Witness name: Bilal Burri

Statement No: WITN0337001

Dated: 28.11.2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF BILAL BURRI

I, **Bilal Burri**, will say as follows: -

INTRODUCTION

1. My name is Dr Bilal Ahmad Burri.

2. I work as a consultant psychiatrist in the home treatment team at Sheffield Health Partnership University NHS Foundation Trust and have done so since 2nd December 2024.

BACKGROUND AND QUALIFICATION

3. I hold the Bachelor of Medicine, Bachelor of Surgery (MBBS) degree and am a member of the Royal College of Psychiatrists (MR Psych).

4. After my graduation, I had worked initially in Pakistan and then in Saudi Arabia before moving to UK in 2012.From February 2012, I started working in NHS in Wales till August 2014.Before joining psychiatry, I had worked in various specialties including medicine, surgery, and accident & emergency. My career in psychiatry started in August 2014. At first, I did my core psychiatry training (3 years program) at North Essex Mental Health Trust from August 2014 till August 2017. After that I did middle grade locum work at various regional Mental Health Trusts in East of England & London for next two years. I started my higher training (3 years program) in general adult psychiatry at Nottinghamshire Mental Health Trust in August 2019 that finished in August 2022.Subsequently I was awarded CCT (certificate of completion of training) in general adult psychiatry from GMC. Since then, I have been working as consultant psychiatrist at various regional Mental Health Trusts. Currently I am working as consultant psychiatrist in crisis & home treatment team at Sheffield Health Partnership University NHS Foundation Trust since 2nd December 2024.

ROLE AT NOTTINGHAM HEALTHCARE NHS FOUNDATION TRUST (NHFT)

5. I joined Nottinghamshire Healthcare NHS Foundation Trust (NHFT) in August 2019 as part of my 3 years higher training program. My first placement as ST4(Specialty training Year 4), between August 2019 to August 2020 was at Highbury Hospital in acute inpatient unit, Rowan 2 and

the Crisis Resolution & Home Treatment (CRHT) team. This placement was a mix of both inpatient work (Rowan 2 ward) and community work. My next placement as ST5 (Specialty training Year 5) was at City South Local Mental Health Team/EIP, Stonebridge Centre, from August 2020 to August 2021.

6. During my first placements as ST4, I saw patients with acute mental health crisis and acutely unwell patients. During my second placement as ST5 at EIP (Early Intervention in Psychosis), I saw more stable and less acutely unwell patients who needed long term community care.
7. Typically, during my inpatient job at the Rowan 2 ward, I would assist my consultant supervisor during ward rounds and Multidisciplinary Team (MDT) engagements; see acutely unwell patients who were admitted in the ward; advise/guide junior psychiatry trainees and GP trainees; and write reports for Mental Health Act 1983 (MHA) tribunals under consultant supervision for the detained patients.
8. While working at the Crisis team, I would see 3-4 patients on the given day, which were allocated to me by consultants in the team. These are acutely unwell patients who are in mental health crisis and may need hospital admission. During my stay at Crisis team, I had the chance to do Mental Health Act Assessment (MHAA) in local health-based place of safety where patients were to be brought by police under s136 (police power under MHA to remove a person from a public place on suspicion mental disorder or need of immediate care or control) .I would attend crisis MDT and shared the decision making for the patients. During those placements, I acted as second on-call doctor, out-of-hours and on weekend as per rota. On these

calls, I would advise junior doctors who were first on call and nursing staff for clinical matters and liaise with the consultant on-call in case I need any advice.

9. As far as MHA experience is concerned, during those placements, I had opportunities to do mental health act assessments in my capacity as on call registrar where you can act as first doctor or independent second doctor in decision making. These on calls were usually once every week and then 48 hours weekend on call that come every 4-6 weeks. Most of my time during those calls was spent doing MHA's. On average during one 12 hours on call I would usually do 1-2 MHA's, sometime even more than two MHA assessments.

EARLY INTERVENTION IN PSYCHOSIS AND LOCAL MENTAL HEALTH TEAMS

10. As the name implies, the main aim of "Early Intervention in Psychosis (EIP)" is for this community-based team to intervene "early" in patients who are suspected to show signs & symptoms of psychosis. There is evidence that early recognition and then early subsequent treatment improve outcome and prognosis in case of psychosis. Keeping that aim in mind, every patient who comes under this type of team will have a dedicated care coordinator (CCO) which is usually a qualified mental health nurse. It is worth pointing out that unlike Early Intervention Teams, a traditional community team does not provide a dedicated care coordinator to all of their patients. The care coordinator keeps a close eye on patient progress on a regular basis and liaises in close coordination with medical teams and other agencies to coordinate the care provided.

11. National Institute of Clinical Excellence (NICE) guidelines and local Trust guidelines serve as points of reference and guidance when decisions are made about care of the patient. This includes the making of formulation by incorporating all information, risk assessment, nursing & medical reviews/support, provision of medication, psychotherapy support, vocational support, social care needs assessment if indicated, financial & housing support, support monitoring of physical health, liaising with family and other agencies and care planning in timely manner.

12. EIP keeps patients under its care for 3 years if they are on first episode psychosis pathway and have a diagnosis of psychosis. After 3 years, patients are either transferred to local mental health team for onward care or are discharged into the care of a GP, if no further care needs identified.

13. I understand the general procedure and scope of EIP services for the care of patients who come under the Team's s care. As per policy, a patient is to be seen within two weeks of the initial referral being made to the Team. After an initial nursing assessment, the assessor would bring matter to weekly MDT meeting for broader team's discussion. A consultant psychiatrist usually decides who will be the appropriate medical person who will then see the patient as a first medical assessment. The urgency given to the appointment is dictated by the clinical needs and concerns in the light of initial nursing assessment and MDT discussion.

14. First Episode Psychosis (FEP) refers to a patient who has experienced symptoms of psychosis for the first time. The duration of the symptoms could be variable depending on individual situation but for the purpose of operation of EIP, the cut-off is 3 years. It means any patient who has symptoms longer

than 3 years will normally not be accepted by EIP team but will go to community mental health team.

15. There are many roles and responsibilities for clinical professionals within the EIP services team. They include the following:

- **Community Consultant Psychiatrist** - Consultant psychiatrist is ultimately responsible for the care provided to the patient. The consultant provides medical leadership to the decision making, supervises trainees and junior doctors, oversees and contributes to care planning & risk assessment and escalates the care depending on evidence.
- **Junior Doctors or Trainee Doctors** – These doctors provide medical input to the care of patients under consultant supervision. Each doctor, according to their level of experience and training grade, usually has their patient that they see in clinics. These doctors then discuss the patients with consultants during dedicated weekly supervision times, during MDTs, as well as informally by reaching out to consultant.
- **Team Leaders -** They provide ultimate leadership for smooth running of the team, making sure standard operating procedures are being adhered to, do allocation of appropriate staff to clinical duties and attend MDTs.

- **Clinical Leads -** They provide senior leadership cover for clinical matters, situations and act as bridge/liaison with medics in the team.
- **Nurses -** Act as care coordinators and provide regular nursing reviews of the patients, bring cases for discussion in MDT's, work in close liaison with the families, other allied health professionals and external agencies.
- **Support Workers -** They provide supportive roles like helping patients with social activities, housing, and benefits claim if any etc.
- **Psychologists -** They provide psychology support such as making psychological formulation to help patient understand psychological bases of their experiences, help team to understand patient's symptoms and to decide and then provide appropriate mode of psychological therapy to the patients.
- **EIP Managers / Service Managers -**They have a managerial role for smooth running of the services.
- **Social Workers -** They provide social care assessments, identify care needs and then provide and recommend appropriate social care packages accordingly if need.

TREATMENT, CARE AND MANAGEMENT UNDER EIP SERVICES

16. When an individual is referred from an inpatient setting or from any other service, the team or assessor would usually look at the referral letter to have the initial thoughts and concerns raised by the referrer. After this, one usually would go and take a good look and read at available records on our system, any previous assessments by a mental health practitioner, GP records, any discharge summary from inpatient unit and risk assessment on RiO.

17. During an initial assessment, in addition to clinical assessment and formulation, the patient would be asked about their aims and expectation from the services. Consent is sought to share information with family or friends; or if there is any other external agency involved that needs contacting for information. During the initial assessment rating scales including CAARMS (Comprehensive Assessment of At- Risk Mental State), HONOS (Health of the Nation Outcome Scale), QPR (Questionnaire about the Process of Recovery) and DIALOG (a standardised patient reported outcome measure to assess patient's satisfaction with various aspects of their life and treatment) are completed. Additional rating scales such as BDI (Beck's Depression Inventory) and BAI (Beck's Anxiety Inventory) are used depending on the situation.

18. EIP Service providers are the main body responsible for initiating, coordinating, implementing and monitoring Care Programmed Approach (CPA) care plans in all three domains of physical, psychological and social aspect of needs and management. The team makes sure that patient's problems and issues are clearly identified in all three domains and appropriate remedial strategies are in

place to promote recovery, risk management and to improve outcome. EIP have main role that the issues and the agreed plan that was made at CPA are clearly documented, conveyed to any other team or agency for their attention & action and are follow through by further review.

19. After a patient is accepted onto the FEP pathway provided by EIP services, EIP would offer what is generally called as "*bio-psycho-social*" treatment model. The three component parts are explained as follows:

- The "*bio*" part includes provision of anti-psychotics which we generally advise that patients should continue for 1-2 year after resolution of symptoms in align with NICE guidelines. There can be individual variation for the duration of anti-psychotic treatment depending on clinical presentation. This part also includes provision of other psychotropic medication if needed such as anti-depressants, anxiolytics, sleep aids medication and any other medication to counter the side effects of medication. This part also involves monitoring of physical health with bloods and ECG. There are also regular medical and nursing reviews of mental health and of progress. There is no end to this part but under EIP patient stays for three years.
- The "*psycho*" part includes provision of CBTp (Cognitive Behavioural Therapy for psychosis) which generally consist of 12-30 weekly individual sessions with a therapist (number of sessions can be variable).

