**Witness Name:** Sarah Rivers

**Statement No:** WITN0218001

**Dated:** 05 December 2025

**THE NOTTINGHAM INQUIRY**

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**FIRST WITNESS STATEMENT OF SARAH RIVERS**

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I, Sarah Anne Rivers, will say as follows:

## Introduction

1. I am a Community Psychiatric Nurse (CPN) / Care Co-Ordinator (CCo) (Band 6) at Nottingham 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 26 September 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 on my behalf by the external solicitors acting for NHFT 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 studied BSc (Hons) Mental Health Nursing at the University of Nottingham and qualified as a Mental Health Nurse in September 2018. I have been registered with the Nursing and Midwifery Council since September 2018. I am a member of the Royal College of Nursing (RCN). I confirm that I do not hold any professional appointments.

5. From around July 2017 until I qualified in September 2018, I worked as a bank Healthcare Assistant (Band 3) for NHFT.

6. Upon qualification, I started my permanent position with NHFT as a Staff Nurse Preceptee (Band 5). I worked on Rowan 1 from September 2018 until approximately October 2020. Rowan 1 is an acute male ward at Highbury Hospital, and this was where I worked at the time of my interactions with VC.

7. From around October 2020 until around October 2021, I then worked on Rowan 2 as a Clinical Team Leader (Band 6). Rowan 2 is an acute female ward at Highbury Hospital.

8. Since October 2021, I have been working in the Early Intervention in Psychosis Team (EIP) City Central team as a Care Co-Ordinator (CCo) (Band 6), based at Highbury Hospital. I continue to work in this role today.

9. I describe myself as a CPN / CCo because not all CCos are nurses; some as social workers, and some are occupational therapists. So, although I am a CCo, my badge also describes me as a CPN.

## Training and system of work

### *(a) Training*

10. I cannot recall what training I received in the assessment of risk for mental health patients of violence towards others during my nursing degree. I know that I received some training on the wards while on placements, but I completed my degree over ten years ago, so I cannot remember specific details.

11. While I was working on the inpatient wards at NHFT, I completed the Managing Violence and Aggression (MVA) training, which included breakaway training. Now that I work in the community, I only have to do the breakaway training, which I have regular refreshers for. I have also completed e-learning modules and face-to-face training on Clinical Risk and Safety and Clinical Risk Assessment and Management. These are all mandatory training modules, which I also complete regular refreshers for.

### *(b) Handovers*

12. Routine handovers were a core part of daily practice, delivered verbally at the start of each shift to ensure continuity of care. Each patient was discussed, and this was supported by a written handover sheet maintained throughout the day. This was primarily completed by the nurse in charge, sometimes with input from other multi-disciplinary team (MDT) members like healthcare assistants. Across different wards, handovers followed the same format: verbal briefings supported by written notes.

13. Handovers included key details such as risk, Mental Health Act (MHA) status, Section 17 leave, observation levels and rationale, mental state, incidents, physical health, medication, treatment plans, social needs, safeguarding concerns, and other relevant updates. A board in the nursing office displayed essential information like Section 17 leave and MHA status for quick reference.

14. Admissions were typically handed over verbally via phone, either from an Approved Mental Health Practitioner (AMHP) or another ward. These were sometimes accompanied by written documents (e.g. AMHP reports), which were uploaded to Rio.

15. There was also a ward diary for information about appointments, depot injections due, planned visits, escorted leave, and other scheduled plans or tasks which needed to be completed.

***(c) Accessing Information***

16. All staff had access to clinical records via Rio, and additional context for each patient was gathered through direct communication with families, carers, and other services, to support a holistic understanding of patient needs.

17. I had access to Rio, and I am not aware of any restrictions to my access. I do not recall having access to SystmOne or any other systems.

18. At the start of each shift, I would typically read the information recorded on the handover sheet. This would usually include key details which I list in paragraph 13 above. I would also look for more detailed information regarding presentation, care planning, and risks recorded in Rio, if time pressures, staffing and other priorities allowed. I would also look at this information prior to dealing with a patient, if there was something in particular that I needed to check.

***(d) Recording and Sharing Information***

19. While working on the ward, I recorded information about the patients I was involved with using both written handover sheets and electronic clinical records via Rio. The handover sheet was updated throughout the day by me and other staff, capturing key details such as changes in mental or physical health, risk factors, observation levels, and any incidents or updates in care.

