Witness Name: Dr Rupert Dinsdale Ackroyd

Statement No.: WITN0260001

Dated: 13 November 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF

DR RUPERT DINSDALE ACKROYD

I, Dr Rupert Dinsdale Ackroyd, will say as follows: -

1. I worked for Nottinghamshire Healthcare NHS Foundation Trust ("**the Trust**") between August 2016 and February 2021 and currently work as a consultant psychiatrist in Western Australia. Details of my career are set out below.

2. I am writing this witness statement to assist the Nottingham Inquiry ("**the Inquiry**") with the matters set out in the Rule 9 request dated 7 October 2025, with regards to the treatment and care of Valdo Calocane ("**VC**") in July 2020.

3. When writing this statement, I have had access to copies of electronic records and I have received drafting support from the external solicitors acting for the Trust in respect of the Inquiry, following discussions in writing by email and by video conference.

4. I do not recall my encounter with VC in July 2020.

5. I think it is important to highlight that I have progressed through Higher Specialty Training in General Adult Psychiatry since my encounter with VC and, therefore, my knowledge and experience of the concepts, legal framework, and broader queries will be vastly different to that at the time that I was involved in VC's care in July 2020. I have found it difficult to look back and transcribe my level of understanding at that particular juncture in my professional development.

Background

Career and Qualifications

6. I graduated from University of Keele Medical School in 2013 and moved to Nottinghamshire for Foundation Training in the East Midlands, where I remained until January 2025. Following my Foundation Year 1 (Nottingham) and Foundation Year 2 (Chesterfield), and approximately 6 months as a Locum in Chesterfield, I started Core Psychiatry training in Nottingham in August 2016. From January 2019, which was towards the end of the Core Training, I moved to working less than Full-Time for family reasons.

7. I briefly came out of training between February 2020 and February 2021 as I required more time to complete postgraduate qualifications. During this time, I worked as a regular locum doctor (Locum Approved for Service) for the Trust filling vacant training posts and participating in the on-call rota. It was during this time that I met VC.

8. At this stage, I had been working at Highbury Hospital for the preceding 3-4 years in various roles where I completed the training and time-based competencies of Psychiatry Core Training. I opted to remain in a familiar role and hospital for this period and was employed directly by the Trust.

9. I completed training in November 2024 with a specialist endorsement in Liaison Psychiatry. I worked as an acting consultant for three months as part of my Higher Training programme between August and November 2024 with the Crisis Resolution and Home Treatment team with the Trust. I then worked as a locum consultant with the Trust covering female acute inpatient and male psychiatric intensive care units between November 2024 and January 2025.

10. Qualifications and Relevant Courses:

    10.1 Bachelor of Medicine, Bachelor of Surgery with Honours (MBChB), University of Keele, 1st July 2013.

    10.2 Section 12(2) Induction Course MHA, RCPsych, 20th November 2020.

    10.3 Membership of the College (MRCPsych), Royal College of Psychiatrists, 4th January 2021.

    10.4 Approved Clinician (AC) Induction Course, RCPsych, 22nd May 2024. Registered as AC from 12th September 2024.

    10.5 Certificate of Completion of Training (CCT) – General Psychiatry with sub-specialty endorsement in Liaison Psychiatry, General Medical Council, 5th November 2024.

11. In January 2025 I moved to Western Australia. I am working as a consultant psychiatrist.

Locum Work

12. I have been asked by the Inquiry to comment on any particular issues or considerations which arise when working as a locum clinician. It is worth noting here that the locum roles that I have held have been as a permanent locum, directly employed by the Trust, within the service that I had previously been

working with for more than three years consecutively. From personal experience, I was very familiar with the electronic records system, local protocols and policies, regular staff, and the environment.

Mental Health Act 1983 ("**MHA**") and Capacity

13. It is likely that there was some teaching around the MHA during psychiatry placements at medical school, but I cannot recall specifics from this time.

14. I can recall teaching sessions regarding the MHA at most induction programmes when initiating new rotations at all psychiatric hospitals, including when I started at Highbury Hospital. This was a basic introduction with a focus on inpatient settings where patients may already be detained and the use of doctors holding powers (Section 5(2) MHA). I also received 'bedside teaching' from supervising consultant and senior doctors regarding the MHA during different training posts at Highbury Hospital.

15. Since my contact with VC, I have I completed training through the Royal College of Psychiatrists - "Section 12(2) Induction Course MHA" - on 20th November 2020 and MHA Approved Clinician Induction Course" on 22nd May 2024.

16. When assessing an individual under MHA, one should consider evidence of mental illness, current mental state, risks, and the availability of treatment in community/hospital that is proportionate and with least restriction of liberties. An individual's capacity to consent to treatment and hospital admission should also be considered.