This part helps making psychological formulation, help patients to understand their symptoms, provide therapy support and psychoeducation.

- The "*social*" part of the treatment includes social care needs assessment & support like provision of support worker, occupational support regarding voluntary/involuntary work, financial support & benefits claims and housing etc. This type of support can continue throughout the three years while the patient remains under the team depends on individual case.

20. There are several observations or indicators which demonstrate that a service user is recovering appropriately while under the care of the FEP-EIP services. These include firstly subjective reporting by the patients about their progress and recovery. Secondly, it is objective assessment by the clinicians involved in care. Lastly it can be third party reporting (family, friends, GPS, other allied health professionals and any other external agency).

21. All the observations or indicators, both positive and negative are picked up through regular contact with the patient, their attendance at reviews and MDT discussions. At a more practical level, appropriate recovery will be evident when original/baseline symptoms are resolving. These include scenarios where patients are more able to cope with their symptoms without undue distress, no new symptoms reported or observed, their engagement

is good, patient remains compliant with their medication and their functioning gets better while no further risks identified.

22. I would say that there are no strict criteria to say if patients are or are not acutely unwell because this can be quite individualistic and is also a clinical-based judgement. The lines I follow to form a view if a patient is acutely unwell would be how the patient presents clinically with their symptoms and its severity, any indicators of their relapse, previous and current risks, their insight and willingness to accept treatment and their capacity. Any opinion that I would have will also include views or concerns of other significant and interested people involved with the individual patient.

23. Clinical indicators that suggest a patient is acutely unwell includes severe anxiety, perplexed looks or behaviour, being overwhelmed with distress, severely depressed, suicidal, neglect of self-care and the environment they live in, appearing dehydrated, thought disordered ,confused, disoriented, manic, very elated in their mood ,disinhibited with poor sense of personal space and social norms/boundaries, cannot provide any assurance for their own safety, imminent/acute thoughts, intentions or plans to harm self or others.

SYMPTOMS OF MENTAL HEALTH ILLNESS

24. In a diagnosis of psychosis, key factors include symptoms such as delusions, hallucinations, disorganised speech & behaviour and signs, including shift/drift from the baseline, subjective distress, poor self-care,

withdrawn, isolative behaviour and poor functioning. These symptoms are not exhaustive but are nevertheless, key indicators.

25. Broadly speaking, symptoms of schizophrenia include positive symptoms such as delusions and hallucinations, then negative symptoms like poverty of speech, lack of emotional reactivity/response, lack of interest, withdrawn behaviour, reduced motivation, social isolation, reduced self-care, then disorganised thinking/behaviour and finally motor symptoms like catatonia, posturing and agitation.

26. Diagnosis of schizophrenia requires presence of at least one core symptom either from persistent delusion or hallucination or disorganized thinking or experience of influence, passivity & control AND one symptom either from negative symptoms or grossly disorganized behaviour or psychomotor disturbances like restlessness, agitation, posturing, negativism & mutism. The symptoms must be present for at least one month with significant functional impairment. Key factors for the diagnosis of schizophrenia are the duration of psychotic symptoms (at least for 1 month) with significant degree of functional decline.

27. Hallucinations are manifested mainly through hearing. However, they may also be experienced through vision, the senses off smell, taste and touch. Delusions can be of many kinds but would be persistent (e.g., delusions of persecution, reference or grandiose). Thought disorder can present as thought interference phenomenon include thought insertion/withdrawal or though broadcast. It can also be experienced as very disorganised thought process which can manifest as disorganised speech. There may also be passivity control symptoms, which is patients thinking that their feelings,

impulses and actions are not in their control but controlled by external agency/agent. Grossly disorganised behaviour like bizarre/purposeless behaviour, poor self-care, environment and poor planning are also a manifestation of hallucinatory experience. Negative symptoms can include poverty of speech, lack of emotional reactivity/response, lack of interest, withdrawn behaviour, reduce motivation, social isolation and reduction in self-care.

CRITERIA FOR MENTAL STATE EXAMINATION

28. Mental state examination is the medical narration of patient's mental state. Mental state examination involves clinician's documenting patient's symptoms and signs in formal medical description. For mental state examination, the assessor uses all the information that they have in front of them including the patient's record and their current presentation at the time of interview.
29. Mental state examination is the objective reporting and documenting what a clinician has observed in a patient during the assessment. This examination can be very formal during a scheduled assessment, or it can be brief during any other kind of patient's encounter.
30. A Summary is a concise summation of clinical presentation with technical narration of identification of clinical issues, a working diagnostic formulation and proposed action plan. The care plan is an agreed plan of action based on the individual needs and issues. It covers the whole plan of care that the team has proposed in collaboration with patients. The care plan covers a wide range of interventions and approaches for addressing issues. Factors

that influence the formulation of a care plan include thorough clinical assessment of patients, knowledge of patients' information, correct identification of issues and needs and involvement of patient in formulating care plan.

31. Within the FEP-EIP multi-disciplinary team ("MDT"), it's largely the responsibility of the care coordinator to formulate the care plan with input from MDT. This care plan should be amended once new clinical situation arises or risk changes. This care plan should be reviewed at every CPA meeting. Any change in care plan is mutually discussed and agreed upon between care coordinator and senior medic, which in most cases is consultant psychiatrist.

32. Where a patient has had multiple admissions under the MHA, it can be a challenge for clinicians to ensure that patterns in respect of their presentation and condition are captured within the ongoing care planning. This is done through weekly MDT discussions and during clinical reviews. Good and clear communication amongst MDT and amongst clinicians can ensure that the full picture regarding a patient is captured in a care plan.

33. Inpatient care plans will target more for acute issues: For example, how to prevent self-harm or what to do if patient do self-harm in the ward. While the patient is admitted in inpatient unit, usually the CCO will attend ward reviews and convey views of community team to inpatient team to help plan inpatient care plan. Inpatient care plan keeps into account the views or concerns raised by community team.

34. The care plan of the Local Mental Health Team (LMHT) is more medium to long term. Plans consider the long-term trajectory of care, such as how often

patient will be seen or what is the long-term plan for medication. Community care plans will also look at the plan made by inpatient team and amend their plan accordingly by incorporating any proposed intervention by inpatient team.

35. Risk assessments are vital for any care plan. These assessments help care providers to understand the risks pattern, risk history, degree of risks, if risks are general or specific, are risks static or dynamic, mitigating factors for risk management, what has worked well in the past, what has not worked and what increase the risk.

OUTPATIENT APPOINTMENTS ("OPA")

36. The purpose of Outpatient Appointments (OPA) is to review the progress of illness and recovery, any new clinical issues, discussion around medication and to consider if current trajectory of management is still appropriate or if changes are to be made. There are no set standard operating procedures around how often these appointments are to be offered. These could be anything from a few weeks to few months. In between the outpatient appointments in EIP, there are lot of opportunities and occasions like weekly MDT and informal discussion amongst involved clinicians that can suggest that an outpatient appointment should be arranged. There is sufficient flexibility to arrange OPA's frequently depending on the individual's clinical needs. Generally, the next outpatient appointment interval and a rough date is decided by the clinician after the previous appointment, depending on what they have seen on that day and what's their next plan.

37. Generally during these OPA's on a day, a psychiatrist would see one new patient and 4 or 5 follow up patients who are already known to the team. New cases are usually seen for one hour and follow up patients seen for 30 minutes. On average a psychiatrist will have 3 or 4 days of such outpatient reviews every week.

RISK ASSESSMENT

38. Risk assessments are vital for any care plan. These assessments help care providers to understand the risk patterns, risk history, degree of risks, sense of whether risks are general or specific, whether risks are static or dynamic, what are the mitigating factors for risk management, what has worked well or not in the past and what increases the risk.
39. There is a range of information from a patient's history that is relevant for identifying the risks they pose to themselves and/or others in the event that they deteriorate and experience a "psychotic crisis" or if they become "acutely unwell." Such information includes details about actual risk incidents in the past; triggers and circumstances of previous incidents; time taken for risky behaviour to emerge; patterns of risk behaviour and mitigation strategies. The profile of a patient's symptoms is also relevant, including their demographic, age, occupation, environment, community, family, access to weapons, history of drugs uses and forensic history if one exists. These are all factors to consider in quantifying or predicting risk.
40. Risks to self will include suicide thoughts or behaviour, severe self-harm, drugs use and if unable to assure their own safety and well-being. Risks to

others include history of violence/aggression, forensic history, access to weapons.

INSIGHT

41. The notion of insight for a patient with FEP or paranoid schizophrenia encapsulates their thoughts, views and attitude towards their illness and treatment. Essentially, it is about whether the patient thinks that they have a problem; whether they perceive that any problem is mental health related; and if so, whether they are in need of treatment. It may also include whether they think that treatment needs admission into hospital. Different patients can have different level or degrees of insights. There is no precision to the measurement of insight and it can fluctuate from time to time.

MASKING

42. Masking in patients diagnosed with FEP and/or paranoid schizophrenia is the downplaying of symptoms by patients. A patient who is masking may not be very forthcoming in their responses, engage poorly during interview and actively or passively avoid engagement to give an assessor the impression that there is nothing wrong. There may be proof of masking when there is a mismatch between what the patient says about their symptoms and what is evident in their behaviour, conduct and functioning.

