two neighbours' flats and causing damage to a door, due to VC hearing screams

and believing one of his family members was being raped. One neighbour was in the shower at the time and was very fearful, and we believe that she was injured by jumping out of the window. These were the only times the team were aware that VC had contact with the police. Generally, if people are going to be having further contact with the police (for example, if a statement needs to be taken), the ward will be made aware of that as well, usually by telephone, but we had not received any such contact in relation to VC, so we were under the impression that VC had not been charged with offences relating to these incidents.

26. As I was not on shift when the handover was given by the Bed Management Team, I would have obtained my understanding of the situation through the handover that I received, reading through the notes, risk assessment, and care plan, and attending the MDT. I cannot recall whether I reviewed the A4 Form [NHFT0000004], and/or the Approved Mental Health Professional Report [NHFT0000008] at the time of VC's admission, due to the amount of time since this event. These documents would usually be reviewed by the admitting nurse, and summarised within areas of the RiO record (progress notes, care plan, risk assessment), and within the Core Assessment (by the doctor clerking in VC).

27. I cannot remember specifically discussing the events that led to VC's arrests on 23 and 24 May 2020 and the subsequent MHA 1983 referrals with VC.

(b) VC's psychiatric presentation and condition

28. At the start of this admission, VC appeared vacant, guarded around his mental health, and at times, lost. VC appeared to be responding to unseen stimuli: he appeared distracted and would take long pauses before answering questions, which made maintaining conversation difficult. At times, VC appeared suspicious and reluctant to engage, only giving one-word, short answers to conversations. This presentation is typical of psychosis, which was VC's working diagnosis during his first admission, and which was my understanding of VC's condition at this point.

29. To provide some context, patients experiencing psychosis usually present with hallucinations and delusions, and a loss of contact with reality. We did not know how long his symptoms had been ongoing for, and so our initial diagnosis was the broad umbrella term of psychosis. The longer you know each patient, the more you can map how long their signs and symptoms have been impacting their day-to-day functioning, which is why on VC's Second Admission, we were able to confirm that he met the diagnostic criteria for schizophrenia.

30. In terms of VC's psychiatric history, we were under the impression that VC had been born in Africa, had moved to Portugal during his teenage years, and then came to the UK, where he had resided in Wales. We understood that VC had never had contact with mental health services anywhere in the world.

31. Regarding VC's capacity, he had been detained under the MHA, and his capacity to understand, weigh up, and retain information, and communicate his decisions to us was lacking. VC had been offered medication in the community;

it was unclear whether he had been taking this or not, but our impression was that he was not.

32. In terms of my understanding of VC's care plan, patients have a 72 hour admission care plan when they are first admitted. At the point of admission, we do not know the patient very well, so this care plan was essentially for VC to be on 10-minute intermittent observations completed by nursing staff members; this is normal when patients are first admitted to the ward for observation, promote safety and to observe for risk behaviours. We were also treating VC for psychosis, so we were offering him antipsychotics. That was his treatment plan at the point of admission. During the first 72 hours, we then have the senior medical review, which is completed by the responsible clinician, and that dictates the next pathway for treatment.

(c) VC's general presentation

33. As a person, VC was a very quiet individual who generally liked to keep himself to himself on the ward. He reported enjoying reading, music, walking and being outside. VC was a very studious person who spent long periods of time in his bedroom at the desk area studying from textbooks and using his laptop computer for coursework and exam revision. VC appeared to put pressure on himself to gain good qualifications in order to have a good career. As VC was admitted during May 2020, which is typically university exam season, Rowan 1 contacted the University of Nottingham in regard to submission dates for VC's coursework and exams.

34. At times during VC's admissions to Rowan 1 ward there were concerns that he was studying excessively, and this in turn impacted his sleep, and led to him declining other activities on the ward in favour to study. VC's family echoed our concerns, and there were times where we would ask VC to hand in textbooks and his work to the ward office, to allow him to have some space away from studying.

35. In terms of VC's presentation, as a MDT team we considered if this was due to stress induced psychosis due to stresses around university, moving house and sleep deprivation.

36. At the time of admissions in 2020, the COVID-19 pandemic had been happening in society, but restrictions were reducing during VC's admissions to hospital. VC reported that COVID lockdown restrictions had not impacted him negatively. He spoke about previously living in Portugal where he had a lot of friends, but after moving to the UK this changed due to him believing he did not "fit in" here in the UK, and preferred to spend time alone. He reflected that he was very comfortable being alone as this was something he was used to and at university he was older than most students so had not made friends due to the age difference.

37. As a team, we felt COVID would have impacted VC due to the changes around university: most lectures would have been online, most students would have gone home, and he was a long way from Wales where his family resided.

Therefore, it was our feeling as a team that isolation would have been apparent for him, however VC denied this. VC spoke of friends in Birmingham who would let him stay with them if required, however, to my knowledge, these friends did not attend the ward during VC's admissions.

38. Whilst VC was admitted to the ward, there were different COVID restrictions for England and Wales (VC's Mum resided in Wales at the time of admission). We supported VC's Mum to visit the ward by booking appointments for her to visit, providing a letter in case she was stopped by Police, and we also facilitated communication via telephone as much as possible. For example, at times we provided VC with the ward mobile phone, as he had misplaced his phone and his family were voicing their concerns to the ward team that he had not been in contact with them. However we were aware that VC's Mum was a nurse herself working in intensive care environments in Wales.

