Witness Name: Rahul Sushil Gandhi

Statement No: WITN0302001

Dated: 01/12/2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR RAHUL SUSHIL GANDHI

I, Dr Rahul Sushil Gandhi, will say as follows: -

Introduction and Background

1. This witness statement is made to assist the Nottingham Inquiry with the matters set out in the Rule 9 Request dated 15 September 2025 and the further request dated 8 October 2025.

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. I also sought advice from my Medical Defence Union and have endeavoured to answer the specific questions set out in the Rule 9 requests referred to in paragraph 1 above.

3. My name is Dr Rahul Sushil Gandhi, and I am a Consultant Perinatal Psychiatrist employed by Derbyshire Healthcare NHS Foundation Trust ("the Derbyshire Trust").

4. I completed my undergraduate degree in Medicine ("MBBS") from Sri Devaraj Urs Medical College, Kolar, India in April 1999. I undertook junior doctor jobs in Accident and Emergency in Bangalore, before I started my Senior House Officer training in the UK in Psychiatry in 2006 which I completed in 2011. I became a Member of the Royal College of Psychiatrists ("MRCPsych") after completing my membership exams in October 2010. I also completed a Diploma in Clinical Psychiatry from University of Nottingham in December 2010.

5. Throughout my training I have worked in various specialities within Psychiatry, including General Adult Psychiatry and Old Age Psychiatry. I have also worked in various sub-specialities within Psychiatry i.e. Child and Adolescent Psychiatry, Assertive Outreach, Perinatal Psychiatry, Liaison Psychiatry, Crisis Resolution and Home Treatment Team, Substance Misuse Psychiatry and Rehabilitation Psychiatry. The majority of this training has been undertaken in NHS Trusts in Nottingham and Mansfield.

6. I undertook my specialist registrar training under the East Midlands Deanery between 2011 and 2015 in General Adult Psychiatry and achieved my Certificate of Completion of Training on 27th May 2015. I have an endorsement in Rehabilitation Psychiatry which means I have had specific training which focuses on working with patients with enduring complex needs and multi-morbidity. It is recommended that this training period is for 12 months whole time equivalent. Similarly, I also have an endorsement in Substance Misuse Psychiatry which means I have had specific training which focuses on assessing, diagnosis and treating addiction disorder. The two endorsements have been on my entry in the Specialist Register since 28th May 2015.

7. I was employed very briefly as Locum Consultant in Liaison Psychiatry (9th February 2015 to 31st March 2015) and Locum Consultant in Perinatal Psychiatry (18th May 2015 to 30th June 2015) at Nottinghamshire Healthcare NHS Foundation Trust ("NHFT"). In 2016, I was employed by the Derbyshire Trust as a Locum Consultant for The Beeches, (an in-patient mother and baby unit situated within the Radbourne in-patient Psychiatry unit at The Royal Derby Hospital site) and Community Perinatal services across Derbyshire. In 2019, I was appointed as a substantive Consultant in Perinatal Psychiatry for The Beeches and South Derbyshire Community Perinatal Services.

8. I am approved under section 12(2) of the Mental Health Act 1983 as having specialist experience in diagnosis and treatment of Mental Disorders. I have full registration with the General Medical Council (GMC No: 6060690). I have a licence to practice with the GMC, undergo annual appraisals (my last appraisal was in June 2025 and next appraisal is due in June 2026) and re-validation every five years (my last revalidation was 24th December 2024). I am in Good Standing for Continuing Professional Development with the Royal College of Psychiatrists. To obtain a Certificate of Good Standing from the Royal College of Psychiatrists, I need to be a member of the college, log in to member's area, and submit my continuing professional development (CPD) activities (minimum of 50 credits per year).

9. Since 2016, in addition to my consultant post, I have worked as a Locum Higher Specialist Trainee ("HST") in Nottingham. This is because when the HST rota has gaps, I have been asked by the medical staffing team and agreed to be on the bank to provide cover for shifts, as a locum HST.

10. The staffing rotas require three doctors to be on-call: a Consultant, a HST, and a junior doctor. The junior doctor has to be a residential Senior House Officer, remaining on the hospital grounds for the duration of the shift. The HST are within 30 minutes of the area that they are covering.

11. On 24 May 2020, I was working a bank shift as a locum on-call HST for NHFT.

12. I have over 10 years' experience as an RMP.

13. As a part of my training as a Specialist Registrar (as a Higher Trainee in Psychiatry), I undertook on-call duties out of hours. One of the responsibilities during the on-call shifts was to undertake Mental Health Act Assessments ("MHAAs") in various community and in-patient settings.

14. I have undertaken numerous MHAAs in various settings such as police stations, 136 Suites (also called "places of safety" for those patients detained under section 136 or section 135 of the Mental Health Act), Accident and Emergency departments, medical/surgical assessment units and wards, acute mental health wards, and in the community.