CARE PLANNING AND DISCHARGE UNDER EIP SERVICES

43. There are a raft of observations, behavioural changes and indicators that are a pre- requisite to commencing discharge planning for a service user under the care of the EIP service. Firstly, there must be an examination of what symptoms of psychosis are still present. Assessment should be carried out to decide if symptoms still need 24 hours observation or if they can be managed in the community. Matters to be considered are whether the patient is still actively psychotic or if their symptoms have resolved, even partially. The matter of whether the patient has been sent on some leave in the community (or has had overnight leave) to test if they can manage themselves, provides a good indicator. The assessor should look at how the patient manages medication taking (and their attitude towards concordance), what is their level of insight about illness and what is their commitment to engage with community team. An updated new risk assessment should be done at the point of discharge to reflect improvement in the risks and to add new risk if any.
44. If a patient disengages from EIP services or refuses to engage with assessments, the question of whether to deploy an assertive follow-up approach depends on individual patient history and risks involved. If history suggests that any likely relapse of illness in future due to non-engagement and non-treatment will be quick to emerge and likely lead to risky outcome, then the MDT may consider assertive follow-up so that some level of community oversight is in place to intervene if situation escalates.
45. Before discharge from inpatient, the patient in question should be at least partially, if not fully, stabilised on medication. They should have reasonable

commitment to continue medication in the community. If there is any doubt about their commitment to oral medication, then consideration should be made for depot injections as an option. A proper and thought through follow up plan should be agreed upon in the community with identification of appropriate community team. Before discharge, a patient's psychological support needs should be properly assessed so that it may be accessed in the community.

46. There are no specific criteria for patients, but every patient can have their unique profile and care needs. Where there is a history of violence and aggression in the community and/inpatient settings, careful and detailed risk assessment for violence or aggression must occur prior to the discharge. Consideration should be made if patient needs forensic formulation before discharge.

47. Patients who are considered by clinicians to be at risk of becoming violent in the absence of treatment can be considered for depot medication. Careful and detailed risk assessment for violence/aggression prior to the discharge should be done. Consideration is to be given if the patient needs forensic formulation before discharge.

48. Similarly, where there is a history of non-concordance with medication, there should be consideration given to depot injections in place of oral tablets. Where there is a history of social isolation, there must be careful consideration of social care needs assessment and consideration to provide support workers for activities planning. A history of disengagement from treatment should also attract consideration for depot injection and Community Treatment Order (CTO). This also goes for patients with a history of masking psychotic symptoms.

49. In my estimation, patients who should not be considered for discharge include those who are still symptomatic with psychosis, have previous history of violence or aggression, bear overt or covert thoughts or behaviour to harm self or others, show poor insight, are socially isolated, seem to have little or no family support, and in all this, do not demonstrate any long term commitment to taking medication. It is to point out that engagement with community team cannot be forced upon a patient without their consent in the absence of any formal legal framework like community treatment order (CTO).

50. The decision to discharge patients usually comes after discussion at MDT, presumably after thorough review of history and risks. If EIP has discharged the patient to another community mental health team, then a thorough transfer of care with possible joint transfer review should be done to the receiving team. If the patient is to be discharged to a GP, then a formal and detailed discharge letter should be done by EIP with the mention of a contingency plan to a GP, discharge medication if any and how a GP can re-refer the patient and where.

51. Depot injections must be considered in patients who have a history of non-concordance to medication, who have history of quick relapse after non-concordance, history of violence/aggression when unwell, patients with forensic history, patients who has history of vulnerability with a poor sense of personal space when unwell and patients whose risk history suggest risks to public when unwell,

COMMUNITY TREATMENT ORDERS ("CTO")

52. When a patient is on CTO and under EIP services, they have a named consultant psychiatrist who will act as their community responsible clinician ("RC"), who will have overall responsibility for the care and management in the community. The RC decides if the patient has capacity to consent for the treatment within 30 days after patient is put under CTO by the inpatient RC. There is need for certification of this, with the relevant forms. The CTO operates under the MHA and there are renewal meetings that consider its continuation and validity. The RC has the power to recall a patient to hospital if they are satisfied that the patient has not complied with the conditions of CTO, are mentally unwell and need to be seen/assessed and if inpatient treatment becomes necessary. Patients would also have a named CCO who is usually a qualified mental health nurse that monitors and sees patients more closely in the community and who appraises the RC and MDT. The CCO must make sure that the patient is taking their medication, complies with the conditions of the CTO, attends review meetings as and when required and is administered depot if injections are the treatments. Depending on the nature of the individual cases, patients may also have a named social worker because being on CTO makes a patient entitled for section 117 after care leave (provision under the MHA that entitles a person to support after detention and treatment). EIP can also provide help for vocational support, and broad support by provision of support workers.

53. CTO should be considered in patients with psychosis or paranoid schizophrenia, who have frequent relapses and admissions. They work where the subject has relatively quick relapses that don't give much time to

arranging Mental Health Act detention regimes; where there are concerns about medication compliance followed by relapses and patients who are difficult to get hold of in the community. Regarding risks and CTO, patients who have a history of poor compliance in the community, quick relapses, aggression/violence during relapses, risks of suicidal behavior patterns in the past while relapsing and forensic history should be considered for CTO.

54. I am not aware of any specific criteria for patients with violence or aggression in relation to CTOs. There are specific criteria for CTO in general, that an inpatient RC must justify before putting someone on a CTO. A CTO can only be considered for a patient who is currently detained in inpatient on a long-term detention like section 3. The inpatient RC must be satisfied that the patient doesn't need continuous detention in the hospital to receive treatment and that the treatment required by the patient can be provided in the community under legal framework of CTO. Legal criteria for CTO include that patient should have a nature or degree of mental illness under the meaning of MHA that requires treatment but does not need continued detention in the hospital; that this treatment can be provided in the community; and that the patient poses a risk either to their own health, safety or protection of others if not treated.

55. The inpatient RC must make a case that there are enough risks that exist that warrant continuous treatment in the community, and the patient must make themselves available to be seen by community team whenever asked to do so. The community RC will have the power to recall patients to hospital to be assessed and then treated quickly if they do not comply with the conditions set out in CTO. Risks to consider in these kinds of patients where

CTO can be considered include previous history of violence, history of drugs & alcohol misuse, major psychotic disorder, associated anti-social personality disorder, previous forensic history of violent nature.

NON CONCORDANCE AND DEPOT MEDICATION

56. There are types of behaviours or observations that would lead me to conclude that a patient poses a risk of non-concordance with medication. These behaviour/observations include lack of engagement with services, compromise of insight, apathy and expression of ant-medication views, a sense of medication overload due to lot of medication, medication avoidance, minimising of symptoms, non-engagement or avoidance of medication and refusal to have health education for medication concordance.
57. Depot injections must be considered in patients who have history of non-concordance to medication, who have a history of quick relapses after non-concordance, history of violence/aggression when unwell, patients with forensic history, patients who have history of vulnerability with poor sense of personal space when unwell and patients whose risk history suggest risks to public when unwell. Risks to self-include suicide thoughts/behaviour, severe self-harm, drugs use and if patients are unable to assure their own safety and well-being. Risks to others include history of violence/aggression, forensic history, and potential access to weapons.
58. For depot medication to be effective, the patient has to agree to it and give their consent to let the team administer the depot. Without their consent, depot administration and compliance in the community would

be very difficult and challenging to follow through.

INVOLVEMENT WITH VALDO CALOCANE ("VC")

Background information – VC's second period under Community Care at Stonebridge Centre, NHFT - 31 July 2020 – 3 September 2021

59. VC's medical records indicate that I reviewed him at the Stonebridge Centre on 7 September 2020 [NHFT0000274]. I had no previous interactions or dealings with VC prior to that review on 7th September 2020.The purpose of this review was to see VC for first medical review under the team after the referral to us. This was a scheduled appointment after he was already seen by qualified nurse and was discussed in MDT already. It was standard protocol that after a patient is referred to EIP, the patient is discussed in MDT, seen by qualified nurse and then a medical appointment is scheduled with a doctor.

60. It is noted that I signed the letter as follows: "*Dr. Bilal Burri, ST5 to Dr. Tuhina Lloyd, Consultant Psychiatrist*." ST5 means "Specialty trainee year 5". Psychiatry training program in UK is 6 years duration. The first three years are called "core training." Every year a doctor progressed through as "core trainee 1" (CT1)-CT2-CT3.During these years, a trainee typically rotates through various branches of psychiatry like general adult psychiatry, old age psychiatry, children psychiatry and psychiatry for learning disability. A trainee typically rotates through a mix of both inpatient and community teams to gain a broad breadth of experience. After these three years with successful completion of "core training" with positive reports form their supervisors and attainment of membership of Royal College post-

graduation degree (MRCPsych) a trainee then usually applies for "higher training program." This also means they choose a special area of psychiatry out of many psychiatry branches to become a consultant in that branch of psychiatry. This higher training program is again for a further 3 years—passing through training grades called "Specialty trainee 4" (ST4)—then ST5 and the last year, as ST6.

61. During these training years, a trainee has a named "consultant clinical supervisor" who supervises their daily work. A trainee works under their clinical supervisor in same team. Both trainee and the trainer meet every week for one hour as a dedicated hour to discuss work, patients, progress of training and anything that they both want to discuss in that one hour which is called "clinical supervision". This supervision is more formal, with allocated and protected time although typically trainee and the trainer daily works in close proximity and they both usually have lots of informal conversations and supervision throughout the week. In addition to clinical supervisor a trainee also has "consultant educational supervisor" who supervise their overall progress of the training covering academic aspect of the training and keep a check that if a trainee is progressing well with all the essential training needs met or not. Usually, a trainee meets with their educational supervisor once every three months in a year.