(d) Physical examinations

39. When a patient is admitted to mental health wards there are many assessments which are completed to ensure we have a holistic view of the patient's health and wellbeing. Some of these are completed by the nurses, and some are completed by the wider MDT.

40. I completed VC's AUDIT C assessment [NHFT0000226] which is an assessment about alcohol use. We were aware VC did not drink alcohol or take substances, so this was completed by asking him about this; this was also

confirmed by the initial documentation that was completed whilst VC was in the Bridewell Custody Suite. The documents that I would have reviewed were the entries in the RiO progress notes on 24 May 2020, at 9:54am, 24 May 2020 at 5:03pm, and 25 May at 6:05pm [NHFT0000168, pg1 and pg4]. I cannot recall whether I have seen the Bridewell Custody Suite record [NGPF0000095] before or not.

41. We also review physical health of all patients using a thorough physical healthcare assessment tool [NHFT0000251]. This includes taking patient's physical observations (blood pressure, pulse, oxygen saturations, temperature), as well as recording admission blood tests, ECG results and the patient's weight.

42. As a nurse, you have to look through the record and coordinate the relevant information: the blood and ECG results are documented in the progress notes, physical observations are done regularly on the ward, and weight is completed on admission. You then have to record it on one form. To ensure the patient is treated holistically, there are other questions which they are asked, regarding exercise, sleep, smoking, drug and alcohol use, sexual health, genital checks, feet checks, eye tests, and dental checks. VC was able to engage in some of these questions, but some he was unable to answer, or did not want to answer, which was not unusual. There were no major concerns regarding his physical health during his admissions to Rowan 1.

43. We are also required to ask all patients about smoking status when they are admitted to mental health wards; VC reported he was a non-smoker, which again was confirmed by family [NHFT0000254].

44. I also completed VC's Compulsory Client Information Form [NHFT0000178], which I did by using the RiO running record, and asking VC questions to clarify information. This was completed on 03 June 2020, and by this point of his admission VC was able to engage with us more readily and had started to build up therapeutic relationships with the team.

(e) Care and Treatment Plan

45. During VC's First Admission I did not formally formulate VC's care and treatment plan. This is normally completed on a weekly basis by the named nurse, which I was not, and therefore I did not assess VC's capacity to consent to or participate in the formulation of, his formal Care Plan.

46. However, in addition to the formal Care Plan, on a day-to-day basis we must also respond to new developments in relation to each patient, because a new event could happen that has not been planned for. So, part of the nursing process is about assessing situations, planning, implementing, and evaluating interventions. These are basic skills taught to nurses at university, as they are skills which are needed to respond to the type of environment we work in. We need to be able to risk assess situations and respond in a safe manner.

47. So, every time a new development happened in the context of VC's care, I would be assessing VC's capacity to consent to the next step that needed to be taken: for example, if I wanted to undertake a physical examination, I would need to assess VC's capacity to consent to this.

48. In terms of monitoring a patient's mental state, we would be observing for signs of symptoms of mental illness and recording these within the RiO running record, ensuring these are fed back to the MDT in all relevant meetings, recording in relevant parts of risk assessment and care plan and responding to observations in terms of treatment (such as patients requiring verbal support, medication, completion of activities of daily living for example).

(f) Communicating Risk

49. In terms of communicating VC's risk to others, this was done on a daily basis in handovers to the nursing team and MDT, through documentation in risk assessments and on discharge to community, however it was also discussed the management strategies to reduce this ongoing risk. I set out the specific discussions that I had regarding VC's risk to others below.

(g) 26 May 2020

50. On 26 May 2020, VC was kicking doors on Rowan 1, which gave rise to concerns about his safety, and the safety of other people. VC was unable to explain why he was kicking doors and still appeared very guarded. He was

therefore commenced on 1:1 within eyesight observations, meaning a member of staff was allocated to stay with VC at all times.

51. The normal practise would have been for VC's Care Plan to be updated to reflect this change to his observation level; these updates are usually made by the named nurse, unless significant changes happen whilst on shift. This change to VC's observations would also have been discussed in nursing handovers to ensure people who are delegated to stay with VC know what to do and their duties whilst allocated to VC. Observation levels would also regularly be discussed within board review, ward round and MDT meetings, to ensure this observation level was correct for VC's care needs at the time and not a restrictive intervention. Observations at all levels have an impact on a person's privacy and dignity so therefore are restrictive in their nature. Therefore, to promote patient's human rights, privacy and dignity needs we review these regularly as a wider team.

52. In order to decrease observations, the responsible clinician and wider MDT have to review these levels. Documentation should be completed within RiO progress notes and paper observation record, and the observation prescription on eObs (which I believe stands for electronic observations) should be completed for increase and decrease of observations.

53. VC was also commenced on medications: Olanzapine, which is an antipsychotic that VC had been prescribed in the community prior to admission to hospital (although it was unclear whether he had been taking this), and

Clonazepam, which is a benzodiazepine used to calm and relax patients. To give some context for how the medication process works, we normally have a medical medication review, which is completed by our pharmacy colleagues, who can access medication records and see what patients have been prescribed in the community, and on previous admissions to hospital. This informs what medication should be prescribed to each patient.

