THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF
CAMPBELL MTETWA

I, Campbell Mtetwa, will say as follows:

1. I have been working at the Nottinghamshire Healthcare NHS Foundation Trust (the "**Trust**") since 2018, initially as a Staff Nurse and currently as a Clinical Team Leader. I provide this statement to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 25 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.

3. The statement is structured according to the topics I have been asked to address in the Request: (A) Career and role; (B) Training and system of work; (C) Interactions with VC; and (D) Reflections and recommendations.

A. Career and role

4. I am a registered mental health nurse having qualified with a Higher Diploma in Mental Health Nursing from London Southbank University in 2005 and Return to

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Practice Mental Health Nursing from University of Derby in 2018. I am registered with the Nursing and Midwifery Council and the Royal College of Nursing.

5. I have been employed on Rowan 1 ward in Highbury Hospital (the "**Hospital**") from 08 August 2018, initially as a Band 5 nurse and then as a Clinical Team Leader from 21 December 2021 to present. My interactions with VC which are referenced in the Request took place whilst I was a Band 5 staff nurse on Rowan 1.

B. Training and system of work

6. I have been asked to set out the training I received in the assessment of risk for mental health patients of violence towards others, and the sharing of patient information in Rowan 1.

7. As part of my qualification in mental health nursing, I received training in the importance of and how to carry out risk assessment for mental health patients. I have been completing annual online clinical risk assessment training since joining the Trust in 2018.

8. Information in Rowan 1 is shared verbally and in written form via the RIO records. At the beginning of each shift, we would have a handover, in which we discuss the patients currently in the ward, including their medical history, reason for admission, current presentation, patient risks, and current physical and medical wellbeing. Information is also shared in Board Reviews and Multi Disciplinary Team ("MDT") patient reviews. I would receive and share information in these meetings and via the patient's RIO record (I did not have access to SystemOne).

9. During VC's First Admission to the Hospital (which I will address below) I was VC's keyworker in Rowan 1. Keyworkers are important because they act as the main point of contact for the service user and as a link between the care team and family and carers, providing support and information. Keyworkers help in providing consistency of care for the service user and reduce fragmentation in care delivery. They promote recovery by encouraging service users to be active

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participants in their care. They also carry out ongoing assessments of the service user's mental, physical, and social needs. Keyworkers work with the service user to develop a person-centred care or recovery plan. They monitor progress and risk factors (e.g., suicide and self-harm) and implement and review risk assessments and safety plans. The keyworkers also advocate for the service user's needs, preferences, and rights, and help them navigate systems like housing, benefits, employment, or legal support. When working as keyworkers, we would aim to develop a relationship with the patient and convey to the wider team any requests they might have.

10. The Inquiry asked me to explain the aim and purpose of a "Summary and Care Plan", the "Mental Health Clustering Tool", and "Risk Assessments".

i. A *Summary and Care Plan* is aimed at providing both a snapshot of a patient's current health and a roadmap for their ongoing care, ensuring that everyone involved (professionals, patients, and carers) has the same understanding and direction regarding the person-centred goals and outcomes and how these will be best achieved. When a patient has had multiple admissions, patterns of relapse would be documented within the care plan, and the care plan would be regularly updated after each admission or significant event. MDT meetings provide an opportunity to review information relevant to formulating a patient's care plan and identify recurring themes, because these meetings involve psychiatrists, doctors, ward nurses, community psychiatric nurses, social workers, psychologists, occupational therapists, Crisis teams, and the patients and their carers. The MDT meetings ensure that insights from different stakeholders, professionals and settings (e.g., inpatient, community) are captured and highlighted.