62. During these 6 years training, a trainee can only progress to the next year grade if they have positive reports from both clinical and educational supervisors, have attained all the required competences set out by Royal College of Psychiatrists, an independent three-member panel from the Deanery (usually all senior consultants). This process is the Annual Review

of Competence progress (ARCP). Ultimately this ARCP panel has the final say and recommends if a trainee has satisfied the panel to be promoted to the next year.

63. I was enrolled into a “core psychiatry training” program in August 2014. I was rotated through various psychiatry branches including general adult psychiatry, forensic psychiatry, psychiatry of learning disability and old age psychiatry. During these years I had opportunities to work with various teams including inpatient wards, community teams, EIP, rehabilitation team and medium secure forensic unit. During these years I also completed my psychotherapy competence cases (Cognitive Behavioural Therapy (CBT) and psychodynamic therapy) which are an essential criterion for core training.

64. After core training I spent some time doing various locum roles as a middle grade non-training doctor in various Trusts and teams including inpatient unit, community teams and EIP. In August 2019, I was then enrolled into the higher training program for general adult psychiatry as my chosen specialty. My first-year placement (ST4) was at Highbury Hospital. I was placed in a mixed post where I worked 3 days in an inpatient acute unit and 2 days at the local crisis resolution and home treatment team. During this post I had opportunities to see acutely unwell patients who reach mental health crisis points and in need of inpatient care. I was also doing out of hours on call work as registrar on call, providing guidance and support to junior doctors and nursing staff. Part of this on-call work also involves doing MHAA work. This placement ended on 4th August 2020.I was then promoted to ST5.

65. On 5th August 2020, I joined Stone Bridge Centre as ST5 trainee. My clinical

supervisor for this post was Dr. Tuhina Llyod. During this post, I saw VC after he was scheduled and placed in my diary by the team. Dr. Lloyd decided to put VC in my clinic for medical reviews.

66. During that ST5 Post, I usually meet with Dr. Lloyd every week for one hour as a dedicated time slot for weekly supervision. During these supervisions, I discuss various topics and issues related to my everyday work and training. We discuss patients - sometime one patient in detail- or a few patients with specific issues. During those meetings I discussed VC from time to time. Besides these formal supervision meetings, we would also discuss my work and patients during MDT. There are loads of informal discussions happening in everyday work almost on a daily basis. Dr. Lloyd and I share same office space and sat next to each other, so there was ample opportunity to discuss cases where appropriate. During weekly MDTs, all cases were discussed with the various level of details.VC care and management was part of regular discussion and conversation amongst members of MDT, including myself and Dr. Lloyd.

67. I reviewed VC a few times during his Second Period under Community Care. I provided regular feedback about VC progress to Dr. Lloyd. That feedback was provided during our weekly supervision sessions and during weekly MDTs. Dr. Lloyd was on board with all the decisions made for the care of VC. I informed Dr. Lloyd after every medical review that I did for VC. The progress of VC was regularly fed up to the attention of Dr. Lloyd. I regularly attended MDT every week. The only exception would be when I was on annual leave.

68. VC's progress was shared in MDTs. Usually, it's the care coordinator who

will regularly appraise the MDT about progress and bring in any concerns for wider MDT discussion. I don't have any formal correspondence as such, but all the information must be held in VC's record. From my memory, I can recall that the care coordinator brought in the issue of memory, so I offered to do a formal memory test, which is included in VC's records. I also remember CCO brought in the call CCO made to VC's mother in Wales about her concern about VC. Besides that, his engagement and progress were regularly discussed in MDT.I also gave my views and thoughts on my own encounter with VC in the MDT to discuss and share decision making with Dr. Lloyd and wider MDT.

69. The CCO and I regularly communicate with each other about VC by means of informal daily face to face contact at stone bridge Centre, via emails and during MDTs. My working relationship with CCO was good and healthy without any conflict or any communication hindrance or barrier. I was approachable and non-judgmental whenever support was asked by CCO about any concern that CCO might have about VC. We worked together as team to support each other and to provide good quality care to VC.

70. I have been asked to say whether I reviewed any aspect of VC's medical record prior to undertaking the assessment on 7 September 2020, including any entries contained within VC's Ri0O record. In particular, I have been asked to state whether I reviewed the Discharge Summary in respect of VC's Second Admission at Highbury Hospital [NHFT0000222], the "*Summary & Care Plan*" dated 1 September 2020 [NHFT0000202], any of the Risk and Safety Assessments which had been undertaken in respect of

VC during his First Admission and/or his Second Admission at Highbury Hospital (for example, [NHFT0000197; NHFT0000196 and NHFT0000195]). The query also includes whether I reviewed any of MHAAs which had been undertaken by independent medical practitioners in advance of VC's First and Second Admissions (for example [NHFT0000399 and NHFT0000037]).

71. Respectfully, I have to remind the Inquiry that it has been 5 years since I saw VC. I do not remember each and every document that I might have reviewed prior to seeing VC on 7th September and what were the precise thoughts that operated on my mind at that time. I do remember that I reviewed the MHA assessments, discharge summary and summary care plan. I was aware of the two admissions, as well as the incidents at VC's block of flats and the police involvement.

72. I will also say that usually it was my practice to review as much notes as possible before seeing patients and to also have an informal conversation with the CCO to get a picture from the CCO's perspective, as well as identify any current issues to discuss in the review.

73. Before the review on 7th September 2020, I spoke with VC's CCO before seeing him to ask CCO's views about VC; and if the CCO was keen on any issue for me to discuss with VC. I did not seek any information from VC's nearest relatives, the police, university or any other third party because all the information that I needed at that time was present in the clinical record.

74. To establish that the background to VC's admissions was accurate and up to date, I read the relevant notes and assessments prior to seeing VC. I had good knowledge about VC's pre-admission circumstances and subsequent

course before seeing him. Generally during MDT, it is the CCO who brings patients for discussion. Overall responsibility for up to date understanding about their history is shared between the CCO, the consultant psychiatrist & their junior doctors, any psychologist involved and any other involved member of MDT in the day-to-day care of that patient. Ultimately, it is the community consultant psychiatrist who oversee the medical care provided to the patients. The MDT also had responsibility to the extent that it was a decision-making collective that incorporated views and input from a range of psychiatric professionals involved in VC's care and well-being.

75. Prior to reviewing VC on 7 September 2020, my understanding of the details of the following incidents was as follows:

VC's first arrest on 23 May 2020.

- I understood that VC was arrested by police on 23 May 2020 after he damaged his neighbour's front door and tried to enter that property. The resident of that property had to flee the place by jumping from window, apparently for their safety.VC was assessed and the least restrictive option of home treatment was suggested/made and he was let go to the care of home treatment team.

VC's second arrest on 24 May 2020.

- My understanding was that once back at home, VC was again arrested on 24 May 2020 because he tried to gain access to neighbour's property. He was reported to be concerned that resident of the

property was in danger.VC was assessed and was detained under MHA.

VC's third arrest on 13 July 2020.

- I understood that VC was arrested on this occasion when he tried to force his entry to neighbour's flat. During the assessment at 136 suites (a facility where individuals detained by the police under s136 of the MHA are taken for a mental health assessment), he was reported to have concerns that his neighbour was trying to put voices in his head. He was assessed and detained under MHA.

76. I was not aware of any previous history of violence and aggression before those multiple arrests started in May 2020.

77. Based on the circumstances around three arrests that were made and in the buildup of two inpatient admissions, I understood that VC had a history of non-compliance to medication. Consequently, there was a risk of him becoming non-compliant again. I also understood that the record showed that he could get ill quickly. Previous incidents showed that when he did, there could be incidents of serious aggression and violence. I also anticipated that VC could be at risk of poor engagement if he was to become non-compliant. Sources that I relied on to reach my conclusions were previous MHA assessments, RIO notes, summary care plan and risk assessments

78. I think as far as any procedural safeguarding is concerned, I would say robust communication between police and mental health services would be important for risk formulation and quick intervention should risk escalate. During the care episode while I was involved (from September 2020 till late June/July 2021), there was no further incidence of violence/aggression seen/observed or reported so far as I remember. There was no further communication between EIP and police except once when I spoke with a police officer about how and when to disclose a compensation claim made against VC by his neighbour due to previously reported door damage caused by VC. If I am correct with my memory/knowledge, there was no other communication with police. During VC's reviews with me, I did not feel the need for police support as VC condition was stable and was engaging with the team.

79. I did not update VC's risk assessment after the review on 7th September 2020 because there were no new risks identified. Risks assessments usually get updated at each CPA meeting or if there is new risk seen. Usually care coordinators do updates of risks assessments during CPA. Risk assessments can also be done by the doctors seeing patients or anyone who has reasons to do so at any point of the patient's care.

Historic Pattern of non-concordance with medication – Second Period Under Community Care

80. Within a day of VC being discharged from Highbury Hospital, Crisis Resolution and Home Treatment Team ("CRHT") nurses noted that there were issues with his willingness to engage with community

clinicians to monitor his medication concordance. He represented that he had misplaced them and it is then recorded on 1 August 2020 at 4:49pm that VC called the CRHT team to confirm that he had found his medication [NHFT0000168, at p.119]. I was not aware of this episode. These observations may suggest that there was some reluctance to take medication but at same he agreed to daily compliance visits as suggested by CRHT and was not totally antagonistic to daily visits. Notes recorded that he later called CRHT to confirm that he had found the medication.