54. On 26 May 2020, VC continued to kick doors and was restrained and given Lorazepam via an injection. Lorazepam is a fast-acting benzodiazepine which can be utilised to calm people down quickly, giving a light sedation. The nursing team on shift would have had to make a decision about when to use this, as this is a medication which is utilised when required; it is not given at a set time every day, but rather it is generally used in response to patient's mental state or risks which are being observed on the ward. Both as a qualified nurse at university and after university, we are required to complete training around giving this medication, which includes training around how to assess whether medication is required for the patient, physically giving the medication and what stages to complete after, including awareness of the impact this medication has on patient's physical health.

55. Over the next few days VC appeared to improve in terms of his mental health and wellbeing. VC's sleep also appeared to improve and he was able to communicate more with the team, talking more about his mental health and how this had been affecting him for the years prior to him being admitted to hospital. VC explained how he had been sleep-deprived for three years, hearing voices

for several months prior to admission, and sending out of character messages to family members.

(h) 28 May 2020

56. I attended VC's ward round on 28 May 2020 [NHFT0000168, pp.10-11]. This was VC's first senior review ward round since his admission to hospital, and his first opportunity to meet his consultant.

57. I was the ward round nurse for this shift, and so my role was to give the nursing handover and feedback to the MDT about the patient's presentation since admission, discuss his mental state, discuss any risk behaviours being observed whilst on the ward or in the past week, and to empower and advocate for our patients. All members of the wider MDT (including community teams if they are involved with patients) will also do this and then the patient is invited to the review. Carers and family members are invited also to give their view. The minutes of this meeting (usually taken by a junior medic) are included within the RiO progress notes under the title 'Senior Review' or 'Ward Round'.

58. As the ward round nurse, feedback is given by verbalising the nursing team's observations of signs and symptoms of mental illness and by reviewing the RiO progress notes for the patient since admission or in the past week.

59. In terms of my handover and the feedback given to the MDT at this point, I discussed VC's progress on the ward and the changes seen in his presentation:

how he appeared less chaotic, less aggressive and less hyperactive, but also how he appeared distracted at times and was responding to unseen stimuli.

60. In terms of risks at this stage of his admission, we were aware of VC breaking into other people's property and causing damage to doors; VC reported this was in the context of lack of sleep for long period of time, the stress of moving house, and exam pressures. This is in keeping with the diagnosis of psychosis. Kicking doors on the ward was also identified as a risk.

61. I did not complete his documented risk assessment whilst VC was on the ward during this admission. This was done by somebody else.

62. VC's observations were reviewed (as per the observation policy) and changed to intermittent 10 minutes observations. This was due to VC's mental health showing signs of improvement, VC not kicking doors, and his sleep improving. This would be a normal process for patients going from 1:1 within eyesight observations, as a staged way to reducing observations gradually and safely.

63. During this ward round, VC requested to stop his medications (Olanzapine and Clonazepam). VC reported feeling like he "had a problem" and needed to do some "soul searching", and that medication would not help him to do this. The MDT agreed to stop VC's medications at his request due to this being his first admission to hospital, and the fact that patterns had not emerged at this time. Prior to his admission, VC had not slept properly for a long period of time however this was now improving, and we were not seeing the same risk

behaviours as we had in the community prior to admission. In mental health this would be considered a least restrictive intervention and positive risk taking, with the team working together, collaboratively with our patients.

64. VC was referred to the ward occupational therapist who attempted to build a therapeutic relationship with him, in order to discuss and engage with VC about occupation other than university work. VC reported he had been using breathing exercises, body mapping, reading the bible and meditation as forms of stress management but admitted that stress had been building in the community and these were not effective in keeping him well. VC spoke about how moving house had been very stressful for him due to him believing his neighbours were "against him" which lead to him feeling angry.

65. During this time on the ward, VC would play chess with peers, which he engaged with well as an activity, showing good understanding of the rules, and his ability to process. Generally though, VC did not spend much time with peers on the ward, opting to spend more time on his own. At the time of admission, the ward was full, with 16 patients aged from 18 to 65. Acute mental health wards are busy environments and have patients with many different needs, and those admitted to Rowan 1 in May-June 2020 would have been no different. I remember Rowan 1 being a loud environment, often with patients shouting, and some patients using racially aggressive language towards staff and fellow patients. VC would play chess regularly with a patient who was often racially abusive, however both patients had admiration for each other in the way they played chess so logically.

(i) 02 June 2020

66. On 02 June **2020** VC's observations were reviewed again, and changed to general observations, which means patients are observed every 60 minutes. This was due to improvements being seen in terms of VC's mental health, no risk behaviours being observed, and the fact that as a team, we were building a therapeutic relationship with VC where we felt VC would raise any concerns that he had; this was in line with least restrictive practice. This change in observations would have been included in VC's care plan, and discussed in all handovers, ward rounds, board reviews and multidisciplinary reviews.

67. The ward had numerous contact episodes with the university student support services team regarding VC sitting his exams and handing in his coursework. VC was disappointed to find out he would have to do this during the university's resit period. Accommodation was also discussed, and the university recommended that VC should go back to Wales during the resit period, rather than returning to the student accommodation he was residing in. VC reported that he did not want to return to Wales, and instead wanted to go to Birmingham, where he previously lived and worked there (in a warehouse). He insisted he wanted to return to the university accommodation he was in previously, despite the university recommending that wasn't a good idea.

(j) 04 June 2020

68. On 04 June 2020, VC was reported to be play fighting with a peer on the ward. The peer on the ward was a similar age to VC, and both patients appeared to instigate the interaction. VC reported this was a stress relief for both patients and thought this incident was fun, and it was humorous that was misconstrued as one patient assaulting another. This was the only incidence of violence to others from VC whilst on Rowan 1 during both admissions to the ward, however no injuries were sustained.

