

**Witness Name:** Abigail Parsonage

**Statement No:** WITN0317001

**Dated:** 14 January 2026

## THE NOTTINGHAM INQUIRY

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### FIRST WITNESS STATEMENT OF ABIGAIL PARSONAGE

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I, Abigail Parsonage, will say as follows:

#### **Introduction**

1. I am a Community Psychiatric Nurse (Band 6) at Nottinghamshire Healthcare NHS Foundation Trust.
2. This statement responds to the Rule 9 request dated 22 September 2025. It provides details of my career and role in the Nottinghamshire Healthcare NHS Foundation Trust (“**NHFT**”), and my interaction with Valdo Calocane (“**VC**”) on the following dates:
3. 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.

## **Career and role**

4. I graduated from the University of Nottingham in 2016 with my degree in Mental Health Nursing. This degree is validated by the Nursing and Midwifery Council I am a member of the Royal College of Nursing. I do not hold any professional appointments.
  
5. After graduating, my first role at NHFT was as Staff Nurse (Band 5) on Rowan  
2. Rowan 2 is a female acute psychiatric ward at Highbury Hospital.
  
6. In 2018, I then moved to be a Community Psychiatric Nurse (Band 5) at the Stonebridge Centre Local Mental Health Team (LMHT).
  
7. In 2019, I then became a CPN (Band 6) in the Early Intervention in Psychosis (EIP) Team, also based at the Stonebridge Centre. This is the role that I continue to work in today.

## **EIP Service and the Role of the Care Co-ordinator (CCo)**

8. The EIP team have an important and integral role to play in supporting service users and their families/carers in a community setting. EIP is founded on an extensive and compelling evidence base which has demonstrated EIP can contribute significantly to the amelioration of initial problems and consequently improve long-term outcomes. Effective early treatment is thought to reduce the probability of the emergence of longer term "treatment resistant" symptoms and contributes to the avoidance of the "revolving door" syndrome of repeated relapse. Moreover, as suicide is highest in the first few years of First Episode

Psychosis (FEP) EIP can reduce the risk of suicide. I have exhibited a copy of the EIP Operational Policy [NHFT0004012] to this statement.

9. The aims and functions of the EIP Team are to intervene early, assess early, treat early; to prevent relapse; to promote recovery; to reduce risk to self and others; to reduce inpatient admissions; to provide comprehensive support from the multi-disciplinary team (MDT); to prevent further relapses, improving prognosis; and to support people and their families.
  
10. Individuals would be referred to the EIP Team upon experiencing FEP. First episode psychosis is the term used to describe the first time a person experiences the combination of symptoms known as psychosis. During an episode of psychosis, a person's perception, thoughts, mood and behaviour are significantly altered. Each person will have a unique experience and combination of symptoms. Core clinical symptoms are usually divided into 'positive symptoms', so called because they are added experiences, including hallucinations (perception in the absence of any stimulus) and delusions (strongly held beliefs that are not in line with the persons' social and cultural norms), and 'negative symptoms', so called because something is reduced (such as emotional apathy, lack of drive, poverty of speech, social withdrawal and self-neglect). A range of common mental health problems (including anxiety and depression) and coexisting substance misuse may also be present.
  
11. In terms of the treatments that the EIP Service provides to patients, these include: offering the EIP pathway (if appropriate); support for families; cognitive

behavioral therapy for psychosis; allocation of a care-coordinator; reviews with a psychiatrist every 3-6 months; support worker support to integration within the community (e.g. if someone had the goal to go to college); referrals to other agencies (e.g. mental health wellbeing team, support with benefits, housing support); and referral to crisis agencies/assessment of risk. We try and offer as many of these options to each patient as we consider to be appropriate for them. However, due to staffing issues and the uncoupling of the EIP team from the LMHT at the time of my interactions with VC, we were not always able to do as much therapeutic work we would like.

12. The EIP service would monitor patients through face-to-face appointments; telephone appointments; liaising with other agencies who have contact with the patient (e.g. probation); liaising with family; seeing patients at home, our base, at their GP, or in public places. Ideally, we would see patients face-to-face, but if this was not possible, then we might offer them a phone call. If a patient was difficult to engage and we were not successful in our efforts to see them, we would then ring their family and other agencies who were involved in their care.

13. If the EIP Service had concerns about medication concordance, we would take over prescribing from the patient's GP as this made it easier for us to monitor whether the patient was collecting their medication. If we had concerns about medication management and concordance, we could ask the patient to show the blister pack. However, the patient may decline as there is no legal framework to monitor concordance, and we do not routinely check medication packs. If our doubts about concordance continued, we would bring this concern

to the MDT and also refer to crisis who can do medication concordance, depot injections, and community treatment orders. I have also previously known blood tests to be done for certain medication which will show in the patient's blood (such as Olanzapine and Clozapine); however, we would not start a patient on Olanzapine or Clozapine if we had concerns about their concordance.

14. I did not receive any formal training in dealing with medication concordance. I believe it may have been briefly covered in lectures at university, and it would also have been covered in placements where these took place in the EIP and/or LMHT services.

15. In terms of the procedures that were in place for non-engaging patients, this was covered in the Operation Guidance [NHFT0004012]. We would text and call the patient in the first instance. If this was unsuccessful, we would then ring their family members or other agencies who had contact with them. These agencies would range from probation services to university mental health teams, to soup kitchens. We would also complete "cold calls" (unannounced visits) at the patient's house. As a last resort, we would report the individual as missing to the police.

16. The Operational Guidance also set out the circumstances in which a patient might be considered unsuitable for EIP treatment [NHFT0004012]. I had not read this guidance in full, due to the time constraints in my role, however, it is likely to have been quoted in communications to staff members, supervisions, and in MDT meetings.

17. We did not have any formal training on how to deal with non-engaging patients, but rather it was something that was learnt on the job.
18. The EIP team would refer patients to other community health services as appropriate. For example, we would refer patients to the Crisis Team via the phone. We would also refer patients to their LMHT if we felt they were not appropriate for the EIP Service (for example, if they did not have a primarily psychotic illness). Where our service users were university students we would have 'shared care' with their local EIP team, who would take over their care during the summer.
19. The EIP team worked with inpatient service by attending ward rounds, receiving referrals from the ward for new patients, and visiting the ward to see patients.
20. In terms of my caseload, in 2020/2021, the EIP team split from the LMHT. This meant that we had a review of our team and our caseloads, and we stopped support from duty (as standalone EIP teams do not have a duty system). Emma Robinson, who was our manager at the time, and the rest of our team thought we would be merged with EIP East, to ensure we had a bigger team in case there staff members were off sick, and to allow broader MDT discussions. However, senior management declined to combine our team with EIP East. In the LMHT, there were around 15 nurses, social workers, and occupational therapists; when we moved into the EIP team, we initially had four CCos.

21. I cannot recall the exact numbers on my caseload between 2019 and 2023. However, it has almost always been over 15. On occasion, I have had 15 patients on my caseload, but this has been brief due to referrals. In 2020, I had 23 patients on my caseload.
22. Gary Carter was employed as an agency nurse to help us with staffing. If we were full time, we would have had bigger caseloads.
23. In July 2022, I remember helping Gedling EIP due to sickness in their team. In 2022, it also appears we had sickness in our team, meaning higher caseloads and more cover.
24. We were also trialing the at-risk mental state pathway (ARMS) at this point. Typically, before an episode of psychosis, many people will experience a relatively long period of symptoms, which is described as having an 'at risk mental state'. This may include: an extended period of attenuated (less severe) psychotic symptoms; an episode of psychosis lasting less than seven days; or an extended period of very poor social and cognitive functioning (perhaps accompanied by unusual behaviour, such as withdrawal from school, or friends and family) in the context of a family history of psychosis. When treating a person presenting with an at-risk mental state, it is important both to support them with their current needs, as well as to try to prevent transition to psychosis.
25. We would also do three-month assessments of the patients who we were unsure if they were experiencing FEP.

26. MDT meetings were held weekly. They were attended by doctors, nurses, support workers, employment support workers, management, and cognitive behavioural therapists. There was an expectation that all members of the MDT would attend the meetings, but inevitably some members would be off sick or on leave or have an urgent visit to complete.

27. The purpose of MDT meetings was to discuss all of the patients on our case load, and the referrals that had been made in relation to them, plans for next steps for the patients, and any changes in their risk. Having an MDT approach meant there was an opportunity for individuals from different roles to suggest ideas for treatment or engagement which we had not thought of.

28. At the time of my involvement with VC, we did not have the weekly risk meeting like we do now. However, if we were worried about someone, then we could bring this up at the MDT meeting. We could also speak to our manager at the time if we were worried about someone's risk or speak to somebody in the office in a more informal way.

29. The risk meetings now happen every morning, and we discuss the patients who are not engaging and who we are concerned about. We then plan what our next steps will be.

30. At the time of my interactions with VC, following each interaction we would discuss risks as a team in the office; for example, I would explain that I had

seen VC on a particular occasion, and then explain how he presented on this occasion. We would also contact our manager who would support us with concerns and let the medic know.

31. Supervision meetings were usually held once every one or two months. However, at times of bigger caseloads or high levels of burnout, we could ask to have more regular supervision meetings. We would then have a meeting perhaps every two to four weeks for a short period, in order to provide additional support.

32. Between 2019 and 2020, I was supervised by different people across the EIP and LMHT team; these were Gemma Wright LMHT Clinical Team Leader (CTL), Helen Taff LMHT manager, Emma Robinson EIP manager, and Sarah Hayler LMHT CTL. From 2021 to 2022, I was supervised by Emma Robinson, EIP manager. From 2022 until the present day, I was supervised by Sharon Heath, EIP manager.

33. In supervision meetings, we would discuss my personal wellbeing, any issues with my training or my performance, any safeguarding issues, any patients I was worried about, any concerns with the team, and any team updates or changes to practice. I would pick the cases that I wanted to discuss in these meetings.

### **Care Co-ordinators (CCo)**

34. The purpose and role of a CCo is to coordinate and oversee the care of patients in the community. They assess mental health and risk, provide treatment, liaise with patients' families and other agencies, make referrals to other agencies, ensure the EIP interventions are being offered, discuss patients in MDT, assess medication side effects and/or efficiency, and escalate any concerns about patients as necessary.
35. The frequency with which I monitored patients would depend on each patient. I might see higher risk patients every week, and lower risk patients who are working toward discharge once a month. For most patients though, I would see them once every two weeks.
36. If a patient deteriorated at any point, then we would increase contact. Equally, some patients do not want regular contact with services when they are well, and we will aim to meet that request so long as the patient has capacity to make it. If a patient was not engaging, we may not be able to see them as often as we would like (because they were not engaging).
37. The length of the contact with each patient would also depend on the patient. Ideally, we would see them for between half an hour and an hour, but if a patient was in crisis, we might be with them for two hours. On the other hand, if a patient did not want to see us, they may only tolerate 5 to 20 minutes of contact before asking or to leave, disengaging or becoming aggressive. In those circumstances, staying and forcing the patient to communicate with us causes a breakdown in our relationship.