17. Assessing capacity is a core skill of any physician, regardless of specialty. Indeed this would also be an expected skill of most professionals working in health and social care. I know this would have been part of the syllabus at

medical school, although I do not recall specific teaching sessions. Discussions around capacity come up commonly in case-based discussions in clinical supervision and at the Trust's weekly academic meeting. I do not remember if capacity was covered in induction training.

18. There are two stages when assessing capacity; a functional test to determine whether somebody lacks the ability to make an informed decision and an assessment of whether that is caused by an impairment or disturbance of mind or brain. The 'functional test' looks to ascertain whether an individual is able to understand the relevant information, retain the information for an adequate period, weigh the information, and communicate their decision. Assessment of capacity is not always straightforward.

Insight and Masking

Insight

19. "Insight" in the context of psychosis is rarely "all-or-none" but commonly partial. I was taught an approach to assessing insight as a Higher Trainee (~2022); the 'three As of insight', Awareness, Attribution, and Action. Awareness relates to an individual's awareness that they have a disorder/impairment. Attribution is where an individual is able to identify symptoms being related to an underlying disorder/impairment. Action is whether an individual is seeking appropriate medical treatment.

20. Insight is most typically considered as part of a Mental State Examination; which is supposed to be a clear description of their mental state at the point in time that they are seen. When considering insight in the context of treatment decisions, one might take into account other sources of information if there were

particular concerns. Reviewing the records, team discussion, and collateral history might be appropriate if there were concerns that insight was fluctuant.

Masking

21. "Masking" in psychosis typically refers to a guardedness that individuals might display in sharing symptoms with professionals. This might be in the context of perceived persecution and an associated lack of trust or belief that professionals have their best interests in mind. Individuals might not disclose symptoms and, further, might work hard to conceal or play down certain symptoms. This would not necessarily reflect attribution of insight, or "conscious masking," as the motives for "masking" might be in the context of a broader delusional framework.

22. The term "masking" is also commonly used in mental health services outside of the context of psychosis where it might suggest that individuals are able to compensate for symptoms/difficulties to reduce the observed impact on function with some degree of awareness and attribution. For example, young females with autistic spectrum disorder are thought less likely to present to services at an early age as higher social functioning "masks" symptoms/functional impairment.

23. The presence of masking can be significant as patients might be less likely to report concerns to mental health services and might be more difficult to engage in the community. Therefore, if suspected on assessment, one might review the notes for evidence of previous engagement and obtain collateral history to determine whether the risk of poor engagement is evident and/or relevant.

24. I am not aware of "conscious and unconscious masking" as a specific differentiation. I think differentiating what is conscious and unconscious in the context of psychosis would be difficult and highly subjective. If somebody is suffering with a psychosis characterised by persecutory beliefs, it seems logical that they might mask symptoms if they perceived potential threat if they were to disclose them. I do not know if this would be considered conscious or unconscious. I do not feel able to comment further.

"Needs-Led"

25. I have been asked by the Inquiry what is meant by engaging on a "needs led" basis. Although not a term I can particularly recall being used, my understanding of engaging on a needs led basis would be where an individual engages only when they have specific needs that they identify needing support for. I can imagine it might be used to suggest an individual engages minimally beyond the basic or minimal requirements. Most people engage to have needs met in some way; it is not a term I use commonly or can recall using in a specific situation.

Knowledge and Involvement with VC

26. My first knowledge of VC was during a shift on the night of 14 July 2020 / early hours of 15 July 2020. I do not recall having any knowledge or contact with VC prior to that date.

27. On the night of 14 / 15 July 2020, I was the duty Senior House Officer covering Highbury Hospital overnight. VC was brought to the Cassidy Suite under Section 136 and was assessed under the MHA. I was not however involved in the MHA assessment of VC.

28. I do not recall my interaction with VC or any of the circumstances around it, so the following is based on what my normal practice was, and from what I can read in contemporaneous documents.

29. When a patient is admitted out of hours, they should be seen by the on-call resident doctor (either Foundation Year 2, GP trainees, Psychiatry Core Trainee, or a locum working at a similar level). The minimum standard would be to collate some history around the circumstances leading to admission, assessment of their current mental state and risks, and complete a physical examination and investigations, as far as we are able.

30. Therefore, as the duty Senior House Officer overnight, one of my roles was to complete the clerking in process for new admissions received across the hospital during the shift. Two to four new admissions during an overnight shift would be a normal occurrence across the hospital. During the shift, I would carry a mobile phone that the hospital switchboard would have the number of. I would then receive a call from nursing staff on the ward where the new patient had been received, to request that I attend to complete the clerking admission process.