81. I see that on 3 August 2020 CRHT, Nurse Clive Chimbi undertakes another home visit to VC [NHFT0000168, at p.121-122] and VC told Mr. Chimbi that he had already taken his morning medication. VC is recorded as having "*showed [the CRHT Nurse] the meds with evidence of tablets having been dispensed*." Mr. Chimbi informed VC that the CRHT team "*need to do medication concordance with him*," VC responded that this was "*a bit excessive of staff to come in and watch him take meds [and said] [h]e prefers to take his meds between 8 and 9. He said he did not want to take it any later. He would not give a valid explanation why*." This recording demonstrates that the plan was still that CRHT would visit him again the next day to monitor medication compliance. Mr. Chimbi also recorded that there should be a discussion during the CRHT MDT meeting as to what should be done if VC continues to refuse medication concordance monitoring.

82. I personally do not recall that I had seen those observations in the record made by CRHT.I cannot be sure if later on we at EIP as a team had discussed those observations by CRHT or not. To the best of my

recollection, I joined EIP team on either the 4th or 5th of August 2020.

83. VC's medical records indicate that I attended an Urgent Home Visit with VC's CCO on 10 November 2020 [NHFT0000168 at pp.137-138]. There is a record of VC calling Highbury Hospital on 5 November 2020 to speak with his inpatient consultant ([NHFT0000168, at p.135-136]). It's difficult for me to recall after 5 years if I reviewed any RIO record before that visit or if I was aware about the call he made to Highbury on 5th November 2020; but looking at the record now , I can see that the CCO sent me an email asking if I have capacity to see VC earlier than the arranged appointment because "*Valdo has something to say but will only say to a doctor*". It was my usual practice to review notes and discuss with CCO before an encounter with any patient so I can only imagine that I must had done so before embarking on that visit on 10th November 2020. Although VC was going to have a pre-scheduled appointment with me in next two days, I offered and agreed to go and see him straight away rather waiting for next few days. I can only guess that I must have been made aware by CCO that VC had made a call to Highbury hospital; or that maybe in CCO's view, VC should be seen urgently. That was reason we had the facility of urgent visit same day; but again, I cannot be 100 % sure what was the content of discussion between me and CCO.

84. I noted that VC had disclosed that he had misled inpatient clinicians during his last admission. At the same time, I was conscious that he had now disclosed this to EIP voluntarily – and had instigated this engagement. He could have easily kept all this to himself; but he opted to disclose it to us by his own volition. When I asked him the reason for why he misled the inpatient clinician, he said

that he got tired being in the hospital. He said that he thought that the easiest way to get out of hospital was to deny hearing voices; and that if he denied hearing voices then the inpatient clinician would discharge him from the hospital. After VC told me the reason for misleading inpatient clinician, I thought that he could have continued to mislead us, but that he voluntarily disclosed that information to me. I thought that this voluntary disclosure suggested that he was prepared to be open about his mental health and willing to continue engage with the EIP team. I appreciated his openness. I increased the dose of anti-psychotic medication and prescribed benzodiazepine for anxiolytic effect on short term use. He agreed with the plan so we continued the care but added that we could involve crisis team if situation escalates.

85. Risks associated with masking symptoms include that the full extent of patient's symptoms become more challenging to understand and may give a false impression as if symptoms are controlled. Masking symptoms is not uncommon behaviour in patients with psychosis. Clinicians in EIP are normally aware of this behaviour by patients.

86. As clinicians, what we do with these patients is first aware to be alive to masking and be vigilant around it, maintaining a low threshold for intervention. The interventions that could be considered in patients who tend to mask symptoms include continuous psychoeducation, building a trusting therapeutic relationship, involving any other interested and significant family or friends to get their views and concerns and consideration of depot injections if patient agrees for injections and not taking oral medicines.

87. From my memory and notes written by me, I will say that when I asked VC to tell me more about what he meant when he spoke of a need to "*prove*

his power" my understanding was that he said so because voices were saying that he should be punished for the "crimes" he did. The suggestions by voices are that he should prove his power by violating the lock down rules and going out. He denied any special powers or on any mission; and any thoughts/intentions or plans to harm anyone or do something violent. Rather, he maintained that he did not want to "trouble people" and that's the reason he decided to be honest and disclosed his previous act of misleading the inpatient clinician. He denied any intention or plan to do any harm to himself or anyone else.

88. At that stage, I wrote that there was escalation of symptoms, but risks were contained because VC did not have any thoughts to harm anyone, he was not thought disordered, not actively responding to any unseen stimuli, not overly distressed, appeared calm and clean with no self-neglect, agreed to increase medication and to see the team. We kept a backup option to involve the crisis team should risks escalate. We were able to make a follow up plan for VC to be seen by CCO closely, and for the CCO to appraise the MDT and continue the review progress.

89. At this stage, I understood VC's risks were around non-compliance and quick relapse if he was to become non-compliant, with potential risk of aggression and violence due to previous similar incidents. I cannot recall if I had reviewed any medical record about masking symptoms, but I can say that I had known that VC had stopped medication between two admissions. I thought at the time that VC was of the view that voices that he was experiencing were real voices and not just in his mind when he said they were not a result of mental health issues. I got the impression that he meant

that these were real voices and not just fake products of his mind. He agreed that he was not well and needed medication.

90. I was aware that there were risks where patients do not have full insight. These include risk of poor engagement and non-compliance to medication. I gave my input through my conversations with CCO directly and through MDT about risks assessment for VC. All my reviews and encounters with VC were in the company of his CCO who then updated the risks assessment with input from me.

91. Before that review on 10 November 2020, I cannot recall if there were any concerns raised either by VC's CCO or any other professional or external observer that VC was not taking his medication. When I enquired directly from him, VC told me that he was compliant with medication mostly but openly said that he had missed few doses. He appeared to be open and honest about his medication intake to me at that review. He did not appear to dodge the questions about medication, compliance or side effects. Due to these observations, I got the impression that he was mostly compliant with medication.

92. I cannot recall exactly what I thought at that time were the possible reasons for VC's deterioration; but perhaps this could have been a mix of reasons that included intermittent compliance; stress at university, so much that he decided to take a gap year; being away from his family in Wales and not having spoken to them for a month; and moving to a different accommodation and wanting to start a job.

93. I also prescribed diazepam for VC as short term anxiolytic. We agreed to a plan that the CCO would monitor him closely and appraise the MDT.

discussed with CCO that our contingency plan would be to involve crisis team if situation escalates.VC also agreed that CCO can contact his mother in Wales to share information and to take her views and concerns if any. I offered to see him again at short notice early but otherwise put a plan to see him in 6 weeks' time. Later, we discussed this visit at MDT as well to see if the plan was appropriate and adequate. MDT was on board about the current presentation and plan made.

94. I wanted close monitoring of VC in the community. This meant the CCO keeping in contact with the patient and seeing them regularly. Contact with the patient could be contact every day, every other day, every few days or every week. I cannot recall what was the frequency of visits agreed between the team and VC but I suspect this must have been at least once or twice every week. If a patient needs daily contact, then in that case we would usually consider involving either the crisis team or through our daily duty team because daily contact was not possible or sustainable. There is wide range about the frequency of those reviews. There was quite a lot of flexibility around level of contact based on individual cases. This was usually discussed and agreed mutually between CCO and the patient because sometimes over involvement can be too overwhelming for some patients. This was usually a fine balancing act between patient and team. There are no rigid rules around it. Because of the way EIP team worked with their weekly MDT, there was regular update about the patient's progress, and a plan could be revised regularly based on update provided by CCO.

95. I can recall that VC gave his consent that his family can be contacted. I also

recall that CCO was to ring his mother in Wales about him. I cannot recall observing an eye injury when I reviewed him. I did not formally assess his capacity but on reflection, I don't think I had doubt about his capacity to consent for the treatment decisions that I made during that visit at that time.

September 7, 2020

96. I acknowledge the letter which was addressed to VC's GP following this review [NHFT0000274] which includes an observation under the heading "Assessment" page 2, that VC was *"compliant with his medication."* During his review on 7th September 2020, VC did not express any negative views about medication. He openly expressed his intention that in future he would like to come off medication and seemed open and honest about these intentions. VC was thankful to me for the explanation that I gave about how we treat psychosis in general and the minimum duration of anti-psychotic medication that he should consider. There was a discussion in an open and frank way about what happens if medication can be reduced or stopped. I invited him to consider that should he change his mind in future not to take anti-psychotic, then we could have a frank conversation about it and see what's the best course of action. He seemed relaxed to know that medication could be discussed in the future.
97. I don't remember that there were any concerns or doubts raised about his compliance by his CCO or any other professional/family member. It was reported by his CCO at the MDT that VC regularly picked his medicine prescriptions from EIP base at Stonebridge Centre and was taking his medication. His presentation during the review on 7th September 2020, plus

the fact that there was no other evidence to believe that he was not taking anti-psychotic medication were the reasons that I made the conclusion that he compliant in taking his medication.

98. The letter addressed to VC's GP following this review [NHFT0000274] noted that: "*...he showed insight (superficial one) but I am not very confident if he has a deeper grasp of his illness in the long term and they may be some element of minimisation*." During this review, VC agreed that he was mentally unwell around the time of admissions. This agreement by VC demonstrated that VC has some insight, though it was more superficial insight than deep insight. Lacking deep insight means that VC did not seem to grasp the degree of his symptoms around admissions, possible causes behind his symptoms and long-term role of treatment. He was not dismissive about the idea that he was mentally unwell and expressed his willingness to work with services; but at same time, appeared not to have a full understanding of his illness. He did not elaborate on his symptoms but only answered the questions posed to him with not much follow-through. This is the kind of presentation that one can expect to see in patients who might minimise their symptoms.