20. I always tried to ensure that any paper-based documents, such as AMHP reports or transfer notes, were promptly uploaded to Rio to maintain continuity and accessibility for the wider team. All staff involved in patient care had access

to Rio, where formal documentation like care plans and risk assessments was stored.

21. Information was shared verbally during shift handovers, allowing me to communicate current patient needs and risks clearly to the incoming team in a structured format. For admissions or transfers, I often received verbal handovers via telephone, which was supplemented with written documentation when available. Throughout the shift, I also shared and received updates informally with colleagues to ensure we remained responsive to patients' changing needs.

22. To build a fuller understanding of each patient's circumstances, I regularly liaised with families, carers, and external services. This collaborative approach helped ensure care was holistic and person-centred. A whiteboard in the nursing office displayed key information such as MHA status and Section 17 leave, which I referred to frequently to support safe and informed decision making during the shift.

***(e) Summary and Care Plan***

23. The Summary and Care Plan is a structured formulation of a patient's overall mental health and history. The 'Summary' provides a snapshot of their current presentation and relevant history, while the 'Care Plan' outlines treatment and interventions based on their individual needs, risks, and circumstances. The Care Plan considers different factors such as observation levels, family, and

medication, and runs alongside the risk assessment. The Care Plan should be person-centred, and developed in collaboration with the patient, their family, and other professionals involved in their care.

24. If a patient has had multiple admissions under the MHA, this should be reflected in the formulation section of the Summary. The document must be reviewed regularly to ensure it remains accurate and up to date.

25. Both inpatient and community mental health teams have access to Rio, allowing care plans, risk assessments, and clinical notes to be shared across services, supporting continuity of care.

26. The approach to formulating a Summary and Care Plan in Rio is determined by the patient's current presentation, level of risk, and stage of care and treatment. For acutely unwell or highly risky patients, the focus is usually on safety and risk management and the Summary and Care Plan should be reviewed or updated regularly. For more stable patients, the focus shifts more towards recovery goals, relapse prevention, and longer-term support planning.

27. The Summary and Care Plan should reflect the MDT's understanding of the patient's needs, align with legal and policy requirements such as MHA status, and use clear, person-centred language. The author of the care plan should include the patient and family/carers if possible. If this is not possible, the reason should be documented clearly in the care plan.

28. When a patient has had multiple admissions under the MHA, clinicians should consider historical documentation when formulating a care plan for the current admission, to ensure that any patterns in respect of the patient's presentation and condition are captured within ongoing risk planning. Past risk assessments, formulations, identification of recurring stressors, triggers, and early warning signs are examples of the documentation that should be considered.

29. In terms of the relationship between inpatient care planning and care planning undertaken by local mental health teams (LMHT) in the community, these are part of a continuous and co-ordinated process, rather than separate or isolated activities. Inpatient care plans are typically focused on managing acute mental health needs, addressing immediate risks, stabilising the patient's condition, and planning for safe discharge. Once the patient transitions to community services, care planning shifts toward longer term recovery, relapse prevention, and building social and practical support networks.

30. Both inpatient and community teams can access and contribute to the same care plans via Rio, to ensure consistency across settings. Historical care plans and clinical notes are also available, allowing professionals to understand the patient's journey and make informed decisions based on past interventions and outcomes. This shared access supports collaborative working and helps maintain a person-centred approach throughout the patient's care pathway.

31. The Mental Health Clustering Tool (previously 'HoNOS PbR') is used to group patients based on their needs and the level of care required. The tool helps to

inform care planning by providing a structured way to assess and categorise mental health presentations. It should be completed regularly, as it mainly focuses on the patient's presentation in the past two weeks.

32. In terms of the use of Risk Assessments in the formulation and development of an inpatient's Care Plan, these two documents are closely linked and should ideally be developed in tandem. The Risk Assessment identifies current and potential risks, which directly inform the Care Plan. As risks evolve, both documents should be updated to reflect new information, ensuring care remains appropriate and responsive. For instance, if a safeguarding concern is noted in the Risk Assessment, the Care Plan should be updated to include clear actions for managing that safeguarding risk. This ensures that key information is accessible to staff and supports safe, effective care delivery.

33. Both documents are considered live and should be reviewed regularly. This ongoing review process helps ensure that interventions are based on the most current understanding of the patient's needs and risks.

***(f) Discharge***

34. I confirm that I did contribute to discharge planning for patients in my care as part of my role within in-patient services at NHFT.

