Witness Name: Claudia Birtles

Statement No.: WITN0348001

Dated: 29 January 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF
CLAUDIA BIRTLES

I, Claudia Birtles, will say as follows: -

1. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 request dated 14 October 2025 (the "**Request**").

2. It was drafted on my behalf by the external solicitors acting for the Trust in respect of the Inquiry, with my oversight and input and assistance from counsel, following discussions in writing, by email and by video conference.

Career and Role

3. I qualified as a mental health nurse in May 2010, having completed a Diploma in Mental Health Nursing at Nottingham University. I had previously obtained a

degree in Psychology from Nottingham Trent University, graduating in 2006 with a 2.1.

4. In 2010 I began work as a band 5 Community Psychiatric Nurse ("**CPN**") in the community rehab team (STAR team) of Nottinghamshire NHS Foundation Trust ("NHFT"). This was a city-wide service working with patients with serious mental illness, helping them to reintegrate into the community. The patients were mainly in long-term supported housing, and we would support intensely to get them into their own homes with additional support. The caseload patients' main presentation was psychosis / schizophrenia / bi-polar illness.

5. In 2013 I moved to work in in the Early Intervention Psychosis Team ("**EIP**") as a band 5 CPN on a secondment basis. This was subsequently made a substantive position, and I progressed into a band 6 CPN role within the EIP.

6. Initially the EIP service was a standalone service, working with first episode psychosis patients between the ages of 18-35 in the city's north locality. Between 2017-2018 the EIP service was disbanded, and the pathway was put into the Local Mental Health teams ("**LMHT**"). I mainly kept an EIP caseload, but I would take non-EIP patients. I had new roles added at this time, e.g. covering duty calls.

7. In July 2017, I took maternity leave for approximately one year. At this time, the EIP was a standalone service. The EIP disbanded into the LMHT in 2018 while I was on maternity leave. When I returned from maternity leave in 2019, I came back to the LMHT but held mainly an EIP caseload under the LMHT.

8. The EIP was gradually brought back out of the LMHT and into a standalone service between the end of 2020 and spring 2021. I moved back into the standalone EIP service when this was reinstated at the end of 2020 and have remained there until the present day as a band 6 CPN. I went on Maternity leave in August 2022 for approximately 1 year. I returned to work from maternity leave in September 2023.

EIP and the Role of the Care Co-ordinator

9. I refer the Inquiry to **[NHFT0004012]**, the EIP Operational Policy. This sets out the circumstances in which a patient is referred to the EIP and the aims and functions of the EIP Team.

10. A patient would be referred to the EIP if they were suspected to be experiencing a first episode of psychosis or an at-risk mental state. Referrals to EIP services could come from a patient's GP, Crisis services, A&E, Talking Therapies, University, Wards or a transfer from another EIP service across the UK. Patients could also self-refer to the service. The aim for the EIP is to be as responsive and accessible to the patient group as possible. Referrals can be verbal or written and can be sent via email or made by telephone.

11. The clock for the two-week pathway starts when a referral received by any Nottinghamshire Healthcare NHS Trust service has been flagged as a 'suspected first episode psychosis' or is recognised as such upon receipt.

12. Once a referral has been received by EIP, the duty worker will gather some preliminary information about the service user and their difficulties and carrying out an initial screen of their suitability for the service, either face-to-face or via telephone. Service users who do not meet the criteria for the EIP will be signposted to more appropriate services or referred back to their referrer.

13. The aim and functions of the EIP Team are to

    i. reduce treatment resistant symptoms
    ii. reduce 'revolving door patients';
    iii. reduce distress;
    iv. maintain independence and integrity;
    v. shorten illness;
    vi. prevent relapse;
    vii. promote recovery and social inclusion;
    viii. minimize the impact of disabilities;
    ix. offer culturally, age and gender sensitive care;
    x. offer family orientated care;
    xi. offer meaningful and sustained engagement based on assertive outreach principles.

14. The EIP team aims to provide treatment in the least restrictive and stigmatizing settings, with an emphasis on normal roles and service-users' development needs around education and/or employment. The emphasis of treatment is to work with distressing experiences rather than diagnosis in order to

    i. reduce hospital admissions;
    ii. reduce access to emergency departments;

iii. reduce the risk of suicide;

iv. reduce the risk of homicide;

v. help patients recover and have a better quality of life;

vi. support carers/ loved ones;

vii. intervene early in any episode of mental illness.

15. Patients are provided with a variety of treatments:

    i. Pharmacological treatment in the form of oral / depot injection medications. Where there had been 2 unsuccessful trials of anti-psychotics, Clozapine is offered as a recommended treatment (see EIP Operational Model **[NHFT0004012]**, p.18);

    ii. Psychologically informed interventions – Cognitive Behavioural Therapy for Psychosis ("**CBT-p**") / Cognitive Behavioural Therapy ("**CBT**") / CBT-informed work (worry intervention, sleep better feel better, coping with voices and visions, thinking fast and thinking slow, enhancing social inclusion and recovery) psycho-social interventions;

    iii. Support for family and carers in the form of educational work / behavioural family therapy work / general emotional and practical support;

    iv. Comprehensive assessments and treatment of patients' needs including support re mental health, physical health (assessment and monitoring), social needs (housing / income), social inclusion work, comorbidities including substance and alcohol use, neurodevelopmental disorders (ASD / ADHD), employment / educational support options.

16. The EIP seeks to actively engage service-users and their carers in the EIP model in order to reduce disengagement. It does this by taking flexible and creative approaches to engage 'hard to reach' service-users. Three outcome measure tools are recommended for routine use - Health of the Nation Outcome Scales (HoNOS) and Health of the Nation Outcome Scales for Children & Adolescents (HoNOSCA) for under 19s (clinician-rated), DIALOG (service user rated, Priebe et al., 2007) and the Process of Recovery Questionnaire (QPR) (developed in collaboration with service users, Law et al., 2014)(see EIP Operational Model **[NHFT0004012]** p.8).

Patient Monitoring

17. The EIP is commissioned to work with patients for up to 3 years from their first referral into the EIP service.

18. In accordance with the Care Programme Approach ("CPA"), within two weeks of referral, and following comprehensive assessment, all patients in the EIP are allocated a care co-ordinator. As part of the CPA there is an expectation that a minimum of one CPA meeting per year is arranged with all involved in the service-user's care. If the patient does not want to engage with the meetings, it is important to gain their views and continue the reviews. In accordance with the CPA, the core documents, care plan and risk assessment should be updated and shared with the care and support team. The care plan would be shared with the patient and also with carers if the patient has consented to this.

19. Treatment and care-plans will be different based on an individual patient's needs and wants. They will be offered regular appointments with their allocated CPN in order to build a therapeutic relationship. During these appointments, CPNs will attempt to find common ground, assessing patients' mental health, physical health and social care needs to develop a collaborative care plan.

20. Patients will also be offered regular outpatient appointments with their consultant psychiatrist.

21. Patient risk and safety is subject to review and contingency and crisis planning. These discussions are held in a multi-disciplinary meeting forum (minimum of once per year, although in practice likely to be more frequent) where there will be ongoing assessment and intervention around comorbidity e.g. alcohol, substance misuse, depression, etc. Patients are also subject to comprehensive assessments and interventions including assessment of their housing needs, income, finance, physical health care and practical support.

22. The EIP followed an assertive approach to engagement to reduce the risk of service users being lost to services and potentially experiencing a longer duration of untreated psychosis. This was underpinned by assertively engaging in situations where service users missed multiple appointments or appeared resistant to working with the team. The EIP follows a flexible and creative approach in its engagement with `hard to reach' service users

23. The EIP also conducted regular reviews of outcome measures – HONOS, DIALOG and QPR forms, including liaison with a service-user's family and social networks so that it could respond to events as needed.