The relationship between inpatient care planning and care planning undertaken by local community mental health teams ("**LMHTs**") is one of continuity and coordination of care across different stages of a service user's recovery journey to ensure consistent, person-centred support. LMHTs are invited to attend ward MDT reviews and offer insight and input on a patient's wellbeing and continue

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the support after discharge, focusing on rehabilitation, relapse prevention, and integration into daily life.

ii. The *Mental Health Clustering Tool* provides a measurement and monitoring of mental health and social care outcomes in mental health services over a period of time (for example, to monitor how the patient was doing a month ago and whether anything has changed since). This would then help in the allocation of resources, as determined by the patient's needs. Both inpatient mental health services and outpatient community teams could use this tool to assess the effectiveness of interventions and identify areas for improvement and changes that need to be made.

iii. *Risk Assessments* play a vital role because they help in identifying potential risks to the patient's safety, wellbeing, and recovery. They ensure that care is person-centred and that clinicians are proactively working towards preventing any escalation in the risks identified.

11. Any concerns that I may have about risks posed to others by patients, I would report to the nurse in charge and the nursing team on duty and record in the patient records. I would also feel comfortable raising these concerns in MDT discussions and ward Board Reviews.

12. As a nurse working in Rowan 1, I would also take part in discharge planning. Ordinarily, a registered consultant psychiatrist would suggest considering discharging a patient, based on the patient's progress and interactions with staff. A discharge meeting would then be held and attended by the consultant, nurses, family, and Crisis or local mental health care team. Everyone would give feedback about the patient's admission, whether the patient is clinically ready for discharge, and if so, how they would be best supported in the community.

13. I would take part in such discharge meetings either as a keyworker or as a staff nurse. As a keyworker, I would share my opinion on the patient's progress and engagement with care and treatment, based on my interactions with the patient, as well as the interactions of other nurses and healthcare assistants with the

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patient while on the ward. As a staff nurse, I would take part in discharge meetings and have a similar role to that of a keyworker, when the keyworker would not be available to attend.

14. To the best of my knowledge, I have never been involved in the care of any other mental health patient, other than VC, who, following discharge or when in the community, has killed or seriously injured a member of the public.

C. Interactions with VC

15. I have been asked to address my interactions with VC, as documented in his medical record, divided into (I) VC's First Admission, made under Section 2 Mental Health Act 1983 ("**MHA**"), at Rowan 1, between 25 May 2020 and 17 June 2020 ("**VC's First Admission**" or "**First Admission**"); and (II) VC's Second Admission, made under ss.136 and then Section 3 MHA, at Cassidy Suite and Rowan 1, between 13 July 2020 and 31 July 2020 ("**VC's Second Admission**" or "**Second Admission**").

I. VC's First Admission

16. During VC's First Admission, I was a nurse at Rowan 1 and VC's allocated keyworker (the key working team consisted of 2 nurses and 2 healthcare assistants).

17. Building a therapeutic relationship between a patient and his keyworker is essential to delivering compassionate, person-centred and effective care. The same was true for VC. A good therapeutic relationship helps the patient feel safe, respected, and valued. When trust is established, patients are more likely to openly share their feelings, symptoms, and concerns, which allows nurses to provide better support and accurate assessments. It is known that patients who feel understood and supported are more willing to engage in their treatment and care planning. This cooperation improves adherence to medication, therapies, and recovery goals.

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18. On 25 May 2020, when VC arrived at the Hospital, I reviewed his Form A4 "Medical recommendation for admission for assessment" and the "Report Referral and Assessment", as part of completing a Form H3 "Record of detention in hospital" (**NHFT0000004**). My understanding at the time was that VC was presenting with psychosis in the form of auditory hallucinations and thought disorder with delayed response. I was aware that during his MHA assessment, VC had been guarded and distracted and that he had no previous reported mental health issues or substance use issues.

19. My understanding at the time was that on 23 May 2020, VC was arrested after kicking a door to one of the flats in the building where he resided and causing damage. Whilst in custody, he was referred to the mental health liaison service for assessment as he appeared to be presenting with mental health issues, including hearing voices and appearing vacant after not sleeping for 5 days. Following assessment whilst in police custody, the team agreed that the least restrictive option should be offered instead of inpatient admission. VC was agreeable that he was unwell and needed help. He was consenting to home treatment and prescription of Olanzapine 2.5mg and Zopiclone 7.5mg. The plan was that the City Crisis team would visit VC at home and observe him taking medication and undertake further assessment of his psychopathology and risk and consider referral to EIP. VC was released from custody under investigation.