***(g) Reporting risks***

35. During my time working on Rowan 1, if I had concerns about a patient posing a risk to others, I would report them to the senior nurse, ward manager, or the Responsible Clinician, depending on the nature and urgency of the risk. I also felt comfortable raising concerns during MDT discussions, particularly when safeguarding or risk management needed to be addressed collaboratively. This was because the team fostered an open and supportive environment where patient safety was prioritised, and all voices were valued. Regular MDT meetings and psychiatric reviews helped reinforce this. If I ever felt unsure, I could seek guidance from senior staff, including the consultant psychiatrist Dr Seedat. I generally found senior colleagues to be approachable and responsive.

36. I have not 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.

**Interactions with VC**

37. I will now provide detail on my interactions with VC. Where I am unable to specifically recall a detail that has been asked about by the Inquiry, this is due to the passage of time between my interactions with VC and the present day unless otherwise stated. I have dealt with so many patients since I interacted with VC, and my interactions with VC were not particularly memorable for any reason.

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

38. At the time of VC's first admission, I was a staff nurse on the ward. I cannot recall from memory what my understanding of the events which led to VC's arrests on 23 May 2020 and 24 May 2020 was, or what I understood regarding the subsequent referrals for MHA assessments on that occasion, but my understanding would have reflected what was in the notes. I also cannot recall whether I discussed these events with VC at all.

39. We were required to use MONITOR (Mental State, Observation level, Note appearance, Individual time, Therapeutic Activity, Other Needs & Risks) for our observations of VC.

40. In terms of my understanding of the purpose of the nursing observations in the context of the wider care and admission plan provided to VC during his First Admission, I cannot specifically recall what my understanding of that purpose was. However, generally, nursing observations during a first admission play a vital role in informing the wider care and treatment plan. They provide a continuous assessment of the patient's mental and physical state, helping to establish a baseline, monitor changes, and identify risks. This real-time information supports clinical decision making, guides interventions, and ensures that care is tailored to the individual's needs. Observations also contribute to the development and review of care plans and risk assessments,

making them an essential part of safe, person-centred care during the early stages of admission.

41. I cannot recall what my understanding of the risks associated with VC's condition and the care and treatment plan which was being pursued to assess his condition during his First Admission was. But, as part of the MDT, I would have engaged in regular handovers and MDT meetings where risks and care planning were discussed and reviewed.

42. I cannot recall the specific information I received in advance of my involvement with VC during his First Admission; I also cannot specifically recall whether I reviewed the observations entered by other nurses about VC, any of the MHA assessments which led to VC's First Admission, or whether I ever spoke with anyone from the police or any other external agency.

43. However, the normal process would be for any relevant information to be shared via handover at the beginning of each shift. I also had access to clinical documentation via Rio, but I do not recall what I read specifically. But, where a patient had been admitted while I was not on shift, when I came onto shift, I would receive the handover, and I would ideally look at the Risk Assessment and Care Plan on Rio. I would not have had chance to read every single document before interacting with a patient; what I was able to read would depend on how busy the shift was.

44. My Rule 9 request asks me to review three entries in the Patient Record Summary from the time of VC's First Admission. I cannot recall VC's presentation on any of these occasions from memory, but based on my entries, I did not see any obvious outward signs of psychosis at that time, and I noted on more than one occasion that he interacted with others appropriately, though minimally.

45. I also do not recall the specifics of the factual background knowledge that I had at the time about the risks of aggression posed to others by VC during his First Admission. I did not record aggression in my progress notes, but this was documented in VC's records by a number of other staff.

***(a) 29 May 2020, 07:02pm***

46. The Patient Record Summary includes an entry on 29 May 2020 at 07:02pm which states:

> *"Long day entry*
> *Mood and mental state – Valdo has largely been observed spending time in his bed space today and has presented as quiet. He has spoken to staff in a pleasant manner and spent a brief time in the garden in the sun. Valdo also attended the dining room for meals. There have been no overt signs of psychosis noted today.*
> *Observations – Valdo is on 10 minute intermittent observations.*
> *Note appearance – Valdo is appropriately dressed and was noted to be taking a shower during observation checks.*
> *Individual time – Valdo engaged in casual conversations with staff*
> *Therapeutic – Time in the garden, drawing in bed space*
> *Other needs – 1:1 with staff*
> *Risks – No new risks identified"*
>
> [NHFT0000168, pg.14]

47. I do not recall this interaction. However, based on this entry, there was nothing to suggest that VC did not have capacity.

