Witness name: Dominic Lloyd

Statement No: WITN0197001

Dated: 12.11.2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DOMINIC LLOYD

I, Dominic Lloyd, will say as follows: -

INTRODUCTION

1. This witness statement is made to assist the Nottingham Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 23 September 2025 (the "Request").

2. 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 name is Dominic Lloyd and I qualified as a registered mental health nurse in 2003 with a BSc from the University of Middlesex. I am registered with the Nursing and Midwifery Council and affiliated with the Royal College of Nursing. I first worked in North London Forensic Services as a D Grade staff nurse on a rehabilitation ward for offenders. In 2005, I moved to work at Rampton Hospital as a band 5 staff nurse in the Personality Disorder Care Stream.

4. In 2015 I moved to the Liaison and Diversion Team, initially as a band 6 and in 2023 I became the team manager. When I joined the team, the service was in the early stages of development with the current model. The Liaison and Diversion Team address all vulnerabilities identified by the police. This is based on the individuals risk assessment and can include mental health, drug and alcohol, homelessness or financial difficulties for example. The team aim to address these vulnerabilities to ultimately improve their health outcomes. Interventions include assessment, referrals to other community services or liaison with services and the criminal justice system to ensure that vulnerabilities are known and supported throughout whichever pathway the individual is diverted to.

TRAINING

5. In a generic sense, the identification and mitigation of risk are key aspects of both the training and on the job experience of a mental health nurse. I do not

recall any specific training received that is directly relevant to the matters under investigation. However, I did complete my dissertation on the management of violence and aggression in mental health settings. Throughout my nursing training, I have been mentored and supervised in the assessment of patients and risks.

6. I have undertaken the Trust e-learning and face-to-face training courses on the management of risk, namely HCR 20, clinical risk assessment and Management. Mental Health Act training and Mental Capacity Act training, suicide awareness training.

ACCESS TO INFORMATION AND INFORMATION-SHARING

7. In the Liaison and Diversion Team, we all receive a handover from the police before we see individuals and likewise, we hand over the details to the police of our assessments. The police formally refer individuals, and we would then first discuss the individual with the police sergeant and the officer in charge of the case, as they are in custody this will support the intervention. A handover back to the police about actions being taken is then undertaken verbally and we document on their system which is NICHE and the healthcare system RIO. NICHE is a police record system used by all East Midlands Police forces.

8. Between the team, we hold a caseload where we have not been able to fully meet their needs in custody. There is opportunity for further support in the community where we offer an assertive follow up service whilst in the criminal justice system. These cases are discussed weekly in the MDT forum and

supervision sessions. VC was not on a caseload in the team as we arranged an MHAA in custody and his care was transferred over to the MH Team.

9. The team have full access to RIO Local services, which includes all secondary mental health services in the Trust, including community and low secure forensic services. The team does not have access to System 1 or Forensic RIO. The team has access to NICHE, which is the police record keeping system. The team writes in both NICHE and RIO and use both to support team intervention.

10. The team has access to and uses NICHE and RIO to inform the interventions required and undertaken. This enables robust information sharing relating to risk. There is an information sharing agreement. The team would share relevant information with the police as well from RIO, specifically relating to mental state and risk.

11. After receiving a referral from the police, the team checks RIO to understand if the individual is known to services and reviews the police risk assessment on NICHE. If the individual is from out-of-area, contact is made with the relevant Crisis Team to gain information.

RISK

12. I report concerns about risk to the police as we are co-hosted in the police station. I also report unresolved concerns to my line manager or out-of-hours to the on-call manager. I am confident to speak up and raise concerns if required. The calling of an MHAA is also an escalation of risk as I am reporting

my concerns regarding someone's presentation to another clinician for further assessment. This is something I have done on many occasions within my role with Liaison and Diversion.

13. I can confirm that I have been involved in the care of a mental health patient who, following discharge or when in the community, killed or seriously injured a member of the public. This was on 5 August 2022.

Involvement with and knowledge of VC

14. I had no knowledge of VC prior to 24 May 2020.

15. On 24 May 2020, I completed an "Adult triage assessment" of VC whilst VC was in custody (NGPF0003440). The Laision and Diversion Service would have received a referral from the police and I attended to assess VC in custody. The assessment was undertaken with VC to understand his needs and I identified that he appeared to be psychotic and in need of an MHA assessment.