15. Since working as a Consultant Psychiatrist, I have continued to undertake MHAAs as part of my on-call role and out of hours. By May 2020, I estimate I would have undertaken over 2400 assessments. On average, I conduct around 5-6 assessments a week.

16. I am approved under section 12(2) of the Mental Health Act 1983. This is a certification for doctors under the Mental Health Act 1983, that recognises them as having special experience in the diagnosis and treatment of mental disorder which enables me to conduct assessments, providing medical

recommendations, being the Responsible Clinician ("RC") for patients detained under the Mental Health Act. It also assists me in making decisions about treatment and reviewing detention. I am also involved in community treatment orders (CTOs) and interviewing patients in a place of safety.

17. I have undertaken the relevant mandatory training to undertake MHAAs. This training includes a two-day course on the Mental Health Act 1983 (I first undertook this course on 26th and 27th March 2009) to be approved under section 12(2). I have also attended a two-day induction course (11th and 12th February 2014) that covers the roles, responsibilities and administration related to the Approved Clinician role (AC). Before my last section 12/AC expired, I completed a one-day section 12/AC refresher course on 18th February 2021. Every 5 years (due before 2nd August 2026) I undertake the refresher course ahead of my renewal procedure.

18. As a Section 12(2) approved doctor, I follow the Mental Health Act 1983 and its associated Code of Practice, which clearly outlines the legal criteria for using the mental health powers. I also follow the Mental Capacity Act 2005 when assessing patients, and also the Human Rights Act 1998 which is relevant to my work.

19. The Code of Practice is the key document used in undertaking assessments.

20. As a RMP there are two ways typically I become involved in an MHAA.

21. The first being, as in this case, where I was working as a locum on-call HST for NHFT. Part of the on-call role is to be available for a MHAA if requested for any patient within the area I am covering.

22. The second way an RMP becomes involved in an MHAA, is by being available to attend an MHAA as a second doctor in the MHAA Process. Typically, the Approved Mental Health Professional ("AMHP") will contact the doctor to act as RMP in both scenarios.

23. The RMP's role working alongside the AMHP is to use their experience and expertise in diagnosing and treating mental disorders. The AMHP co-ordinates the professionals providing care.

24. The RMP also provides the medical recommendations to the AMHP regarding the patient's condition and the need for the hospital treatment or detention under the MHA. The AMHP relies on the RMP to provide the medical expertise to understand the severity of the mental disorder and its potential impact on the individual.

25. Prior to the assessment, there is discussion between RMPs, AMHP, and any other professional involved in the MHAA about the reason for the assessment, what each of the professionals know about the patient, what information has been collected and if any is missed. Following the assessment of the patient there is further discussion considering all the information, the patient's history and presentation, and what is the best outcome and the agreement between all the professionals.

26. Following the assessment, the outcomes will be either that the patient is:

- discharged back home without any further involvement of mental health services;

- discharged back home with a referral to the local Community Mental Health Team ("CMHT");
- discharged back home with referral to the local home treatment team; or
- admission made into the mental health ward informally or under the relevant sections of the Mental Health Act 1983.

27. A risk assessment is a structured process to gather all available information. Factors of increasing or decreasing risk are evaluated and the best management and treatment plan is determined to ensure safety and promote recovery. This is a dynamic process.

28. In accordance with my normal practice, I would consider the demographics of the patient because they provide essential context about an individual's background, which can influence their mental health and risk factors. The relevant factors include their age, sex, race, socioeconomic status, employment status and family history of mental illness and the reason(s) for the MHAA. I would gather all of the available information from the custody officer, the Liaison and Diversion services and information from other staff involved.

29. I would also check the patient's previous medical records, and whether there is a history of illicit drug or alcohol use, previous mental health issues, any non-compliance to medications, and any planned reduction of psychotropic medications.

30. I would also seek the patient's forensic history, such as any violence or assaults. I would consider any social factors, any loss or bereavements, any previous history of self-harm or suicide. I would also consider any previous

history of violence or posing risk to others, any safeguarding concerns, if any children were involved, any domestic violence and other salient risk factors.

31. I do not believe that I have been involved in the care of any other patient who has been discharged into the community for treatment, who subsequently killed or seriously injured a member of the public.

Knowledge and treatment of VC

32. I did not have any prior knowledge of VC before Sunday 24 May 2020, nor did I have any involvement with him following the MHAA assessment on that date.

33. I do not have any independent recollection of my involvement with VC on 24 May 2020 and I am therefore reliant on my contemporaneous records and my usual practice when conducting such assessments in order to answer the Inquiry's questions. I have been given access to the entries I made in computerised records on 24 May 2020 [NHFT0000168] (RiO Record Extract). In addressing the Inquiry's questions, I have located a handwritten note I made at the time of the assessment as an aide memoire. I exhibit this note to my statement as WITN0302002.This note was made whilst I was in the police station conducting the assessment and records VC's details including contact numbers. I did not have access to the Trust computerised records in the police station and therefore transferred the information from the handwritten note when writing up the computerised records as soon as I returned home later the same day.