***(b) 07 June 2020, 06:31am***

48. The Patient Record Summary includes an entry on 07 June 2020 at 06:31am which states:

> *"Night entry*
> *Mood/mental state – Valdo was in his bed space at the start of the evening. He has remaining in his bed space throughout the night, he has appeared to sleep well.*
> *Observation Level – General observations*
> *Note appearance Appears well kempt and appropriately dressed*
> *Individual time None.*
> *Therapeutic activity – None to note*
> *Other needs None noted*
> *Risks – No new risks identified"*
>
> [NHFT0000168, pg.25]

49. I do not recall this interaction. Based on this entry, there was nothing to suggest that VC did not have capacity, and he appeared to be asleep throughout most of this observation.

***(c) 16 June 2020, 05:22am***

50. The Patient Record Summary includes an entry on 16 June 2020 at 05:22am which states:

> *"Night shift*
> *Mood/Mental State*

*Valdo was in his bed space at the start of the evening. He attended the dining room for support and took himself back to his bed space. Valdo interacted minimally with others but was polite and pleasant. No overt signs of psychosis observed during the night. He was observed sleeping through the night.*
*Observations:*
*General observations maintained*
*Note Appearance*
*Appropriately well kempt*
*Individual Time*
*None*
*Therapeutic Activity*
*Reading in his bed space.*
*Other needs*
*None identified*
*Risks*
*No new risks identified*
*Smoke Free*
*Valdo is a non smoker*
*Physical Health*
*None reported on this shift"*

[NHFT0000168, pg.47]

51. I do not recall this interaction. Based on this entry, there was nothing to suggest that VC did not have capacity, and he appeared to be asleep throughout most of this observation.

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

52. At the time of VC's inpatient MDT during his Second Admission, I was a staff nurse on the ward.

53. I do not recall reviewing Form A8, "Medical recommendation for admission for treatment" [NHFT0000357 at pp.3-8] or the "Report Referral and Assessment" carried out by an approved mental health professional [NHFT0000028]. However, I would typically have reviewed both documents at the time of signing the Form H3 "Record of detention in hospital" [NHFT0000357].

54. I do not recall what my overall understanding of VC's psychiatric history and presentation was at the time I completed his Form H3, but in a progress note recorded on the day of his Second Admission to Rowan 1, I noted that VC was familiar with the layout of the ward due to his previous admission. I also noted that VC was quiet and polite, and there were no overt signs of psychosis observed during the brief time I observed him, but that he had been experiencing distressing auditory hallucinations [NHFT0000168, pg.59].

55. I do not recall any details of what happened or who I spoke to when VC was transferred from Cassidy Suite to Rowan 1, but typically there would have been a handover from another professional. The usual practice when a patient was transferred from another ward was to receive a verbal handover from the transferring ward, and then I would usually review the documentation completed in Rio. This would have informed my understanding of VC's psychiatric history and current presentation when I completed the Form H3.

56. I cannot specifically recall the issues and risks associated with VC's presentation and/or condition.

57. Based on the section 3 paperwork [NHFT0000357] and the progress notes on RiO [NHFT0000168, pp56-58], it appeared that VC was detained under Section 3 MHA because that section is for the purpose of treatment. VC was already known to mental health services, and he was believed to be experiencing a relapse of psychosis, like his first presentation. Section 3 can last up to 6 months, whereas section 2 MHA is for the purpose of assessment and can only last up to 28 days.

***(a) 14 July 2020, 12:13am***

58. The Patient Record Summary includes an entry on 14 July 2020 at 12:13am, which was made by Nigel Wade (Liaison and Diversion Nurse). This entry reads:

> *"[t]he Police were contacted by residents of a flat near to Valdo's. Valdo had been banging on the door and when someone opened it, he immediately forced his way in, attempting to push past the resident. He was restrained on the floor by a number of residents until Police arrived. One of the Officer's had dealt with the previous incident where Valdo forced his way into someone s property in May, and therefore asked Street Triage to attend."*
>
> [NHFT0000168, pg.56]

59. I don't recall if I was aware of this when I updated VC's Risk and Safety Assessment on 15 July 2020 [NHFT0000195], but I believe I would have added it if I had been aware of it. This information would have strengthened the Risk and Safety assessment as it gives a detailed account of the events leading to VC's Second Admission.