VC's Records and Medical History

31. Unfortunately, I cannot recall reviewing VC on 14th July 2020, and therefore I am unable to advise of the specific sources of information used to inform the Core Assessment document. Having worked at the Trust for 3-4 years, I would have completed scores of Core Assessments in both routine and out of hours duties. My usual practice would be that once I was available (I may have been seeing another patient or completing another job) I would tend to log onto a

Trust computer and look at the electronic ("**Rio**") notes for the patient to gather some context before going to see them. I would be looking for information such as their background history, how they normally present, how they are presenting currently, if there is an existing plan in place, and if they are well known to mental health services.

32. This information would normally be in the Rio record, and I would review the recent progress notes, previous discharge summary and Core Assessment documents to have some understanding of the past history and risks prior to assessing and documenting the patient. I would use the records to get an understanding of what had been going on in the build up to the admission. I would look at any details of the MHA assessment that had been entered into the Rio progress notes, which would tend to happen if one of the assessing doctors was based at the Trust (as I can see was the case with VC, as Dr Seedat had been VC's Responsible Clinician on the previous admission, had conducted the MHA assessment on 14 July 2020, and had made an entry into the Progress Notes [NHFT0000168 p58]). It would not be practicable to review his entire history at this point, but I would tend to ensure I have enough information to be able to engage in a reasonably informative encounter. The level of detail might be influenced by the workload of the particular shift. As I quote Dr Seedat's Rio entry in my Core Assessment documentation, it is clear to me that VC's records were available to me prior to my attendance. I would also have been aware that VC had been admitted back to Dr Seedat's team that had treated him on his first admission. At the time, I believe Dr Seedat was the only consultant covering Rowan 1 so it would be inevitable that he would be the Responsible Clinician again.

33. When reviewing the existing documents, I would typically write a few handwritten notes from that review, which would be prompts for me to raise with the patient if they were not forthcoming with information (which I would later dispose of in confidential waste at the end of the shift once I had entered the key information into the Rio records).

34. I would then go to the ward and have a verbal handover from the nursing team about how the patient was presenting, which room I should see them in, and whether I would need another member of staff with me. In addition to the electronic records, I would have had access to the handwritten paperwork from the MHA assessment on attendance to the unit as these would be stored on the ward that the patient had been admitted to. I would particularly review this if an entry from the MHA assessment was not available on Rio. On the ward, I would also be able to see the nurse's board which would have information about the patient such as observation levels, MHA status and consultant allocation.

Core Assessment – purpose and process

35. The purpose of medical clerking in of a patient very soon after they have been admitted would be to have an early assessment of their mental state but also includes a review of their physical health. This would provide confirmation they are medically suitable to care for on a psychiatric ward and to have a baseline of their cardiometabolic status before making any medication changes. The Core Assessment documentation which I completed for VC [NHFT0003403, p.3-4] shows that I undertook, and VC complied with, a physical health examination of VC, took bloods for testing, and carried out an electrocardiogram.

36. The admission clerking process is recorded in the Core Assessment. My understanding of the function of the Core Assessment is to provide a summary of a patient's care and risks that is easily accessible and succinct. Ideally this should give a description of the current context of the encounter, and I understand that the past history should be pulled through from existing Core Assessment documents, as this information is static, continues to be relevant, and can then be updated accordingly during the new Core Assessment.

37. My recollection is that Core Assessments should be completed or updated with the care co-ordinator at their Care Programme Approach ("CPA") review meetings, at least six monthly. They would also be completed/updated at significant points in care, such as admission to hospital, or review with liaison psychiatry service when attending the emergency department.

38. When a patient is unknown to you, a recent and well completed Core Assessment can be very helpful to provide a succinct summary of past care to prepare for an initial review. This should mean that previous symptoms, risks, and treatments can be easily identified and reassessed.

39. My practice would be to make some handwritten notes during the assessment and then enter the relevant information into the Core Assessment document on the system following the assessment.

40. Core Assessment documents should be accessible by any individual who has access to the electronic records system. They sit separately from the progress notes, or 'running record,' in a different tab. After completing a Core Assessment, I would routinely document in the progress notes so others would be aware it was updated if only scrolling that area of Rio.

Recollections on Assessment

41. Unfortunately, I do not have any recollection of my interaction with VC and therefore I do not have anything to add to the records that I have made and can only explain my understanding of the records as I read them now. Upon review, I believe that most of the technical terminology would be understood by medical staff working in psychiatry and many experienced allied and nursing professionals. Some of my recording in the Core Assessment document states out the facts of what was said, to allow interpretation by the reader rather than simply stating my conclusions. Documenting what was said rather than labelling it with a conclusion and technical terms is often encouraged as it allows a discussion about what symptoms relate to pathology. I think that the style and wording used is typical of a Core Assessment document, though I appreciate it may not be for a lay reader, hence the explanations given below.