Concordance with medication

24. The EIP predominantly prescribes and monitors the effectiveness and concordance of medications. This means when a patient is first referred to our service, is having regular changes in medication, has poor concordance, risk to self via medication, EIP will prescribe the medication. If someone goes into crisis, the Crisis Team will monitor alongside EIP. If medications are safe to go back to the GP, EIP will continue to review & monitor the effectiveness of treatment alongside GP. We have regular discussions about the patient's medication, their views of medication, if they are experiencing any side-effects, and their concordance with treatment. This would be discussed with their consultant psychiatrists or medication prescriber within the team, as well as discussions in the Multi Disciplinary Team ("**MDT**") forum.

25. We speak with family or friends involved in a patient's care who may know about the concordance, in some cases they will dispense and remind the patient of when their medication is due. We would offer a depot medication option to patients if their concordance was poor or they were forgetful for any reason. For some people, depot is a preference.

26. We would try to monitor a patient's medication concordance by looking at the medication in their possession – ie to see if they had empty or full packages. However, this relied on the patient engaging: if a patient was in the community

and not under a Community Treatment Order ("**CTO**") and refused to show us evidence of concordance, we had no way of compelling them to do so.

27. If we had concerns of relapse, which might in turn indicate medication non-concordance, we would refer to the Crisis Teams for daily medication concordance.

28. In terms of side-effects, these would be monitored using the Glasgow Side-effect Scale (GASS) for atypical antipsychotics and the LUNSERS (Liverpool University Side Effects Rating Scale) for typical antipsychotics.

Non-engagement

29. The EIP SOP **[NHFT0004012]** advises an 'assertive approach" to engagement for patients who are hard to engage or not engaging, with a view to reducing the risk of service users being lost to services and potentially experiencing a longer duration of untreated psychosis. It recommends assertive engagement in situations where service users have missed multiple appointments or are resistant to working with the team.

30. The EIP is flexible and creative in the approaches it uses to establish engagement with `hard to reach' service users'. As appendix 2 of the EIP SOP sets out in a section headed "service response to disengagement" **[NHFT0004012, p.24],** there are different approaches of how to manage disengagement of a patient, dependent on the service assessment of risk.

Practitioners must recognise that there is a continuum of low to high risk which is dynamic.

31. As the SOP sets out, where there is evidence suggestive of prodromal signs (ie early signs) or non-psychotic difficulties, service-user disengagement should be considered in the context of: consideration of the service-user's capacity to consent to treatment and informed choice; any involvement with other services; whether they have good social support and are involved in a network; whether they are being monitored.

32. In such circumstances, the service-user would be assessed at being at a lower risk, which should lead to the EIP considering discharge after an MDT discussion.

33. The SOP also sets out the matrices by which a patient would be determined to be of higher risk. These include:

    i. High level of concern from others;
    ii. Evidence of risk of harm to self or others;
    iii. Evidence of risk of self-neglect;
    iv. Concerns about mental capacity;
    v. Child protection or safeguarding concerns.

34. Any of these factors could indicate a higher risk of acute psychosis and would warrant an increased level of assertive engagement.

35. The policy states all factors are assessed on best available evidence having liaised with the referrer and significant others outlined in the protocol. In circumstances where there is a risk of disengagement, the EIP team should

assess the reasons for disengagement and should be actively exploring any associated risk. Where possible the person's family or support network should be involved and a plan put in place to cover risk, actions (time frames, contact methods (telephone / cold call / points of escalation) and for this to be clearly documented in the risk assessment and progress notes.

36. The trust wide Did Not Attend ("**DNA**") policy procedure for non-engaging patients is dependent on risk identified by the care team – see **[NHFT0004725; NHFT0000417]**.

37. Where risks are identified:

    i. The clinical lead must make repeated efforts to contact the patient via the telephone or by any other known method of contact on the day of the missed appointment;
    ii. They must assess if the non-attendance is a change in behaviour patterns and what the implications of this may be. This will be based on the patient's risk assessments and care plans;
    iii. Contact will be made with the patient's GP on the day of the missed appointment and consideration will be given to an urgent home visit;
    iv. Making contact with known relatives/carers, neighbours and friends where appropriate;
    v. Consideration will be given to arranging a Mental Health Act assessment.
    vi. The Police may be contacted to request a welfare visit;
    vii. Other services such as the Crisis Team or the Assertive Outreach Team may be asked to continue trying to contact the patient out of hours;

viii. A letter will be sent to the patient offering another timely appointment with details of how to re-arrange if necessary and a time limit for them to respond;

ix. Inform the GP by letter within 5 working days of the patient's non-attendance and actions taken;

x. If risks to the patient and/or others are identified:

xi. The clinical lead will attempt to contact the patient via the telephone or by any other known method of contact;

xii. They must assess if the non-attendance is a change in behaviour patterns and what the implications of this may be. This will be based on the patient's risk assessments and care plans;

xiii. A letter will be sent to the patient, copied to the GP offering another timely appointment with details of how to re-arrange if necessary and a time limit for them to respond;

xiv. With the support of the clinical team, the clinical lead will decide on the most appropriate actions to be taken based on the patient's risk assessments and care plans.

38. In terms of training, I was provided with mandatory safeguarding training. I have not had any other formal training regarding disengaging patients.

39. In terms of the tools or practices available to the EIP Team when faced with patients who were not concordant with medication, all staff were provided with relevant policies – such as the DNA policy – and it was an expectation that staff were aware of the trust- wide policies. While the EIP SOP does not provide

specific guidance regarding management of medication non-concordance, my practice was as follows.

40. Where the EIP has concerns a patient is becoming unwell and is not concordant with their medication, we would consider a referral to the Crisis Team for daily medication concordance. EIP do not visit patients daily so we cannot monitor medication concordance 100%. We would have regular discussions with the patient and their support network (if any) regarding concordance.

41. If medication was missed, we would discuss with the prescribers if there would be any resulting implications or negative effects, (e.g would the dose need to be reduced and re-increased gradually).

42. We would speak to the patient regarding reasons for non-compliance – e.g. could forget, side-effects, may not feel they want medication and they would act accordingly (help set plans / reminders, review side-effects, discuss with prescriber alternative medications.

43. Much of the work we carried out would depend on the patient's honesty regarding concordance and the awareness of any support network that the patient may have. We would keep issuing the medication; change the interval for providing of medications e.g. weekly to have a closer review on this. We would also offer reviews with prescribers to suggest alternative medication treatments, oral or depot medication as well as providing psycho-educational work regarding medication and non-concordance and asking direct questions regarding concordance. As above, we would examine patients' medication boxes and strips where possible and appropriate, while acknowledging that this is not a wholly

accurate method of monitoring concordance. We would review if a flexi-pack of medication would support the patient's concordance where they may forget or have poor memory. All of these elements would be discussed in MDT meetings and in supervision for further advice and guidance from the team.

Suitability for the EIP

44. Not all patients were suitable for the EIP or EIP treatment. EIP would receive a referral, which would be reviewed by the team and discussed in MDT; we would then consider whether it was appropriate to conduct a telephone screening or face-to-face assessment. In circumstances where we received referrals with no appropriate information indicating a first episode of psychosis, we would refer patients directly to the LMHT for review.

45. Assessment of potential service users was carried out by way of an initial assessment, including a core assessment, risk assessment and CAARMS assessments. This model was introduced while I was on maternity leave: I completed the CAARMS training when I returned from maternity leave.

46. Following completion, the initial assessment would be discussed in MDT with the wider team. A patient may have been declined when reviewing the initial referral as the information in the referral would have indicated they were not for EIP due to exclusion criteria, therefore no screening or assessment would take place. If it was not clear if a patient was experiencing a first episode of psychosis, we could accept for an extended assessment. This is a common practice as patients may have co-morbidities which can complicate the assessment, and we work with

diagnostic uncertainty. Following completion of this assessment, we would signpost and/or discharge to the appropriate services based on assessment information. The patient, referrer / GP and family (if the patient consents) would be updated on this information via letter.