34. That handwritten note reads:

24/5/20 Bridewell Police Station *Ben Williams*

GRO-B Valdo Calocane GRO-D Malik

Selesto Amessao Live in flat, Radford Annette Crisis team

2007 Portugal – UK 16 yrs

Born in West Africa

(Wales) Parents – mum – name, father – steel worker

Live in flat – Nottingham University – Mechanical Engineer

3rd year, single

1 brother, 1 sister I am oldest

35. When I receive a call from the AMHP requesting I undertake an MHAA out of hours, I will firstly review the patient's computerised medical records to see if there is any information. As VC was not previously known to NHFT's mental health services, the only entry on his records related to the circumstances of his arrest in May 2020. I would liaise with the AMHP and review the patient's records at home before travelling to the police station. Having reviewed the medical notes on RiO (the electronic recording system NHFT use), I can see VC was arrested by police for criminal damage (having kicked a door in of another flat). The police were called for burglary.

36. I cannot remember who I spoke to about the events surrounding VC's arrest.

37. My normal practice is to speak to the AMHP by telephone and ask for all the available information and look at electronic patient records before I travel to the police station. Once I arrive at the police station, I would speak to the Liaison

and Diversion Team (who are based in the police station) and the Custody Sergeant in person and usually to any available family members by telephone.

38. My notes document the reason for assessment and that information is likely to have come from a discussion with the AMHP, the Liaison and Diversion Team and the Custody Sergeant as well as the electronic records. I have recorded information provided from VC's mother which means that I or the AMPH had contacted her to gain that information [NHFT0000168, p2].

39. I cannot remember whether VC was aggressive or violent. There is nothing in my notes to suggest that he was at the time of the MHAA.

40. I cannot remember what VC told me about the events around his arrest.

41. Looking at my notes, when asked about the events the previous night I recorded 'VC was initially confused but then told me he heard someone screaming and he went to investigate. Upon further questioning, VC revealed he had heard his mother screaming and voices were telling him that his mother was being raped, and she was in pain [NHFT0000168, p2]. VC stated that earlier that evening his mother had texted him and told him she wanted to visit him, but VC had told her not to travel' [NHFT0000168, p2].

42. I cannot recall what information I accessed for the purposes of conducting the MHAA. The relevant medical records on the RiO entry were written by me, which I rely on in setting out what information I accessed.

43. It is the responsibility of the AMHP to organise the MHAA. The AMHP receives the referral, and they collect all the relevant information before the MHAA is

carried out. The AMHP organises the MHAA by calling the on-call doctor (non resident HST) and requesting the second doctor to attend at the agreed time.

44. As part of the corroborative history, once I get to the police station I always look at the events that led to the request for the MHAA, such as the S.136 Suite paperwork and Custody Suite paperwork. I will talk to the Custody Sergeant or S.136 Lead Nurse and speak to family if possible and available. If I am able to identify the patient's care co-ordinator and their RC, I would ring them to gain further information. Neither a care co-ordinator nor RC were in place, as VC had not had previous contact with NHFT mental health services.

45. Prior to starting the assessment, the team (4 people – 2 doctors (RMP and the second doctor), the AMHP and someone from the crisis team) meet at the police station to discuss amongst themselves the information available and share information with each member.

46. Around this time, there were still covid restrictions in place. I recall that some of the restrictions were lifted in April 2020 briefly, but there was still the matter of wearing masks and distancing to consider.

47. I cannot recall if there was any information that I did not access.

48. As I have set out, I always take a corroborative history. (From available resources like electronic patient records, staff involved, family, friends and depending on where the patient is presenting) I would have sought information that would allow me to understand what has happened to the patient and gather information from relevant people. In this case VC's mother would have been included along with Liaison and Diversion Services, & Custody Officer. It is

general practice to put a relevant person on speakerphone if they are not present, so that they can be included in the information gathering.

49. From the information I recorded in VC's medical notes [NHFT0000168], there is no information that is obviously missing.

50. The way in which an MHAA is carried out is the same, whether the patient is known to the RMPs or not. If it is the patient's RMP, they might have good insight into patient's condition.

51. As an on-call RMP, we come across patients who we may not have seen or assessed before or are new to mental health services. I undertake a corroborative history before I assess any patient under the MHAA.

52. There was no RMP who was a previous acquaintance to VC, as this was a first presentation.

53. Where an RMP is a previous acquaintance, there may be additional information from their experiences with the patient. Having reviewed my notes, I can see that he was not known to the mental health services.