16. The Adult Triage Assessment serves two purposes: It collects demographic data that NHS England requires for service development and it allows for a very basic assessment to determine if there are unmet needs of an individual that either require referral on to other services or further assessment from our service to determine what those needs are and how they can be met. The form is uploaded onto RIO and the data is shared with NHS England as the commissioner of the service. I would have received an email referral to the police registered L and D email address. This is copied into the RIO record and I would have also looked at the NICHE system and RIO Local. I am not aware that I did not have

access to any key information. VC was new to MH services and therefore I started the RIO record.

17. I do not recall feeling uncomfortable in VCs presence.

18. I recorded the following:

i. That VC's suspected mental health needs were "*unclear*" (p.3). I would have written this as VC did not engage fully with the assessment which left me unclear of the extent of his symptoms. The symptoms displayed were negative in nature, so a robust assessment can be quite difficult. By "negative", I am describing the absence of normal emotional and motivational behaviours. This would have manifested in an appearance of emotionlessness, with little speech and affective flattening.

ii. That I was "*unable to properly assess*" the risks to self and others (p.5). The assessment from the L and D team is at a set period in time and we do not have the ability to undertake a longitudinal mental health assessment. A practitioner assesses and deals with the information that is obtained. As I felt that there was more to VC's presentation than I was able to determine due to the symptoms being mainly negative ones, I wanted to escalate him for further assessment. In this instance, for VC, it meant a referral to mental health services.

iii. That VC appeared to be suffering a "*psychotic episode*" (p.6). From my entry in RIO, I was under the impression that VC was responding to stimuli by his delayed responses to questions

asked and the short answers he gave, indicating a reluctance to engage with me. He also appeared distracted. This is a presentation I have seen before and would indicate that there was an underlying psychosis that needed further assessment.

19. I can confirm that I made the following note in the RiO medical records pertaining to VC (NHFT0000168, p.1) on 24 May 2020 at around 09:54:

> "*Liaison and Diversion Service: Valdo is currently detained at Bridewell Custody Suite having been arrested for alleged Criminal Damage in the following circumstances:*
>
> *POLICE CALLED TO A BURLGARY IN PROGRESS. DP LOCATED AT A BLOCK OF FLATS. DP RESIDES IN ONE OF THE FLATS HOWEVER IT IS ALLEGED THAT HE HAS KICKED THE DOOR IN TO ANOTHER FLAT CAUSING DAMAGE.*
>
> *Whilst he was here, he was referred to our service by the Police for the following reasons:# "DP has come in to custody this evening, presenting some MH issues. Hearing voices. And appears vacant and lost a times. States he has not slept for 5 days. No previous Police or MH history. "*
>
> *Prior to this referral he was seen by Custody Healthcare and following this was sent to ED in order to rule out organic causes to his presentation, I understand that he had bloods taken there which came back clear of substances.*

Attended cell, explained role and remit of service,Valdo agreed to assessment.

Remained under blanket throughout, appears reasonably well kempt. Valdovery delayed in his responses, sometimes forgetting what had been asked of him, appears distracted, eyes dancing around- appears to be responding to internal stimuli, when eventually he did respond gave rational response. Asked directly about voices, more obvious responding and eventually said no but I was under the impression he wanted to tell me otherwise.

Have contacted EDT to request full MHA Assessment

Have also contacted Crisis for Gatekeeping- am currently awaiting call back."

20. I know nothing further about VC other than what is recorded in the aforementioned note and have no new information to add. I can make the following further observations:

i) I would have accessed NICHE and spoken to the custody sergeant before seeing VC.

ii) I am unable to recall what I would have said to VC but my practice would have been to undertake as much of a mental state examination as possible. I note however that this was difficult as he appeared distracted and suspicious of me and those around me.

iii) I attended the cell to see VC. Usually, they would be taken to an interview room. However, due to COVID restrictions, VC was seen in the cell. There would have been a custody officer as they hold the keys to the cells. This is not something the team would do on their own

iv) I am not able to say more about VC's presentation, behaviour and demeanour. VC did not move from under the blanket. He was suspicious and appeared distracted My role therefore was to refer him for a further assessment.

v) I would have tried to elicit information about his mental state from VC. I am not able to recall if I had asked the custody sergeant permission to speak about his alleged offence. This is something I routinely do when suspecting an individual is suffering acute mental illness. Discussing any alleged offending prior to the police interview can compromise any police investigation; but can also assist with assessing mental state. However, on this occasion, it is unlikely to have made any difference due to VC's non engagement.