20. I was aware that VC had been arrested again on 24 May 2020 after breaking the door of a neighbour's flat and gaining entry. The female neighbour was in the shower and was reported to be fearful for her life and jumped from a first-floor window. Following another MHA assessment, VC was detained under Section 2 of the MHA, meaning he was being kept as an inpatient in hospital so he could be assessed and treated.

21. On 26 May 2020, I assessed VC's mental state as part of a Mental Health Clustering Tool completed in respect of VC (**NHFT0000184**). I assessed VC's mental state by engaging with him, introducing myself and the ward, offering him orientation to the ward, and offering to carry out physical observations, which VC

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declined to engage with. He presented as suspicious of what was being offered to him and preoccupied.

22. Prior to completing the Mental Health Clustering Tool, I reviewed the information recorded on VC's RIO records, the application made by the Approved Mental Health Professional for admission for assessment, and VC's Form A4 and Form A2 (the two forms which constitute sectioning under the MHA). I did not obtain any information directly from VC's nearest relative but made use of information recorded in the RIO records from the nearest relative. I concluded that his mental state was likely to be in line with a first episode of psychosis.

23. VC's Summary & Care Plan was completed on 26 May 2020 (**NHFT0000207**). VC was reluctant to engage fully with staff on admission and declined all offers given to him, only opting to go to his bed space. He presented as suspicious and preoccupied as if he was listening to unseen stimuli. Due to this, VC did not engage in the formulation of his admission care plan. I had to make use of recent RIO notes entries and MHA assessment paperwork to draw up an admission care plan, and my conclusion was that VC needed assessment and did not appear to have capacity to consent at that time. VC presented as someone experiencing a psychotic episode. VC had been prescribed Olanzapine 2.5mg nocte to help with the psychotic symptoms and Zopiclone 7.5mg to help with sleep. As VC had not given consent to share information relating to his mental health with anyone, I would not have been able to share such information with his next of kin.

24. The Request refers to the following entry in VC's RIO record from the same day, 26 May 2020 at 5:35PM, made by Nurse Aisha Yusuf (**NHFT0000168)**:

> "VC walked to the end to the corridor and started to kick a glass door. Staff asked him [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 are in passive hold. Vlado then ran from his room heading for the door, he as restrained and sat on a chair on passive holds. Valdo went to the main door and started budging it. He was retrained on the flow and escorted to his bed area once he as settled."

25. I was aware of that incident at the time. It was discussed in our daily shift-to-shift handovers, and I also read about it in VC's RIO record. The incident impacted my understanding of the risks associated with VC's condition. It allowed me to better understand his mental health situation that led to his admission. While I was already aware, from the Mental Health Clustering Tool performed earlier that day, that VC was reluctant to engage with us, this incident further evidenced that VC was not happy with his admission and wanted to leave.

26. The Request refers to the following entries I made in VC's medical records during his First Admission:

i. 29 May 2020 at 01:50AM (**NHFT0000168**, at p.13): Prior to this interaction, I had reviewed the RIO notes entries and MDT ward review notes. I was able to assess VC's mental state through the engagement and conversation I was having with him. My impression was that there was an improvement in VC's mental state as he was engaging with both staff and peers, able to occupy his time meaningfully by reading or playing chess and would approach staff to make his needs known without need for prompting. VC was also sleeping better, had good self-care by showering up to twice a day and dressing appropriately. He maintained appropriate eye contact when speaking to him. To the best of my recollection, the capacity I was referring to in the RIO entry was capacity to decide if he wanted to appeal his MHA section and if he wanted a solicitor or an IMHA advocate. At the time, VC was able to weigh and process the information given to him and would have had the capacity to consent to treatment and participate in the formulation of his treatment plan. I would not say that on that date he was ready for discharge, but that he was able to engage in the conversation about where and what he would like to do after discharge.