54. The doctors available will vary depending on what time the MHAA is undertaken. RMPs will usually only work 9am to 5pm shifts. If the MHAA is done during these hours, there is an opportunity to call the RMP if the patient is under their care. Where possible, this is useful for continuity, as there might be issues around risks, non-compliance, or other factors. However, they still might not be available due to their scheduled work (Outpatient Clinics, Ward Rounds, Attending Tribunals or other relevant clinical work). In this situation, their previous entries in the medical notes will still assist.

55. Where an MHAA is sought out of hours, it would be less likely in my experience to find an RMP with previous acquaintance. In any event, the process is the same.

56. I cannot remember the source for the note that VC had "never experienced any mental health difficulties in the past" as stated in the AMHP report [NOCC0000045, p2]. These events happened over 5 years ago.

57. On the basis of my notes, I can see that I have documented that VC had no previous history which is mentioned by the AMHP, Liaison and Criminal Diversion Team and is also in the RiO records [NHFT0000168, p2]. Looking at the notes, I obtained further information from VC's mother and VC himself. It is likely that the AMHP would have called VC's mother and put her on speakerphone for us to talk to her.

58. I cannot remember nor recall details about VC's behaviour and presentation. I refer to my notes (please see[NHFT0000168, p2]) in answering the following questions:

59. Assessing VC's body language would have been limited because – while the covid lockdown restrictions were beginning to lift – in healthcare and public settings, wearing face masks and keeping distance were still in place. The clinicians and VC would have been wearing a mask, meaning it was difficult to see facial expressions. 'VC was distracted and guarded with minimal eye contact, looking around the room. He struggled with his attention, and I had to repeat my questions number of times'.

60. VC's communication was noted as being low in volume with numerous pauses. He appeared to be muddled and struggled to concentrate. I noted he looked 'bewildered'.

61. On the basis of my notes, I can see that 'VC told us that he was born in Africa but raised in Portugal. When he was 16 years old in 2007, he moved to the UK as his parents had moved here. His mother and father live in Wales. He reported that his mother worked as nurse and father is retired but used to work in a steel factory. He has one younger brother and one younger sister. He denied any family history of mental illness'.

62. 'VC told us that he is currently in his third year at Nottingham University. He is currently single. He has friends at the University. He told us that it was 24th May 2020. He was in Nottingham and Boris Johnson was the prime minister of the UK'.

63. 'He told us that he had heard someone screaming and went to investigate. He heard his mother screaming and people were screaming and telling him that his mother was being raped, and she was in pain. VC stated earlier in the evening his mother had texted him and told him she wanted to visit him, but he told her not to travel'.

64. 'When questioned about hearing voices he initially denied this but then described hearing two voices talking to each other. When I questioned him about paranoid and persecutory delusion, he started talking about being observed and bugged then declined to discuss any further'.

65. 'VC stated that he had not slept for a week. He described being stressed due to coursework and an upcoming exam. He described his mood to be fine. He

denied any thoughts of harming himself or harming others. He described not eating well due to his course work'.

66. My records demonstrate that 'VC was dressed casually and was wearing a face mask. He was distracted, guarded and ambivalent. He made minimal eye contact and was looking around the room. He appeared muddled and struggled to concentrate. His speech was low in volume with numerous pauses. He described his mood to be okay. He was oriented to time, place and person'.

67. The review took place in the medical room, upstairs in the police station. Generally, police will walk the patient up but wait outside or go back to their desks. If there were risks to my safety, I would not invite the patient into the medical room, or I would have a police officer present. Alternatively, I can go to the patient in the cell or even speak to them through the hatch with police present. This did not happen. I therefore believe that I felt safe in VC's presence. I would have discussed the patient's behaviour with the Custody Sergeant and watched any available CCTV to assess their behaviour before agreeing to see them in the medical room.

68. Psychosis affects the way a person thinks, feels and behaves. The experience of psychosis varies greatly from person to person. Psychosis can come on suddenly or can develop very gradually. When questioning a patient who is experiencing psychotic symptoms, I generally tend to ask open and closed questions to understand how they are thinking, feeling and behaving. I would ask them a number of screening questions like 'do you feel that people are bothering you or trying to harm you?' 'Are you afraid of anything or anyone?'

'Do you hear things that other people cannot hear, such as noises, or the voices of other people whispering or talking?'

69. It is important to note that the AMHP Report is not verbatim. Asking a patient if they feel like they are being watched in their house is a common question to ask if they are displaying paranoia, and I would have asked this question.

70. My medical notes do not state that VC reacted in a defensive manner. I cannot remember what VC's mannerisms were, and I cannot visualise him. His expressions would have been difficult to read, particularly as he would have been wearing a face mask at the time.

71. The kind of questions I would have asked depended on the state of mind of the patient. If the psychosis is very early on, the approach would be different to where a patient is acutely psychotic and it is unlikely that you could have a meaningful conversation with them.