42. I am unable to pass comment on what I thought at the time, and whether I believed what VC was telling me, unless I am able to tell this from the contemporaneous documents by reflecting on my usual practice. It is also worth noting that my interaction with VC was in the middle of the night and in an on-call capacity only; I would have been balancing other duties in addition to the admission clerking and would not have previously worked with, or be continuing to work, with VC through the course of his admission.

43. The assessment took place in the early hours of 15 July 2020, and I can see that I have timed the assessment as 02:19, which is likely when I commenced the documentation.

44. I am unable to tell from the records whether a colleague accompanied me during my assessment of VC, but I would usually write "*seen with [name*]" if I was accompanied. I would usually ask the nursing staff if anyone was available and wanted to come with me (as they would be the ones involved with the patient's ongoing care, and so it can be helpful for them to be present to assist their understanding of the patient) but if they were not available (which is more likely at night when there are fewer registered staff) I would see the patient alone, with the nursing staff being aware which room we were in, and carrying my personal safety alarm. If specific risks were flagged to me by nursing staff or in the documents I had read in advance, then I would insist I was accompanied.

The Core Assessment Document

N.B. All page references in this section are to NHFT0003403, unless otherwise stated.

Consent and Capacity

45. One of the first sections on the Core Assessment pro-forma is "Consent and Capacity." I recall that the section of the Core Assessment that denotes consent and capacity was often discussed as being ambiguous as it does not specify what the consent and capacity refers to. My recollection of peer and forum discussions, was that the "Consent and Capacity" section was to be regarded as to whether a patient was in agreement with being assessed itself (as part of a clerking, liaison, CPA review etc), which is in keeping with it being one of the first things in the document. Given that active management is not documented on the Core Assessment document itself, comments about a patient's consent

and capacity in the Core Assessment should not be taken as reflecting an individual's consent and capacity for treatment, just for the assessment itself. I can see that the comment "*Implied consent to examination and history*" [p1] was pulled through from the previous Core Assessment and I have not amended this; given VC did engage in conversation and allow physical examination, electrocardiogram and blood tests, it is fair to assume the comment remained accurate.

46. My documentation of his insight within the Mental State Examination later on the Core Assessment would go some way to informing my assessment of his ability to weigh information (as required as part of the functional test to demonstrate capacity).

47. Given both the level I was at the time and that I was not part of the regular treating team, my perspective of his capacity would have had no impact on my management of the individual in the context in which I was seeing him. The correct framework was already in place to assess and treat the individual in hospital under Section 3 MHA. He had been readmitted to the same treating team that had looked after him a few weeks prior. If he had declined all medication at the point I was seeing him (at 2am on his first night in hospital), I would not have enforced treatment unless necessary to manage immediate risks to self and others.

History of Presenting Complaint

48. The first paragraph of the "History of Presenting Complaint" reads:

> "*From MHA assessment earlier today:*

Valdo had gone to a neighbours flat who was staying above him, knocked at his door to confront him as to why he was discussing him as he had heard voices to that effect and he was certain that it was this person living above his flat responsible. He barged into the persons flat and wanted the person to admit what he was doing and other neighbours came to the rescue and called the police." [p1].

49. I can see that this is a quote from Dr Seedat's entry in the Progress Notes from the MHA assessment he conducted the previous day [NHFT0000168 p58] which I have included as part of the history as it gives clear context to the admission.

50. The Core Assessment then says:

> "*Brought to 136 suite. Assessed and detained under section 3 MHA - prominent concerns regarding insight, medication concordance, risks to others when unwell and risk of further deterioration without intervention*". [p2]

51. I do not recall where this is taken from but from the notes available to me now, I would assume that this is a summary of what I had read on the progress notes earlier. The paperwork from MHA assessments are usually kept in the ward safe and, typically, I would have reviewed those if the MHA assessment was not documented on the progress notes.

52. I believe that the remainder of the text in this box is my documentation of the interaction with VC, and I explain below extracts from that text.

53. It starts by saying:

"*Valdo recalls events and understands why he has been detained into hospital. He reflects that he was not sure he needs to be here but is okay with it now he is here.*" [p2]

54. I would often ask a patient if they can tell me why they are in hospital, so the first sentence is recording that he has described his perspective of recent events to me and understands that he has been detained. Reading the entry now, I think that the second sentence might suggest either fluctuating insight or perplexity in the context of an emerging diagnosis of schizophrenia. The diagnosis on discharge from VC's previous admission had been "*First Episode Psychosis*" [NHFT0000223] but as symptoms develop, it becomes clearer that it may be a first episode in the context of a diagnosis of schizophrenia, which is easier for me to see now with the benefit of hindsight and now as a consultant.