47. The EIP SOP **[NHFT0004012, p.4]** indicates which patients are appropriate for EIP Services:

> *'2.1 Inclusion Criteria The EIP service including the ARMS Pathway will be for:*
>
> *• People with a first episode or first presentation of psychosis, with a maximum of 3 years duration of untreated psychosis*
>
> *• People aged between 14 and 65.*
>
> *• People who have not received treatment for psychosis with antipsychotic medication that commenced over 12 months ago.*
>
> *• People registered with GP practices covered by the seven CCGs within Nottinghamshire (people resident outside of the CCG boundaries will be assessed on a case by case basis).'*

48. The EIP SOP indicates patients who are not appropriate for EIP services. It sets out a number of exclusion criteria **[NHFT0004012, p.5]**, namely:

> *'2.2.1 Exclusion Criteria The EIP service including the ARMS Pathway will not be appropriate for individuals:*
>
> *• Outside of the target age range 14 — 65.*
>
> *• Who have severe learning disability with communication difficulties, which render them unable to benefit from the service.*

- *People who are experiencing psychotic symptoms with a confirmed organic cause, for example, brain diseases such as Huntington's and Parkinson's disease, HIV or syphilis, dementia, or brain tumours or cysts.*
- *Who have an extensive forensic or offending history and are deemed to be at high risk of re-offending and would be better served by community forensic services.*
- *Whose psychotic symptoms clearly occur only in the context of acute intoxication (i.e. when a clear link is observed between the remission of symptoms with cessation of drug or alcohol use within 7 days. In such scenarios the team will direct service users to other services).*
- *Those who have already received three years of EIP and have been discharged.*
- *If already had/in contact with Adult Mental Health Services, this should have been for other problems of a 'non-psychotic' nature such as anxiety/ depression and where current referral for Psychosis is a new emerging phenomenon. If the Service User has been on anti-psychotic medication for another condition for over 12 months the referral will not usually be accepted. But exceptionally when it can be shown that a 'low dose' regime has been used this may be accepted on a case by case basis. Service users who have been assessed as experiencing psychotic symptoms* for the first time as a result of pre-existing and longstanding chronic mental *health problems such as recurrent depression or Bipolar disorder, individuals with personality disorders who might experience hallucinatory voices encouraging self-harm or perceptual abnormalities representing historic traumas or individuals with neurodevelopmental disorders who have perceptual abnormalities* dating back to childhood. In the case of

individuals with a *personality disorder or neurodevelopmental disorder classic ICD or DSM* criteria for schizophrenic spectrum diagnosis are useful to differentiate *symptoms which may be as a result of a comorbid and psychosis therefore warrant assessment by EIP'.*

49. The EIP is commissioned to work with patients with a first episode of psychosis for up to three years following the first episode of psychosis. However, if patients are well, stable, and have engaged well in the service, they can be discharged prior to the end of the three years following a thorough review.

50. Patients can be discharged at their own request if they have the mental capacity to make this informed decision, and, in those circumstances, we cannot enforce engagement. All efforts will be made to ensure that a service user is engaged with the service when a first episode of psychosis is suspected. Working with a service user through an assertive approach to care, multidisciplinary team discussions, supervision and risk management, the team will adopt a creative response when it is difficult to establish engagement.

51. Patients may be discharged from EIP services before the end of the three years if they move out of our area and we would look to transfer their care, but this has difficulties if, for example, we do not know where the patient has moved or they have not registered with a local GP. Patients may also be discharged from EIP services if they leave the UK for a long period and do not have plans to return. They can of course be re-referred to the EIP on their return to the area.

52. The policy states some service users with a first episode psychosis will need ongoing care following their three-year involvement with the EIP. It will be important that transfers to appropriate services (likely to be LMHT for the majority of people) are done as seamlessly as possible. To facilitate this, referrals to LMHT will be made at an early stage (6 months prior to discharge from EIP) to ensure that the service providing ongoing care has adequate time to allocate a care coordinator to the service user at the point of transfer [**NHFT0004012**, p.21].

Working with other community health services

53. The EIP accepts the transfer of care from the Child and Adolescent Mental Health Services ("**CAMHS**") EIP pathway as long as the patient has sufficient remaining time within the three-year window to complete a joint handover of care, which is within the EIP IWI. Patients who require longer and/or ongoing care beyond the end of the 3 year pathway are referred to LMHT. Referrals will highlight patients' ongoing care and treatment needs, as well as a summary of risk. The EIP will then complete a handover to the new care coordinator which can be over several weeks and may include joint visits to the patient.

54. The EIP will refer to and work with the Crisis Team where appropriate. The EIP remains involved with patients who are open to the Crisis Team and will provide feedback on what we hope the patient will achieve whilst under the Crisis Resolution and Home Treatment Team ("**CRHT**") and be involved in the care-planning / risk management plan.

How the EIP Team worked with inpatient services

55. As per the EIP SOP: Careful consideration will be given to the provision of alternatives to hospital care.

56. When service users are admitted to an inpatient service the care coordinator or a nominated team member must remain actively involved throughout the admission and participate in the ward reviews, with a focus on preparation for discharge from hospital. On admission and discharge the inpatient CPA Pathway will be followed. The care coordinator will, in conjunction with inpatient staff, complete an admission and discharge CPA Review. Because the care coordinator has been actively involved in the service user's stay in hospital, he/she will be fully conversant and will be involved in the discharge care plan.

Follow-Up After Admission

57. All service users who have been admitted to psychiatric hospital, regardless of diagnosis or risk must be followed up in three days by EIP or their community team e.g. the LMHT. In some cases, where a patient is discharged on a Friday, they will be referred to the Crisis Team who would complete the follow up over the weekend period when EIP and the LMHT do not work. This requires a face-to-face contact, however, can be conducted via telephone or online video call if the patient will not engage with face-to-face contact. It does not include outpatients' appointments.

MDT Meetings

58. There are meetings with the wider EIP team for MDT once a week. In the EIP South, these have generally been held on Thursdays, based around medical colleagues' availability. These are largely attended face-to-face, however, during the Covid-19 outbreak, MDT meetings were often held remotely; there is still an ongoing option to attend online if necessary. I cannot recall the frequency of MDT discussions whilst under the LMHT.

59. During the time that I worked in the EIP pathway, within the LMHT, rather than the period when EIP was a standalone service, the weekly review meetings would include me, the other Care Co-ordinators ("**CCO's**") and Community Support Workers ("**CSW's**") who predominantly held EIP caseloads and the consultant psychiatrist. The discussions would involve the consultant psychiatrist, Dr Tuhina Lloyd ("TL"), who had oversight of EIP and AO patients. The MDT would discuss new referrals, feedback of new assessments, and cover needed if staff were on leave or sickness. At that time, we would tend to go through every patient on the caseload for updates and discussions. At this time we were a smaller MDT team, therefore we had the time to go through every patient for discussion, this is no longer the case in the current model and set up.

60. The MDT is attended by the team manager and clinical team leader ("CTL"), when they came into position. The consultant would attend, accompanied by any student doctors for whom they were responsible. However, the majority of attendees were the team care coordinators and support workers. MDTs also

have access to CBT/CBT-p therapists, employment support specialists, peer support workers, and physical health support workers. This was around the end of 2020 to the start of 2021, when EIP became a standalone service again and we were fully recruited to these roles.

61. Once the EIP reverted to a standalone service, the MDT would discuss new referrals and feedback of new assessments. We would review any caseload cover if practitioners were off sick or on leave. When we became a standalone service and had a larger MDT, due to the time constraints in these meetings, we would raise patients about whom we had concerns about risk or non-engagement; patients about whose care we wanted advice; and patients who were working towards discharge rather than bring every patient to discussion every week.

62. What was decided in respect of individual patients varied from case to case. In general terms, however, we would discuss patients' care and making changes/amendments to the care plan and risk management plan. In some cases it would be purely to provide updates on patients' care and this could be providing positive achievements or news.

63. Within the LMHT we had access to the daily RAM (Risk Assessment Meetings) which would take place each morning. These meetings were face-to-face at the Stonebridge Centre and were well attended by the team. This included the team manager, CTL, CCOs, CSWs, psychologists, OTs and medical colleagues.