69. I was on night shift duty on 04 June 2020 and can remember an incident where VC reported that he could hear screaming coming from down the corridor (this was not heard by the staff on duty). VC insisted that he could hear this coming from the linen cupboard and appeared distressed by this. A staff member opened the linen cupboard on the ward to show VC there was no one in there. After seeing this, VC appeared perplexed as he was convinced there was someone in there screaming.

70. The MDT were informed of this incident the following day, as there is no MDT overnight, and VC was commenced on Aripiprazole, which is used as a first line anti-psychotic medication for people with first episode psychosis. Aripiprazole can be really beneficial, particularly for younger patients, as it has fewer side effects, but it does need to be taken at the same time every day.

71. VC was disappointed to have to start medications, however he accepted there were problems which he needed to overcome. VC accepted this medication in tablet form at a low dose, with the view to slowly increase his dose as per

medication guidelines. Aripiprazole is given in 5mg doses at first and then can be slowly increased up to a maximum of 30mg; the decision of whether an increase in dose is necessary is made by the prescriber, but is informed by the observations of the patient that nurses provide.

(k) Lead up to discharge

72. Improvements continued to be seen in VC throughout the next part of admission, so discharge planning was commenced, in consolidation with VC's mother. Improvements seen included VC appearing brighter in his mood and less guarded, being able to hold a flowing conversation and not taking long pauses, no signs of him responding to unseen stimuli or voices, and VC accepting medication on a daily basis.

73. In terms of discharge planning, I completed the Early Intervention in Psychosis (EIP) referral and sent this off to the relevant team. This is done by sending an email to the relevant team in the area where the patient's GP is and outlining a summary of what led to admission, an explanation of the issues related to current presentation or behaviour, and an explanation of assessment of the patient's needs and any risks (current or historical). This referral was initially declined due to no GP being recorded for VC in Nottingham, however this was rectified and documented correctly. When this issue was rectified VC was accepted by the EIP team. I have exhibited the EIP referral documents to this statement as WITN0196002 and WITN0196003.

74. Follow up arrangements were also arranged with City Crisis Team, the aim of which was to encourage VC to continue opening up to mental health services and to show him what services were available if his mental health were to relapse again.

75. The EIP Team were also going to visit VC in the community due to the referral being accepted; this was the only time I discussed VC's discharge plans with clinicians in community services. VC was given 14 days of medication to take home which he agreed to take post discharge.

76. Consideration had also been given about whether VC was staying in the Nottingham area or if he was going to Birmingham and how to make arrangements for this. VC was given the Crisis team's phone number if he needed to contact them.

77. VC's diagnosis on discharge from Rowan 1 was First Episode of Psychosis. Following patient's discharge from the ward, it would not be a normal process to have involvement with the community teams unless this was necessary to clarify information or aspects of care. This is because the community team take over the patient's care at the point of discharge.

II. VC's Second Admission (under ss.136 and then s.3 MHA 1983) – Cassidy Suite and Rowan 1, Highbury Hospital, NHFT ("Second Admission")

78. VC was readmitted to Rowan 1 on 13 July 2020, due to concerns around his mental health after he had forced his way into someone's flat. VC reported he had done this due to feeling worried someone was in danger. VC had stopped taking his medications, and he said he felt like the medications slowed him down and he was not able to study due to low motivation. This would have been during his resubmission time for his exams and coursework at university, so at this time VC would have been feeling pressure to perform academically.

79. This information would have formed the handover we received as a ward for VC's Second Admission, and we would have received this information from Bed Management and the 136 Cassidy Suite. The handover would have been done both over the telephone and in person, as the 136 Cassidy Suite was also on the Highbury Hospital site.

80. Rowan 1 would have taken an overview of VC's previous admission, however due to the time span I cannot specify which parts of records would have been reviewed or the ones I specifically looked at. I therefore cannot recall whether I specifically looked at the records or information recorded by those who cared for VC while he was under the care of the Crisis Home Treatment (CRHT) service and/or the Early Intervention in Psychosis Local Mental Health Team (EIP-LMHT) after his First Admission; Form A8 "Section 3 - medical recommendation for admission for treatment" and Form A6 "Section 3 – application by an approved mental health professional for admission for treatment" [NHFT0000037, pp.3-9]; or the "AMHP Report Referral and Assessment" [NHFT0000028].

81. However, normally, the focus would be on the MHA Assessment progress notes and documentation; the community team's progress notes, risk assessment and care plan, which would often be completed by the patient's Local Mental Health Team (LMHT), would also be reviewed. This is a normal process even if patient had been recently discharged from the ward. If I needed more information, then I would look at documents such as the AMHP report. Once somebody is allocated a bed on the ward though, they arrive very quickly, so we do not get that much time to plan and to read the background documentation; it is not possible to read every single note.

82. At this stage I cannot recall gaining further information from the police, nearest relative or third parties, as the ward felt they had enough information at this stage. If the Police had needed to contact Rowan 1, the Cassidy Suite would have been able to direct them to us.

83. In terms of risks associated with VC's condition at this stage, we were aware of VC being non-compliant with medications, hearing voices which he felt meant his family were in danger, gaining entry to properties that weren't his and property damage.