55. I go on to say that:

"*Valdo denies that he has discontinued aripiprazole 5mg OD, but did say he stopped a different antipsychotic (?) after leaving hospital. He identifies this as an error as he can see that the medication had some effect given his deterioration now.*" [p2]

56. I do not recall if I explored this further or made further enquiries. As mentioned previously, I would normally review previous records before seeing a patient but might prioritise the recent entries, discharge summary and Core Assessment documentation prior to initial review. I recorded in the "Current Medication" box of the document "*Aripiprazole 5mg OD*" [p2] so was aware of his current prescribed meds. As above, I did review Dr Seedat's Progress Notes entry and quoted it in the Core Assessment. I can see that the same entry that I quoted

from contains information about VC having stopped taking his medication, and also that the plan was "*He needs to re-start his medication – Aripiprazole 10mg OD immediately*" [NHFT0000168 p58] so I would have been aware of some of the medication background. The fact that it says "re-start" tells me that there was some consensus that VC had not been taking it.

57. This passage reflects that VC was confused about his medication: he has denied discontinuing the medication he was on, then accepted that he has discontinued a different medication, and then accepted that he has made an error. It seems that his thoughts were unclear, and he was struggling to be consistent with what he is saying because he is unwell. I do not know whether I challenged what VC was telling me about his medication but it is not always appropriate to challenge patients directly, especially if they are acutely unwell and there has been limited time to establish any therapeutic alliance; one might prioritise co-operation with the clerking process. Dr Seedat documented that the medication should be "restarted" at a higher dose, suggesting concordance was already a concern so there would have been little to gain in challenging VC's assertion. The fact he later states that he would not "*discontinue it again*" [p2], suggests he was not concordant with prescribed medication.

58. The fact that VC has acknowledged that small doses of antipsychotic medication[1] have had "*some effect*" would have been reassuring that symptoms might be amenable to treatment.

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[1] , the literature (see Maudsley Prescribing Guidelines and British National Formulary) would suggest Aripiprazole at 5mg would be considered a low dose. In practice, one might start at lower doses to test tolerability before titrating in the future to achieve a therapeutic response.

59. I have recorded that VC was able to identify that it was an error to have stopped antipsychotic medication, but I am unable to comment beyond what is documented so cannot say how he was able to identify this or whether I believed him.

60. Later in the document, under the heading "Mental Health History & Patient's Perception of Previous Care – including previous treatments, medication and interventions," I have recorded:

> "*Recent admission with similar presentation. In keeping with first episode psychosis, started on medication and discharged to community follow-up.*
>
> *Reports was taking aripiprazole 5mg OD consistently. Says he stopped a different medication a few weeks after discharge.*
>
> *Valdo states he now identifies the medication as having some effect and would not discontinue it again in future*" [p2].

61. I would have gathered the information in the first sentence from either Dr Seedat's entry on the Progress notes, or from a previous discharge summary. The remainder of that section appears to be from my interaction with VC. I do not recall whether I believed that he recognised it as an error and would not discontinue it again in future. However, in broader practice, if an individual has been started on medication, stopped it and was able to identify they got worse without it, then it would seem reasonable to try again at that stage.

62. I cannot recall whether I had any concerns at the time regarding VC's past compliance, or future likely compliance, with medication or treatment. However, the fact that I have documented that "some psycho-education re treatment

when able" (see below at paragraph 80.6) as part of the initial plan in the progress notes, suggests that I had concerns about his understanding and concordance around treatment.

63. Following the discussion about medication, I have recorded in this section that *"He is aware that he experiences auditory hallucinations" and I have added "(3rd person and running commentary)"* [p2]. This is significant because these are both part of Schneider's first rank of symptoms for schizophrenia, meaning that if present in a patient with psychosis, the diagnosis is more likely to be schizophrenia, so I have recorded this as it would be helpful for those reviewing the document from a diagnostic perspective.

64. I have recorded that VC "*says he is aware that he is a bit more anxious and irritable recently. He could not identify triggers or causes for this*" p2]. I do not recall whether I asked him about how this had manifested itself, but the incident prior to admission would have been an example of how this manifested. I cannot recall or glean anything further from this note.