64. Patients who needed to go onto the Risk Assessment Meeting ("**RAM**"), would be raised by the allocated care coordinator. One of the two duty workers present

at the meeting would document the discussion and plan on the patient's Rio and update the RAM spreadsheet within the LMHT. This recorded the actions a CCO was expected to be responsible for, unless they were on annual leave or off sick.

65. If the patient did not have a CCO under the LMHT then the actions discussed and planned would be carried out by the duty workers that day. This was a common occurrence as not all patients under the LMHT were required to have a care coordinator, which differs to EIP as all patients under EIP are on a Care Programme Approach (CPA) pathway which requires care coordination as part of this.

66. Any patients where there was an increase in risk or disengagement would also be raised and the MDT would formulate a team plan with actions. Patients would be colour-coordinated based on risk and we would also discuss cover needed for shift that day if there is sickness or annual leave.

67. Risks raised in RAM may include increased risk to self via self-harm / suicidal ideation / self-neglect; risks from others in terms of safeguarding concerns; risks to others including physical, verbal violence, safeguarding others; people who were disengaging; people who were relapsing. The MDT would also discuss any concerns raised by family/loved ones or other services including out-of-hours contacts e.g. 999, crisis calls, A&E.

68. When the EIP came out of the LMHT and back into the standalone EIP service in 2020, (a period which coincided with the Covid 19 epidemic), we did not have daily risk meetings. These were re-introduced in the summer of 2025.

Supervision

69. Clinical and managerial supervision was carried out on a monthly basis. I can no longer recall who did my supervision when I was under the LMHT. When I came back to the EIP standalone service, however, I would have supervision sessions with the team manager, Emma Robinson ("ER").

70. The purpose of supervision is to check the supervisee's own personal wellbeing, how the team is working together and whether there are any concerns, performance management, clinical discussions of patients and safeguarding escalations. Personally, I like to discuss all or most of my caseload in supervision, to provide updates and ask advice of my supervisor. I welcome feedback and guidance on my work and caseload management.

Purpose and Role of a Care-coordinator

71. The role of the care coordinator is detailed in the EIP SOP **[NHFT0004012, p.10]** which sets out:
    - The care coordinator is responsible for coordinating care planning meetings and documentation as per trust CPA policy. Care planning should follow the principles and philosophy of the EIP service (see Appendix 5).
    - Keep in close contact with the service user and coordinate their care.
    - Advise the team of any changes in the circumstances of the service user which may require changes to the care plan.

- Update the care and crisis plan, and risk assessment as needs change.

72. I have supported people under the Care Programme Approach in secondary mental health services in my role as care coordinator. As CCO, I am the main point of contact for the person receiving care and the aim is to coordinate all aspects of their care, treatment, support and recovery plan – involving all associated mental health teams, GP's, social care, housing agencies, benefit agencies and supporting family and carers. A CCO's key responsibilities include comprehensive assessment and care planning with service users and their families (where possible) to assess mental health, social and physical health needs; they also involve the development and regular review of a person-centred care plan that sets out goals, treatments and support offered with a set time frame.

73. Coordination is a key component of the role: the CCO is responsible for ensuring that input from other health professionals (psychiatrists / CBT-p therapists, nurses, support workers etc) is included in the care planning process, as well as the service user and their support network. This helps ensure that everyone is communicating and working together towards the same goal.

74. Another key responsibility is the on-going monitoring and review of how a service user is doing: checking whether the care plan is effective or needs adjusting. In my role as CCO, I arrange review meetings and update risk assessments when required; I support service users to have a voice in decisions regarding their care and treatment; I also support them to access benefits, housing, education,

physical health support and social inclusion support if necessary. The CCO is also responsible for supporting the service user with crisis management and is a vital point of contact during crises, ensuring rapid and appropriate support.

75. Once a patient has been referred to the EIP, a CCO is allocated and a period of extended assessment is carried out. The CCO generally aims to see a new patient weekly in order to build a positive therapeutic relationship. Visits are generally face-to-face at the service user's address, alternatively, at the EIP base or in the community; remote communication - MS teams etc – is also available to promote flexibility and engagement. Service users are also provided with the CCO's work mobile number and can contact via text and calls during working hours. Outside of working hours patients and carers are directed to contact the Crisis Team for support or other 3rd sector agencies such as the Samaritans.

76. As patients become more stable, we work to reduce the frequency of their appointments to two or three times weekly, dependent on need. The frequency of appointments is flexible and will be based on the CCO's assessment of the patient and discussion with the MDT, with input from the service user, their family and/or carers. The frequency of visits was a frequent topic in MDT meetings / supervision. On occasion, the CCO might feel that a service user requires more frequent support than the service user is willing to agree to: this would be discussed with the MDT and in supervision. The purpose of this is to try and balance maintaining a therapeutic relationship and contact with the service user with risk management.

77. Once a service user's need escalated to requiring several visits a week, we would consider a referral to the Crisis Team.

78. In the final year of the EIP pathway we might try and reduce the frequency of contact further, perhaps to monthly to prepare the patient for discharge to primary care with an aim to assessing how capable the patient is of managing their care independently.

Length and nature of engagement with EIP

79. Patients can be with the EIP team for up to 3 years. Appointments are generally scheduled for up to 60 mins, but the duration largely depends on service user need and what can be tolerated at that time. Some appointments may exceed this time; others may be shorter.

80. Frequency and length of contact would be determined by assessment of patient need and risk, this would include discussions with the patient, carers, MDT and CCO assessment. There was no specific training provided for this: decisions were largely based on professional assessment / opinion and knowing your service users well.

81. Face-to-face contact with service users was generally up to three appointments per day with a full-time caseload of 15. This did not include additional new assessments, crisis support or carers support.

CCOs: managing/monitoring medication concordance

82. Concordance with medication was discussed with patients, including the reasons behind any non-concordance. As a CCO I would discuss cases of non-concordance with the relevant MDT and medic (ie psychiatrist) / or alternative prescriber as well as with the patient. I would attempt to understand the reasoning behind any non-concordance and offer psychoeducation regarding treatment concordance, suggestions for ways to improve concordance, for

example setting an alarm if the issue was one of forgetfulness rather than intentional resistance. I would also explore any potential side effects and make an appointment with the prescriber to explore alternatives if required.

83. In cases of particular concern, I would refer a patient to crisis for formal medication concordance / daily visits. If a patient declined to agree to increased visits or similar, I would consider whether they had the mental capacity to make such a decision and would consider their mental health with a view to discussing the option of Mental Health Act ("**MHA**") assessment / admission. If a patient refuses medication in the community, the EIP had no obvious means of forcing them to agree to it. In contrast, where a patient was under a CTO, if they were non-concordant with medication, we could request a recall to hospital under the MHA 1983. In these circumstances, however, we would still be unable to enforce treatment in the community.

CCO's role in devising patient care plans

84. Care plans are devised in collaboration with the service user (wherever possible) and their support network. Where patients are unwilling or unable to engage in the care planning process, plans can be completed on their behalf. An initial care plan is completed during the initial assessment period; they are then reviewed with the patient to ensure their views have been appropriately considered.

85. Care plans are completed and reviewed at least annually, as part of the CPA process: where there are changes in a patient's care or needs, their care plan is adjusted and updated accordingly. If there have been, for example, medication changes, changes in engagement, frequency of appointment, psychological need, risk assessment, carer needs, safeguarding, this should all be reflected in an updated care plan.

86. Care planning is based on the comprehensive assessment of individual needs, regardless of diagnosis, so care planning was carried out on the same principles, whether or not a patient had, for example, an established diagnosis of schizophrenia.

87. We receive CPA training every three years by way of e-learning. Care planning is part of the CPA process and is completed at a minimum annually. I am not aware of any formal guidance on care planning frequency, much of our knowledge will be based on experience from working within services.