38. If a patient was not tolerating contact with us, we would contact the patient's family and other agencies and ask how the patient presents to them. For example, the patient might have a better relationship with a team who is not healthcare related, such as the University Mental Health Advisory team. We would also think of creative ways to build trust with the patient, such as whether the patient might feel more comfortable if we went for a walk or a coffee with them instead.

39. I was not given any formal training or guidance on the frequency or length of contact with patients, rather, this is something that I learnt on the job; it is also something that is different for each patient that we deal with. However, I could discuss my cases at the MDT, and the patients who were not engaging or tolerating visits would frequently be raised at the MDT meeting.

40. My approach to managing/monitoring medication concordance would again depend on patient needs. For some patients, we would not have any concerns regarding their concordance; for other patients, we might use a 'flexi pack', which is a bit like a dosset box, so it helps the patient to keep track of the medication that they have take. Whatever the patient's attitudes to medication were, these would be included in their care plan. Concerns about medication concordance were also raised at the MDT.

41. If a patient was new to our team or they had been an inpatient, they would need a new care plan. Otherwise, I would review care plans every year, or more frequently, if there were changes to the patient's needs.
42. I would update a care plan if there changes such as to the patient's medication plan, their presentation, where we were seeing them, the number of CCo's that needed to attend to manage risk, or any changes to their relationships with their CCo or others in the team (for example, if there had been a breakdown of such a relationship). Other changes which would lead to the care plan being updated included if any other agencies became involved; if the patient's cultural or spiritual needs changed; any changes to the patient's finances; changes to the patient's consent for familial involvement; or if I was taking over as their CCo.
43. Previously, there was the standalone Assertive Outreach (AO) team who would deal with AO patients. Before the EIP team uncoupled from the LMHT, we had a joint MDT to discuss EIP and AO patients. When the EIP team did uncouple from the LMHT, it was EIP only.
44. For EIP patients and patients with an established diagnosis of schizophrenia, their ongoing care planning would be brought up at the MDT at the end of three years after their referral to the pathway. We would then refer to the LMHT, and they would have a clear care plan, although LMHT did not have a formal AO pathway.

45. The guidance I was given on undertaking care planning and the frequency with which it should be undertaken is that it should be done every year, or when there is a change to the patient's needs.
46. For a patient who was not engaging or not concordant with their medication, their care plan would include a section about that medication needs; what actions are to be taken and who is to take them; what has been trialed already; and why the patient is non-concordant. There are lots of reasons why a patient might not be concordant; for example, they might be paranoid, they might not agree with medication, or they might be experiencing side effects.
47. We would implement care plans by putting the various tasks contained therein into action. We would also use them to formulate our visits to patients.
48. In terms of assessing the effectiveness of care plans, I would monitor care plans at least every year, and more regularly if there had been a change to the patient's needs. I also take random dip samples of care plans to ensure they are up to date, or whether anything can be added.
49. I do not recall assessing the effectiveness of discharge and discharge planning or having feedback if a discharge was poor.
50. I would attend MDT meetings every week, but I do not recall contributing to discharge planning.

51. At the time of my interactions with VC, the discussions that were had in MDT meetings were not documented. However, now, the CCo for that particular patient is usually responsible for documenting what happens in an MDT; if that CCo is away, somebody else might discuss their patients on their behalf, and that same individual will document what had been said.

52. In terms of liaising with the consultants and clinicians in the community health team, I would discuss my patients with the EIP doctors at the weekly MDT, or sooner if we had concerns or if there were any changes. Additionally, if the patient was booked in for an outpatient appointment, we would also talk before.

53. There were two policies in place for when patients did not attend an appointment. There is the Procedure 01.08 – Do Not Attends [NHFT0000417]; I do not know when this was first introduced, but NHFT0000417 is version 8 of this document, which was introduced in November 2018. There is also Procedure 01.08a – Merged Do Not Attends/Cancellations [NHFT0004725]. Procedure 01.08a was introduced in September 2021. Procedure 01.08a did not replace Procedure 01.08, but rather the two work together.

54. Procedure 01.08 sets out at length the steps that should be taken for different types of patients who did not attend (“DNA”) their appointment.

55. Procedure 01.08a sets out the role of the CCo as follows under paragraph 7.2.3:

*“If the patient is not contactable at their address or by phone, the care coordinator or other nominated team member should call all recorded contacts*

*to ascertain the patient's whereabouts and clearly record these attempts in the healthcare records and RiO.*

*A letter should be sent to the person's home address and other usual addresses inviting him/her to make contact and detailing actions to be taken with timescales if contact is not made.*

*If the patient is not at his/her address, the care co-ordinator and service team should agree other agencies to be contacted e.g. GP, housing departments, works and pensions departments etc. including a discussion regarding contact with family members even if the patient has requested no contact with their family. This requires to be judged on a case-by-case basis determined by the level of risk, whilst at the same time, must respect patient confidentiality in not discussing or passing on clinical information.*

*If all contacts fail the care co-ordinator should discuss their concerns with the MDT and agree the next steps to be taken. This may include involvement of the police. If the police are contacted concerns for the patient should be clearly articulated including what assistance is requested from the police. The police have the power of entry in the case of suspected concerns regarding risk including harm or serious concern in relation to the patient's wellbeing."*

56. Procedure 01.08a then goes on to set out the steps that may be taken in terms of Care and Treatment Orders (CTOs), further assessments, referrals to other services, alternative support services, and capacity assessments.

57. The Procedure was updated again in October 2025, to remove the 'opt in' policy. I have exhibited a copy of the updated Procedure 01.08 to this statement as WITN0317002.

58. The CCo may give an opinion on medication and/or discharge, but ultimately this was a decision taken by the team. The views of the CCo were considered when making decisions about patients, and I do feel that my views in respect of patients were fully considered when it came to decision-making by responsible clinicians.

59. In terms of the role of a CCo in arranging for a patient to be placed on a Community Treatment Order, we may suggest this as an option, or state what we have noticed and how treatment is not working. However, we would not have the final say in such a decision.

60. Similarly, if medication concordance is a concern, we might suggest depot medication. If the patient is willing and the medication will remain the same (for example, if the patient is prescribed haloperidol, they might want a depot injection if they kept forgetting to take their tablets), then this can be done immediately. However, if the patient agrees to depot medication but their current medication is not compatible with the same (for example, Olanzapine cannot be administered as a depot injection), the patient will need to discuss with a medic. Alternatively, if a patient does not agree to the depot medication, or the situation is more complex, medic review would be required. Depot medication cannot be commenced without the patient's consent or a CTO.

61. The recommended caseload for CCo in EIP teams at NHFT is 15 patients per CCo.

### **Assessment of Risk**

62. The role of the CCo in assessing risk includes to assess the patient's risk at every contact, to document risks (and changes to risks) appropriately, to raise concerns as appropriate, to update the risk assessment as required, and to take

necessary action following interactions with patients (for example, bring to the MDT, discuss with manager, or refer/update other agencies).

63. I would use the risk assessment tool on RiO provided by NHFT to risk assess patients.

64. A risk assessment should be carried out every six months, or more frequently if there has been a change.

65. I would assess risk by considering family feedback, feedback from the community / other professionals (such as GPs and the police), my own observations when meeting with the patient, and the observations of the doctors involved in treating the patient. If the patient was someone on our case load who we knew well, then we would know their risks, and could look out for the signs of them.

66. The risk posed by mental health patients to others would be assessed using our own assessment, and the information we had from other agencies. For example, we would review whether it was safe to see that patient alone, or whether they should be seen in pairs, and/or at a particular location. We would update the risk assessment at least every six months and also check any reference in the risk assessment to "forensic history i.e. convictions", and update this if required.

67. Moreover, we would liaise with other agencies. For example, probation might have requested that an individual is made subject to a mental health treatment order, perhaps because they had committed a crime as a result of their mental health issues, or because they had committed a crime for separate reasons, but this was a route to improve our engagement with them. We would also call the police if a patient was being aggressive towards us.

68. I would update a risk assessment where there was a change in the patient's risk to self as a result of a huge variety of reasons, ranging from an increase in self-harming, safeguarding concerns, or receiving a criminal conviction.

69. The first type of risks encountered in the EIP team were risks to the patient themselves, such as suicidal thoughts and self-harming. We would manage these using stabilization skills, updating the patient's care plan and risk assessment, bringing our concerns to the MDT, safety planning, considering how their medication quantities can be managed to reduce an overdose risk.

70. The second type of risk encountered in the EIP team were risks to others, such as the patient displaying violence and aggression, criminal activity, or carrying a weapon. This would be managed by reviewing their care plan and risk assessment, seeing the patient in pairs in a public place, calling the police if the patient became aggressive, liaising with police colleagues, discussing the case in the MDT, and referring to the forensic team if the patient had several serious convictions.

71. Since the attacks by VC, we have had in-person training on assessing risk; we also had e-learning on it beforehand. I cannot remember exactly when this training happened. However we did have one session delivered by a crisis doctor on one occasion, and another session delivered together by someone who worked in court liaison and a nurse prescriber. I am not sure if this training will be repeated again in the future.

72. I am not familiar with, and have not been given training on, the Royal College of Psychiatrists' publication 'The Assessment and Management of risk to others' (College Report 201) [NHFT0015099].

### **Capacity**

73. CCo's would assess patients' capacity when considering their consent to treatment.

74. I received online e-training from NHFT on assessing capacity. This involved PowerPoints on the Mental Capacity Act 2005, followed by a quiz at the end.

### **Raising concerns**

75. If I had concerns about the risk of harm posed by a mental health patient to members of the public, then depending on the nature of the concern, I would raise these with my manager, the MDT, the psychiatrist, or other colleagues in the team. I could also raise concerns with the police and the crisis team and request a mental health act assessment.

76. I do not know what the procedures were for patients who were relapsing, not engaging, not taking their medication, or unsuitable to EIP treatment.

77. In terms of the process for patients who were relapsing, not engaging, or not taking their medication, I would bring these to the MDT, discuss with colleagues, medic, manager and/or talk to family members or loved ones (providing the patient had given their consent). For all of those individuals, we would consider referring to the crisis team, undertaking a Mental Health Act Assessment (MHAA), admitting to hospital, increasing contact (if possible), and liaising with other agencies that the patient may have contact with.