72. On the basis of my notes, I asked VC about paranoid and persecutory delusion to further understand his symptoms. It would appear that VC started to talk about being observed and bugged but then declined to discuss any further [NHFT0000168, p2].

73. I cannot remember how VC reacted to the questions posed to him beyond what it is my notes.

74. The AMHP's report [NOCC0000044 p2] notes VC "became guarded and suspicious" which having reviewed my note [NHFT0000168 p2] appears broadly accurate.

75. I cannot remember how VC's reactions were factored into the assessment and decision-making, but my notes and my mental state documentation concluded that he was having a first episode psychosis due to sleep deprivation and stressors [NHFT0000168, p2].

76. As part of the MHAA team, we discuss with the AMHP and the second doctor the circumstances that lead to the current MHAA request and obtain a corroborative history. We generally do not receive the AMHP Report which will be completed after the MHAA. The AMHP Report is held in the Social Services Record. If the patient is admitted, it will then be handed over to the Ward Manager via email or in person.

77. The AMHP report recorded that VC struggled to follow the thread of the conversations, specifically that:

"Valdo seemed to struggle to follow the thread of conversation – it would often take him a number of seconds to respond to a question. He often also at times didn't register the question that was asked and so it would have to be repeated." [NOCC0000044, p2].

78. Having reviewed my notes, this appears broadly accurate.

79. I recorded in my notes that VC had reported that he had not slept for 7 days and he felt confused and tired [NHFT0000168, p2].

80. My notes state VC reported that he could hear screaming and that he could hear voices telling him that it was his mother and she was being raped. My note records that he mentioned that he kicked the door into another flat causing damage [NHFT0000168, p2].

81. The conclusion that VC was experiencing a psychotic episode would have been reached diagnostically. I can see from my notes that VC was presenting with a collection of symptoms which falls under the category of first episode psychosis, which would need further assessment and treatment.

82. The symptoms included:

- Experiencing auditory hallucination: the perception of voices or sounds that have no real external source, making the experience feel real.

- Thought disorder: the clinical symptoms are characterised by disturbance in the organisation and expression of thoughts, often leading to disorganised speech and difficulty in expressing ideas logically.

- Paranoid and persecutory delusion: in this case, believing himself to being observed and his home bugged.

83. This diagnosis would have informed the treatment plan.

84. The risks considered would have been discussed by the team. The AMHP Report would have summarised those risks, taking into account the 2 doctors' views. However, I did not write the AMHP Report, so I cannot comment on why any references to risks were made other than it likely being a reflection of the conversations between the team members.

85. In my experience, the discussions that feeds into the AMHP Report are holistic. After the patient is seen, the discussion will include whether the patient has a history of substance use, any charges or convictions they might have. These discussions form the basis of the assessment of risk and what can be done to address those risks.

86. The holistic approach is taken to look at the whole situation, but information that is not known cannot be taken into account. What the AMHP takes into account is something for them to comment on.

87. Having reviewed my notes, I documented VC responses to the questions I asked about risk and he confirmed he did not have any thoughts of harm to self or others and there was no history of mental health difficulties, illicit substance misuse or forensic history. His mother confirmed this as well [NHFT0000168, p2].

88. In my normal practice, after assessing the patient, I would normally discuss with the second doctor, the AMHP and any other professional present, the patient's symptoms, the likely diagnosis and the risks identified through information collected. This information includes records of any historical risk, any assessments of the patient and their mental state examination. On the basis of this information, we would come to an agreement about the outcome of the assessment: whether to discharge the patient back to primary care; make a referral to the CMHT; make a referral to Crisis and Home Treatment Team; make an informal admission; or consider detention under the Mental Health Act.

89. The AMHP report was written after the MHAA was undertaken and I did not have access to it before being provided with a copy by the Inquiry. I would not be asked to comment upon it or to approve an AMHP report. Other than by reference to the information I have recorded in VC's records, I cannot comment on how they reached the conclusions about specific risks.

90. I cannot remember details about why the notes about VC's capacity were made by the AMHP in their report. Looking at my notes, however, it is clear my opinion

was that VC had limited insight, and he lacked capacity to consent to treatment. However, he acknowledged that he was unwell and needed help. He then consented to home treatment.

91. The plan was for the City Crisis Team to visit on that night and observe VC taking olanzapine 2.5mg and zopiclone 7.5mg [NHFT0000168, p2].

92. I cannot recall specific details about his capacity, but my notes state that he lacked capacity to consent to treatment. This would have been my view at the time, having assessed capacity as usual [NHFT0000168, p2].

93. My assessment of VC's capacity would have been a factor in my decision-making. I can see from the notes that we considered both in-patient and community treatment, given that this was his first presentation. Also, the Crisis Team was part of the MHAA, and they informed us that they would offer twice daily visit with monitoring of medication.

94. The notes reflect that we were of the opinion that the least restrictive option should be tried prior to considering admission under MHA 1983. The Crisis Team would continue to assess his mental health and risks. If they had any concerns, they would consider admission or request a further MHAA if required.