ii. 2 June 2020 at 7:26PM (**NHFT0000168**, at p.18): I cannot fully recall the whole conversation I had with VC during this one-on-one keyworker session, but I remember VC saying that he would not ignore people when spoken to or damage property. This may or may not have been an indicator of risk, as VC may not have been void of all psychotic symptoms, even though his mental state had improved significantly. Prior to meeting with VC, I would have reviewed notes made by other nurses, though I do not recall any specific ones I reviewed at the time. The Request refers to an entry recorded by Nurse Tafadzwa Matosi on 1 June 2020 at 5:18am, where it is noted that VC was hiding in another patient's bedroom toilet (**NHFT0000168**, at p.15). I do not recall whether I discussed this incident with VC or whether I considered it to indicate any risk. I cannot conclude, based on the information available in that entry, whether that incident would have been an indicator of risk.

iii. 9 June 2020 at 8:08AM (**NHFT0000168**, at p.27): This entry refers to a one-on-one keyworker session that I had with VC. The entry states that "I suggested to [VC] that he should try going off the ward for 30 mins at a time in the morning and afternoon. [VC] stated that 30 mins was too long, and we agreed that he would start with 15-mins and increase this daily". From what I can recall, because VC considered 30 minutes to be too long, I suggested that he start with 15 minutes, and he agreed. I do not recall why VC considered 30 minutes to be too long.

iv. 10 June 2020 at 8:41PM (**NHFT0000168**, at p.3): This entry also refers to a one-on-one keyworker session that I had with VC. The entry states that I had a telephone call from VC's mother, "who expressed concerns about [VC] discharge plans and she stated that she was hoping to speak to his RC tomorrow over the phone as [s]he felt discharge was too early". From what I can recall, VC's mother wanted him to be discharged to her place in Wales, but VC refused. He wanted to stay in Nottingham. In these scenarios, we could try to convince the patient that it would be better for them to be discharged to their family's house or somewhere else that would seem optimal. However, ultimately, it is the patient's decision to make, and it was the same for VC. VC's Responsible Clinician was Dr Faizel Seedat. From reading the RIO records now, it is my understanding that Dr Faizel Seedat spoke with VC's mother two days later, on 12 June 2020.

27. During VC's First Admission, between 29 May 2020 and 10 June 2020, I made six entries to VC's medical record (29 May 2020 at 1:50AM, 29 May 2020 at 6:35AM, 31 May 2020 at 8:34PM, 2 June 2020 at 7:26PM, 9 June 2020 at 5:53PM, and 10 June 2020 at 8:41PM; **NHFT0000168,** at pp.13-15, 18, 27, 30 and 32). I noted that one of the risks associated with VC's condition was "aggression". This was because of the events leading up to VC's first admission, when he had come into contact with the police due to aggression towards property by banging and damaging his neighbours' doors. After admission, it was recorded that VC had kicked a glass door and would not stop when asked by staff, leading to a response team being called and VC needing to be physically restrained twice. Taking these incidents into account, I concluded that aggression was one of his risks.

28. On admission, VC did not appear to have capacity to consent to assessment or treatment, as he seemed not to have insight into his presenting condition. However, as time went on and through my interactions with VC, my understanding was that he gained capacity to be able to consent to assessment and treatment. To the best of my recollection, and after reviewing my entries to VC's medical record now, my understanding at the time was that VC had capacity to consent to assessment and treatment in each of my interactions with him between 29 May and 10 June 2020.

29. In the course of my work with VC during his First Admission, I was required to note and record his mood and mental state, behaviours indicating risk, psychotic symptoms (such as responding to or being distracted by unseen stimuli), sleep pattern (because sleep deprivation had been considered as a contributing factor to his psychotic breakdown), interactions with peers and staff, engagement in activities on and off the ward, medication concordance, whether his treatment was effecting any change to his mental state, any side effects of the medication, and VC's dietary intake.

30. My understanding of the purpose of nursing observations is to provide a comprehensive picture of VC's emotional, physical and psychological state.

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These observations would then be used when formulating a diagnosis, making treatment adjustments, and informing clinical decisions made by the multidisciplinary team. These observations would also be used to identify any changes or risks such as mental health decline and would allow for early intervention. The nursing observations would also be used to track whether treatment is effective, identify patterns of improvement or deterioration, and provide evidence for changing or continuing with the same care.