99. It was still early days of VC with the EIP, so my intention was not to overload him with too much information and discussions. I gently challenged VC to test his insight and his understanding about what happened in the last few months but at same time was conscious that I wanted to build a therapeutic relationship with him to improve the recovery and long-term outcome. In such situations with superficial insights and possible minimisation, EIP offer psychoeducation, psychotherapy and relapse prevention work.

100. Relapse prevention work is planned by the CCO. During reviews, the

opportunity is often seized to have discussions with patients to help them understand their experiences and illness as a form of psychoeducation. Psychotherapy is another support that EIP offer to their patients to improve their insight and understanding about the illness. This was offered to VC but he was not keen on it.

101. In the letter to VC's GP following this review [NHFT0000274], it was noted that *"[VC's] CCO will try to do some relapse prevention work with him at the first opportunity."* Relapse prevention work involves joint collaborative work with patients keeping in view their individual illness. This work involves giving autonomy to patients with professional support. It identifies what could be potential causes of relapses such as everyday life stress, pressure from studies/ work or medication compliance. It also identifies the signs that indicate to the patient that they are headed towards relapse: for example, withdrawn behaviour, irritability or disengagement. These signs are called "relapse signatures". There is then a process of joining with the patient to device coping mechanisms to deal with those situations, such as listening to music, speaking with a friend/family, reading, watch a film or play. It teaches the patient who, how, where and when to reach out to seek support. This includes psychoeducation about their illness in a non-judgmental way that promotes autonomy.

102. The signs that relapse prevention is working include better engagement by the patient, more forthcoming conversations by the patient, longer inter-relapse periods, less crisis points, improved medication compliance, improved functioning and recovery. During

MDT's, progress is continuously discussed. CCO expressed their views if they have any concern about compliance, such as any concern raised by the GP if patient is not picking up their prescription; if the patient has expressed views that they are not going to take medication; or if any family members have reported issues with compliance. If it appears that the patient is not taking medication, then the idea of depot can be discussed with them if the problem is one of difficulty taking daily tablets for any reason.

103. The assertive approach can be considered in patients who are difficult to reach, who do not attend their appointments, do not pick their prescriptions, express negative views about medication, are not open around medication discussions, are isolative and withdrawn patients with risky history and frequent relapses.

104. I determined that VC was suffering from FEP. This has been brought to my attention with a question that asserts that this diagnosis was different to the diagnosis that was recorded on VC's discharge summary by VC's inpatient consultant, which records that VC had paranoid schizophrenia. ([NHFT0000222]). First Episode Psychosis is just the title/diagnosis given to a patient who is on the "First Episode Psychosis pathway" under EIP team. Generally, there are two pathways in EIP team. One is called "AT risk mental state" (ARMS) pathway, which includes patients who are at risk of developing psychosis. The other pathway is "First Episode Psychosis pathway". First Episode psychosis pathway includes patients who are already diagnosed with formal psychosis.VC was placed into first episode psychosis pathway, so that's why I put "First Episode Psychosis" as a

descriptor. VC's psychosis was undisputed, and he was getting treatment for psychosis. When it comes to psychosis, there can be many different causes of psychosis. Under the EIP team first episode psychosis pathway, patients stay with the team for 3 years. EIP monitors their illness, develops relationships with patients to help them understand their illness, see how their symptoms progress and see the patient as a whole to understand their illness and psychopathology.

105. In any event, diagnosis in mental health may evolve over a period of time. Sometimes a patient can attract a diagnosis at start which subsequently changes or evolves into newer or even additional diagnosis. I did not change VC's diagnosis. VC was treated for schizophrenia. Paranoid schizophrenia was still his diagnosis but as I said, EIP team continued to evaluate illness progression in the next 3 years to understand the illness. The treatment that VC was getting from EIP team when I saw him was the standard treatment for psychotic disorder, including schizophrenia.

106. I did not make any major changes to VC's treatment plan after that review. I advised him to continue anti-psychotic medication, told him about the Driving and Licensing Agency (DVLA) guidelines for psychosis and driving, wrote to his GP to monitor bloods tests and arranged a medical follow up in EIP.

107. On the question of how often psychiatrists within the LMHT meet with patients under their care, I would say it depends on individual patients and their progress. This could be anything from few weeks to 2 or 3 months. It was very flexible and dynamic. Because patients were discussed in MDT

every week, there was flexibility to see patient even on the same day and on short notice. The team would keep spaces in weekly schedule for urgent reviews which can take place at short notice. CCO's and doctors would discuss patients and if there were indications or suggestion by either side that patient should be seen in outpatient review or needed home visit then that would be arranged without undue delay.

108. On the issue of the role of the GP, the GP was to offer yearly physical health checks as part of monitoring anti-psychotic medication. GPs could also be asked to investigate any physical health issues that arise during the course of care under EIP. The GP could also be requested to take over repeat prescription once the patient was established on a dosage. Every medical review was to be followed up by a detailed letter to GP outlining current progress and care plan. The GP would also to be made aware of how to reach for support during hours and out of hours. There would be close liaison between EIP and GP on regular bases and both services could reach each other easily without any barrier.

7 December 2020 review

109. VC's medical records indicate that I reviewed him at the Stonebridge Centre on 7 December 2020 [NHFT0000264]. I did discuss that review and progress with Dr. Lloyd and at MDT. We regularly discussed VC's progress in MDT so this review was discussed at MDT as well but again, I cannot recall exactly the details of the discussion at MDT. I did discuss with Dr. Lloyd quite few times about VC's progress in our weekly supervision as well as during MDT. Throughout my time with EIP, Dr. Lloyd was regularly

appraised and kept informed about VC care and progress. Every plan that I made about VC was discussed with Dr. Lloyd either informally or during weekly supervision and during MDTs.

110. I cannot recall if I reviewed any RiO record prior to that review but it was my standard practice and routine to discuss with CCO before the review and review recent progress notes to get an idea about current progress. I personally did not update summary or care plan after that review, but CCO usually does the update care plan in the light of medical review.

111. The letter which was addressed to VC's GP [NHFT0000264] notes: *"…he continues to experience the 2nd and 3rd person auditory hallucinations with suggestibility, but he is now able to keep his calmness and carry on… He is taking his medication regularly with no reported side effects... In terms of risk, I cannot identify any acute risks to self or others, no self-neglect and he is willing to keep engaging with CCO and the team…**[Impression]** Slow but steady progress with much better presentation, gained significant insight with better functioning, compliant with medication."* Plan included that "*CCO will keep in close contact with him.*"

112. At that review I did not see any acute risks to self or others. There were no new risks reported or observed. There were still symptoms of auditory hallucinations present, but VC reported not being distressed by their presence. He was able to secure a job at a warehouse. Due to his previous history of aggression/violence, I specifically enquired about the environment of his job to see if he was able to cope with other people. His job was 11/12 hours a day most of the days of the week, sorting parcels.

He was working with a lot of people (reported 50) around him as team. He was very pleased with the job and the money he received from that job every week. That kind of work required a fair bit of concentration, but VC was able to do that. This was quite reassuring that he was able to cope with job and was able to put enough concentration into it despite still experience auditory hallucinations.

113. In describing hallucinations with suggestibility in VC case, this was a reference to his baseline voices that suggest to him random stuff as before in previous reviews. There were now new suggestions made by voices to him. At review on 7 December 2020. He did not express any thoughts to act on the voices nor to harm himself or others. Although he still experienced those voices, he was able to keep himself calm and not feel distressed with them. He was able to "carry on" meaning carry on with his daily life. This was evident with him working, eating and sleeping well. He also looked well-kempt and objectively appeared brighter and was more engaging in the review.

114. Due to his previous history of aggression/violence, I specifically enquired about environment of his job to see if he was able to cope with other people. His job was 11/12 hours a day most of the days of the week, sorting parcels. He was working with a lot of people (reported 50) around him as team. He was very pleased with the job and the money he received from that job every week. That kind of work required a fair bit of concentration, but VC was able to do that. This was quite reassuring that he was able to cope with job and was able to put enough concentration into it despite still experiencing auditory hallucinations

115. There were no reports about non-compliance from his CCO or any

other professional/ family. He was also surprised when I told him that he does not need to take diazepam as regular because this was to be taken only when he felt particularly anxious or distressed. He said that he was taking both medicines (Aripiprazole and Diazepam) as regular thinking that we want him to take both tablets as regular. That expression itself in a way was an indication that he was taking medication. He did not dodge or avoid discussion about medication, compliance or side effects.

116. VC's presentation and engagement at that review was a lot better than previous engagements. We were able to talk about psychosis and the need for medication in some detail. He seemed more eager and receptive to have this discussion. This was the reason I thought his insight was better than before. The words "*significant insight*" was a comparison about how he was when I first met him back in September 2020.

117. In VC's case, the purpose of psychotherapy would be to help him understand his symptoms, challenge his thoughts and feelings around symptoms to develop alternate thoughts, improve psychoeducation and insight. VC was offered psychotherapy, but he did not seem keen for it. He was more inclined to take medication rather than talking therapy, meet his CCO regularly to discuss his progress, attend his medical reviews with the team and to look for a job. VC had not given any signal that he was interested to even discuss and explore psychotherapy so for me, it is difficult to comment on his reasons against the therapy. We kept that therapy option as open ended to him because I did not want to overwhelm him at that stage. EIP wanted to develop a therapeutic relationship with him and let him have the autonomy to decide what he preferred as his

treatment. The last thing I wanted at that stage was that he disengaged with us and decide not to even take medication or see his CCO.