95. Having looked back at my notes, I have documented that he had limited insight and was agreeable to accept help which the City Crisis Team was happy to offer.

96. VC's limited insight and capacity poses some risk that he might not comply with treatments. These factors influenced the decision-making process which involves considering all information and examining the patient's mental state,

capacity and risks posed. It is a dynamic process considering all of this before making a decision.

97. I cannot remember any conversation with VC's family. On the basis of my notes, discussions did take place with VC's mother.

98. I have documented information provided by VC's mother 'who informed us that there was no family history of mental illness. She denied VC having any mental health issues in the past and denied that he had a history of risk to himself or others. She had noticed that for a week VC's behaviour had changed and she has been concerned' [NHFT0000168, p2].

99. I can see from my notes that the conclusion was that he could be treated in the community with a referral to the Crisis Resolution and Home Treatment Team (CRHT), rather than making an application to admit him to hospital for an assessment. I agree with this decision, as it was the least restrictive appropriate option at that time [NHFT0000168, p2].

100. I considered home treatment to be appropriate in the circumstances. Based on my notes, it appeared that the risk posed could be managed in the community, with support. I considered that the risks to others were low enough for this approach.

101. The role of the CRHT Team is to provide intensive support for people experiencing acute mental health crises at home, acting as an alternative to hospital admission. Their role is to offer support and conduct ongoing assessments and to monitor the patient's mental state, including any risks. They also monitor medication compliance. If there are any new or escalating

risks or deterioration of the mental state, they can request a further MHAA or informal admission to hospital.

102. Looking at my notes I can see that Annette Palmer from the City Crisis Team was part of the assessment team and was involved in the discussion and decision making at the MHAA on 24 May 2020 [NHFT0000168, p2].

103. I cannot remember the conversations between myself, Benjamin Williams, Dr Malik or Ms Palmer. Having reviewed my notes, it appears that we were in agreement with the decisions that were made for the least restrictive option of home treatment and a referral to the Early Intervention in Psychosis ("EIP") Team [NHFT0000168, p2].

104. I have reviewed the medical records and can see that it was identified that VC was probably experiencing his first episode of psychosis, as he was exhibiting symptoms suggestive of a psychotic episode. To ameliorate his symptoms and prevent further deterioration, and so as to avoid undue delay in the start of the treatment, antipsychotic medication Olanzapine was prescribed. This medication was also appropriate due to the fact that he reported that he had not slept for a week.

105. National Institute for Health and Care Excellence (NICE) clinical guideline (CG178) published 12th February 2014 and last updated 18th March 2014 [NHSE0000539] advise in First Episode Psychosis the treatment option is offering oral antipsychotic medications. When the patient is discharged home with follow up with the Crisis Team, we provide medication because it is an out of hours service and the patient's GP cannot prescribe it (on a Sunday).

106. From my notes, I can see that VC agreed that he was unwell and needed help [NHFT0000168, p2]. Further, he agreed to take medication. I cannot recall or remember as to how he reacted when medication was discussed.

107. Witnessing a patient taking medication is not generally part of my role as an on-call RMP. The role of the Crisis Team was to visit VC twice a day and observe him taking the medication that was delivered by them. I cannot comment any further as to their experiences and this is not in my medical notes, as I did not see VC again after 24 May 2020.

108. VC was not given medication at the police station when I was present. Antipsychotic medications are not stocked or available in the police station.

109. The medication would need to be obtained from the hospital pharmacy. The Crisis Team would deliver and observe the patient taking the medication.

110. Usually, the on-call junior doctor would have to organise this by writing a community medication card for the Crisis Team, once the RMP advises the junior doctor to do so. The RMP's name is therefore on the prescription, but they are unlikely to be present when it is administered.

111. I cannot remember whether I had any concerns about his capacity impacting his ability to take medication. My notes state that he had limited insight and he requested help [NHFT0000168, p2]. Therefore, I had no reason to believe following my assessment that he would not take the medication.

112. I did not have any further communication with the CRHT, or any other medical professionals involved with VC's care.

113. I did not have any further input with Nottingham City Council regarding VC.

114. I did not discuss his needs in the community with anyone else.

115. I did not discuss VC with Ms Cullen and had no involvement in the second MHAA.

116. I do not have any comments about whether there are any structural issues, regarding the MHAA process, local procedures/policies, training, and information-sharing.

117. I do not have any recommendations about what could be considered to help prevent any of the issues identified in respect of this matter.