31. The risks associated with VC's condition during his First Admission were that he had been experiencing auditory hallucinations which posed a risk to his own safety and to others, as evidenced by the events leading to his admission. The impression of the team was that this was a first episode of psychosis, and an antipsychotic medication was prescribed to help relieve symptoms such as hallucinations and delusions. On the ward, VC was encouraged to engage whilst on the ward and utilise leave off the ward to enable assessment of him in social and public situations. VC was to continue to take his prescribed medication Aripiprazole 5mg during and post-discharge with support from the Crisis team.

32. On 9 June 2020, I attended an MDT review regarding VC (**NHFT0000168**, at pp.27-28). I was VC's keyworker and therefore provided nursing feedback to the team. My feedback was that VC was isolative in his bedroom and that he was reluctant to utilise leave off the ward. It is evidenced that isolation can reinforce psychotic symptoms such as delusions or auditory hallucinations, as the person has fewer opportunities for reality testing or supportive feedback from others. Stress and loneliness can heighten paranoia, suspiciousness, or negative thinking patterns. The types of interventions recommended for patients who exhibit patterns of isolation are proactive engagement and multidisciplinary support (including social work, occupational therapy, and peer networks), as these are critical to reducing these risks and promoting recovery. My impression was that VC was aware that he had been hearing voices, that he was stressed and that he had not been getting much sleep prior to starting treatment. VC expressed that the medication had been helping him. He stated that he no longer felt that he had paranoia or suspiciousness and that he was not hearing any

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voices. VC also stated that he was embracing his illness but was finding this difficult.

33. On 10 June 2020, I attended a Board Review regarding VC (**NHFT0000168**, at pp. 30-31). The Board Review was part of a daily ward discussion to discuss any agreed plans that had been made during MDT meetings and any tasks that had to be carried out by the ward in relation to that patient's plan of care. The discharge plan was that VC was to be discharged on 16 June 2020 with Crisis team support post-discharge. I cannot recall further details from that Board Review, but based on ordinary practice, the Board Review would have summarised the observations of the MDT, including prior risks.

34. My understanding was that VC was going to be discharged with Crisis team support post-discharge. I did not contribute to the completion of any formal risk assessments for VC during his First Admission (excluding VC's Mental Health Clustering Tool completed on 26 May 2020 which was not specific to risk). These were carried out by other nursing staff, as documented in the RIO records. I do not recall having any reasons at the time to conclude that VC lacked capacity to manage his condition in the community. Based on my observations and interactions with VC, I did not consider that he was "masking" his symptoms at any stage during my observations of him.

II. VC's Second Admission

35. During VC's Second Admission, like in his First Admission, I was a nurse at Rowan 1 and VC's allocated keyworker (the key working team consisted of 2 nurses and 2 healthcare assistants).

36. My understanding at the time was that VC had been detained on Section 136 of the MHA after police were called. VC had been banging on a door and when someone opened it, he immediately forced his way in, attempting to push past the resident. He was restrained on the floor by a number of residents until police arrived. One of the officers had dealt with the previous incident where VC forced his way into someone's property in May and therefore asked Street Triage to

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attend. It was decided to place VC on a Section 136 to safeguard him and others. VC was discharged on 17 June 2020 following his First Admission after starting Aripiprazole 10mg with Crisis team support. Given the circumstances that led to his Second Admission and because he was discharged from his First Admission just a month before, VC was now detained under Section 3 of the MHA (rather than Section 2) so that he could restart his medication treatment.

37. In advance of my interaction with VC during his Second Admission, I reviewed his RIO notes and other entries made regarding his mental health, including the RIO notes made since his readmission and the Street Triage assessment which led to his Section 136 assessment in the Cassidy Suite.