118. As far as the significance of VC refusing psychotherapy at that stage goes, it is difficult to say what and how much this might have made a difference. I think VC would have been helped by psychotherapy, to the extent that it might have improved his understanding of his illness and increased his insight. Sometimes, patients start therapy and stop it midway. I cannot comment on whether VC might have continued or even started therapy.

119. I did not personally make any update to VC's risk assessment after that review but usually CCO update the risk assessment after the review

1 February 2021

120. VC's medical records indicate that I reviewed him at the Stonebridge Centre on 1 February 2021 [NHFT0000273]. I provided feedback to Dr. Lloyd about this review particularly on issues of memory and later also discussed it in the MDT as well. Dr. Lloyd agreed with my plan to offer VC a formal memory assessment and increase his dosage of anti-psychotic. Overall progress was discussed and the MDT agreed with this plan.

121. I am asked whether VC's CCO provided any feedback about VC's condition and presentation in respect of the period between 7 December 2020 and 1 February 2021 prior to this meeting. This was asked with special reference to issues around medication concordance and in the context of VC using the "*lower dose Aripiprazole tablets*" and having leftovers to show. (17 December 2020 at 11:20am [NHFT0000168, at p.141]). I cannot recall if I reviewed any

record before I saw VC on 1st February 2020, but I must have done notes review as is my very standard way to do before any review. I must also have had some discussion with CCO because we used to discuss VC regularly during MDT and informally. I can say that VC's progress between 7 December 2020 and 1 February 2021 would have been discussed at MDT many times because this was the usual way of monitoring patients using the mechanism of the MDT. Again, I cannot recall if I reviewed the 17 December 2020 entry, but I can assume that CCO might have told me about it. Respectfully, it is hard for me to remember each conversation I had with the CCO that happened 5 years ago.

122. The letter which was addressed to VC's GP following the review dated 1 February 2021 includes the following observations [NHFT0000273]: *"[VC] continues to maintain usual monosyllabic speech … He said that although his "condition" improved, he doesn't think that this was psychosis…. He said that he is not sure if it's because of the medicine he is taking but the voices have calmed down now although still there always in terms of frequency. He said that he is in contact with his family back in Wales and he spoke with his mother last week and all is ok with them."*

123. On the matter of why I increased VC's medication dosage following this review, there were indications since VC came under the EIP team that his current medication was helping and not causing any side effects. There was still room to increase the dose of Aripiprazole to 20 mg. (Maximum dose of Aripiprazole is usually 30 mg daily). The purpose of increasing the dose of anti-psychotic medication was to target auditory hallucinations which have significantly calmed down but that were still present. There was also

evidence of some poor concentration and memory which was seen as effects of the psychosis, so my aim was to optimise treatment dose to target these symptoms and help improve recovery.

124. Aside from medication, I planned a formal memory assessment to investigate VC's memory issues in detail, to determine possible causes. I also discussed with him about previously discussed option of psychotherapy, but he was not keen on it. Psychotherapy was part of the treatment that the EIP offered to their patients. I also discussed with the CCO about the plan for the next few weeks and asked CCO to arrange a review with me in 6 weeks for formal memory test. The reason for this was to monitor VC's progress, to see the effect of the increased dose of aripiprazole and see if there were any side effects. I also discussed and planned with the CCO that they would continue to review and monitor VC's progress in the community and appraise the MDT every week about the progress. There were ongoing monitoring and discussion at MDT level to discuss VC's progress and the effectiveness of the various interventions.

125. During this review, when VC was referring to the episodes of previous admissions, circumstances around admissions and his voice hearing experiences. I inferred that what he meant was that it was all linked and not separate episodes. This was actually a positive statement in the sense that he was able to see it as a whole and he wanted us to take it as whole as well. I would say when he said "*he does not think that this was psychosis*" he meant that he did not agree with the word "*psychosis*" as explanation for his experiences but otherwise agreed that he had mental health problems. That meant his insight was not full. Risk wise, it did not

make a massive difference at that stage because VC was still engaging with the services and was taking treatment. He did not report any thoughts to harm himself or others. At that stage there were no new reports or observations about any aggression or violence.

126. This is again not a very uncommon occurrence in daily practice where patients don't agree with a particular diagnostic label but still work with services and take treatment. During the patient's journey with the mental health team, their views, thinking and insight can get better. Generally, a complete lack of insight means the patient 's illness remains untreated, they will not accept treatment, they will remain at risk for further deterioration in the absence of any treatments, they will be at risk of poor or complete lack of engagement with the services and their risks cannot be observed or contained.

127. That was not the case with VC at the time when I reviewed him on 1st February 2020. Although his insight was not totally full at that review, his clinical presentation was comparatively better than before. He was working and appeared well kempt with no sign of self-neglect. He was engaging with his CCO and team regularly, always attended his appointments with me, was taking medication and did not express any negative views about medication. There were no observed or reported thoughts or behaviour of self-harm or harm to others, nor further or new reports of any aggression or violence behaviour towards others. I concluded that VC did not present with any "*acute risk of self-harm, suicide or harm to others*." I did consider those previous risks and was aware of his risk history. When I said "*no acute risks*" it meant that he did not display any current or imminent risks of

self-harm, suicide or harm to others. Before that visit, I had met VC few times since September 2020 and was totally aware about his previous risks around aggression, non-concordance, social isolation, masking symptoms and lack of insight. This was again a very usual brief comment on current risks that was to be done at every medical encounter with the patients to touch on their acute risks. It does not mean that their previous risks history has been overlooked or not kept in view. I did not personally make any update to his risk assessment after that review but usually the CCO updates the risk assessment after the review

128. In concluding that VC was "*Making a slow but steady recovery*", I had a general impression about his overall recovery that I had about VC after that review on 1st February 2020 keeping in view my overall interactions with him since I first met him in September 2020. The observations and behaviours that I relied on for my conclusion included that voices have reduced although still there, no more distress reported or observed, not depressed and personal care was intact. He was able to secure a job and was working, appeared well-kempt with no sign of self-neglect, not thought disordered or actively psychotic. He was engaging with his CCO and team regularly, always attended his appointments with me, was taking medication and did not express any negative views about medication. There were no observed or reported thoughts or behaviour of self-harm or harm to others, no further or new reports of any aggression or violence behaviour towards others.

129. On the issue of capacity, VC's capacity was not formally assessed but he appears to have the capacity based on his overall presentation. I had no doubt about his capacity so that's why I did not assess it formally. He consented to increase the dose and did not express any negative views about it.

130. I did not have any doubt that VC had a psychotic disorder. His symptoms and overall illness were suggestive of psychotic disorder because he fulfilled the criteria for that diagnosis. Since he came to EIP, I discussed his presentation and progress with Dr. Lloyd many times as part of our weekly supervision sessions and at MDT. Dr. Lloyd agreed with his diagnosis of psychotic disorder. I also have no doubt about the diagnosis. The whole EIP team and MDT were aware of his diagnosis and were part of the discussions.

131. As far as my memory is correct, apart from Dr. Lloyd and other MDT members I did not discuss VC with any other clinician. I might have told my replacement trainee about VC as part of a handover when I left the team in July 2021.

15 March 2021

132. VC's medical records indicate that I reviewed him at the Stonebridge Centre on 15 March 2021 [NHFT0000267]. The reason for this review was to undertake a formal memory test to assess VC's difficulties with concentration and memory. The letter which was addressed to VC's GP following this review includes inter alia: "*Overall, result is encouraging with no real concern. We discussed that his difficulties with the concentration and memory could be the cognitive deficits of psychotic illness…*" While VC

was there with me, I took the opportunity to discuss his recent blood tests results which showed slight raised lipids. We discussed that this could be the result of anti-psychotic medication. We briefly talked about importance of a healthy lifestyle with eating and exercise. I also told him that I will write to his GP for these abnormal blood tests. After all the discussion he agreed to continue medication.

133. VC consented to this treatment and the need for the test. The reason for my belief and the need for a memory test had to do with his overall presentation. While we discussed his medication, VC talked about it freely and did not expressed any negative views. I had the impression that he consented to medication by verbally saying it and expressed his willingness to continue the medication. This review was not a formal medical review. He seemed in good spirit and fully participated in questionnaires for a formal memory assessment. Overall, my impression was that he appeared stable, and I could not see any acute risks on that day. VC did not have any concern about continuing to take the medication due to issues of memory. When I explained to him that the issue of concentration could be part of his illness, he seems receptive and satisfied with my explanation. He did not express any negative views in general about medication.

134. On the matter of whether VC accepted that his difficulties with concentration and memory were "*cognitive deficits of psychotic illness*" he seemed receptive to my explanation that his difficulties with concentration and memory were due to his illness. He participated in the discussion and was not averse to the suggestion that I made. Our discussion was open and non-judgemental. I gave him sufficient time to ask questions and

express his views, should he think otherwise. He accepted my explanation and expressed his willingness to continue the medication.

135. The memory test that I did was the first test we did for memory. Usually, that first test can be kept as a baseline test and if we think that memory issues are getting worse, then one can consider repeating the test to check and compare it with the baseline to see if there are any changes in the score. So that's why I wrote this plan should it needed. I recorded the need to see him again after 3 months as part of the usual follow-up plan but at same time kept it open ended, so that I could also see him early depending on his progress in the community. Observations that would show recovery include degree of symptoms present, degree of distress due to symptoms, effect on functioning, self-care, engagement with CCO and team, medication compliance and any risks escalation.

136. At that review on 15 March 2021, my observation about VC's medication compliance and insight was that he was taking medication and had not expressed any negative views about medication. My feeling about his insight on that review was that his insight remained probably same but not worse than before. He seemed to be trying to understand the reason behind his symptoms and was willing to continue work with services. I did not personally make any update on 15 March 2021 to his risk assessment after that review; but usually CCO updates the risk assessment after the review. The reason for it was that it is usually the CCO who updates risk assessment in the light of what we have discussed at review and with medical input.