78. At the time of my interactions with VC, I believe we also did 'opt in' letters, to say that if the individual had not engaged by a particular date, they would be discharged from the service. This would not be used for everyone though; for example, an assertive outreach patient would not engage with this so they would not receive this letter.

79. For individuals who were considered unsuitable for EIP treatment, the process would be MDT discussion, and referral to Local Mental Health Team (LMHT) colleagues.

80. I would request a forensic assessment of a patient if the patient had multiple convictions or posed a risk to the public. For example, I recall doing this for a patient who had been convicted of a crime which they committed as a result of

their mental health. Another time, I did this for someone who voiced thoughts on harming others as part of his psychotic symptoms and acted on them.

### **Information sharing**

81. We do not have a shared system with the police, and therefore we cannot see if an individual has a criminal record, and/or has had contact with the police unless we request a Police National Computer (PNC) check, which must be done by a manager. A PNC check takes a month to come back to us, and would only show basic information about arrests, charges, convictions, bail status, wanted or missing persons markers, Multi-Agency Public Protection Arrangements (MAPPA) (if relevant). The PNC check does not show policy intelligence, domestic abuse history, soft information, local incident logs, neighbourhood concerns, crisis/welfare checks, low level allegations, or any unproven or recordable information.

82. I have previously worked with an officer who was part of a beat team (i.e. local police team) who knew a patient well, and who would have informed us if that patient had been arrested. However, this is rare, and it would only be certain beat teams or officers who liaise with us. Information must only be shared when needed, and therefore we would not be able to see police records.

83. There is also the Street Triage team, who are Mental Health Nurses who go out with police (one mental health nurse per police car), and those nurses use RiO if they have had contact with someone. But the Street Triage team is only involved when an individual is crisis, and they would not provide routine updates

to mental health teams regarding an individual's contact with the police, as this would be too much work (there is often just one Street Triage Nurse to cover the whole of Nottingham). We now rely on two Police Officers with links to the trust, but clinicians reach out to them.

84. Police cannot access patients' medical records, mental health notes, GP summaries, or their psychiatric history. Police only know if a patient has been sectioned if there were directly involved in the sectioning, and even then, it may be hard to find this information, as incident logs can become inaccessible by regular officers and/or archived after a few years. Police would also know if they had been told by mental health services that there was a safeguarding protocol in place.

85. Generally, we do not have shared systems with physical health services, so we would not know if someone was admitted to hospital for physical health reasons or have access to running records regarding the same. However, we would find out this information if the patient told the ward, if we found out from one of their loved ones, or we rang the main switchboard to find out what ward the patient was on. Likewise, physical health services do not have access to our records. Some members of staff, such as psychiatrists and our pharmacy prescribed, do also have access to SystemOne.

86. We also cannot see adult social care records. Social workers have access to RiO, but we cannot see their notes.

87. If someone moved to a different part of the country, other mental health agencies would not have access to our records and vice versa. For example,

when VC moved out of Nottingham, other mental health services who treated him would not have been able to see our notes, and would not know that he had been under mental health services or how he presented, unless he told them himself.

88. We also do not share the same note system as hospitals which have private beds occupied by NHS patients. So, if someone is in a private hospital, we cannot see their running records, which set out the patient's day-to-day presentation, their care plan, what medication they are on, and so forth. Instead, we rely on the ward sending us the discharge summary, and inviting us to ward rounds.

89. In NHFT, we use RiO for our notes, care plans, risk assessments, and paperwork. However, not all trusts use RiO, and even if a patient moves to a different mental health team who also use RiO, we still cannot see each other's notes and documentation. Instead, we have to rely on the clinician to share the information.

90. It could be difficult to obtain information from the police. Sometimes, if we did not know where someone was, we could email the police for information. Sometimes, however, we would call 101 for information, but when we told the Police we were Mental Health Nurses, they would say they could not share the information.

91. In terms of barriers to the sharing of information relevant to clinical treatment and risk assessment that limited the effectiveness of multi-agency working,

police and mental health services did not have the same system as us at the time (unless it was street Triage, where police officers and nurses work together, and the nurse will have access to RiO). There was no dedicated police officer within the trust either. Moreover, GPs, secondary services, and mental health advisory team in universities do not have the same systems as us.

92. I would share information with a patient's family either through face-to-face contact, phone calls, or text messages. Again, the method of contact that we would choose would depend on the circumstances. In some cases, the patient would have a family member present in every visit, so we would visit them face-to-face. In other cases, the patient might be a student who does not live in Nottingham full-time, in which case we would call or text them.

93. If a patient did not consent for information to be shared with their family, we would not share information with them unless there were overt concerns for safety (either from patient to self or patient to others), in which case we would contact their family.

94. If a patient withdrew consent for us to share information with their family, I do not know what consideration would be given to a patient's capacity at the time they withdrew consent.

95. We would share information with family members despite objection from the patient if there were certain changes to their risk profile (for example, if they

had assaulted someone), or if we wanted to know if they had seen the patient or knew where they were.

96. We would share information with third parties (such as the police, local authorities, and GPs) through telephone calls, emails, and letters. These were the same methods that were used to share information with us.

### **Related events**

97. I have been involved in the care of one other patient (other than VC) who, following discharge or when in the community, killed or seriously injured a member of the public. This happened in 2022.

### **Interactions with VC**

98. I would be involved in a patient's case whilst not being that patient's CCo if their assigned CCo was off sick, on leave, out on a visit; I am on duty (LMHT times); I am in the office a call has come through about him (CCO on visits) I offer to take it as I know him vaguely; I am involved in the MDT so would hear about patients.

99. I cannot recall whether VC had been discussed in previous MDT (or other) meetings, or what had been said about him, prior to his referral to us.

100. I cannot remember specifically but I had probably discussed with Claudia Birtles who would be VC's CCo, and who had capacity to pick him up.

101. I did discuss VC on 23 June 2020, when I put an email from the Crisis home Treatment Team in the Teams chat for Assertive outreach/EIP, asking for a joint visit to handover care to our team [WITN0317010]. This will have been when we allocated VC.
102. I thought he had psychosis and that perhaps this would turn into schizophrenia, but from reading the notes I can see it is clear he had schizophrenia.
103. At the time of VC being under the team, I understood his insight to be changeable (although I know now that he did not have insight).
104. In terms of VC's medication concordance, I understood this to be patchy. This was an ongoing issue throughout his time with trust.
105. My understanding of the risk posed by VC was that he was experiencing paranoid beliefs, he had intimidated his housemates and took one hostage (he said he was waiting for witnesses for when the police arrived); he went into someone's flat because he heard the voice of his mum being attacked, which caused the occupant of that flat to jump out of the window as they felt distressed; had attacked police when he was being detained; and had poor concordance with medication.

106. I was aware of VC as a result of covering him in MDT meetings on behalf of other CCos. When I describe VC's belief system as 'complex' [NHFT0004885, pg6], which meant it was difficult to build a rapport with him, as he struggled to trust any of the team members. As I have read through VC's notes in the course of drafting this statement, I realise that there is a lot I did not know about VC as a covering CCo. For example, I suspected that he had schizophrenia, but not that it had been mentioned several times. I think my knowledge of the true extent of his condition was vague, however, VC's psychotic beliefs were very detailed, and appear to get more entrenched the longer he was with us. I now know that VC believed he was subject to neural remote mapping, which could scan and manipulate his thoughts at a distance; he also felt that EIP were working with the judicial system and Highbury Hospital, and that 'voice hearing experiences' had been created to monitor him.

107. I do not believe that I ever read VC's care plans and/or risk assessments. This is likely because I knew what the risks were as a result of the MDT meeting, and I also knew what his care plan was.

### **Chronology of events**

#### ***(a) June 2020***

108. The Patient Summary Record (PSR) includes an entry on 25 June 2020 at 2:36pm by Jo Baker, which states:

*"I have spoken with EIP LMHT City South (Abi Parsonage) and informed her that Valdo will be staying in Nottingham for at least the next 6 weeks. Email sent requesting if we are able to arrange a joint visit to hand over care."*

[NHFT0000168, pg52]

109. I did not speak with Jo Baker, and therefore there is no discussion for me to recall.

110. I received the email from a duty worker at the time (when we were still merged with LMHT) that is when I put on the MDT chat for us to allocate VC.

111. I believe that Claudia Birtles would have arranged the joint visit.

**(b) July 2020**

112. The PSR includes an entry on 24 July 2020 at 9:33am by Claudia Birtles which states:

*"City South EIP contacted ward, Valdo and Celeste to inform them that the contact person is due to go on leave next week, returning w/c 3rd August. Colleagues Abi Parsonage and Sabrina Edwards will cover in my absence"*

[NHFT0000168, pg90-91]

113. The PSR includes an entry on 24 July 2020 at 3:52pm, which refers to an email from Claudia Birtles (CCo). This is described:

***"Email from CCO - Birtles Claudia - Community Psychiatric Nurse.***

*She wanted to let the team know that she was going to be on leave during the coming week and will be due back to work on the 3rd of August.*

***So as not to delay discharge, she has suggested the team can either contact Sabrina Edwards or Abi, who will be happy to support discharge in her absence.***

*She was going to let Valdo and his mother know that she was due back to work on the 3rd of August "*

[NHFT0000168, pg91]

114. I would not have had specific discussions with Claudia Birtles before she went on leave. In the team, we would say we were going on leave, to ensure VC may be discharged. So, then it would be my responsibility to look in VC's notes for what happened.

115. My understanding of VC's condition at this time was that he had FEP, but that he was motivated to start university again. He also seemed to have more insight, saying that he knew he was bad before he came into hospital. I understood that a three-day follow-up would be necessary to support discharge, as well as ongoing monitoring from EIP.

116. I did not receive any contact from the inpatient team, at least that I can find at this time.

117. The PSR includes an entry on 27 July 2020 at 10:35am by Carly Kane, which refers to an email sent by Claudia Birtles, which reads:

*"Just wanted to let you know I am due to go on leave next week so if possible could you contact one of my colleagues Sabrina or Abi if it looks like VC is likely to be discharged"*

[NHFT0000168, pg98]

118. The PSR includes an MDT meeting note on 27 July 2020 at 1:14pm, which states (inter alia):

*"CCO is on leave this week, but the CCO has said we are able to contact Sabrina Edwards or Abi to do his follow-up as not to delay discharge."  
Plan: "Review tomorrow (Tuesday) at 2:30pm, please invite either Sabrina Edwards or Abi (LMHT). Please invite mother. Crisis in Reach have been invited."*

[NHFT0000168, pg99]

119. I did receive an invite to attend the review meeting, but I could not attend.

I sent an email which read:

*"Morning Carly,*

*I am unable to do that time sadly as I am seeing a patient with an interpreter.*

*Sabrina may be able to.*

*If not can you do any earlier? (I can do 10-12) Or can we ring the ward after for an update?*

*Kind regards"*

120. I have exhibited this email to my statement as WITN0317003.

**(c) August 2020**

121. On 12 August 2020 at 1:10pm, I made a telephone call to VC regarding medication provision. The entry in the PSR states:

***"LMHT CITY SOUTH BLUE RAM***

*Valdo being seen by crisis long term support from Claudia Birtles Valdo's allocated CCO"*

[NHFT0000168, pg128]

122. The purposes of this entry were to give an update on the plan for after discharge, and VC's CCo was named for future correspondence.