2025 interview with NHFT

118. On 22nd May 2025 I received an email from Dr Anna Hiley, Deputy Medical Director at NHFT. The email stated 'I'm getting in touch from Nottinghamshire Healthcare. I wonder if you would kindly confirm this is the correct email address for yourself?. I need to send you some correspondence and potentially arrange a meeting, relating to your time working at NHFT but would like to confirm we have the correct contact details'. Once I confirmed it was my correct email. I further received an email form Dr Anna Hiley on 5th June 2025 stating that the Trust 'was gathering information in order to respond to a letter of concern/complaint from the VC's victims' families [NHFT0004863] with regards to his overall care. In preparing our response, we are interviewing the staff who were involved in specific aspects of VC's care'. I responded to the email with dates and times I could meet Dr Anna Hiley. I received further email on 5th June 2025 to confirm that a meeting was booked for 13th June 2025 between 4 to 5pm on MS Teams. I was advised I would be given access to my medical notes but this did not happen until the late afternoon of 12th June 2025. The

questions were sent to me in an email on 12 June 2025. I did not write any notes or response to the questions. The questions sent to me via email were:

I. Confirmation of the Knowledge that each medical practitioner had in relation to Calocane's previous sectioning events.

II. A summary of the event that occurred during each sectioning event including the treatment and medication provide to Calocane.

III. Confirmation of whether or not capacity assessment were ever carried out or considered to determine Calocane's capacity to consent.

IV. Was consideration ever given to the potential drug induced psychosis?

V. What were the Calocane family made aware of in relation to his diagnosis?

119. I did not make any notes for the interview and was given access to the notes I made on the electronic notes of the NHFT.

120. I was interviewed on 13th June 2025 between 4pm to 5pm via MS Teams. I provided verbal responses to the questions. I made clear to Dr Hiley that I had no independent recollection of my involvement with VC on 24 May 2020 and that I was reliant on the notes I made and my usual practice. I took the opportunity to reflect on the decision making and possible scenarios of my thought processes at that time.

RG Contact with VC was on 24.05.20 for a MHA assessment

<u>Role at the time of contact</u>

RG was qualified d as a consultant psychiatrist. However, he had previously worked and trained at Notts HC and after leaving he stayed on the bank, taking adhoc shifts on the Registrar rota.

On this day he was acting as locum SPR Confirmation not the knowledge that each medical practitioner had in relation to Calocane's previous sectioning events. This was VC's first contact with services.

RG spoke with VC's mum to gather background information and mum stated no previous mental health history or concerns. The information regarding the incident at the flat that had led to the MHA assessment was provided by police and the AMP (Ben Williams)

The AMP report was not available for reference during this conversation, However, would have been RG's source of police incident information and context. RG checked Rio for any background information and had time to review available information before attending to see the patient.

RG confirmed that adequate time and resources to do background work is given and clinicians can take the time needed to read notes/prepare before attending.

Summary of the events that occurred during each MHA assessment What was the rationale for not detaining him?

In addition to Rio entry RG would add that:

Having reviewed the patient, RG's view was leaning towards admission under section 2 of the MHA, (though he acknowledges this is not explicitly stated in his notes) RG recalls that he thought admission was indicated as this was a

first presentation of psychosis, with many "Blind spots"/ unknowns, lack of information on risk history and that VC had forced entry into a flat

At the time of the MHA work was being undertaken with the Crisis team. CRT were sitting in on all assessments to facilitate discussion and reflection non least restrictive practice options.

RG states that the team of professionals considered the research evidence that shows over representation of young black males in detention and recalls that Anna palmer was able to persuade us that CRT could provide a safe and reasonable alternative of supervised medication and 2 visits / day. With the option to admit if the community treatment plan failed.

RG reflected that the discussion around options felt open, clear conversation, and helped the team reach a shared decision not to detain, but to trial community treatment. capacity assessments Capacity was considered and documented "Lacked capacity to consent".

"Agreeable to home treatment Was consideration ever given to the potential of drug induced psychosis?

Yes this was considered and enquiries made.

However, Mum did not believe there was any substance misuse / use.

Confusional screening – had not identified any organic cause (though accepts may not have been tested for drugs)

Covid hindered physical examination due to social distancing and urine screening was not available. However, there was clinical curiosity and there was no evidence of withdrawal or intoxication that identified da need for further

investigation. What were the Calocane family made aware of in relation to his diagnosis

RG spoke to mum to find out more about VC as a person. He is unable to remember if he soke to them again after the assessment, but she knew he was being assessed under the MHA. This was the first presentation, and no formal diagnosis had been made, the recommendation was further assessment and so no diagnosis was given to VC or family. Any other comments?

RG remembers the context of working during covid. It was a very difficult time for covid, social distancing, masks, cannot show your face to support emotional expression or recognition. (NHFT0004927)

121. The above document is the minutes taken by Dr Anna Hiley during the interview on 13th June 2025. The document has not captured that my involvement in the event was 5 years ago and that I have no independent memories about the event in question. I had only received my medical notes about the event less than 24 hours previously. I did not receive any other documents (AMHP report or Progress Notes). From the outset I had made it clear that I was reliant on what is written in my medical notes and could not rely on my memory. It was a reflective session for me trying hard to remember what factors would have been considered or possible thinking process including unconscious and conscious bias during my contact with VC in the MHAA.