84. VC was initially detained under section 136 MHA because he was found in a public place showing signs of mental illness. Whilst on the 136 Cassidy suite, VC had a MHA Assessment and was detained under section 3 of the Mental Health Act. Section 3 MHA is considered a 'treatment' section, in contrast to

section 2, which is considered an 'assessment' section. VC was detained under section 3 rather than section 2 because he was showing similar signs and symptoms and risk presentation to his previous admission, and therefore the assessment completed on the previous admission did not need to be completed again.

85. VC reported hearing voices, the voices making a running commentary of his actions, and thoughts which made him feel like he was not in control of himself. This was again in keeping with a Psychosis diagnosis, however due to the length of time that VC had been experiencing these signs and symptoms, the working diagnosis was given as Schizophrenia.

(a) 16 July 2020

86. During ward round on 16 July 2020, a frank conversation was held with VC about his risk to others and how his behaviour in the community might be interpreted. I was not present for this conversation.

87. As a ward, we found that being very direct with VC was a supportive way of communicating with him due to how guarded he was in his presentation. VC agreed that his behaviour was not okay and that the public may be fearful of him and his presentation, however he reported that the use of "willpower" would allow these symptoms to go away.

88. Aripiprazole was restarted on 16 July 2020. Aripiprazole is an antipsychotic medication which was utilised in VC's First Admission, and which had been shown to have a positive impact on VC's mental health. This time, VC was advised to stay on this medication for a minimum of two years, in line with the National Institute for Clinical Excellence guidance for treatment of psychosis. I have exhibited this guidance to this statement as NHSE0000539.

89. The question of whether depot medication (which I discuss in detail at paragraph 91 below) could be administered to VC was discussed with his Responsible Clinician during the 72-hour review [NHFT0000168, pg65]. I was not present at that discussion; my name features on the record because I approved an entry by an Aspirant Nurse, which I discuss below.

90. At this point, I was the acting manager of the ward, and it would not be normal process to attend ward rounds for every single patient. I would attend ward rounds if there was a specific issue that I needed to feedback, if I needed more information, or if more senior support was needed to manage a certain risk or a certain aspect of a patient's care. Equally, I would cover the ward round if we were not able to staff it in the normal way with a ward round nurse.

91. Depot medication (also known as long-acting antipsychotic injectable) is a longacting medication, which stays in the body for a long period of time and is slowly released from the muscle. Depots are normally injected into the deltoid muscle (upper arm) or the gluteal muscle. Aripiprazole depot is normally given

on a calendar month basis and can be administered into the deltoid or gluteal muscles.

92. Whenever medication is started it is good practice as healthcare professionals to educate the patient about the medication verbally and give them a medication leaflet so the patient can read more information. This allows patients to make informed choices about medications. This is a normal process and part of best practice guidance. At NHFT clinicians have access to a service called "Choice and Medication", which provides leaflets about medications in different formats such as information for adults, easy read formats, different languages etc.

93. To give some background as to the conversations that are had with patients about medication, patients should always be offered all the information about how medication can be administered. We are collaborative in the way that we work with patients, because if we make decisions about how they are to be treated on their behalf, the patient will not feel empowered to engage in that process. Of course, there might be occasions where we must enforce medication due to persistent issues with compliance, but there is no hard and fast rule about when that point is reached.

94. On the 16 July 2020, VC was given a leaflet about Aripiprazole depot medications in his bedspace on Rowan 1 by an Aspirant Nurse. Aspirant Nurses were final year nursing students who could not complete their university placements in the usual way due to the pandemic, but who would be employed

by NHFT (and other trusts across the country) and were able to complete their university placements this way instead.

95. The Aspirant Nurse offered to speak through this leaflet with VC but reported he would read the leaflet and get back to us if he had any questions. Due to this being completed by a student nurse under my supervision, once this task was complete, I asked her to document a note on progress notes. Due to her being a learner and requiring supervision, I validated her note on the RiO notes system. VC reported he was happy to take oral medication, and he would have fed this back during his ward round with the wider MDT who would have assessed his capacity around this decision.

96. Due to VC agreeing to take oral medication at this time, it was not felt necessary to enforce medication via injection which would be considered a very restrictive method of administrating medications and not a collaborative way of working together with the patient. The team deemed him to have capacity for this decision and VC appeared to have more insight into his mental health condition at this stage of his care.

(b) Board Reviews

97. On Rowan 1 we held weekday board reviews. Board reviews are a brief clinical handover encompassing: the last 24 hours of care; treatment and development of each of the ward's current inpatients; a review of any urgent untoward incidents or emerging risks involving the ward patients; each patient's carers/

families, staff, and/or ward environment; review of medication factors that are not considered to be suitable to wait until the patients next scheduled review; review of patient observation levels; review of patients community leave and recovery planning; and highlighting any physical healthcare needs for discussion or referral including any care planned investigations, interventions or monitoring required.