123. On 21 August 2020 at 9:09am, I made the following entry:

*"T/C to Valdo to arrange a home visit today - No answer  
Text message sent to Valdo.*

*PLAN:  
Await response"*

[NHFT0000168, pg130]

124. I no longer hold the phone I used to contact VC, as I was given a replacement phone on 7 December 2022. However, in the course of responding to this Rule 9 request, the Trust have retrieved my old handset, and I provided a password. The handset was unlocked, and I exhibit six screenshots of text message exchanges between myself and VC from 21 August 2020 – 18 July 2022 [WITN0317011, WITN0317012, WITN0317013, WITN0317014, WITN0317016, WITN0317017]. I believe that all other text messages I had with VC have been deleted and the Trust have not been able to find any additional text messages on the handset. I also exhibit a contact card for VC [WITN0317015]. This shows the record of calls made to VC on this number. Unfortunately, I am informed that the call log for this handset is only retained for one year and although the handset has been checked, the records of the calls made to VC cannot be shown within the call log history.

125. On 21 August 2020 at 2:20pm, I made the following entry:

***"LMHT CITY SOUTH EIP***

*I saw Valdo at his home address. He was well kempt, the house was clean and tidy.*

*Valdo welcomed me in, he was monosyllabic in his responses but was polite and pleasant.*

*Reported no change in mental state, feels like he is doing well. Reports no psychotic symptoms, however may be masking. Continues to review for his exams which are next week (25<sup>th</sup>) feeling ready for these. Valdo has also been reading non-fictional books. His concentration and memory are good. Enjoy his curse and has a year left of this.*

*Valdo continues to be concordant with his aripiprazole. He has found no side effects with this and is happy to continue taking this. Valdo is on calciferol which he will run out in a few days, plans to go to GP for this.*

*Low risk to himself*

*We spoke about making an OPA with a psychiatrist and I will text him this.*

*Briefly spoke about his family whom he speaks to most days but is happy to have his independence in Nottingham*

*Overall Valdo seems well however difficult to full assess due to monosyllabic.*

*I will update Claudia, Valdo happy to engage with the team.*

*No further concerns to note”*

*[NHFT0000168, pg131]*

126. The state of somebody's home can indicate their mental state. A neat and tidy home suggests a level of functioning to maintain it.

127. VC was monosyllabic but polite and pleasant. I formed the view that he was guarded, and would not discuss things with me. However, the fact he was polite and pleasant was indicative of the fact that he was doing better than he was prior to his admission to hospital.

128. By 'masking', I meant VC was covering up or hiding his psychotic symptoms. I suspected that VC was masking due to his guarded presentation. I have since learnt that the NHS was part of his belief system, he would not often talk about it at length. I was also not VC's CCo, so he may not have wished to open up to me. I was not overtly concerned about VC's mental state. He appeared motivated to continue with his university work; he was functioning and engaging.

129. We would not routinely check someone's medication pack. My note that VC continued to be concordant with his aripiprazole was made as a result of me asking VC about this. I imagine that I asked VC his thoughts on the medication he was taking, and any side effects he was having.

130. I reached the view that VC was low risk to himself because suicidal thoughts were not a feature of his presentation, and he did not show any signs of self-neglect (for example, his house was clean, as discussed above).

131. When I said I would text "him" about making an appointment with his psychiatrist, I meant I would text VC; I would not text a psychiatrist to make an appointment, I would go through their medical secretary instead.

132. I cannot recall what my discussion with Claudia entailed. I imagine I will have said I saw VC, but not for a lengthy period, and that I was not concerned about him at that time.

**(d) October-November 2020**

133. On 09 October 2020 at 12:16pm, I originated a note regarding concerns raised by VC's mother. The PSR entry states:

**"LMHT CITY SOUTH EIP**

*CCO off work, concerns raised as Valdo's mum Celeste had left her several answer phone messages.*

*T/C to Celeste Calocane, contact number GRO-B*

*Concerned about Celeste as she had spoken to Valdo and he had stated "Don't speak to me for 2 months". She has since been unable to contact him. This is out of character for Valdo, him and mum normally talk daily. She has asked someone from the team goes out to see him.*

*I will go out this afternoon with someone from the team I know Valdo get's very unwell when mental health deteriorates"*

[NHFT0000168, pg135]

134. The potential significance of VC's reported interactions with his mother were that they were a change from the norm and likely indicated a change in his mental state. I suspected that VC might be relapsing, so I put someone to go out and see him, to go and explore what this was about.

135. On 09 October 2020 at 3:35pm, I conducted a cold call visit together with Anthony Walthall. The PSR entry states:

**"LMHT CITY SOUTH EIP**

*Myself and Anthony Walthall went to Valdo's home address in snienton in order to complete a cold call. We were met by Valdo's housemate who stated he was in the city centre. She stated he is okay and she has no concerns.*

*I tried to ring Valdo's mum to feedback to no avail.*

*I have rang Valdo - phone offline text sent.*

*Spoke with my supervisor and we spoke a further cold call is not necessary today due to housemate stating she is not worried.*

*I will e-mail the Emma Robinson manager to follow up next week"*

[NHFT0000168, pg135]

136. I cannot recall this discussion with VC's housemate.
137. I cannot recall which supervisor I spoke to, nor specifically what I told them, or the advice that the supervisor gave. The note was made at 3:35pm, meaning there was not much time left until the end of the working day (at 5pm); I imagine that as VC's housemate did not raise concerns, we did not feel it was urgent for that day, and it appeared to have been appropriate to take action the following day. As we had confirmation from the housemate he seemed okay we did not refer to crisis.
138. The concerns raised by Celeste were the most important, as she knew VC the best. However, the comment from VC's housemate was reassuring for that day. It did not mean that we were not concerned at all though.
139. I cannot see that a further home visit was planned on RiO. I then went on leave for a week.
140. However, I did email Emma Robinson and Gary Carter at 03:53pm on 09 October 2020, with a handover note for my EIP patients. Regarding VC, I wrote:

*“Mum worried as Valdo has stated that he does not want to see his mum for 2 months. Mum has asked that we see him. Valdo can get very unwell quickly. Anthony and I went round and housemate stated he was in town but she had no concerns. Can this be followed up next week?”*

141. I have exhibited a copy of this email to my statement as WITN0317006.

142. On 15 October 2020 at 1:11pm, there is reference to me being on leave [NHFT0000168, pg135].

143. On 23 October 2020 at 11:29am, I made the following entry in the PSR:

***“LMHT CITY SOUTH EIP***

*Can you please call Mum of VC GRO-D on her home phone GRO-B*

***T/C to Celeste***

*No answer. I will try again shortly.”*

[NHFT0000168, pg135]

144. This is a message from admin, which has gone through to duty, and was then forwarded to myself and Gary. Gary spoke with Celeste, and it was then that she told him that VC was not talking to them.

145. I have also attached a copy of an email that I sent to Emma Robinson and Gary Carter at 1:46pm on 23 October 2020 as WITN0317007. I set up this email chain to facilitate communication with Emma and Gary while I was not at the MDT meetings. In this email, in relation to VC I state: “I know his mum has been in contact with duty – I think he will need seeing F2F as he has not been seen for some time.

146. On 06 November 2020 at 3:13pm, Gary Carter made the following entry in the PSR:

*"Following on from Dr Seedat's communication I visited Valdo with a colleague CPN Abi Parsonage. Valdo answered the door and after introductions welcomed us both in. We explained the reason for our visit and offered our assistance with any problems or issues he might have. Valdo explained he had been curious as to whether he could contact Dr Burri (or any of the medical team) for advice. He seemed reluctant to explain what advice he needed but stated he was fine and did not need any help at the moment."*

*"I took with me one months supply of medication because they were due (overdue indeed) Valdo said he had about 10 left. I will visit again in a weeks time to determine if he needs any more. No issues of concern at this time and Valdo assured us he would ring Claudia or Stonebridge if he had any problems."*

[NHFT0000168, pg136]

147. Dr Seedat's note dated 05 November 2020, at 12:51pm, following an interaction with VC, states:

*"I feel based on the interaction that he needs more close monitoring and regular visits otherwise he will end up in hospital."*

[NHFT0000168, pp135-136]

148. I cannot remember exactly what conversation I had with Dr Seedat. However, Dr Seedat is an inpatient doctor. It is unusual for a patient that has been discharged to call up the ward, especially as VC had a community team. I imagine this made Dr Seedat question VC's mental state. It also appears that VC presented as paranoid during the call and perhaps muddled. When looking at the notes prior to the call with Dr Seedat, it is evidence that VC's mum is voicing concerns [NHFT0000168, pg135]. Yet VC had not been seen face-to-

face. I imagine Dr Seedat looked at VC's notes after the call and felt VC needed to be monitored closely.

149. I understood that VC was to have weekly visits at this point. Dr Seedat knew VC well from admissions and described him as 'cagey' in his contact with him. Dr Seedat therefore suggested that he needed more contact.

150. The visit was conducted by two community psychiatric nurses (CPN) rather than one, possibly because VC had not met Gary before.

151. I cannot recall this specific visit, however, from the notes and from VC visiting the ward unexpectedly, I imagine he would not have told us why he wanted to contact Dr Burri (or any of the medical team) for advice. I assume that VC would have wanted to talk about his medication; perhaps he was noticing that he was getting unwell, or perhaps he was concerned about the side effects.

152. The fact that VC had ten tablets left indicated that he was not concordant with his medication.

153. Because I really cannot recall this visit, I am unable to remember any discussion I had about VC's medication concordance generally, why he had ten tablets remaining, whether I discussed these matters with VC (and if I did not discuss them, the reasons as to why), or the extent to which I considered the matters of concern raised by Dr Seedat had been addressed or resolved at this

visit. I cannot recall what view, if any, I formed having seen VC, on Dr Seedat's observation that more close monitoring and regular visits were required to avoid further admission.

154. I do not know why VC having ten tablets remaining when his medication was 'overdue' was not recorded as an issue of concern, as it should have been.