65. I have recorded that "*He says he is able to talk to his family when things are not okay*" and "*Valdo says he is more introverted and does not have a big social network of friends. He prefers his own company*" [p2]. I cannot recall what significance I gave this at the time. Looking at it now, and with the benefit of both hindsight, and further training and experience, I think it would be a cue towards further exploration of negative symptoms (the things that people can lose when suffering from schizophrenia, such as emotional reactivity, social engagement, sense of pleasure) in what was an emerging Schizophrenia formulation. It might also be a cue to explore neurodevelopmental history, or to highlight poor prognostic factors that might need to remain under review in

both hospital and in the community. However, it would not be clear at this stage what his pre-morbid personality was and whether these were a change to his norm and were as a result of his moves between countries, rather than as a result of mental illness. They would be points for the treating team to explore in due course. At that stage, the priority would have been to optimise medical treatment as remission would have been the target given this was a first episode psychosis albeit with features suggestive of Schizophrenia. At this point, VC had just been admitted so was at the start of their treatment and it would have been difficult to know what his function would be like when treated. It would likely be something for assessment in the community, or later in an inpatient admission, with consideration of social risks as his treatment progressed, but would not have been something that I would have instigated at this point when completing the clerking in assessment and documentation. If there was a limited treatment response, one might consider extended rehabilitation admission or social care interventions to support social isolation risk and impact. From an overall review of this section, my reading is that I was not getting much from VC, as there does not appear to be any conversation flow, and it reads as though I was having to go through closed questions, with him providing short answers and not voluntarily elaborating further.

Family History

66. Under the heading "Family history" I have recorded:

> *"Valdo reports that his paternal grandfather had an episode of ?psychosis in the past but reflects that he does not know the details and it was more "gossip" than anything" [p2].*

67. I have recorded this because it can be another indication of schizophrenia. Gottesman conducted research into the heritability of Schizophrenia, and I had to learn the risk percentages for Membership examinations. According to this research, if his grandfather had schizophrenia, this would mean 5% risk of developing Schizophrenia, compared to 1% of the population risk. The closer the relative, the greater the risk[2].

68. In VC's case, if his grandfather had Schizophrenia specifically, this would suggest his risk is five times greater than that of the general population. Given he was presenting with psychosis, including Schneider's First Rank Symptoms (a cluster of symptoms that, when present in patients with psychosis, suggest schizophrenia is more likely), a diagnosis of Schizophrenia was increasingly likely in the context of First Episode Psychosis. The significance would be mainly in terms of diagnostics and therefore informing prognosis and treatment. It is not clear whether his grandfather had schizophrenia, and VC seems to have played it down as "gossip." However, I recorded it nonetheless, as I imagine I thought that it may have been collateral information that the treating team may have wanted to explore.

69. I do not recall if I explored family history further with him.

Contact with Family

70. I cannot recall having any contact with VC's family or next of kin.

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[2] Gottesman II, Shields J. *A polygenic theory of schizophrenia*. Proc Natl Acad Sci U S A. 1967;58(1):199-205. doi:10.1073/pnas.58.1.199 [https://genepi.qimr.edu.au/contents/p/staff/1967GottesmanShieldsPNAS199-205X.pdf]

71. Under "Personal History" [p2-3], I have recorded some details in addition to some of the existing data from the previous Core Assessment. Looking at the detail, it might be that VC found it easier to elaborate on details of various moves across different countries, and his academic history, including taking his A-levels and GCSEs, attending college, and then university to study mechanical engineering, and hoping to complete his masters degree. Looking back, these details could help determine whether there had been a significant shift in his trajectory, which can commonly occur with severe mental illness. VC's family details are also recorded, including contact details, which appear to have been kept from the previous Core Assessment.

72. Under "Views of Carer / Family" I have recorded "*not available to me at time of assessment*" [p4]. From the records available to me, it suggests that I was reviewing the patient at around 1-2 am. The records also reflect that the next of kin was identified and contacted by the Approved Mental Health Practitioner as part of the MHA assessment and by the ward team upon transfer to Rowan 1 ward. I do not think it was indicated to contact them again at the point of my assessment.

Mental State Examination

73. There is a section headed "Mental State Examination," the contents of which was all drafted by me based on my examination of VC. I set out below some extracts from the notes, but the full text can be found at NHFT0003403, p3.

74. I have stated that:

> "*Valdo was polite and cooperative throughout the assessment. Good eye contact but was quite rigid in his interactions, perhaps effortful control.*"

75. We often see patients who are unwell and might sit upright and tense, and you can see how hard that are having to work just to maintain a conversation. They might speak slowly and precisely, and you can tell that they are trying to hold back a flood of other stimuli or thoughts, or they are struggling to work through their thoughts and it is as if you can see the cogs turning with all in an effort to keep it together. Although I cannot recall the encounter, the wording implies that I thought there was evidence of guarding (rigid interactions) and masking (effortful control). There might be lots of reasons a patient with psychosis might mask symptoms, such as fear of persecution in the context of delusional belief system, stigma, fear of restrictive psychiatric treatment, or if they are not at a stage of acceptance with a life-changing diagnosis. I am not able to determine specific reasons from my documentation.