60. The wider MDT is responsible for ensuring that an inpatient's Risk and Safety Assessment is accurate and up to date.

61. I do not have any independent memory of this stage in VC's second admission. After reviewing the documentation, however, I remember that VC was admitted to hospital for treatment with anti-psychotic medication. He was believed to be experiencing a relapse of psychosis which resulted in a similar presentation to his previous psychotic episode and he had been arrested by police. VC was placed on 10-minute (intermittent) observations when he arrived at Rowan 1, which was normal practice for new admissions. 10-minute observations were considered the least restrictive observation level whilst also allowing staff to monitor an individual closely to observe signs of risk and to note their mental state.

***(b) Mental Health Clustering Tool, 15 July 2020***

62. On 15 July 2020, a Mental Health Clustering Tool was completed in respect of VC [NHFT0000182]. I do not recall specifics of my interaction with VC prior to completing the Mental Health Clustering Tool but based on my documentation in his progress notes ([NHFT0000168, pg.59], as discussed above), there was nothing to suggest he lacked capacity in relation to this assessment.

63. I noted that VC was familiar with the layout of the ward due to his previous admission, and that he was quiet and polite. I documented that there were no overt signs of psychosis observed during the brief time I observed him, but that

he had been experiencing distressing auditory hallucinations. As the interaction was brief, I would have also taken into consideration collateral information from other sources, such as the handover from Cassidy Suite and AMHP report when I completed the Mental Health Clustering Tool.

***(c) Risk and Safety Assessment, 15 July 2020***

64. On 15 July 2020, a Risk and Safety Assessment was completed in respect of VC [NHFT0000195]. I do not recall specifically what information I received or reviewed prior to completing the Mental Health Clustering Tool and the Risk and Safety Assessment. I cannot recall whether I reviewed VC's medical records from his First Admission or any of records or information which related to the period following his First Admission while he was under the care of the community mental health teams. I also cannot remember whether I sought or obtained any information from VC's nearest relative, the police or any other third party. Nor can I remember if I reviewed information contained within VC's RiO record from the 24 hours prior to the assessment. I do not recall if I knew at the time who VC's closest relative was.

65. However, the usual process would be to review the records available on Rio, including previous risk assessments, progress notes, and assessments. Information would also typically be sought from family/carers and other agencies to ensure that all relevant details are captured. It was sometimes not possible to complete assessments immediately, especially if the patient was admitted during the night. Any assessments and admission paperwork which

was incomplete at the end of the shift would have been handed over to the nurse in charge of the next shift.

66. The wider MDT was collectively responsible for ensuring that historic information which may be relevant to understanding any pattern associated with VC's condition was captured and reviewed within VC's records and care and treatment planning.

67. The Risk and Safety Assessment included the following information under the heading of risk "to Others"

> "14.07.20: *Arrested for attempting to gain entry into random neighbours flat as he felt that someone is in trouble. Valdo did not gain entry or harm anyone but he was kicking the door. Prior to previous admission Valdo was involved in a similar incident whereby he entered into another resident's flat whilst experiencing distressing auditory hallucinations. The woman that resided in the flat jumped out of the window due to being frightened, she injured herself severely and needed surgery on her back."*
>
> [NHFT0000195, pg.1]

68. I do not recall who wrote this summary specifically, as the risk assessment form in Rio can be updated by multiple professionals. Due to the way the form is designed, it is not possible to see which professional recorded each update without requesting the audit trail.

69. Under the heading "Risk Formulation", the Risk and Safety Assessment included the following information:

*"Valdo is a 28-year-old man experiencing early psychosis. he was previously admitted on Rowan 1 ward and was discharged in June to his flat. He has had input from his CPN and community doctors post discharge, He was detained on section 136 following making attempts to get into neighbours apartments, he appears to be responding to Auditory hallucination. Valdo seemed to be responding to unseen stimuli. Acted suspicious of all activities. Valdo is a student at Nottingham University studying Mechanical Engineering. He lives on his own in block of flats. He is currently single. His parents live in Wales. He has no past history of mental health difficulties. He has no past history of illicit substance use or forensic history. Valdo was arrested by the police for criminal damage (kicked a door in of another flat). The police were called for burglary but they found Valdo who resides in a group of flat. No history of violence or aggression. Has been hearing voices and believed his mother was in the flat that he was trying to get in to, had a lack of sleep during the past week and has been feeling the pressure from his studies. Not eating and drinking well from his own admission."*

[NHFT0000195, pg.4]

*70.* Under the heading "Risks under Investigation", the Risk and Safety Assessment included: "criminal damage to a flat door" [NHFT0000195, pg.3]. I do not know who was responsible for this specific entry.