**(e) February 2021**

155. On 01 February 2021 at 2:22pm, there is an entry in the PSR which states:

*"City South EIP Clinic  
Diagnosis; First Episode Psychosis*

**Medication;** *Aripiprazole 20 mg OD (increased from 15mg).*

*Met with Vald along with CPN(Abi Parsonage), and medical student a (Roshni).*

*He continue to maintain usual monosyllabic speech although a lot less than before. He said that although his "condition" improve but he don't think that this was psychosis. He said that he himself can not explain what this was but he don't think this was an "Episode" but what he experience is continuous. He said that he is not sure if its because of medicine he is taking but the voices have calmed down now although still there always in terms of frequency. He continue to function with his job at local warehouse 12 hours/day for 3-4 times a week. He is attentive to his nourishment, sleep and self care. He is compliant with his medication without side effects. He is no longer using PRN Diazepam. He said that he was in contact with his family back in Wales and spoke with his mother last week and all ok with them.*

*He said that he noticed difficulties with short term memory but no problem with long term memory. On some screening questions he did well. He said that while doing some every day chores sometime he forget what he was doing but this has not ended up in trouble for him. Knowing him from last few months, I shared with him that I think this is part of cognitive deficit for psychotic illness. I told him that as his psychosis get better, the hopes are he would see much better concentration and the memory. He express his feeling of reassurance to my explanation. We*

agree that we can meet in 6 weeks time to do a formal memory assessment as well.

In today review, I could not elicit any acute risk of self harm, suicide or harm to others.

**Impression:** Making slow but steady recovery. There is scope for increase dose of Aripiprazole for which he gave his capacity consent. Issue of concentration and memory seems part of psychotic cognitive deficit.

**Plan:**

1 - Increase Aripiprazole as above

2 – He is not keen for Psychotherapy offered

3 - CCO to continue monitor risks and progress in community

3 – I will ask CCO to book him in after 6 weeks in my clinic to do a formal memory assessment with ACE-R."

[NHFT0000168, pg146]

156. On 02 February 2021, at 2:34pm, I made an entry which states:

**"City South EIP**

*Medication drop:*

*14 days of aripiprazole 20mg (5mg and 15mg dispensed due to having 15mg available).*

**Next due:**

*16th of February"*

[NHFT0000168, pg146]

157. Considering that I saw VC the day before in his outpatient appointment, I imagine this was a brief interaction. I have not documented any concerns.

158. On 17 February 2021 at 4:30pm at 4:28pm, I made an entry which states:

**"City SOUTH EIP**

*Medication dropped - 4 weeks of 20mg aripiprazole.*

*Valdo seemed well. Agreed to ring him Monday the 22nd at 16:30"*

[NHFT0000168, pg146]

159. As VC did not speak at length to me, I imagine that when I said he seemed well, I was going off the basis that he appeared polite and warm. This was an indication of his mental health, and that he was functioning. He was going to university, working, engaging with us, and had consented to medication increase.

160. On 22 February 2021, at 4:28pm, I made an entry which states:

***"City South EIP  
T/C to Valdo***

*Valdo sounded bright in mood. Reports he has noted no changes since the increase in his aripiprazole. Valso has been trying to improve his short term memory loss with meditation at the start of his day, and mentally stimulating games like puzzles. This has been helpful.*

*Valdo continues to work at the warehouse although these are long shifts he does not find it to challenging. He likes to come home and watch movies from the 50s and 60s. Valdo has also been reading. He feels he is making steady progress and does not feel like he needs to make any further changes.*

*Valdo's voices are much better, he describes them as quieter and in the distance. When he does hear them, he is able to ignore them.*

*Low risk to himself and others*

***PLAN***

*I will ring Valdo in 2/3 weeks*

*I will make a further OPA with Dr Buri to do the memory test as discussed"*

[NHFT0000168, pg147]

161. I cannot say for certain, but I imagine that on the basis of this entry, I felt there was an improvement This appears to have been a longer contact with VC,

where he is open about struggling with his memory, and that he has taken his doctor's advice and is open to coming in for a memory test.

**(f) March 2021**

162. On 08 March 2021 at 11:00am, I made an entry in the PSR which states:

***"LMHT City South EIP***

*[t]ext sent to Valdo asking how he is.*

*Valdo has an OPA on the 15<sup>th</sup> of March*

*I asked Valdo if I can give a ring Wednesday 10<sup>th</sup> at 11am for a catch up"*

[NHFT0000168, pg147]

163. On 10 March 2021, I made an entry in the PSR which states:

***"T/C to Valdo as planned***

*No answer*

***PLAN:***

*Await contact"*

[NHFT0000168, pg147]

164. VC replied to my text message asking if I could call him on 10 March 2021, saying "Sure sounds good". [WITN0317012]. I do not know if I received a response to my unanswered call to VC on 10 March. I did not receive a response to my text to VC to check in and request a home visit the day after 01 June 2021 [WITN0317013].

165. On 15 March 2021, at 3:09pm, I made an entry in the PSR which states:

*"28 days of Aripiprazole given 20mg OD whilst Valdo was in his OPA"*

[NHFT0000168, pg148]

166. I cannot remember my interaction with VC when I gave him his medication in his outpatient appointment. However, I either walked into the

outpatient appointment to give VC his medication, or I gave it to him outside the outpatient department. As VC had just seen a medic, I did not assess his mental state or condition. I was not worried about his mental state here.

**(g) June 2021**

167. On 01 June 2021, at 10:19am, I made an entry in the PSR which states:

**"City South EIP - CCO currently on leave**

*Text sent to Valdo to check in and ask if myself and CPN Adele Pinder can do a home visit tomorrow at 9am PLAN: Await contact"*

[NHFT0000168, pg153]

168. On 02 June 2021 at 10:02am, I made an entry in the PSR which states:

**"City South EIP**

**Face to Face**

**Present:** Valdo, Myself, Adele Pinder CPN

*Valdo welcomed us in, he was well kempt. He was bright and reactive in mood. He was less monosyllabic than I have seen him in the past. Valdo understood why we had come round, he states he was unsure what his mothers specific concerns was as she did not say. He stated he wanted to tell her not to ring the crisis team but stated she has been so kind to him he said it's okay.*

*Valdo does not know why was concerned, voices remain faint and he is able to ignore them. No changes to presentation. We spoke about his mum being far away and any slight changes may cause an alarm due to how poorly he has been in the past. Valdo understood. Valdo has been working at the warehouse and keeping busy, he has been out in the park and enjoying the sunshine. He is sleeping well. Eating and drinking well."*

*I do not think Valdo has relapsed at this point, he appeared well in himself. He does not know where the concerns have arisen regarding his medication and is adamant he takes them daily. Valdo spoke about his plans for his masters, he is a little nervous as it will be challenging. But had a very upbeat and positive attitude towards it.*

*Valdo's CCO is on leave this week, encouraged him to contact the team should he need any support. Planned contact with CCO next week."*

[NHFT0000168, pg153-4]

169. In terms of my impression of VC at this appointment, he was warm, reassuring, and not guarded or cagey as he could be when he was unwell. He allowed us into his house. At this time, VC appeared the same as he did during our previous visits; there was no change to his presentation, or any concerns. At this time, we did not routinely check a patient's medication; rather, this was something that the crisis team would do if undertaking medication concordance. I cannot recall for certain, however I imagine that this home visit was conducted by two CPNs in case he relapsed.

**(h) August 2021**

170. On 16 August 2021 at 1:49pm, I made an entry in the PSR which states:

***"City South EIP  
T/c to Valdo following wards concerns –***

*Valdo stated he is fine, very monosyllabic in words. Stated he did not get the answers from the ward, I asked Valdo if he could share his concerns with myself. Valdo stated if we were to meet face to face he would share them. We agreed to meet Thursday the 19th at 3pm. Valdo stated he is still working and stated there are no concerns.*

*Further assessment 19/08"*

[NHFT0000168, pg160]

171. On 16 August, VC contacted the ward again and expressed a desire to talk to Dr Seedat. This was unusual. It appears that VC wanted to unpick his beliefs with the ward staff and was being open and honest about his psychotic beliefs.

172. I imagine that I thought this was unusual; VC was voicing psychotic beliefs around artificial intelligence, and hearing voices. He was also being

honest and open. It seems that in November 2020, when VC requested to speak to Dr Seedat's Personal Assistant, an urgent outpatient appointment was made [NHFT0000168, pg136]. So, due to concerns that VC was relapsing, and starting to disengage, I brought this to the MDT. I do not believe I formed an impression of VC's condition at this point, just that this is someone who needed to be seen quickly, who had psychosis, and who was at risk of relapsing.

173. On this visit, my impression of VC was that he was starting to relapse. He agreed to share his concerns with me face-to-face, which was also out of character for him. He then appeared to change his mind mid-conversation, saying there were no concerns. The ward probably found his visit to be unusual, as discharged patients would not usually come to the ward, unless they had left their belongings or maybe wanted to share gratitude with the staff.

174. On 19 August 2021 at 3:18pm, I made an entry in the PSR, which states:

*"City South EIP  
Home Visit*

*Myself and CPN Adele Pinder attended Valdo's address. He opened the door appearing muddled about the day, stating he was not expecting us as we had said Thursday and we explained today was Thursday. Valdo stated we could not come in as he was busy, we stated are you working and he stated "Correct". He stated he would not have time for us to talk. We spoke about his concerns he had raised the other day he stated he no longer had any questions. We asked Valdo if he was still taking his medication? There was a pause and he stated yeah.*

*Valdo seemed guarded and did not want to talk to us. He looked more unkempt than I have seen him previously. Less friendly and warm than he usually is.*

*Valdo stated we needed to send him a text/call to book another appointment in.*

*Impression - likely relapsing. No risks noted today but difficult to assess due to guarded presentation.*

*PLAN:*

*Liaise with CCO when back off leave and arrange visit next week."*

[NHFT0000168, pg161]

175. I formed the view that VC was likely relapsing because he presented as guarded, was not warm or friendly, and did not invite us in. He paused before taking his medication. No risks had been reported or noted at this time; I imagine that our plan was to keep contacting VC, and to refer to crisis if our concerns remained.

176. On 23 August 2021 at 10:27am, I made an entry in the PSR which states:

***“City South EIP***

*Text to Valdo to ask if he is free for myself and CPN Adele Pinder to visit  
24/08 13:45*

***PLAN:***

*Await contact*

[NHFT0000168, pg161]

177. I did not receive a reply to my text to VC to arrange a home visit on 24 August 2021 [WITN0317013].

178. On 24 August 2021 at 3:37pm, I made an entry in the PSR which states:

***“City South EIP***

*I had text Valdo an appointment for today*

*Myself and Adele Pinder CPN attended his home was not in We rang  
Valdo*

*Valdo stated he was not in nor was he free to talk. He stated again just  
to text him a new appointment. He stated he was fine there is nothing to  
worry about. We could others in the background.*

***PLAN:***

*Discuss in MDT”*

179. I do not know what was discussed in that MDT, as I have not documented it. I therefore cannot comment on the decisions that were made in that meeting.