122. I can confirm that “RG” mentioned above, refers to me.

123. I can confirm that “Anna Palmer” refers to Annette Palmer, the nurse who attended the MHAA with me.

124. Following my interview with Dr Anna Hiley on 13th June 2025 this document [NHFT0004927], was produced by her.

125. As said in the interview, I cannot recollect the events of the day and my thinking during the MHAA. In my usual practice I consider both inpatient and community treatment. When there is an abundance of information about the patient regarding their previous admission(s), their presentation, compliance with medication, engagement with services and risk it is slightly easier to make that decision based on the past history and the known trajectory of their illness. When it is the first presentation, it is difficult to predict the course of the illness, how gradual or how quickly the symptoms of psychosis will progress, the root cause of psychosis and unpredictability to the illness and the associated risk.

126. The 'blind spots/unknowns' I referred to in the interview are in general terms rather than in this specific case. As a psychiatrist, curiosity is an important part of your day to day work with patients. The curiosity to know about how they think, behave and feel. When a patient is suffering from psychotic illness there is disturbances in the way they think, behave and feel and you rely on family and friends to find out what their premorbid way of thinking, behaving and feeling was. As in this case this was first presentation there are a number of unknown factors which you are not aware of, in spite of gathering all the available information, like how the illness will progress, and predictability of their behaviours.

127. This is in the context of seeing a patient who is not previously known to mental health services, in spite of your effort of gathering as much information required to make an assessment, there is always this feeling whether you have all the

information. As a new patient you do not know how their illness responds to the treatment, how the course of illness will progress and how this will inform the risk.

128. The information that VC had "forced entry into a flat" is the information available at that time. VC was clearly presenting with psychotic illness and hearing voices. He was responding to unseen stimuli.

129. As a psychiatric trainee and Consultant, we must keep our professional knowledge and skills updated. A part of this to be aware of research evidence and data. One such example is patient demographics including age, gender, ethnicity and socioeconomic status which are crucial in ensuring research is generalisable, identifying health inequalities and informing the development of culturally competent and effective treatments. The context of the discussion would have been whether this evidence and data was thought about at that time or not. I cannot remember whether we had this conversation during the MHAA. As mentioned before this was a reflective process to aid the trust in their investigation. Even if this was discussed, it would not have affected our decision to admit or treat VC in the community. The decision to admit or treat in the community would have purely on his current needs, acuity of the symptoms he was presenting with and the risks.

130. As discussed in the interview my normal practice is to consider both inpatient and community treatment. In my normal practice I would consider all the information available (i.e. past psychiatric history, past drug and alcohol history, past forensic history, compliance with medication, information from family, patient's presentation, mental state examination and risk assessment). Taking

everything into consideration there is a dynamic discussion between two doctors, AMHP and other professionals about the effectiveness, safety and feasibility of the options.

131. As discussed in the interview with Dr Anna Hiley, all of the statements are speculations of what could have happened during the MHAA. These are not true facts but reflection on the event on 24th May 2020 and what could have been my thinking. Annette Palmer is a band 7 nurse who works for Crisis Resolution and Home Treatment Team. They have the expertise in providing home treatment for acutely unwell patients. They attend the MHAA, purely to look at whether home treatment can be effective and safely provided in the community in the context of risk to self and others. They have expertise in home treatment feasibility. As mentioned in my medical notes, the crisis team were able to offer twice daily visit with monitoring and observing the medication compliance.

132. Covid in general was a difficult time for everyone. But in healthcare settings, a lot of changes had to be made. The main changes in mental health settings were seeing patients via video appointment and telephone appointment. When seeing patient's face to face, wearing mask and appropriate PPE (personal protective equipment) was a new change. If a patient is already psychotic or paranoid it is difficult to build rapport or therapeutic alliance. Establishing therapeutic alliance involves non-verbal cues, such as the patient noticing the clinician's empathy and non-judgement by facial expression and tone of voice. For the clinician completing the MSE (mental state examination) the face mask (both the patient's and the clinician's) presents a barrier.

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 01-12-2025

Index to the first witness statement of Dr Rahul Sushil Gandhi

No	URN Reference	Document Description
1.	WITN0302002	Handwritten Note completed on 24.05.2020
2.	NOCC0000044	AMH Report Referral and Assessment dated 24.05.2020

3.	NOCC0000045	AMHP Report Referral and Assessment dated 25.05.2020
4.	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary ("PRS")
5.	NHSE0000539	National Institute for Health and Care Excellence (NICE) clinical guideline (CG178)
6.	NHFT0004863	Letter of Concern/ complaint received by VC's victims' families
7.	NHFT0004927	RiO Record Extract - RG contact with VC – 24.05.2020