98. My Rule 9(2) request lists the following board reviews that I was a part of:

15 July 2020 at 9:30am [NHFT0000168, pg.60];

17 July 2020 at 11:44am [NHFT0000168, pp.67-68];

21 July 2020 at 09:22am [NHFT0000168, pp.76-77];

22 July 2020 at 09:35am [NHFT0000168, pp. 84-85];

23 July 2020 at 09:22am [NHFT0000168, pp.87-88];

28 July 2020 at 10:12am [NHFT0000168, pp.102-103];

29 July 2020 at 09:41am [NHFT0000168, pg.110];

30 July 2020 at 1:00pm [NHFT0000168, pp.113-114]; and

31 July 2020 at 10:00am [NHFT0000168, pp.116-117].

99. My role in each of these reviews was the same. As the acting ward manager of Rowan 1, I ultimately had oversight of the care of all patients on the ward and therefore needed to have awareness of what stage of admission patients were at during their admission to hospital. Following the board review, I would highlight actions that needed to be completed by the MDT, and support the nurse in charge to chair this meeting on a weekday basis.

100. It would not be normal process to review people in advance of board review. The MDT would attend this meeting every morning which was held on Rowan 1.

101. At the board review meeting, the team would share their observations of VC's mental state, including signs and symptoms, whether he was accepting his treatment, any risks identified whilst on the ward, barriers to discharge from the ward and overall view of his progress on the ward.

102. The board reviews would be quick meetings to discuss all patients on the ward; it was not the appropriate place to discuss patterns of behaviour, unless it was a day-to-day pattern that was being observed on the ward. In terms of a pattern of VC gaining access to other people's properties, that would not have been an appropriate topic to discuss at the board review; it would have been more appropriate to discuss this at the ward round. The ward round happened on a weekly basis and were the opportunity for longer conversations to be had about patients.

(c) 27 July 2020, 1:14pm

103. The Patient Summary Record includes an entry which records an MDT discussion dated 27 July 2020 at 01:14pm, which states under the heading "Team Discussion":

No change in presentation. No overt signs of psychosis. Polite and pleasant, spends most of his time reading in his room. He has accommodation to go to. CCO is on leave this week, but the CCO has said we are able to contact Sabrina Edwards or Abi to do his follow-up as not to delay discharge. Valdo said he stopped his medication prior to admission because he felt as though they were slowing down his thinking. Valdo appears to be very remorseful. Has been very polite but seems to want to focus on his studies. Has said that he will take his medication on discharge." (original emphasis)

[NHFT0000168, pp.98-99]

104. Beyond what is recorded in the above, I cannot remember any further discussion that was had about VC's accommodation, where it was, or who he would be living with. I do know that VC was returning back to a rental property that he had previously left, and that this had been suggested by VC's Mum.

105. I do not recall whether I provided any other feedback or observations that I provided in this meeting in respect of VC's presentation and condition. However, more generally, on the ward VC was doing well. He was pleasant, polite and engaging with us better. He was also attending for his medication every day.

(d) 28 July 2020, Board Review

106. The Patient Record Summary shows that a Board Review took place on 28 July 2020, and that under the heading "Plan and jobs to be completed", there is the information "Nursing staff to continue to monitor mental health and risk" [NHFT0000168, pp.102-103].

107. VC's mental health and risk was monitored by the nursing staff through observations, and by communicating with him. For example, VC's manner of conversation was noted to have improved since his First Admission, and he was able to ask me questions about myself, rather than just giving one-word answers to questions he was asked. Other examples of what we would observe included a patient's presentation, their mannerisms, and whether they were able to do everyday tasks such as feeding themselves and doing their laundry.

108. I did not consider that there were any specific risks that needed to be monitored at this stage, however risk assessment is a skill which is complete each and every moment of the day on a mental health ward. VC was engaging and was doing the things that we required of him at the time. We believed that he was safe to be on the next step of his journey and was showing signs of independence and moving towards mental health recovery.

(e) Discharge planning

109. During his Second Admission, VC had visits with family, spent time studying for university, and praying using the Bible or the Qur'an. VC continued to report he wanted a good career and completed a heavy studying schedule.

VC's sleep appeared to improve however there were some issues intermittently. VC studied during this admission using his textbooks and computer but was

also exploring other interests as a way of occupying his time, such as learning to draw, which he would do alone at his desk, in his bedroom.

110. Often during this admission, VC would make statements about "being able to manage symptoms" but wouldn't go into details of how he would do this or what he would do to prevent this becoming an issue again in the future. VC was able to say that the admissions to hospital had given him time to unwind and recognised it was not safe for him to be at home.

111. VC continued to show signs of improvement: he was not observed to be hearing voices nor was he responding to voices verbally, conversation was able to flow easily, and he appeared less guarded on the ward. In comparison to the First Admission, VC was able to open up to the team and engage in 1:1 conversations with various members of the team, including occupational therapists, psychologists, nurses and medics.

112. During this admission we did not observe any risk behaviours from VC on the ward. VC did not believe there were screams coming from areas of the ward, he did not attempt to gain entry to other patient's bedrooms, and he accepted medications and spoke about continuing these in the future.

113. VC appeared to have capacity for his care and treatment decisions because he was able to understand and retain information, weigh up decisions, retain information, and communicate decisions. His insight

seemed to improve when talking about continuing to take medication in the future, as he spoke about accepting that he needed this but also spoke about not wanting to return to hospital. Therefore, discharge planning was commenced with the agreement of VC's family.