**(i) October 2021**

180. On 22 October 2021, at 4:00pm, I made an entry in the PSR which states:

**"City South EIP**

*I rang Priory Arnold to ascertain what happened at Valdo's ward round yesterday*

*Valdo was discharged this morning, mum rang and was annotated she had not been informed Neither had we. I asked them what he had been discharged on medication wise they did not know. I asked them if they had sent the discharge summary to Claudia, they stted not yet as the ward has been busy. I will ring crisis to see if they can do a 3 Day F/U over the weekend. Caludia (CCO) is back Monday but she will then only have M/nday to complete*

**Valdo's new address**

*278 Queens Road  
Beeston  
Nottingham  
NG9 2BD*

**T/C to Crisis**

*Would be unable to complete due to capacity, from an influx of referrals in from GP and crisis's over the weekend. CCO to complete Monday.*

**T/C to Valdo**

*Confirmed he's at home. I asked Valdo what time would work for him Monday for CCO to do 3 Day F-U. Valdo stated he has a group project due so would not be able to meet all Monday. I expressed the importance of us seeing people after discharge from hospital to ensure their wellbeing. Valdo said he understands but next week is a bad week as it is enrichment week. I asked Valdo if he could have a small bit of time for someone he said no.*

*I stated I will speak to crisis and see if they can see him as he is not wanting to see us Monday, Valdo said maybe he will see crisis over the weekend*

***T/C back to crisis***

*Line engaged awaited call back but working day ends soon*

*I rang Valdo back and told him Caludia would ring him Monday. Valdo accepted this, confirmed his address. Monosyllabic in answers by stated he is okay focusing on University work.*

***PLAN:***

*Ask CCO to ring Valdo Monday to make a plan (telephone 3 day F/U?)."*

[NHFT0000168, pg194]

181. When a hospital discharges a patient, my expectations are that EIP should be invited to the discharge meeting and be an active part of discharge planning. This means that the three-day follow-up can be arranged. EIP should have email contact advising around discharge, if for some reason they were not invited to the discharge meeting. Discharge planning should be an ongoing conversation.

182. I have documented that we were not told by the Priory that VC was being discharged.

183. It appears from the notes that Miss Birtles was aware that VC's discharge was coming up, but not that she knew he would be discharged that week.

***(j) December 2021***

184. On 17 December 2021, at 11:59am, I made an entry in the PSR which states:

**"City South EIP**

*Valdo attended to see Claudia to collect his medication, however she was out on a visit. Valdo had his hood up and mask on, our receptionist had stated he was very curt with her. He was fixed in his staring and had a hostile edge to him.*

*We explained Claudia is not in but we gave him his medication 4 weeks of Aripiprazole 20mg*

*We asked if there is anything Valdo wants us to handover to Claudia. Valdo stated he has one question "who came to his house the other day, was it you?" to myself. I stated no it was Dr Lloyd and Claudia, he asked what address they went to I stated it was a Beeston address.*

*Valdo then walked away without saying goodbye mid conversation. I shouted to Valdo to ask if he is okay and he stated "I'm fine ... everything is fine."*

*"We will update Claudia"*

[NHFT0000168, pg202]

185. In light of VC's hostile edge and my interactions with him, and the receptionist's report of his manner, I formed the impression that he was not well. This was also demonstrated by the fact he was guarded and cagey in his presentation. However, he was not at the point of detention at this stage.

186. At this point, I was concerned that VC was relapsing. I would have discussed my attendance with VC on this occasion with the MDT.

**(k) January 2022**

187. On 06 January 2022 at 3:30pm, Claudia Birtles made an entry in the PSR which states:

*"CPN's C Birtles and A Parsonage attempted to visit Valdo at home address in Beeston however there was no answer. Appears to be a*

house of multiple occupancy however no-one answering and all blinds shut.

**Plan:**

*Attempt to call Valdo tomorrow again. It does however appear he has disengaged from support. OPA scheduled for next Monday with Dr Lloyd."*

[NHFT0000168, pg202]

188. My view of VC's engagement at this point is that it had gotten worse.
189. On 18 January 2022 at 11:32am, I made an entry in the PSR which states:

***"CITY SOUTH EIP - email from Ellie Turner***  
*Valdo's address*

*Valdo's address is:  
Flat 15 Room D  
Madison Court Block 2  
Raleigh Park  
Derwent Way  
Nottingham  
NG7 2EG*

*His phone is off currently but I have established that he left the library on Jubilee campus at 6am this morning so I would imagine he is currently at this address sleeping. Please let me know when you are able to attend with the police so I can liaise with the accommodation provider."*

[NHFT0000168, pg204]

190. On 18 January 2022 at 11:41 am, I made an entry in the PSR which states:

***"City South EIP***  
*T/C to social care to give information regarding Valdo for a MHA today  
Time to be confirmed"*

[NHFT0000168, pg204]

191. On 18 January 2022 at 2:05pm, I made an entry in the PSR which states:

**"City South EIP**

*Spoke to AHMP warrant needs to be obtained due to needing police she is going to ring Ellie at the University  
Likely going to be tomorrow"*

[NHFT0000168, pg204]

192. It appears that my colleague Adele Pinder has taken the report from Eleanor (Ellie) Turner regarding the concerns from VC's presentation and risk to others, and that he has assault another student. I requested police presence as VC had assaulted someone the day before. A MHAA was request, as VC assaulted someone and was not engaging. The assault indicates a deterioration in his mental state requiring a crisis or MHA assessment.

193. On 19 January 2022, at 11:38am, I made an entry in the PSR which states:

**"City South EIP**

*· Rang social care no beds available - Therefore not done yesterday  
· Awaiting safe place before MHA can be arranged  
· E-mail sent to Ellie Turner at the Mental Health Advisory Team to ascertain if she had any updates*

**PLAN:**

*Await contact"*

[NHFT0000168, pg204]

194. The AMHP Report referral and assessment of 19 January 2022 [CHCA0000011] states that I was the referrer, and contains the following statement:

*"Abi advised [VC] has not really engaged with his LMHT. [VC] has missed five appointments... [VC] last collected his medication 17/12/21, and was reported to be paranoid and short with the worker at the time. The team question if [VC] had been taking his medication since discharge. [VC] is reported to have been paranoid, angry and confrontational..."*

[CHCA0000011, pg4]

195. This is an accurate description of my referral.

**(I) June 2022**

196. On 15 June 2022, I made an entry in the PSR which states:

***"City South EIP***

*2 weeks of Aripiprazole 20mg given*

***Next due:***

*Wednesday the 29th of June*

*Valdo came to see Gary today at 3pm, stated to reception he had an appointment. Gary is out on visits so I gave Valdo his medication. Valdo was well kempt but his facial hair and head hair was overgrown. He looked suspicious, was looking around. Valdo took his medication off me as I asked how he was he walked off. He did not put the medication in his pocket but held it and examined it as he walked away. I will update Gary"*

[NHFT0000168, pg268]

197. As a result of this interaction, I formed the view that VC was paranoid of us, and his medication. I also considered self-neglect to be present.

198. Throughout my notes, I comment about VC's presentation when he is well (warm, bright, polite, talking about university). When he is unwell, he is guarded and suspicious, so the significance of him looking "suspicious" is that I am indicating that his presentation shows he is relapsing.

199. Regarding VC not putting his medication in his pocket, I imagine that he wanted to look at it in more detail (i.e. examine it) due to being paranoid, and that he then put it in his pocket. Due to VC's paranoia, I do not think he would have put his medication in a bin, as his name may have been seen. He was very wary of sharing information with others about his condition. My view around medication concordance was that he was paranoid of us and our medication, and that non-concordance was an issue.

**(m) 18 July 2022, 10:03am**

200. On 18 July 2022 at 10:03am, I made an entry in the PSR which states:

**"City South EIP**

**CCO Gary Carter on leave**

*18th July - Valdo (GRO-D) His meds are due he may come to SBC at anytime. I'd ring or text him in the morning to get a estimated time.*

**Text sent to Valdo this morning**

*Hi Valdo it's Abi from Stonebridge are you coming to collect your meds today? what time are you thinking?*

**Valdo**

*Not in the UK at the moment*

**Me**

*Are you on holiday? Hope you're having a nice time. When do you think you'll be back to get your medication?*

**Valdo**

*I'm good. I'll probably be back in Nottingham in October"*

**Me**

*What about medication?*

**Valdo**

*Still have some. Won't make much difference.*

**Me**

*You'll run out by October. Do you not find the medication helpful?*

[NHFT0000168, pg269]

201. In light of the report that VC still had medication left, even though his medication was due that day, I formed the view that his medication concordance was likely patchy.

202. In relation to his report that he was away until October, I cannot remember exactly what I thought. However, we have a lot of students who travel over the summer, either to their home country, or to different parts of the country. Sometimes they may tell us when they are already here, or the day before, meaning we do not have a chance to arrange medication. In that instance, we would ask their home team to arrange this (shared care as previously discussed), or if they were abroad, we would ask for the details of their psychiatrist. This was not uncommon for our team, but it was a concern.

203. I imagine that I also queried whether VC was away until October, or if he was saying this to avoid contact. VC was not someone who had a friendship group, or would go on holiday, or would visit other countries unexpectedly. It is possible that I responded to VC in order to keep engagement, even if this was very superficial and unusual. I cannot remember specifically though.

204. The concerns that I had as a result of this interaction were that this was out of character. However, I also did not have an in-depth knowledge of VC's family to know if he had gone abroad as noted. It was not unusual for members of our team not to have this type of knowledge.

205. I sent an email about this interaction which read:

*“Hi guys please can you mention one of Gary's VC in MDT just about him going abroad and meds likely gary will need to contact mum next week. Sorry i am on stabilisation training :D”*

206. I have exhibited a copy of this email to my statement as WITN0317008.

207. On 25 July 2022, I sent an email to Gary Carter which read:

*“Hi Gary please see rio about Valdo  
I asked it was discussed MDT they advised you contact mum just to find out where he is  
Thanks Gary”*

208. I have exhibited a copy of this email to this statement as WITN0317009.

**(I) 22 September 2022**

209. On 22 September 2022, an MDT meeting took place where it was decided that VC would be discharged [NHFT0000168, pp270-271]. I believe that I would have been at this meeting, because we had a lot of sickness in the team at the time. An email was sent by me with all the initials of the patients who we were covering, stating to discuss discharge for VC [NHFT0018292]. However, VC's discharge had also been discussed at several MDTs prior to this.