vi) The assessment would have just been me with a custody sergeant. I am not able to recall who this custody sergeant was at this time. Although I cannot remember specifically in this case, it is my usual practice when discussing an individual's presentation with the custody sergeant, to determine if calling an MHAA is appropriate. This is because I am not always aware of the details of the alleged offending

(which is being investigated whilst individuals are detained) and it is important to determine if a generic section would be appropriate or if he should be charged and sent to court so that Part 3 of the Act can be considered. However, the decision as to whether to call for an MHAA or not lies with the custody sergeant.

vii) I wrote that VC "*appears to be responding to internal stimuli*" because of his delayed responses and the fact that his eyes were darting around. This is a routine presentation for a patient that is displaying negative psychotic symptoms and I drew on my knowledge and experience in making this observation.

viii) I acknowledge that I referred to VC's "*rational response*" but I cannot recall the specific detail and would imagine that this relates to the response not being delusional in nature and therefore appearing to be a realistic answer.

ix) The presence of auditory hallucinations in the mental health assessment is an indicator that a patient might be responding to voices. I would have asked if he was hearing any other voice other than mine and although he said no, there would have been a non-verbal cue that made me think otherwise. I am not able to recall this detail

x) It was hard to elicit symptoms in the assessment due to the symptoms displayed being negative ones which are more

difficult to assess. I therefore made a referral for a further assessment to understand and explore this matter.

xi) I referred VC for an MHAA which would indicate that I was under the impression that he lacked capacity about his mental health.

21. On the discrete matter of my decision to refer VC for an MHAA, I make these further observations|:

i) I made this decision based on my assessment of VC at the time and also the knowledge of his behavior in the community

ii) I am not able to recall the process in place at that time. However, the records indicate that I contacted the Emergency Duty Team (EDT) which is the local authority access to AMHPS and the Crisis Team who gate keep acute admission beds. I note from my records that the crisis team practitioner attended to support the assessment and that he was not detained at that point as he agreed to community treatment.

iii) I was the first contact VC had with MH services and therefore I could only share the information from my assessment and the incident in the community at that point in time.

22. It is recorded on p.13 of the Nottingham Adult Social Care Teams "case notes" (NOCC0000034) that I "*handed over*" the assessment to Benjamin Williams, who was an Approved Mental Health Practitioner. When I request a MHAA, I handed over the clinical information available to me to the Local Authority AMHP. They are the lead professional in relation to undertaking MHA assessments. I can confirm that I handed over the risk information in the community and that I did not believe VC had the capacity to understand care and treatment in the community. The record shows that the AMHP convened the assessment with two doctors who undertook a full mental health assessment.

23. I can see from the records that the MHAA appears to have subsequently been carried out by Benjamin Williams, Dr Rahul Gandhi and Dr Khuram Malik, together with Nurse Annette Palmer. Benjamin Williams completed an "AMHP Report Referral and Assessment" (NOCC0000044) ("the AMHP report"), in which it is recorded that I made the original referral at around 09:15 and that the MHAA took place at around 14:00. I was VC's first contact and therefore I had limited information at that time. However, I would have shared details of his presentation during my assessment as well as details of his alleged offending. I was not present for the MHAA and had no further input.

24. It is recorded that I spoke with Samantha Woodings at around 16:24 the following day (25 May 2020) to discuss VC's detention under section 2 of the Mental Health Act 1983 (NHFT0000168, p.4). I would not have spoken to VC this day. I believe I was working a late shift and it was handed over to me from the early shift to contact the Bed Management team with the outcome of the MHAA. I would have had discussions with staff on the early shift and would

have had a handover of all individuals currently in custody having been referred to our service. I simply shared the outcome of the MHAA and that the police were willing for him to remain in custody until a bed was available for him.

25. Following June 2023 incident, I completed a Criminal Justice Agency Form [NHFT0002476] based on his presentation over the past 3 years and shared this with police, courts and HMP Nottingham to ensure they are able to deliver suitable care when leaving police custody. I did not see him on that occasion.

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 Dominic Lloyd

No.	Inquiry URN	Document Description
1	NGPF0003440	Medical Records of VC, dated 24/05/2025, Nottinghamshire Healthcare re Adult Triage Assessment
2	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023. Various NHFT staff/Teams, re Patient Record Summary
3	NOCC0000034	Report undated, compiled by Nottingham City Council Re~: Nottingham Adult Social Care Teams.
4	NOCC0000044	Report dated 24/05/2020, compiled by Dominic Lloyd, RE: AMHP Report Referral and Assessment of Valdo Calocane
5	NHFT0002476	Criminal Justice Agency form, completed 15/06/2023