114. In relation to VC's social isolation (which I referred to in the interview with Theemis [TCLT0000753]), during VC's first admission to hospital he had reported that whilst residing in the UK he felt he "didn't fit in", and this was quite different from his life in Portugal where he had more friends. VC reported that he had accepted this here in the UK and that he did not feel isolated. He moved away from his home with his family in Wales, for his university qualification to here in Nottingham and denied that COVID had impacted him in terms of feeling lonely - which was common feedback at the time for patients (and for members of the public generally during the COVID pandemic and lockdowns). In terms of planning for discharge on his second admission to hospital and whether consideration had been given to interventions to improve feelings of social isolation, I believe consideration had been given to this. VC had been offered support from occupational therapy during the admission regarding exploring interests, we had discussed him going back home to Wales to reside with his family to complete his studies; this was something VC didn't wish to explore further and it was deemed he had capacity for this decision, he was referred to the Crisis Team for further support, and also EIP teams for ongoing long term support too. Both teams would be able to provide support around isolation and signpost people to ongoing support in this area.

115. Follow up arrangements were completed, and VC returned to his rental property. This had been discussed with VC, VC's Mum (who had reminded VC that this was an option for him) and the wider team. Upon discharge, VC was given 14 days' worth of tablets to take home, which he agreed to continue taking

as he did not want to return back to hospital, and he highlighted they had helped him manage his symptoms.

116. In terms of whether VC was being honest about his willingness to take his medication on discharge, I do not think this is a question of honesty; I think it is a question about the mental state of our patients, and whether they want to accept the medication, or whether, for example, there is a voice in their head telling them not to or whether they experienced negative side effects.

117. As a clinician we have to treat patients as individuals, and work with them collaboratively to continue our therapeutic relationships, particularly in regard to medications. During VC's admission, he attended daily for his medications (rather than the nursing team having to take these to him), and spoke about wanting to continue to take his medication in the future. I think VC believed he was going to take his medication, and I believe that this is what he thought his actions were going to be.

118. In terms of mental illness, patients can be non-concordant with

medication, however this is not directly due to dishonest behaviour. Rather, this can be for a wide variety of personal reasons for patients, some examples include- negative side effects of medications, delusional beliefs about medications or patient's lifestyle- this is multifactorial and several factors could play a part in patient's being non-concordant. Being described as dishonest behaviour gives a negative, stigmatising view of mental illness.

119. Follow up arrangements had been made with the Crisis Team who would do a three-day follow up appointment, and the EIP team would continue to see

VC on a regular basis to support him. On discharge, VC was diagnosed with Paranoid Schizophrenia which VC was made aware of. Again, we would not communicate with VC's community team after discharge unless this was required, for example, to share or clarify information.

120. During this admission I did not formally complete VC's risk assessment, however as I said previously, I would have been part of the team to respond on a daily basis to manage all patient's risk.

(f) 16 August 2021, 01:01pm

121. The Patient Summary Record includes an entry dated 16 August 2021 at 01:01pm which states:

> *"Valdo attended the Rowan 1 entrance today and requested to speak to the management team about his care.*

WM A.Smillie went to speak to Valdo with CTL J.Hathaway present. Valdo reported he could remember WM A.Smillie. He spoke about whether he could speak to Dr Seedat- reported that I could maybe help in the first instance. Valdo reported that Dr Seedat had said that he Valdo was hearing voices during his admission and wondered whether this was correct or if there was an alternative explanation. I asked Valdo whether he thought he was and he then went onto ask whether staff hear voices on the ward, and whether they communicate with Artificial Intelligence. He continued to ask whether Dr Seedat could confirm this. Reported that I was not of the opinion this happened on the ward and Dr Seedat would not be able to help with this matter. Valdo appeared to accept this. Valdo went on to say that the police had information about services.
J.Hathaway contacted LMHT CIty South and spoke to Abbey who is covering for Valdo's CPN."

[NHFT0000168, p.160]

122. I confirm that this is a complete and accurate record of the conversation that I had with VC on this day.

123. During this conversation, VC was very polite, did not show signs of distress, and was able to hold a conversation with us. VC was showing signs of listening to answers and being able to ask questions; there were no long pauses like he was hearing voices or responding to unseen stimuli, he was not showing signs of violence or aggression, and nor did I feel threatened by his presentation. VC appeared well kept in terms of his appearance.

124. However, I had concerns around VC's mental health due to the content of the conversation, and this being very different to my memory of how VC was when we discharged him the previous year. In terms of the type of interaction that I had with VC, this can be a usual occurrence for people who are experiencing symptoms of schizophrenia in terms of

hallucinations and delusions. It was my belief at the time that he was showing signs of chronic symptoms of schizophrenia which members of the public live with in the community on a daily basis.

125. This interaction did not show risk behaviours; if it had I would have considered whether VC was presenting with acute symptoms, but this was not the case. It is not particularly unusual for patients to return to adult mental health wards (or mental health wards more generally) to ask questions about their care. I considered my actions of requesting my colleague to contact the LMHT to be appropriate at this time due to this.

126. I requested that my colleague (J. Hathaway) contact the LMHT City South (the team VC was under at the time) to inform them of our interaction with VC. I feel this was appropriate action at this time as we did not observe any clear signs of risk from VC at this time and he engaged well during the conversation; moreover, this action would have been considered good communication with community teams. At this time, VC was not an inpatient, so I could not invite him on to the ward, nor could I hold him to the ward. In any event, it would not have been appropriate or proportionate for VC to have been on the ward due to his presentation at the time of the conversation.

127. If VC had shown any threat to me whatsoever, my only option would have been to contact the police. If I had any immediate concerns about VC's mental health, I could have contacted the crisis team or contacted 999

for him to be taken to A&E. But as I felt neither threatened nor immediately concerned for VC's mental health, I had no other options available to me in this situation.