88. When the EIP had a patient who was not engaging or was not concordant with medication, we would begin trying to aid engagement by looking at things like the venue and timing of meetings, the involvement of carers/families/other services; we would consider attempting different forms of contact (call, text, letter); whether a cold call visit to them at home might be appropriate (dependent on the patient's known risks). We would also attempt joint visits with other agencies the patient may be known to e.g. housing / university, where appropriate. We would discuss the escalation points that would happen in the

event of non-engagement e.g. within the MDT, with EIP management structure, with the patient's consultant psychiatrist. At this time, there were no morning risk meetings with EIP and Situation Report ("**SITREP**") meetings which team managers now attend. We would also discuss whether a change in CCO would be beneficial, in the event that disengagement is associated with a breakdown in that relationship. We would also discuss the patient and their potential disengagement with the consultant psychiatrist, and other members of the EIP IN MDT meetings. Periods of fluctuation in engagement is common within our caseload and we manage this regularly, which could be driven by various factors including mental health and social factors.

89. Non-concordance with medications carries both physical and mental health risks. In the event of non-concordance, we would consider whether we need to re-titrate medications, whether we can provide alternative medications – oral, depot; whether we can adapt the care plan or commence using flexi packs; whether a carer is overseeing medication. We would also consider a review of a patient's prescription and whether practical interventions such as the setting of alarms/reminders would be helpful. In the event of prolonged non-concordance, we would consider whether admission is required.

90. Care plans are shared with all those involved in a patient's care: in the absence of the CCO, the wider team would have access to the care-plan and would be able to follow and implement it. Care is reviewed at every appointment, and care plans are frequently adjusted. This is discussed with the patient, carers and wider MDT team and in supervision as appropriate.

CCOs and discharge

91. Discharge is a decision made over a period of time following discussions with the consultant psychiatrist, within the MDT, and within supervision. The possibility of discharge should also be discussed at length with the patient, carers, and their wider support network for their views and involvement.

92. Part of discharge planning is ensuring that all parties are aware of what to do in emergencies or if a patient relapses. This involves making sure they know where to access help and support; are able to detect the early warning signs of relapse and know what to do in these instances. It also involves ensuring there is a plan for medication after discharge, or, if the patient wishes to discontinue medication, the role of his or her GP.

93. At the point of discharge, the CCO arranges a final discharge meeting with the patient and their consultant psychiatrist to ensure that everyone is happy with the plan. If there are any ongoing concerns, the patient should not be discharged.

94. As set out above, CCOs are expected to attend weekly MDTs. In the event of sickness, training or absence, the expectation was that a CCO would share the information they wished to have discussed with a colleague who would lead the discussion at MDT and effect any escalation in the CCO's absence, reflecting the outcomes in the patient's plan. This is now referenced within the EIP IWI, which was not available at the time that VC was open to EIP.

95. The person responsible for raising a patient at an MDT held responsibility for documenting the MDT meeting and discussions. At the time of VC's involvement with NHFT, there was no clear guidance regarding the need for documentation of the MDT discussions nor a template of what to document. This led to inconsistency of documentation. All MDT discussions are now recorded on the patient's notes with a clear template prompting what should be recorded. The documents are the EIP Action Log and EIP audit tool: these are reviewed by the EIP administrator and prompts are sent out if it has not been actioned. Completion and assurance that the MDT discussion is documented is now supported by the use of the MDT action log and audit tool, which is a process which has come in following the VC incident.

CCOs and patient failure to attend meetings

96. In the event that a patient did not attend ("**DNA**") a meeting, the NHFT policy on Did Not Attend/Was Not Brought applied **[NHFT0000417]** and, from 2021 onwards, the revised policy **[NHFT0004725]**, applied. The policy **[NHFT0000417]** was in force from November 2018 to October 2021. It sets out the expectations of a clinical lead where a patient has failed to attend an appointment (see p.7). The policy in force from September 2021 onwards assigns this responsibility to the CCO:

> *7.2.3.1 If the patient is not contactable at their address or by phone, the care co-ordinator or other nominated team member should call all recorded contacts to ascertain the patient's whereabouts and clearly record these attempts in the healthcare records and Rio.*

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

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

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

7.2.3.5 Care co-ordinators and Responsible Clinicians should consider the use of Community Treatment Orders (CTO's) for those patients who have been detained under the Mental Health Act and are known to be non-compliant with treatment and follow-up.

7.2.3.6 If the whereabouts of the patient is known and the level of risk has been assessed as high, the care co-ordinator and team should consider the need for further assessment including the Mental Health Act (MHA), Mental Capacity Act (MCA) and Adult Safeguarding.

7.2.3.7 Care co-ordinators/service teams should take advice from other professionals in relation to their requirements under the MHA, MCA, and Safeguarding Adults procedures.

7.2.3.8 The care co-ordinator should undertake an assessment on the appropriateness of referrals to other services.

7.2.3.9 Where a patient says they do not want to receive further support from the team and the assessment of their risk is low all opportunities should be sought to enable the patient to access alternative support services such as the voluntary sector.

7.2.3.10 The care co-ordinator should undertake an assessment of the patient's capacity and appropriateness for discharge from the service.

7.2.3.11 Concerns for the wellbeing of the patient must be identified to other team members at team handovers using the `RAG' zoning system and discussed at the multidisciplinary (MDT) meeting.

7.2.3.12 Staff involved in the operation or planning of this type of activity must understand what actions they need to take in the event of non-attendance.

CCOs and medication

97. CCOs were involved in decision-making with regard to both medication and discharge. That said, while their views were respected and valued, they were one part of the MDT which also involved patients, carers and community consultant psychiatrists. The views of patients were very important: I have been asked whether I think they were fully considered by responsible clinicians in the course of their decision-making: in my view, they were.

CCOs and CTOs

98. When a patient who has been detained in hospital under the Mental Health Act 1983 is ready for discharge, their Responsible Clinician may place them under a CTO. CCOs would make suggestions and give advice on the helpfulness or appropriateness of a CTO by raising it for discussions with the ward / community doctors. While a CCO could make the suggestion that a CTO could be helpful, they would not be the decision-maker in this matter. The Responsible Clinician or other prescriber would be responsible for prescribing depot medication, but the CCO takes responsibility for administering it in the community.

CCO Caseloads

99. When I worked 3 days a week in 2018 – 2020 and again 2023 – 2025, the recommended caseload for EIP CCOs was 9 patients. When I worked 4 days a week in 2020 – 2023, the recommended caseload for EIP CCO's was 12 patients. This equates to being able to see 3x patients per working day of the week. I do not recall whether I ever had in excess of this number.

Assessment of risk

100. CCOs were responsible for asking patients questions regarding risk in appointments: specifically, regarding risk to themselves, to others, from others, any safeguarding. We would observe people's behaviours, environment, body language to supplement this assessment. We would take into account reports from others including family, friends, other services.

101. Each patient's Rio contained a core risk assessment tool found in the patient's core assessment tab. This is a tool which is required to be completed for all patients under services e.g. EIP / Crisis / LMHT / Ward staff / Department of Psychological Medicine ("**DPM**"). Risk assessments were carried out at a minimum once a year at a patient's CPA review and would be reviewed in the event a patient was transferred from services e.g. from crisis to EIP, from ward to EIP, or if the patient's risk was assessed to have changed.

102. In my role as CCO I would assess risk by asking patients direct questions regarding different risk factors e.g. risk to self, risk to others, risk from others. I would also familiarise myself with their past risk factors and early warning signs from their notes. I would also try to take into consideration the things the patient might not be telling me either e.g. a patient being guarded: this may be an indication of relapse or that someone is not well. I would also review body language which helps assessment and speak with any other people involved in their care to gain insight into their potential risks.

103. The fact that a patient posed a potential risk to others could be identified in a number of ways. The patient might inform us of their thoughts and feelings e.g. thoughts of suicide or harm self; but we may also simply observe evidence of this via e.g. self-inflicted cuts to the body. We would then ask about this to try and determine why the patient had self-harmed and to ascertain what the trigger might have been. This would be with a view to putting a safety plan in place setting out how we can support the patient as a team, what they could try to help reduce risk and what others, eg family, friends, could do to assist. This would

then be documented in the patient's notes and put onto the risk assessment document on Rio. This would in turn be shared with other agencies involved. It would also be updated to the patient's crisis plan, which would be shared with the patient, other agencies and their carers – with the patient's consent.