210. I do not know exactly who was at this meeting. I know there were only two nurses in the team at work during this time (Fran Doughty and me); Gary and Adele **GRO-B** Claudia Birtles was on maternity leave, and Kaisha was on annual leave. I imagine that Dr Lloyd was at the meeting, as well as Emma Robinson, our team manager.

211. The DNA Policy [NHFT0004725] was not discussed at this meeting.

212. I cannot recall this meeting; however I imagine that we discussed: there had been no concerns raised by the University about VC; the police were not concerned about recent contact with VC and had stopped doing safe and well checks; VC was engaging via text so Gary would not be able to report him as a missing person; we did not have the correct address to complete cold calls until VC requested his notes; VC's mum had spoken to VC in the last week and did not raise any concerns about his presentation, Gary also gave her VC's correct address.

213. I was not aware of the bench warrant without bail issued by Nottingham Magistrates Court on 22 September 2022 in relation to VC's failure to attend court.

214. If we had been aware of this bench warrant, we could have asked for the re-referral to have been reopened, and to report VC as a missing person. VC would then have been actively searched for by police as a missing person, and he could have been assessed in the cells and sent back to us.

#### **My contributions to other investigations into VC**

215. I gave an interview in the conduct investigation into Gary Carter on 29 January 2025 [NHFT0004885].

216. I agree that the transcript is an accurate record of what I said. However, there are some additional points that I would like to add to this.

217. Firstly, I did not realise how poor my documentation was until I reviewed the notes. I mention in the interview that Gary's notes were not in-depth, but I feel my notes on VC records are also poor.

218. When I say I could have helped Gary with the paperwork, I think mean that I should perhaps have joint worked with Gary, or helped with care plans/risk assessments, and be properly involved as CCo. I discuss this in more detail below.

219. I said in my interview we were well versed in treating patients like VC; by this, I think I meant patients who were psychotic and who have had multiple admissions. But, in retrospect, VC became an AO patient on an EIP pathway. We were not set up like an AO pathway. AO teams have much more face to face contact with the patient, often several times a week, with more than one member of the team, whereas we do not have the resources for this. Also, the AO may try and engage someone more assertively, for example, they might try and see someone every day of the week if they are not engaging. AO patients might also have a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder. Some of our patients may have only one episode of psychosis, so therefore would be discharged after three years medication free.

220. In terms of Assertive Outreach Eligibility, I have exhibited the Sheffield Mental Health Services eligibility criteria for their AO pathway, as NHFT does not have standalone AO teams; instead, they are within the local mental health

teams. The criteria includes: a severe and persistent mental disorder, a history of high use of inpatient or intensive home-based care, difficulty in maintaining and consenting contact with the service, and multiple complex needs. I have exhibited a copy of this criteria (taken from their website) to this statement as WITN0317005.

221. In contrast, the NHFT EIP team provides assessment and treatment for people aged 14 to 65, who are experiencing their first episode of psychosis, or who are at risk of developing psychosis. The aims of the service are to provide early assessment and treatment of the symptoms of psychosis, to provide a range of interventions, to provide support for family and significant others, and to work with other agencies to support the person. Getting help early gives someone experiencing psychosis the best chance of getting better more quickly. This is set out in NHFT's webpage on the EIP service, which I have exhibited to this statement as WITN0317004.

222. Adults experiencing their first episode of psychosis start treatment in EIP services within two weeks of referral. The EIP team offers three-month assessment, or three-year intervention. The rationale for EIP is that EIP services can improve clinical outcomes such as admission rates, symptoms and relapse, for people who are experiencing their first episode of psychosis. The interventions available in the EIP service include Cognitive Behavioural Therapy, employment support, and therapeutic work.

223. I also think it is very rare to have patients who have had four admissions in a short period of time.

224. I feel I have knowledge about schizophrenia as an illness from working in the LMHT and mental health wards; however, my experience is with those who have had schizophrenia for many years, who are older, more chronic in their condition, whose daily living activities are impacted by their illness, and who are established on antipsychotic medication. As I discuss above, I feel I did not realise the extent and prognosis likely for VC's illness. I think I have seen people go from the EIP pathway to LMHT with drug induced psychosis, who are hard to engage due to criminal activity and drugs. But I had not seen someone like VC before.

225. Additionally, in my interview I said we were all aware of his symptoms. I now disagree with that statement. We were aware VC was someone who had psychosis, but not the in-depth psychology behind it. We would not have had chance to go through his notes during admission, and not everyone would know about VC's presentation or risks, only what was discussed in MDT.

226. When I discuss non-engagement, this is something we experience, but I think it can be for various reasons, and a lot of patients do engage. Sometimes the patient is well, so they feel they don't need to be in secondary mental health services, because they are stable, so they may start to disengage for that reason. Other times, like with VC, it is a reflection of the patient's mental health.

227. In response to the question of whether my relationship with VC got better or stay the same, I have said it stayed the same. However, I would argue that it got worse once Claudia Birtles went off.

228. I also think I have said a lot of things which I did not do at the time. For example, I said “you find out a patient is unwell” and I have given a list of things I would do if I was CCo; however, I should have done these things even if I was covering. Moreover, I was asked how I would document my contact with VC when I requested a Mental Health Act assessment, but I did not cover things such as how VC presented at the time.

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

### **Reflections**

230. VC’s attacks were a horrific tragedy that has impacted many lives across the city, and I regret that the system was unable to prevent this outcome. I cannot imagine what the victims of the attacks go through every day. It has also made me change how I practice.

#### ***(a) Medication***

231. I consider that a lot of emphasis was put on VC taking his medication, despite knowing there was a risk of non-concordance. Where there were doubts about his concordance, we should have asked to see the box of medication and then referred to crisis immediately. VC may have refused to let us see the box, due to his paranoia and guarded presentation, but this in itself would indicate that he was not taking the medication. During VC’s February 2022 admission, it appears that a CTO was suggested by VC’s CCO, Claudia Birtles. Dr Thangavelu had also spoken to Dr Lloyd, the EIP consultant, due to the frequency of VC’s admissions. [NHFT0000168, p.238]

232. Also in that entry, it says “Claudia wishes he had been put on a depot in his previous admission due to Valdo’s non-compliance with medication”. [NHFT0000168, p.238] The previous admission that Claudia is referring to was in September 2021, when VC went to an Out of Area bed, and we did not attend the discharge review, or receive the discharge paperwork. VC was therefore not put on a depot (and therefore not put on a CTO), and the reason given is that because he said he did not want to. Aripiprazole had worked for VC, and other medicines had given him side effects; he had agreed to take his oral medication and engage with EIP. It appears that the plan was to put VC on a depot if he relapsed again. However, I cannot discuss this in depth, as I was not present at this ward round.

***(b) Documentation***

233. The MDT discussions that took place at the time were not documented.

234. I also think that my note taking was poor. For example, on some occasions I gave VC his medication, but did not note his presentation at the time, or had not documented it in detail. Similarly, I have not documented the MDT discussions, or the discussions that I’d had with my manager, or why particular decisions were made.

***(c) Joint working***

235. I should have worked jointly with Gary. We could then have worked together to try and engage VC. I believe we were trying a male CCo for VC to

see if this helped therapeutic rapport; VC had also opened up to both Claudia and Gary, so it made sense for Gary to take over.

236. Although I was covering for Claudia or Gary, I had met VC a few times, so I should have done more when I saw him. For example, I feel I should have tried to unpick why he stopped talking to his mum for two months.

237. I also feel that I should have looked through VC's notes to understand his symptomatology and likely prognosis. However, at the time we had big caseloads, and were uncoupling from LMHT, so there would not have been time to do so.

238. I feel that I knew enough about VC's care to cover and request a MHAA, but not enough to formulate a care plan. As I was covering, I probably waited for the CCo to return to do pieces of work, but if I could have seen VC, I should have done so.

239. The Assertive Outreach model worked on a team held basis, meaning that the patient is not just held by one CCo. This meant that engagement and assertive follow up could be organized.

***(d) Discharge***

240. I believe that we should have tried to see VC before he was discharged, in order to complete a mental state assessment as risk assessment.

241. I also feel that we should have called VC's mum or VC's brother, in order to ascertain their views. Given the suspicions around VC not taking his medication, I believe we should have tried to see him face-to-face, in order to assess his mental state. There also should have been documentation around the consideration for an MHAA.
242. The discussions around why VC was being discharged should have been documented, as well as the plan for who would take over VC's care, and how he could re-enter services.
243. I think I should have rung VC when he said he was on holiday, and listened for an international dialing tone. I also feel that I should have rung VC's mum, and asked her about this.
244. I also feel that when I was covering for Claudia / Gary, I should have had more contact with VC's mum or the University of Nottingham, although this is not something that we would usually do as covering CCo.
245. Additionally, I think it would have been beneficial for the whole team to have been involved in the MDT discussion regarding VC's discharge.
246. In relation to VC, I think we should have done cold calls once we had the correct address for VC prior to discharge (although, it is possible that a cold call was done prior to discharge and not documents), and that we should have done

more when VC was coming in (albeit that he had attended without an appointment).

247. I feel that perhaps too much onus was put on VC's mum and brother to raise concerns about VC's mental health or change in mental state to emergency services, and too much onus was put on the GP to re-refer VC if he did not collect his medicine, and I am unsure of the GPs policy on reviewing medication or flagging to secondary mental health services if a patient has not made an appointment.

248. I also consider that perhaps too much onus was put on the fact VC was in full-time work, and that nothing had been flagged at the time to support discharge, although we did not have the contact details for VC's place of work, so we would not have been able to ring them and ask if they had any concerns. Concerns about non-engagement from us would have been discussed in the MDT.

249. I feel that a lot was put on VC reporting that he was able to work, and that he was at University, as we felt that if VC was acting bizarrely at work or university, then this would be raised (as it often was at university). Prior to discharge, nothing was raised at VC's work (via the police) saying his behaviour was odd, and there had also been no contact from public services. However, we had no contact with VC's place of work in order to check this, and we did not even know if he was working.

***(e) Assertive Outreach Patients overview at the time***

250. At the time, we were uncoupling from the LMHT, so the MDTs were readjusting (we used to have our MDTs with AO patients). This meant that our MDTs were different, as we did not have the specialist knowledge of the LMHT.

251. There was also no dedicated AO pathway, and we would not refer someone on if they had been diagnosed with schizophrenia until after the end of three years. The AO clinicians would have mixed caseloads of mental health conditions, so we would be referring to a general LMHT. I do not recall having formulation meetings at this time in EIP, where we may reflect on someone's journey with EIP, and where their future may go.

252. I also think the AO teams would see non-engagement as part of the patient's presentation, rather than a reason to discharge.