THE POLICE

137. VC's medical records indicate that on 22 March 2021 I spoke with a police officer in respect of an outstanding charge of criminal damage which VC had caused to his neighbour's property [NHFT0000168 at p.149]. I made that call to the police officer on the request came from a mental health nurse at the Liaison and Diversion team at Bridewell police station. I received an email that an officer on VC's case wanted to speak with me. In the email, it said that the officer wanted to speak about VC's diagnosis.

138. In response to that email, I spoke with the police officer (Gail Collins). The officer told me that the reason she reached out to our team was to find out if it was possible for either the CCO or someone else from our team could let VC know in advance that the person whose door was damaged by him before his admission was now asking for compensation for the damage that he had made. The police officer said that to avoid any potential impact on VC mental health, it would be prudent if the team could let VC know about the claim being made, before any letter arrived to him asking for compensation. This was with a view to minimising any undue distress caused from serving legal process to VC.

139. I agreed with police officer that EIP could have helped informing VC before a letter arrived at his doorstep. I told the officer that we could put a plan in place to convey this information to VC in a controlled way to minimise the stress to him. The police officer thanked me for the call and agreed with the plan. I cannot recall if the officer asked me about VC's diagnosis or anything else. She thanked me and the call ended amicably with an exchange of pleasantries. This call was meant for that specific task

with no other purpose. I did not need to discuss the incidents at VC's accommodation in the buildup to admissions with that police officer during that call. The police officer also did not ask me anything else.

140. Regarding the sharing of information between agencies about patients who are acutely unwell, I would say that this is not wholly the responsibility of a single professional and depends on the particular situation. Usually, the CCO engages the whole care coordination around the patient and that involves seeking information from other agencies. There is no strict role that no one else can reach out to other agencies. For example, in above question regarding call to the police officer I was asked if I could speak with the police officer - and I did.

VC's MOTHER

141. VC's medical records indicate that I discussed his care plan with his CCO on 28 June 2021 at 2:00pm [NHFT0000168 at p.155]. I have been shown material that VC's mother had raised in respect of VC's mental state with CRHT (29 May 2021 at 6:25pm [NHFT0000168 at pp.152-153]). I can confirm that the 28thJune 2021 was VC'S scheduled CPA review which he did not attended. Again, I cannot be sure which and how much RIO notes I reviewed prior to the CPA but I must have read recent RIO notes before the CPA as is my routine. I was aware of the discussion CCO had with VC's mother about the concerns she raised with CRHT on telephone.

142. I cannot recall the exact content and details of my conversation with CCO when VC did not attend his CPA but I think we generally had discussed

the progress in the light of recent visits, concerns from his mother and views of CCO about him. I remember I was told that VC found the new warehouse job more manageable and appeared well to the CCO when she last visited him. VC requested that his CPA be moved forward to align with his work' schedule. This was done. The CCO and I agreed to reschedule CPA. We also agreed that the CCO would discuss with VC and continue to appraise MDT of his progress. It was usually the responsibility of CCO to incorporate any new information received from the family into the care plan

143. In discussing his care plan review, the only new concerns were the information about his mother's concern about VC. Those concerns were incorporated in the record and were discussed within team and with VC. These concerns were followed up by further contacts by the team with VC's mother. She was thankful for the update about VC and was reassured that VC has been seen and was being supported by the team.

<u>VC's PATIENT RECORD AND CARE PLAN</u>

144. With reference to VC's RiO record, if I correctly remember 28th June 2020 was the last appointment with me but VC did not attend. I remember no particular reason was sighted but there was mention that his new work schedule was such that he might be sleeping early in the day. I cannot exactly recall.

145. VC's CCO updated VC's "*Summary & Care Plan*" on 29 June 2021 [NHFT0000201]. I can only comment on the care plan which was made till late June/early July 2021 when I was with the team. I can say that overall, the care plan reflects all the interventions that I considered necessary at that time. The

sources I relied on includes previous MHA assessments, hospital record, RIO notes, family reports, our own observations, MDT discussions and patient's reports. I did not personally make any update to his risk assessment after that review but usually CCO update the risk assessment after the review. To understand VC's condition, I read through recent RIO entries, discussed with CCO and was part of MDT discussion about current progress of VC. The CCO, Dr. Lloyd and I were the members of the LMHT MDT who were responsible for overseeing the implementation of VC's care plan.

146. VC's medical records indicate that on or around 8 July 2021, I stopped working with VC's MDT [NHFT0000168, at pp.155-156]. I left the team and Stonebridge Centre in early July 2021 as part of the ending of my placement. I handed over VC to Dr. Lloyd. This handover was made during our last clinical supervision session with Dr. Lloyd where we discussed the patients' handover. VC was one of the patients that I handed over. Dr. Lloyd was already aware of VC through our weekly MDT discussion and was on board throughout the time since I first saw VC back in September 2020. I don't have any formal record of this hand over, but it was a formal if verbal one during our supervision session. I think that I also sent an email handover to my replacement trainee who was to join the team after me. I sent her some patients with their overall summary and current issues. I cannot be sure exactly if VC was included in that list because there were quite a few other patients with some issues in the team at that time.

ASSESSMENT OF VC's TREATMENT AND CARE

147. I am aware of the ***Royal College of Psychiatrists' Good Practice***

Guide for the Assessment and Management of risk to others on the risks of: aggression; violence; masking psychotic symptoms; and lack of insight. If I were to do any assessment against the background of this guide in relation to VC, I could only comment on this for VC's care from September 2020 late June/early July 2021. During that time, VC's history and previous circumstances for admissions and risks assessment were properly documented and well known to the team.VC was regularly reviewed and seen by CCO in the community every 1-2 weeks on average .VC was seen for medial reviews regularly (September 2020-Novemver 2020-December 2020-Febreury 2021-March 2021).VC's progress was regularly discussed in weekly MDT with the presence of a consultant psychiatrist and wider MDT members. Issues were discussed and followed by actions. VC's family were contacted and spoken to as well. Their concerns were recorded, followed through and actioned accordingly.

148. There was never any crisis point reached in VC's treatment and care that required inpatient admission. VC's medication was regularly optimised and reached a therapeutic effective dose. During that time, VC started working and had plans for his life. Our team was able to build a working relationship with VC. I had quite few medical reviews with him. My impression was that we both were getting on comfortably and were able to form a good therapeutic relationship.

149. During the time that I saw VC, there was no new risk escalation in respect of any thoughts, intentions or behaviour that VC showed regarding violence and aggression. VC talked about his symptoms and gave an account of intensity and frequency of voices and did not overly masking

symptoms, although he spoke softly and in a monosyllabic tone. He would give his views about his illness and medication. Regarding insight, he agreed that he had mental health issues, although not necessarily agree with the term "psychosis". We offered him psychotherapy to help with symptoms as well as his insight, but he was not keen for it. We regularly checked if he had changed his mind about psychotherapy, but he remained uninterested in it. I cannot comment on subsequent courses of care and management once I left EIP in early July 2021.

150. As a general proposition, a patient needs to be admitted to hospital when the patient needs 24 hours monitoring to keep them or others safe, they cannot give any assurance for their own safety, they need supervised medication administration, they are thought disordered or floridly and actively psychotic, they are extremely suicidal, they are posing risk of harm to self or to others.

OTHER MATTERS

151. I have not given any interviews or made any public comments about the matter related to VC's actions and investigation by the inquiry. I did an informal verbal meeting with Nottinghamshire Health Trust's deputy medical director where few questions were asked about my overall involvement while VC was under EIP team. The deputy director wrote down my answers, but I was not asked to submit any formal statement or be a part of any investigation.

152. I have not been involved in the care of any other mental health patient who, following discharge or while under the care of a LMHT killed or seriously injured a member of the public

REFLECTIONS AND RECOMMENDATIONS

153. All patients should be treated with dignity and respect. This is especially true, even in circumstances where the patient concerned is challenging, has complicated needs and may even be a high risk one. Care planning should be inclusive and engage as many players as are relevant in support of a patient. It is especially important that where appropriate, agencies working in the care of a complex patient are able to draw on family input.

154. I would also say that multiple agencies that work with the public should adapt a learning approach after events such as this. A formal arrangement, standard operating procedures or protocol may be developed to secure barrier free and open communication between mental health services, physical health services including GP, social services and the police.

NOTE

155. 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.

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.

Signature…… …… GRO-B

……………………………………

Dated……………28/11/2025………………………………………..

Index to First Witness Statement of Bilal Burri

No.	Inquiry URN	Document Description
1	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary
2	NHFT0000222	Discharge Summary, second admission at Highbury Hospital, 01/09/2020
3	NHFT0000274	VC medical records, 07/09/2020
4	NHFT0000197	VC Risk assessment of first admission
5	NHFT0000196	Medical Records of VC dated from 26/05/2020 to 14/07/2020, NHFT, Re: Risk and Safety Assessment
6	NHFT0000195	Medical Records of VC dated 15/07/2020, Nottinghamshire Healthcare NHS Foundation Trust, Re: Risk and Safety Assessment
7	NHFT0000399	MHAA undertaken by individual practitioners before VC's first admission
8	NHFT0000037	MHAA undertaken by individual practitioners before VC's second admission
9	NHFT0000264	VC record GP notes 07/12/2020
10	NHFT0000273	VC record GP notes 01/02/2021
11	NHFT0000267	VC record GP notes 15/03/2021
12	NHFT0000201	29 Summary & Care Plan 29/06/2021
13	**NHFT0000202**	**Summary and Care Plan 01/09/2020**