76. I have then stated, *"Assessment of reactivity slightly impeded as he was wearing a face mask."* Ordinarily in a Mental State Examination, you would look for reactivity in a patient, such as spontaneous smiles, but this was impeded by the face masks required during Covid.

77. Although I cannot recall the encounter, based on review of the document, I can provide the following expanded explanations of some of the comments I documented (wording in bold is per the records, and the remainder is my further explanation):

77.1 ***"Although engaging, responses were not elaborative"***: This suggests superficial conversation and that I found it difficult to explore his symptoms with him further in any depth, which from review of this document is my impression of the whole assessment. It might suggest poverty of speech, a symptom of psychosis with reduced spontaneous

speech and short/mono-syllabic responses, and/or guarding. Significance should be weighed with the fact I was reviewing him in the middle of the night.

77.2 *"**Speech was normal in rate tone and volume. A little stilted in character**":* Stilted is a term in psychopathology that refers to when an individual is overly formal in speech and manner. It is not specific for a particular disorder. In this instance, it might reflect the "forced control" as a means of masking underlying disordered thoughts.

77.3 *"**Affect was restricted/blunted to degree**":* These are common terms in psychopathology. Restricted and blunted affect both suggest a lack of reactivity in the individual's demeanour; emotional responses would be highly limited, they might not smile spontaneously or without effort, no or limited reaction to humour or other social cue for response. Blunted affect is often seen in Schizophrenia and suggests an absence of observed emotional reactivity. Restricted affect is a more common description for similar in severe depressive episodes; with hindsight, blunted affect would be a more accurate term in this context.

77.4 *"**Thoughts were perhaps slowed reflected in his controlled and rigid interaction.**":* This is where you can see that a patient is really having to concentrate to convert his thoughts into words. This would suggest some degree of thought block or thought interference. Similarly to the above, the significance might be that a diagnosis of Schizophrenia was increasingly likely.

77.5 "***Commented that he does not always feel in control; seemed more about his life trajectory than made experiences***": "Made experiences" is referring to the passivity phenomena in schizophrenia (another first rank symptom), such as "made volition" where the person does not have control over their will, or "made emotions" where their emotions are not under their control. The way I have documented it suggests that my impression was that the lack of control he described was more around him feeling that his life trajectory was unravelling, rather than suggesting psychopathology concepts of "made volition" or control. If it were the latter, this might be significant as these features are more suggestive of Schizophrenia (Scheider's First Rank Symptoms) and would have risk implications.

77.6 "***Denies thought interference but did reflect that he looks back on previously held thoughts and cannot believe that he would think that***": "Denies thought interference" would have been a response to me probing around first rank symptoms, asking whether his thoughts were disturbed or interfered with. VC must have denied this. The remainder of the sentence suggests some attribution in terms of insight; he is able to identify previous experiences as abnormal.

77.7 "***He seemed to have some insight into auditory hallucinations but this seems reserved to hindsight, rather than in real time experiences***": I think I am suggesting partial insight as he is able to identify the auditory hallucinations as symptoms, rather than genuine experiences. I assume the comment regarding hindsight reflects the fact that he has acted on the auditory experiences by approaching his

neighbour, and is able to look back and realise that he heard voices and that is why he went to his neighbour's house, but he was not aware of it in the moment that it was occurring. I am unable to elaborate further.

77.8 "***3rd person auditory hallucinations - talking about him. Also running commentary. Says not constant. Denies visual or other distortion.***": Auditory hallucinations and running commentary are first rank symptoms, as discussed above, which he has described as not being constant. I will have asked about visual or other perceptual disturbances, which he has denied. I do not know if I enquired further as to the nature of these hallucinations and running commentary, as there is no evidence of further exploration in my documentation.

Entry in Progress Notes

78. In addition to the Core Assessment document, I made a short entry in the Rio Progress notes, which starts "*Admission clerking. Core Assessment Completed*" [NHFT0000168 p59.] The Progress Notes are often the main thing that staff would look at in relation to a patient, so the purpose of making an entry in the progress notes was to flag to anyone reading VC's notes that the Core Assessment had been completed, and to direct them to that document for further detail.

79. In this entry, I have recorded "*Imp: relapse of psychosis shortly after discharge with FEP.*" "FEP" would refer to First Episode Psychosis. At the level I was working at, my opinion would be considered a 'working impression' and I would not have been expected to provide confirmed diagnoses of significant mental

disorders. The impression of the treating team would be more relevant in diagnostics and determining treatment, which would typically take into account earlier assessments.