128. VC had previously had contact with his community team and Crisis Team, both of which are a lesser restrictive intervention. VC care coordinator (community psychiatric nurse) contacted him following this contact. The carecoordinator was aware of the situation and therefore able to take next steps to support VC and his mental wellbeing. I do not feel any other actions or steps could have been taken to alert the community mental health team of the risks associated with a failure to monitor VC's concordance at this stage.

129. The question of what steps could have been taken to avoid VC requiring police involvement and being tasered on the 31 August 2021 is very difficult to answer. We know mental health is influenced by many factors, including life factors, stressors, brain chemistry and physical health to name a few. It is also unclear whether this violence that VC showed towards police was as a result of his mental illness, or whether this was due to him feeling afraid or threatened at the prospect of returning to hospital. Medication (Aripiprazole) had been helpful in the past, however it was unclear at this time whether he was compliant with medications and whether this medication was still working for VC. We know patients with Schizophrenia can relapse and experience chronic signs and symptoms of this illness, and that recovery is not a linear process. I

therefore feel I cannot say what steps could have been taken to avoid VC's interaction with the police on 31 August 2021.

130. The Inquiry has also raised that in my Theemis interview [TCLT0000753], VC's diagnosis during his First Admission was considered to be First Episode Psychosis, and I then said that by his Second Admission, "the picture changed to schizophrenia". VC's medical records from his Third Admission, and the periods he was under the care of the community mental health teams, and his Fourth Admission, continue to record his diagnosis as "psychosis" (e.g. the Summary and Care plan [NHFT0000199], and Core Assessment [NHFT0000186]). In my view and to the best of my knowledge, it would have made no difference in terms of VC's care and treatment whether teams were working with a diagnosis of schizophrenia or First Episode Psychosis. Both these diagnoses are under the same umbrella term of psychosis and therefore treatment options and community pathways (EIP team) would have been exactly the same offering to VC. What differs in these diagnoses is the understanding of signs and symptoms of mental illness and the experiences of these by the patient. In terms of the role of a mental health nurse in diagnosis, we assess and observe signs and symptoms of mental illness, document within RiO progress notes, feedback to the multi-disciplinary team, provide treatment- whether this be administering medications or having 1:1 sessions with patients. The Responsible Clinician is ultimately responsible for diagnosing patients utilising diagnostic criteria.

Reflections

131. In conclusion, the Nottingham attacks were an awful, truly devastating event where three people lost their lives, and three people were injured due to the actions of a person who I previously nursed in hospital. I feel great sympathy for the victim's families but also extend these feelings to VC's family. Whilst VC was on Rowan 1, we had frequent contact with VC's Mum, but we were also aware of his wider family. The media portrayal, the photograph of VC used by the media, the numerous news articles and documentaries, and the opinion held of VC and NHFT have been challenging to be aware of as a staff member being involved in his care, and I can only imagine the impact that this has had on the families involved.

132. In terms of my reflection on VC, he appeared to be a troubled young man experiencing signs and symptoms of psychosis. He had high aspirations to hold down his studies and wanted to work hard for his qualification so much so that this became his whole world in Summer 2020. This does not excuse what happened in June 2023 and I am very aware that people in our care (and members of the public also) have the potential to do appalling things.

133. As a consequence of these events and my involvement in VC's care, I now encourage all staff to be professionally curious by asking questions in regard to risk, even if these are confirming questions or questions which allow patients to reflect on their actions and behaviours. I do this through education sessions I run as part of my role and encouraging this on the ward on a day-

today basis. I also remind staff of the duty of care we have to the patients, their families and also the general public.

134. On 16 June 2024, I was interviewed as part of the Theemis NHS England investigation in relation to VC's car. I confirm that TCLT0000753 is an accurate record of my interaction with Theemis.

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Recommendations

135. In terms of the recommendations that I would like the Chair of the Inquiry to make to ensure that lessons are learned and similar attacks do not happen again in the future, I would firstly ask that the approaches taken to risk to others are standardised by setting out guidance of what is expected at a national NHS level. In my view, this would include guidance to mental health trusts and standardised approaches to mental health nurse education around risk to others.

136. The second recommendation that I would like the Chair of the Inquiry to make is that there should be more guidance or protocols on what community teams should do when patients decline to engage with services despite numerous attempts to encourage this engagement.

Statement of Truth

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

Signed: GRO-B

Dated: 12.11.2025

Index to First Witness Statement of Amanda Frost

No.	URN	Document Description
1.	NHFT0000168	Patient Record Summary of VC
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3.	NHFT0000251	Physical Healthcare assessment Tool
4.	NHFT0000254	Smoke Free Form
5.	NHFT0000178	Compulsory Client Information Form
6.	NHFT0000004	Form A4
7.	NHFT0000008	AMHP Report Referral and Assessment
8.	NHFT0000037	Form A8; Form A6; Form H3
9.	NHFT0000028	AMHP Report Referral and Assessment
10.	TCLT0000753	Transcript of Theemis Interview
11.	NGPF0000095	Bridewell Custody Suite Record
12.	WITN0196002	EIP referral form
13.	WITN0196003	Email attaching EIP referral form
14.	NHSE0000539	NICE guidelines
15	NHFT0000199	Medical Records of VC from 02/02/2022, NHFT, re: Summary and Care Plan
16	NHFT0000186	Medical Records of VC dated 29/01/2022, Re: Core Assessment (CPA and non-CPA)