104. As above, a patient's risk assessment is updated upon transfer from another service e.g. crisis to EIP, ward to EIP; if a patient advises that they see or are experiencing a change in risk e.g. if a patient advises that they are experiencing suicidal thoughts and have been researching ways of how to end their life; if information is received from another source of a change in risk e.g. family friends or other services.

105. In my experience, the main risk factors in the EIP team have been risk to self in terms of self-harm, suicidal ideation, disengagement, substance use (drug / alcohol), self-neglect, social isolation, and risk from others in terms of safeguarding on the basis that EIP patients tend to be vulnerable adults.

106. I received online clinical risk training from NHFT. I have been asked whether I was familiar with or have been given training on the Royal College of Psychiatrist's publication the assessment and management of risk to others (College Report 201). I am not aware of this publication and do not recall receiving training on it.

Mental Capacity

107. I received online training in the Mental Capacity Act 2005 via NHFT. As a CCO I would review patients' mental capacity to make relevant decisions during the course of appointments, asking questions to gauge understanding, checking patients are able to understand, retain, use and weigh relevant information and communicate a decision.

108. If there were no concerns that a patient might lack the relevant mental capacity, I would not document a full capacity assessment. If, however, I had concerns regarding a patient's capacity, I would document my concerns and raise them with others. In the event a patient was assessed as lacking capacity in any relevant domain, this would need to be highlighted in their care plan and decisions would need to be made in their best interests.

Raising concerns

109. In the event I had concerns that a patient posed a risk of harm to the public, I would raise my concerns with my manager, the consultant psychiatrist, the MDT, or the police, as appropriate.

110. In the event I considered a patient to be at risk of relapse, or to be otherwise not engaging or failing to take their medication, or at risk of harm to themselves or others, I would similarly update the MDT, manager, consultant psychiatrist, and the patient’s family as appropriate. I would also, consider referral to the Crisis

Team, and consider whether or not there was a need for a Mental Health Act assessment or admission for hospital treatment.

111. I would follow the same approach in the event I was concerned that a patient was not suitable for EIP treatment.

112. If a patient posed a known risk to others and/or had an extensive offending history, I would consider a referral to forensic services. The EIP as a team has experience of referring patients to the forensic team in such circumstances – for example with former prisoners, patients with a history of weapon carrying etc. However, the forensic team often do not accept referrals we have sent across. In my experience, they will only accept referrals for individuals with criminal offence charges where the offending behaviour was explicitly linked to their mental health conditions; in other circumstances of offending, they would refuse the referral.

Information sharing

113. Within the Trust, there were no set known systems for sharing information, it would be me reaching out to other services involved, sharing core documents, updates. I would ask my seniors / MDT if I was not sure regarding sharing information or could speak to Information Governance on complex cases if not sure.

114. The Trust shares relevant information with other healthcare providers as part of any referral process. Sub-contracted providers also have direct access to the

Trust's electronic patient records. There can still be difficulties with regard to the sharing or receiving of information. The EIP could experience difficulty in getting information from the police on a patient's risk or offences; often the service would not be informed of an incident due to confidentiality.

115. Where a patient was consenting, information was shared in face-to-face appointments with their family; alternatively, via telephone, text or letter. If a patient did not consent to information being shared with their family, I would still offer psycho-educational work and support to the family, keeping communication lines open for them to reach out to me to share information if they chose. In those circumstances, I would still be able to give the family some information, for example informing them I have seen the patient, that they are ok or engaging. If a patient does not consent but does not have mental capacity to make that decision, and there is a clear risk indication, we would discuss with senior staff and/or the MDT and breach patient confidentiality where we considered this to be in the patient's best interests or a matter of public safety. If we had concerns, we were able to speak to the NHFT information governance team who can advise us whether and how to share information lawfully.

116. If a patient withdrew consent to sharing information with their family, we would review whether they had the mental capacity to make this decision. In circumstances where we considered that the patient lacked mental capacity to make the relevant decision, we would be open with patient regarding the fact that we might decide to breach their confidentiality in their best interests if we feel they are unwell and there is a risk which needs escalating. We would also, as

appropriate, inform their family or carers of the change while ensuring they are aware that they can still contact us to share information and get support.

117. If a patient has capacity to make the decision and there is no known risk, we would respect their confidentiality and information would not be shared with their family.

118. Sharing core documentation forms (care-plan, core assessment and risk assessment with GP as standard when updated) are sent via post or email by admin staff at the request of the CCO. Communication with GP, local authority and independent healthcare providers can also be via emails / MS Teams or verbal communication on telephone. Contact with Police is usually via a call to 101 to report an incident or request information.

119. This is my first and only experience of having been involved in the care of a mental health patient who, following discharge or when in the community killed or seriously injured a member of the public.

Chronology of events

120. I have considered the records provided to me and based on those records, I set out below my recollections of my encounters with VC.

121. I have been referred to my NHFT investigation interview, carried out on 17 January 2025 in which I confirmed that I discussed VC's case "…every week in MDT. I spoke about him quite a lot. Just because he was so difficult… if he

missed an appointment or perhaps didn't collect his tablets, then I would immediately have that discussion in MDT" **[NHFT0004906, at p.7]** I noted that I discussed him "…More or less every [MDT] that I attended…" **[NHFT0004906 at p.8]**.

122. I confirm this is an accurate reflection of my experience with VC. My team often have informal conversations within the office about our patients, what we are doing and areas we may be stuck with, asking for advice and guidance based off of their experience. These conversations were not recorded but also not recorded for other patients as well routinely. We would also discuss patients in weekly MDT discussions, which, at this time, it was not part of our operational policy to record in RIO notes. I would write entries if there was a clear action to follow but there was no formal template to prompt an entry. As a result, I cannot point to every occasion on which I brought VC to MDT as a subject of discussion. From memory, however, it was on a regular basis as I had issues with VC's engagement as well as other concerns, such as non-concordance with medication, issues with treatment or relapse, during my time of working with him. I wanted guidance and advice on how best to work with him. As a result of these discussions, the team knew of VC and knew the difficulties I had with engaging him in meaningful work. During planned periods of annual leave, I email my colleagues in EIP with a 'caseload cover'. This highlights any outstanding actions that require cover from a colleague or any current issues or concerns with patients that the team might need to be aware of. Colleagues can then access the Rio records for more details however the summary in the email provides an overview of any urgent needs or concerns in an easily readable format.

123. I discussed my caseload with my team manager in each monthly supervision. I cannot recall the exact dates, times or what exactly was discussed as, as far as I am aware, this was not documented. From memory I can say that it was my practice to raise patients at supervision; to discuss what was happening in their care, what I was doing, which areas I was stuck on, and to seek guidance on next steps, escalating concerns and safeguarding issues. These discussions would include both new patients and patients who were already part of my case load.

124. VC's core documentation (core, risk, care-plan) was sent to his GP as a letter (via email). I did not send these letters directly and would ask these to be sent by the support staff. An example of this letter is exhibited at **NHFT0017942.** I did not consider it necessary to initiate a phone discussion with his GP, because at that time I did not feel there was a need.

125. The EIP offers behavioural family therapy ("**BFT**") to all patients. We cannot compel patients to participate in it however: it requires the patient – and their family - to want to engage with the work. BFT can help improve relationships between carers / loved ones and the patient; it can improve communication and result in a better understanding of mental illness and how it is affecting the patient. If a family is open to the idea of BFT but the patient is not, we can also provide carer support with psychoeducation as an alternative. This was discussed and reviewed as part of VC's care-plan reviews – see for example his summary & care plan dated 1 September 2020 **[NHFT0000202]** which refers to the possibility of BFT as a mechanism for increased understanding, stress reduction, and improved communication and problem-solving skills within the

family – but also notes that VC's family are not living locally to Nottingham **[NHFT0000202,** p.5].