80. I then set out a plan as follows (wording in bold is per the records, and the remainder is my further explanation):

80.1 **"*formal admission for re-establishing treatment*":** this was the plan decided in the MHA assessment and had commenced by VC being admitted to Rowan 1, which I am summarising here.

80.2 **"*chase bloods*":** this was a task that would need doing as I had taken the bloods during the assessment and sent them off.

80.3 **"*drug card updated - aripiprazole increased to 10mg OD as per cons plan from MHA Ax*":** this is to reflect that the drug card needed to be written up to reflect the plan formed by the consultant in the MHA assessment.

80.4 **"*I10s initially - this can be reviewed with ward team depending on presentation*":** "I10s" is a common abbreviation within the Trust that refers to "Intermittent observations every 10 minutes"; the patient is to be checked by ward staff every 10 minutes. This is a well-known abbreviation that is in keeping with the language used by ward teams when documenting and allocating observation duties. This level of observations was the standard admitting level of observations.

80.5 **"*update family in social hours*":** From reading the Core Assessment, I think that I had established that VC was close with his family (I have recorded that "He says he is able to talk to his family when things are not

okay." I would have recognised that they were going to be a good source of collateral information, so this was to flag to the treating team that they should be contacted during daytime hours.

80.6 **"*Some psychoeducation re treatment when able*":** When referring to "psychoeducation" regarding treatment, I assume I was reflecting that his understanding of the role of medication in his condition needed to be revisited with him. There can be a misconception among patients with psychosis that medication fixes the psychosis and therefore is no longer required when well. When counselling patients about medication, I will typically describe antipsychotics as having two roles; one to treat the current symptoms, and the second to prevent further relapse of symptoms in the future. When working with Early Intervention Psychosis teams, there is normally a focus of work with patients around identifying early relapse signs and identifying precipitating factors for previous episodes to improve prognosis. Both would be further examples of psychoeducation in patients with psychosis.

81. I cannot recall who I spoke to regarding the plan documented. Normally, I would hand over to the ward team about observation levels and other ward level duties. Having worked on many psychiatric wards at various levels and Trusts, it would be entirely routine for the regular team to review the clerking notes of newly admitted patients onto the ward out of hours. If there were specific medical tasks, particularly regarding physical health, I might document them in the doctors' job/handover book if they had one or email them directly if I knew who worked on the team. I would not typically contact the consultant unless I

had a specific query. In this case, Dr Seedat was the treating consultant and had reviewed the patient as part of the MHA assessment earlier that day.

82. As far as I am aware, I had no further involvement with VC or input into his care.

83. I have been asked by the Inquiry whether I have ever been involved in the care of any other mental health patient who, following discharge or when in the community, killed or seriously injured a member of the public. I can confirm that I have not had experience of a discharged patient causing serious harm to others on discharge to the community.

Recommendations

84. I am aware that there has been a great deal of scrutiny and reflection regarding this case and wider care and procedures. I think it is unlikely that I am able to suggest anything novel in this regard. However, Core Assessments have been raised in my witness statement and perhaps the process could be improved. I think the consensus on their function is not clear across teams and staff. The triggers for updating them are at unplanned points of care, which often means they are updated by staff that are less familiar with the individual and their history. For instance, asking the on-call doctor to update the Core Assessment as opposed to the regular treating team who will be working with the patient for the entirety of the admission seems counterproductive; it voids an opportunity where the treating team must review the past history in detail and potentially means the lasting summary is transcribed by a professional that met the individual for just 30-60 minutes on one occasion.

85. I do not feel well placed to make any recommendations in terms of prevention of similar attacks in the future. I am thankful that these incidents are rare.

86. It is with great sadness that I reflect on this case and the huge impact it has had on so many people. My thoughts remain most with the families of those directly and devastatingly impacted by these events.

87. I also extend my thoughts to those professionals affected by this case. As a relatively new consultant psychiatrist, I will be following The Nottingham Inquiry and trust the outcomes will offer hope to those burdened with severe mental illness, their families, and professionals doing their best in challenging circumstances.

Statement of Truth

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

Signed: GRO-B

Dated: 13 November 2025

Index to First Witness Statement of DR RUPERT ACKROYD

No.	Inquiry URN	Document Description
1	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary
2	NHFT0003403	Medical Records of VC from 15/07/2020, medical establishment unknown Re: Core Assessment (CPA and non-CPA)
3	NHFT0000223	Medical Records of VC dated from 16/06/2020 to 19/06/2020, NHFT Re: Discharge summary - Version 2.2