***(f) Discharging patients who did not engage***

253. At the time, we would discharge patients who did not engage with our service. There was an implicit understanding that the patient may re-access services in the event of deterioration. For example, they would come back if concerns were raised by their GP, family, the Crisis Team, or the Police.

254. We had not seen VC to assess his mental state when he was discharged, but I imagine the logic was that no concerns had been raised by his place of work, his family, or the public. Perhaps it was considered that VC had achieved partial stabilization, for example, he demonstrated reduced acute systems (he was not going to Highbury wanting to speak to the consultants,

and there were no reports around aggression). However, we now know that VC's belief system remained and was becoming more entrenched the longer he went without treatment. I do think that whilst VC was at University, the Mental Health Advisory Team had helped to update us with VC's presentation and any concerns, however upon leaving University, a workplace would not have had this contact with mental health services, or an awareness of this.

255. When VC was discharged, there was sickness in the team, and significant cover. But, when VC had his CCo, he saw her frequently; even though he did not trust her, this was stability. When the team was short-staffed, deeper recovery work is replaced with firefighting and crisis management; we were so busy firefighting as a team, I do not recall looking at VC's likely prognosis and risk history, to take a step back and look at what could happen in the future. We would never have guessed that something as awful as the attacks would have happened, otherwise VC would not have been discharged.

256. I think VC's early warning signs and relapse signatures changed throughout his time with us; non-engagement was not an issue at the start and the middle, but towards the end, this was evident. It would have been useful to update the Early Warning signs, and to ask VC's mum about these too.

***(g) Communicating with other services***

257. We were not aware that VC had contact with MI5 in 2021, after his mum raised concerns about his mental health, until after the attacks.

258. We also were not aware of the warrant for his arrest, or that he had attacked someone at work before the attacks. I believe at that time VC was in a different locality, so I am unsure if that police service would have known about VC's mental health history in Nottingham.

259. If services had a shared system to communicate (such as police force to police force, or police force to us), or if there was a way for us to be alerted of non-engagement with medication by the GP, VC would have been re-referred to us.

#### **Changes to practice as a consequence of these events**

260. We as a team have made several changes, and I have made several changes to the way that I practice as a consequence of these events.

261. Firstly, the MDT notes now have a clear structure and template which we follow. This captures the attendees, the risks discussed, the views of carers and the patient, and the plan for next steps. There is also now a notes template, which is much more detailed, and is designed to capture risk (both past and present), and medication issues.

262. Regarding discharge, we now have discharge checklists, multiple MDT discharge meetings, direct conversations with the patient's GP and detailed letters that are sent to them, and discussions about discharge with family. Someone with VC's risk history, schizophrenia diagnosis, and multiple admissions would not be discharged from the service now. Moreover, if

someone is not engaging, we no longer send an engagement letter which states that they will be discharged from the service in two weeks if they do not respond (albeit that we did not do this for VC). When we do discharge someone, we now see them face-to-face before doing so. In addition, every discharge is now reviewed by our service manager. Who looks at the quality of the discharge and will tell us if there are concerns.

263. When we have issues with engagement and/or medication concordance, more emphasis is being placed on promoting CTOs with ward staff.

264. We also now involve parents in crisis planning, and discussions around early warning signs. If I had a patient like VC now, and they were not engaging with my attempts to contact them, I would make daily attempts to try and contact both that individual, and others who may have had contact with them.

265. NHFT now has dedicated police officers and links to the police, who we can email if we are concerned about a patient. We can also use this to find out if the patient has had contact with the police, or if they have any convictions that we did not know about. If we suspect someone has previous offences, we may ask for a Police National Computer check to confirm this.

266. Additionally, we now have frequent consultations with a nurse in the forensic team. Patients may not meet their criteria (for example, if they do not have serious convictions), but they may present in a way that can indicate future

crime. So, even if the forensic team do not take the patient on, they can still offer advice. For another patient, I have also done a forensic risk assessment.

267. Risk assessments now involve formulating the full risk profile, including early warning signs and crisis plans for every patient, and involving carers.

268. Managers now ask us who would fit the criteria for the AO pathway, who is on a CTO, who has schizophrenia, and so on. Managers are also doing note audits, which look at care plans and risk assessments, etc. I know that NHFT are reviewing the AO pathway in general, and patients with the diagnosis of schizophrenia.

269. The morning risk meeting now takes place with all EIP teams, and a manager is also present. The managers rate patients using the "RAG system", which can be defined as a red, amber, green risk system. This system highlights patients who are at risk to themselves and/or others, who are not engaging with services, and/or who are waiting for hospital admission. "Red" patients are high risk patients, who we will likely be speaking about daily, and with whom contact is likely needed that day. "Amber" patients will be discussed a few times each week, as teams will still be concerned about them. "Green" patients can likely be removed, and have normal contact with the service. I do not have the full details on how often things are discussed; this is managed by management, who have a spreadsheet that is updated during each meeting.

270. The managers also document who is being discussed at these morning risk meetings, the risks posed, and the plan for next steps. Someone like VC would be discussed in this meeting.

271. We can also have formulation meetings if we are struggling with engagement, or if we want to look at a patient's history, whether present or future.

### **NHFT's Level 2 investigation**

272. NHFT's Level 2 investigation comments that too much emphasis was placed on complying with VC's priorities for his education. I have been asked to consider the extent to which there was reluctance to use diagnostic labels and/or restrictive practices because of the potential adverse impact on VC's long-term prospects and finishing his degree.

273. I think VC's course was very important to him; he was considering doing a masters degree. He would have been behind as a result of being sectioned, but he appeared to catch up, although he did voice annoyance with hospitalization impacting his studies. Despite VC's multiple admissions, I believe he did pass his degree.

274. We often have students who have multiple admissions, and I do not feel this impacts them being detained, because if there is a clinical need for them to be detained, they will be detained.

275. I do think that a lot of emphasis was put on VC “being well enough” to study, and the fact that concerns were not raised by his University (concerns were raised regarding the people that VC lived with, but these were not concerns relating to VC’s course).

276. I do not believe that we actively discussed whether we should avoid using diagnostic labels and/or restrictive practices because of the potential adverse impact on VC’s long-term prospects. Rather, I believe that VC was able to do his studies, this impacted the intensity with which we tried to pursue VC for engagement purposes. Alternatively, it appeared VC was able to mask symptoms of psychosis, in order to function in society, and complete his degree and hold down a job for a period of time.

### **Disproportionate use of NHA restrictive measures**

277. I was aware of concerns about the disproportionate overuse of MHA restrictive measures with black African and black Caribbean patients, publicized in the context of the MHA Reform.

278. However, these concerns, or the publicity around them, did not impact my decision-making regarding VC, and I do not think I avoided the use of restrictive practices and approaches due to such concerns, or the publicity around them.

### **Recommendations**

279. In order to ensure that lessons are learned, and to prevent similar attacks in the future, I consider that there should be a greater emphasis on the development of AO pathways, and more training on the choice between EIP and AO, in terms of the patient's prognosis and diagnosis. I also wonder if it would be beneficial if AO and EIP worked together more.
280. I feel that inpatient and community teams should be encouraged to consider CTOs and depot medication more. I also think it would be beneficial for there to be an ongoing liaison between the University and mental health services.
281. Lastly, I consider that more money should be put into mental health services, to ensure that all community teams are fully staffed, to ensure staff can focus on recovery for patients, rather than firefighting.
282. In terms of the improvements that could be made locally and nationally to multi-agency working to increase effectiveness in preventing similar outcomes in the future, I consider that there should be a system where the police, GPs, and mental health services can view records and risk history. To give the example of VC, even when VC was picked up by a different police force, if that force were able to see the Nottingham Police records, they would be able to see VC's mental health history. I also feel consideration should be given to MI5 being about to share information with mental health services if necessary.

283. There should also be multi-agency meetings with various professionals for people like VC, who have had contact with the police, or who have been disengaging from the service. This is something that is now being done in NHFT.
284. GPs and mental health services should also work together more closely. NHFT has now stated to do this upon discharge, but perhaps this should be ongoing.
285. If someone has frequent admissions, I think perhaps the ward consultants and the community consultants could meet outside of the ward round, or in clinic. They could then discuss the patient's prognosis, their journey with mental health service, and what can be done in order to avoid further admissions and to keep the patient well.
286. Lastly, I feel that forensic teams and community teams should work together more closely; it would be good to receive training from the forensic team, and perhaps use the HCR-20 tool, which is the tool used to assess the risk of violence in forensic psychiatric populations.

**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: 14.01.2026

### Index to First Witness Statement of Abi Parsonage

<b>No.</b>	<b>URN</b>	<b>Document Description</b>
1.	NHFT0004012	Operational Policy
2.	NHFT0000417	Procedure 01.08 – Do Not Attends
3.	NHFT0004725	Procedure 01.08a – Merged Do Not Attends/Cancellations
4.	NHFT0015099	Assessment and Management of Risk to others
5.	WITN0317010	Microsoft Teams chat from 23 June 2020
6.	WITN0317002	Procedure 01.08 – Do Not Attend dated October 2025
7.	WITN0317011	Screenshot of texts with VC – 1 February 2021 – 16 February 2021
8.	WITN0317012	Screenshot of texts with VC – 16 February 2021 – 15 March 2021
9.	WITN0317013	Screenshot of texts with VC – 15 March 2021 – 18 July 2022
10.	WITN0317014	Screenshot of texts with VC – 18 July 2022
11.	WITN0317015	VC contact card
12.	WITN0317016	Screenshot of texts with VC – 21 August 2020
13.	WITN0317017	Screenshot of texts with VC – 21 August 2020 – 9 October 2020
14.	WITN0317015	VC contact card
15.	NHFT0004885	Interview for Gary Carter Conduct Investigation
16.	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary
17.	WITN0317003	Email from Abigail Parsonage to Carly Kane re: ward round VC dated 27 July 2020
18.	WITN0317006	Email 09.10.2020 from Abi Parsonage to Emma Robinson and Gary Carter providing handover
19.	WITN0317007	Email 23.10.2020 from Abi Parsonage to Emma Robinson and Gary Carter while Abi would not be attending MDT
20.	CHCA0000011	AMHP Report Referral and Assessment
21.	NHFT0018292	Email 16.09.2022 from Abi Parsonage regarding cover for Gary Carter
22.	WITN0317008	Email 21.07.2022 from Abi Parsonage asking for VC to be mentioned in MDT
23.	WITN0317009	Email 25.07.2022 from Abi Parsonage to Gary Carter, telling Gary to see RiO about VC
24.	WITN0317005	Assertive Outreach Eligibility for Sheffield Mental Health Services

25.	WITN0317004	EIP Aims as set out on NHFT websites
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