VC's First admission

126. I believe that VC's first admission (under s.2 MHA 1983) was to Rowan 1, Highbury Hospital, NHFT ("First Admission"). He was detained at Highbury Hospital from 25 May 2020 to 17 June 2020 (23 days)

127. VC was allocated to me shortly after this and I had my first contact with him by telephone on 26 June 2020 (see entry in Rio records [NHFT0000168, p.53]. Prior to meeting him, I reviewed his Rio entries and the referral form from the ward and read his core documentation. I would also have discussed VC in an MDT with the EIP team, as was standard practice for MDT meetings.

128. My colleague CPN Abigail Parsonage called Crisis Team to arrange a joint visit with team for the 30 June 2020, which I attended **[NHFT0000168, pp.53-4]**. I do not recall everything that was said at this meeting as it is not all recorded. However, I would have read his notes / referral prior to our meeting and had a check in with the crisis worker when we arrived at the visit and prior to entering the appointment. Looking at the Rio entry for that day **[NHFT0000168, p.54]** I note that it is recorded that VC "stated that everything was okay and he felt ok being back at the flat after his admission. I tried to ask about how things were prior to his admission however Valdo appeared to be struggling to recall events. He appeared quite distracted at times, staring ahead and towards the TV screen which was turned off. Some of his responses were delayed. When I reflected this

back to Valdo, he denied experiencing any auditory hallucinations saying that they 'hardly happen anymore'".

129. The records show that VC denied any current concerns regarding his mood and stated that he was happy to continue taking his medication **[NHFT0000168, p.54].**

130. I became aware of the incident that led to VC's referral to the EIP – the incidents on 24 May 2020 when he damaged a neighbour's flat and then broke into another neighbour's flat causing her to jump from a window in fright - from reviewing his initial and ongoing risk assessments. I read these along with his core documents before taking over his care. The view I formed was that VC had been unwell and disturbed by his experiences; however, I did not form the view that he was an exceptional case as we work with patients who experience paranoia and hallucinations, which leads them to the confrontation of others.

131. In terms of VC's presentation, I understood at the time that he suffered a first episode of psychosis (FEP), and his treatment needs would align with the EIP Nice guidelines of treatment. Accordingly, the EIP worked on the basis that CPA, medication, CBT, BFT, Individual Placement and Support ("**IPS**"), physical health reviews, carer support were all appropriate. In terms of his risk, I was aware of his levels of distress driven by his symptoms which led him to entering his neighbour's room, I felt that in order to manage risk medication was needed to reduce his symptoms and distress with ongoing EIP support. I considered the following documents:

i. The Risk and Safety Assessment completed by Annette Palmer on 24 May 2020 **[NHFT0000197]**
ii. The Risk and Safety Assessment completed by Sindi Ndlovu on 26 May 2020 **[NHFT0000196]**
iii. The "Summary & Care Plan" completed by Mtetwa Campbell on 26 May 2020 **[NHFT0000207]**
iv. The Core Assessment completed by Anna Ludvigsen on 27 May 2020 **[NHFT0000188]**
v. The "Summary & Care Plan" completed by Susie Ip on 3 June 2020 **[NHFT0000206]**

132. I read and considered all of the core documents and was aware of VC's risk and situation. On the basis of this information, VC was accepted to EIP as appropriate for our pathway.

Post First Admission: 17 June 2020 to 14 July 2020

133. I first met VC on 30 June 2020. I note from the entry on his Rio records recorded that day **[NHFT0000168, p.54]** that he *"stated he is happy to continue taking medication. He doesn't feel he has any side effects from the Aripiprazole. He believes he has a couple of doses left but didn't appear clear on how he was going to ensure he gets a further supply. Valdo may benefit from a community card initially. There are some concerns that Valdo may play down some of his symptoms".*

134. Based on this information, I requested a community card. A community card enables the EIP to prescribe medications: a community card would ensure he received his medication and would be helpful as it was unclear he would order and collect independently; it would also provide a means of reviewing concordance. It also allows for quicker changes in treatment to be made, because they can be done via the EIP rather than requiring GP contact, which can take time.

135. From my experience, there can be a risk that after someone's first admission they may stop medication as they feel they are now well: this can be due to lack of understanding and insight. I was not informed of concerns from crisis or the ward that VC had thoughts or plans to stop medications. On considering his RIO records it appears that my main concern was VC 'playing down symptoms' **[NHFT0000168, p.54]**. This was not unusual after a patient's first hospital admission and is why VC was referred to the EIP.

136. I did not update the risk assessment when VC was first discharged from hospital, but a review of risk is standard in the appointments we have with all patients. I was aware of the risks from the RIO records which clearly recorded the episodes of violence in which he had been involved and the risks to others.

137. In terms of my contact with VC, my initial plan was to see him weekly, dependent on patient preferences and constraints of the team at that time.

138. There was no set plan regarding telephone contact: I called him if the need arose or he called me. Similarly, with regard to family contact, there was no specific

plan other than to introduce myself and then maintain contact as appropriate and as needed.

139. I did not write a formal care-plan when VC was initially discharged from hospital, because it is my practice to write this with the patient – and this is not normally something we do at the initial greeting appointment. However, we discussed EIP in our initial call on 26 June 2020 **[NHFT0000168, p.53]**. The notes record *"I offered some brief information on EIP and the support we can offer"*: this reflected my practice which was to inform a new patient that I was their care coordinator and to explain what EIP could offer and why. We made a change to the care plan at our subsequent meeting on 30 June 2020, as I planned for EIP to prescribe medication over GP and ensured this was actioned. This was actioned on the 3 July 2020 **[NHFT0000168, p.54]**.

140. In respect of my first telephone contact with VC on 26 June 2020, I have considered my notes because I do not have a clear recollection of this meeting from memory. My notes **[NHFT0000168, p.53]** reflect that some of his responses were delayed. This could just have indicated that he was tired. I remember that he was generally quiet and shy. I could not assume he was unwell from this initial call. The meeting was by telephone rather than in person, so I was unable to assess VC's body language. His delayed responses could have been because of a number of reasons. This call on 26 June was a courtesy call to introduce myself. I would not have been making assessments of VC's condition or his insight beyond general first impressions. I would normally ask about the symptoms that a person has experienced when unwell – in VC's cases, hearing

voices – so I would assume I would have asked that. I did not make detailed notes or conduct an in-depth assessment however, as this was an initial call and the EIP was going to keep his case under review. VC's care at this time was still with the Crisis Team rather than the EIP.

141. As to my first in-person meeting with VC on 30 June 2020 at 3:00pm **[NHFT0000168, at pp. 53-54]**, looking back at my entry, my impression was that VC was appropriate for EIP. His was not an unusual presentation for a patient just discharged from hospital. I was aware he had only recently commenced Aripiprazole 5mg. This is a low dose, and its effectiveness may not have been at its peak: it tends to take 4-6 weeks before a positive impact can be detected. Aripiprazole has side effects in the form of agitation, restlessness, heightened alertness.

142. I did not check VC's medication or ask him to take his medication in front of me – this would not be common practice at an initial visit and would usually only be done as part of a medication concordance visit carried out by the Crisis Team.

143. From reviewing his records, I can see that I was not confident that VC would order and collect his own medication (see **[NHFT0000168, p.54]**). I therefore decided it was appropriate for EIP to take over prescribing and monitoring of his medication which was and is common practice.

144. The records reflect that, when we met on 30 June 2020, VC *'appeared well kempt and flat was tidy'* (**[NHFT0000168]**, p.54). This was important to note because, in most cases, a tidy flat would indicate that a patient was managing and well. Often, when we observe a patient is unkempt or their home is messy it could

suggest that someone is unwell, chaotic or suffering poor motivation which can be signs or symptoms of psychosis. This forms part of our mini mental state examination.

145. The entry of 30 June records that VC *"appeared to be struggling to recall events" and "…appeared quite distracted at times, staring ahead and towards the TV screen which was turned off. Some of his responses were delayed. When I reflected this back to [VC] he denied experienced any auditory hallucinations saying that they 'hardly happen anymore'"* (**[NHFT0000168, p.54]**.