38. I had a one-on-one key worker session with VC during the night shift of 24-25 July 2020, as recorded in his RIO entry from 25 July at 2:24AM (**NHFT0000168**, at pp.92-93). I concluded that VC "appears to have developed good insight into his condition" because he was able to express what had led to his Second Admission. He told me that he became paranoid about his neighbour because he stopped taking his medications. VC expressed regret and remorse and understood that he needs to continue taking his prescribed medication to avoid his mental health deteriorating. He had also spoken about this and expressed similar sentiments with the APIP (Acute Psychological Interventions Practitioner) in one of their sessions, in MDT ward rounds, and when interacting with other members of the nursing team. I discussed with VC the importance of taking his medications. He recognised the importance of taking his medication because he was aware that if he stops, it could lead to a deterioration in his mental health and cause a relapse, as was evidenced by the circumstances leading to his Second Admission.

39. I had another one-on-one key worker session with VC during the early morning of 28 July 2020, as recorded in his RIO record at 6:27AM (**NHFT0000168**, at pp.101-102). I cannot recall in full what VC said to me during this session. From reviewing my RIO entry, I noted that VC "stated that he would continue to take his medication and would not make the mistake of stopping taking his medication again as he realises the negative impact of this [...]". He was aware

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that if he stops his medication, the "negative impact" would be becoming mentally unwell again, ending up being re-admitted, and further disrupting his studies. Before this session, I read VC's RIO records and entries made by other members of staff, as per my usual practice, but I do not recall the specific entries I read at the time.

40. On 28 July 2020, I also completed and updated VC's Summary and Care Plan (**NHFT0000203**). The plan provided a pin portrait of why VC was admitted to the Hospital and how this informed the care plan. No data was filled in under the heading "diagnosis" as no formal diagnosis had been given at this time. Even if it had been recorded, I don't believe it would have made any difference to VC's care and treatment plan. VC was treated for his psychosis, and the treatment for paranoid schizophrenia would have been the same as that for his psychosis. In general, sources of information relied on to complete a summary care plan are the patient's electronic patient record for medical details, patient and family interviews for personal context, MHA assessment, and previous care records. The person completing or updating the document is responsible for ensuring that it is accurate.

41. As documented in my three RIO entries from VC's Second Admission, my clinical impression was that VC was pleasant on approach and interaction (25 July 2020 at 5:43AM, 28 July 2020 at 6:27AM, and 30 July 2020 at 6:26AM; **NHFT0000168** at pp. 94, 101-102, 111-112). I considered that VC had capacity to consent to assessment and treatment in each of these interactions.

42. As stated above in paragraph 30, my understanding of the purpose of nursing observations during VC's Second Admission remained the same: to provide a comprehensive picture of VC's emotional, physical and psychological state for use in diagnosis formulation, treatment adjustments, clinical decision-making, risk identification, early intervention, and tracking treatment effectiveness.

43. My understanding of risks associated with VC's condition and the care and treatment plan during his Second Admission, was that VC had experienced a relapse of his mental health due to non-compliance with prescribed medication leading to his re-admission. VC posed a risk to self and others due

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to his psychotic symptoms and potential for impaired judgment when not compliant with medication. The plan was to reestablish him on medication and increase this to 10 mg Aripiprazole. Psychology and the ward team were to work on insight into his condition through psychoeducation.

D. Reflections and recommendations

44. I am deeply saddened by the events under investigation by the Inquiry, and I believe these sentiments are echoed by all the staff on Rowan 1 ward. We keep the families, friends, and colleagues of those tragically impacted in our thoughts and prayers.

45. Through reflection, these events have effected a change in the way that I practice. I have learned that I need to provide more context when documenting any interactions with patients, family members, carers and professionals. It has also enhanced my understanding of how important it is to communicate our interactions with patients within the MDT team and with the family, so that everyone is clear about the treatment plan which is being pursued.

46. I have never given any interviews or otherwise made any public comments about the actions of VC or the matters under investigation by the Inquiry.

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: 10/11/2025.

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1	NHFT0000004	VC's Form H3, "Record of detention in hospital", dated 25 May 2020
2	NHFT0000184	VC's Mental Health Clustering Tool, dated 26 May 2020
3	NHFT0000207	VC's Summary and Care Plan, dated 26 May 2020
4	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary
5	NHFT0000203	VC's Summary and Care Plan, dated 28 July 2020