***(d) 18 July 2020, 12:22pm***

71. The Patient Record Summary includes at entry on 18 July 2020 at 12:22pm, which states:

*"T/C with Valdo's mum Celeste: Consent gained to share information I gave Celeste an update on Valdo's presentation on the ward. She stated that she plans to travel from Wales today […] Celeste would like to be involved in Valdo's review if possible. I have agreed that her input would be beneficial for Valdo's discharge planning and treatment […] I told her I will discuss it with the MDT."*

[NHFT0000168, pp.69-70]

72. I cannot recall this conversation with VC's mother, but after reading this note I understand that I obtained consent from VC to share information with his mother. Capacity should always be assumed; it can fluctuate, and it is always decision specific. If there was a reason to doubt VC's capacity to consent at that specific time, I would have formally assessed this and documented it.

73. I cannot recall why I thought VC's mothers' involvement in VC's clinical reviews would be beneficial for VC's discharge planning and treatment at the time. However, more broadly, involving families in treatment and discharge planning supports safer, more sustainable recovery by bridging the gap between hospital and home. Families who fully understand a patient's care plan, medication and early warning signs can help prevent relapse and reduce the likelihood of readmissions.

74. Families can add valuable context about a person's history, triggers, and coping strategies, which strengthens care planning. They can also support medication monitoring and adherence, which is especially important when a patient is being cared for in the community.

75. I cannot recall informing VC's MDT and/or responsible clinician that, in my view, VC's nearest relative should be involved in his post-discharge care. However, my note suggests that it was my plan to do so ([NHFT0000168], pp.69-70, as cited above at paragraph 71).

76. I cannot recall what impact, if any, VC's presentation had on my views about his mother should be involved in his care, or whether the observations that VC appeared 'isolated' on the ward had on the involvement of VC's mother. However, I would generally advocate for families to be involved where possible, unless there are specific safeguarding concerns or other issues.

***(e) 23 July 2020, 09:22am***

77. The Patient Record Summary includes an entry in respect of a Board Review dated 23 July 2020 at 09:22am [NHFT0000168 at pp.86-87]. I cannot recall myself or anyone else having a specific role during this meeting.

78. From memory, Board Reviews were brief, daily reviews to discuss progress and care planning for patients, including discharge planning. I cannot recall the specific information that I provided regarding the types of observations and feedback about VC's mental state and presentation during this meeting.

79. Typically, MDT plans would be based upon contributions from a range of people, including observations from different professionals, families, and the patients themselves. However, I cannot specifically recall whether any nursing observations or feedback were relied on by VC's clinical MDT to demonstrate that he had made progress in terms of insight into the risks he posed to others when he was acutely unwell prior to his first admission.

80. I cannot recall what my understanding was of VC's discharge plan at this stage. I do not recall my thoughts regarding his ability to manage his condition at that stage. After reading some of my observations, I can only recall that VC was reserved during many of the interactions that I had with him.

81. In terms of my role within VC's MDT, I cannot recall any specific details of risk assessments that I undertook or contributed to, but it appears that I did update VC's Risk and Safety Assessment [NHFT0000195] when he was at the start of his Second Admission to Rowan 1. Additionally, all members of the MDT participated in the assessment and management of risk daily.

82. I do not recall personally witnessing any violence or aggression from VC. I also do not recall any discussions about any risk that VC posed to others with any other colleagues during his First or Second Admission.

**Reflections**

83. In light of VC's attacks, I do not feel I have any reflections that I wish to share with the Inquiry.

84. Since these events, I have made changes to my practice, but I consider that I would have made these changes regardless of these events, as a result of my own professional development and gaining more experience, and because I work hard to be a good nurse. I have not felt the need to change anything as a

specific result of the attacks, because I feel that I did everything I possibly could have done with the resources that I had available at the time.

85. I confirm I have not given any interviews or otherwise made any public comments about the actions of VC or the matters under investigation by the inquiry.

**Recommendations**

86. I do not have any recommendations that I would like the Chair of the Inquiry to make as a result of my interactions with VC.

**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: 05 December 2025

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