146. In terms of the significance of this entry, I would say that a patient struggling to recall events prior to admission is not uncommon: patients often either genuinely do not recall events as they were unwell, or do not want to talk about them. This was my initial meeting with VC, and we were yet to establish a trusting relationship: this is built over time and can be difficult with patients with psychosis.

147. With regard to VC's apparent distraction and delayed responses, either may be an indication that someone is experiencing auditory hallucinations, blunted affect, thought insertion, but equally this is not the case for everyone. VC acknowledged that his hallucinations 'barely happen anymore'. This would indicate some level of insight: it demonstrated that he did not deny ever being unwell or having had these symptoms. I do not recall asking VC explicitly about the current or past nature/frequency of his hallucinations at this meeting: as I have said above, it was an introductory meeting with the Crisis Team to start to build a relationship with VC.

148. Daisy Coleman also made a note of the home visit on 30 June 2020 at 4:17pm **[NHFT0000168, at p.54]**. I have reviewed this entry and agree with her observations. Her note states *'no risk to self or other evidence at today's visit'*. I shared this view. She also notes *'Risk of deterioration of mental state should he fail to engage or fully or become non concordant with his medication'.* I agree with this too. Based on what VC said at that meeting, and his body language, which I remember was relaxed, I do not remember feeling at risk or threatened by him on this appointment. I agreed that in the event he failed to engage or be concordant with his medication, his risk could increase.

149. Daisy Coleman's note states that she explained that VC was no longer in the 'crisis phase' of his illness and no longer required intensive input from the Crisis Team, **[NHFT0000168**, **p.54].** Both of our notes reflect that VC did not present as floridly psychotic at that time and therefore did not present as being in psychotic crisis. I agree with Ms Coleman's entry: VC did not appear to be in the crisis phase of his illness at that time. This is some that can change quickly, however: we indicated that should he not engage or have poor medication concordance, the risk of relapse would increase. It is common practice within EIP that patients discharged from the ward would be seen weekly after discharge but could be contacted ahead of appointments for support via phone / text. This is in contrast to the Crisis Team who tend to see people daily or several times per week indicated by risk on their RAG system.

150. I note that in my Theemis interview, I described VC as *'...very pleasant, very polite, seemed quite introverted so it was difficult to build up a conversation... he seemed willing to work with us'* **[TCLT0000748, at p.7].** I think what I was trying

to reflect was that he did agree to appointments with EIP and did not say he did not want us involved; he communicated and provided answers to questions when asked.

151. On 3 July 2020 at 10:33am **[NHFT0000168, at p.54]**: the record reflects that I spoke to VC by telephone to enquire about his medication and he stated he had 'no medication remaining' and did not appear to have taken steps to contact his GP 'as discussed during our appointment earlier [sic] in the week'. The plan included the local mental health team taking over prescribing with a medication delivery planned that day. I can confirm that the earlier discussion with VC about contacting his GP about medication had been on 30 June 2020. VC was discharged from the ward on the 17 June 2020 with 14 days of medication, he would have been due on the 1 July 2020. We issued his prescription on the 3 July 2020 as he did not collect from his GP and was two days late. In retrospect, VC's failure to order his medication from his GP may have indicated he had limited insight into his recent illness and the importance of treatment, it may also have indicated that he was not committed to taking medication long term; alternatively, it may have been that he did not know what to do, or lacked insight into his condition.

152. The decision to move prescribing away from VC's GP was common practice. The EIP takes over prescribing medication if we have concerns about concordance / the effects / side effects / changes to medication: it enables us to have more of an overview of concordance and to intervene quickly if any concerns with effects, side-effects and concordance.

153. On 9 July 2020 at 1:48pm **[NHFT0000168, at p.55]** there is an entry reflecting a telephone meeting I had with VC, having been unable to offer a face-to-face appointment because of my car being off the road. VC is described as sounding in *'bright spirits… everything was good… received his medication last week and everything was ok'*. From the record VC confirmed he received his medication, which was confirmed by Matt Baguley's note of 3 July 2020 **[NHFT0000168, at p.55]**. I do not recall exactly what I asked but my standard practice is to ask about concordance, effects and side-effects and from what I have documented I would assume VC stated things were ok.

154. The 9 July meeting was a telephone meeting. Face-to-face meetings were preferable. The SOP is not prescriptive about how contact is carried out – although it does provide that a follow-up after admission meeting must be face-to-face **[NHFT0004012, p.20]**. Ideally, meetings with service users would be more frequent when initially referred or discharged from ward / Crisis Team. However, this was during COVID so inevitably there was a lean towards more virtual or telephone contacts.

155. 13 July 2020 at 4:00pm **[NHFT0000168, at p.55-56]** it is recorded that I received a message from VC's mother: *'mother of VC… called to speak with you… as she has some concerns about him'.* I cannot now be certain who recorded that message, but I assume it came via the main office at the Stonebridge Centre.

156. An entry in the notes two days early, on 11 July 2020 at 5:20pm, **[NHFT0000168, at p.55]**, also records that VC's mother spoke to Andrew Jackson and reported that she thought VC's mental state may be deteriorating; that his conversation was not making much sense and that she thought he may not be taking his

medication. This entry was received over the weekend so I would not have read it then: it would have been sent through to the duty line on the next working day, 13 July 2020. This was not a wholly reliable system, and it did mean that calls could be missed or picked up too late. I would not have had the opportunity to discuss this call with Andrew Jackson as he would have been on crisis worker shift and so would not have been in the office every day.

157. I note from the entry on 13 July that I attempted to return the call to VC's mother twice and left a message **[NHFT0000168, at p.56]**. I do not recall whether my call was ever returned, but I note there is no entry in Rio suggesting as much, so I assume there was no call back. I did not speak with VC, because I was awaiting contact from his mum. I note my entry is at 4pm, towards the end of the working day. In this case I would have followed up on the next day and offered VC a visit to review.

158. On 13 July 2020 VC attempted to force his way into a neighbour's flat. It was discussed the following day at our morning RAM meeting. I do not remember exactly from memory what would have been shared; however, I would have reviewed the RIO records. I note that there are notes timed at 12:13am and 1:48am on 14 July 2020 **[NHFT0000168, at pp.56-57]**.

159. I do not now recall my precise reaction at the time, but the entry recording that VC had forced his way into a neighbour's flat and had to be restrained by a number of residents would obviously have led me to be concerned about the incident and VC's mental state.

160. I am not now able to recall whether the fact that a 14 tablet strip was discovered in his flat indicated that he had not been taking his medication **[NHFT0000168, p.56]**, but it is likely that this confirmed that VC was non-concordant with medication and was still experiencing the psychotic symptoms which had been present prior to his 1st admission. Nurse Nigel Wade has recorded that his impression was that VC *'was attempting to conceal his symptoms'* **[NHFT0000168, p.56]**. It is likely I agreed with what he reported as there was evidence that VC did not order his own medication from his GP, hence why we took over prescribing on 3 July 2020. This indicated early signs of non-concordance to his treatment.

VC's Second Admission (under ss.136 and then s.3 MHA 1983) – Cassidy Suite and Rowan 1, Highbury Hospital, NHFT ("Second Admission") 13 July 2020 – 31 July 2020 (18 days)

161. I spoke to VC's mother on 14 July 2020 at 1:00pm **[NHFT0000168, at p.57]**. As my note records, she was upset VC had become unwell again. She stated that she had noticed some 'red flags' over the weekend during a call to VC and VC had expressed concern that his mother was at risk despite reassurance from her that everything was OK.

162. I cannot be certain, but I believe that this was the first direct contact I had with VC's mother because previous attempts at contact hadfailed. I recorded her concerns, specifically that she was unsure whether or not he was taking his medication, and that she believed he might be masking the fact that he was still experiencing auditory hallucinations. I did not discuss these concerns directly

with the inpatient team, but they were documented on the RIO notes which the inpatient team have access to and which I would expect them to refer to as a matter of good practice. I do not now recall whether I discuss the unused Aripiprazole discovered at VC's flat with his mother.

163. VC's concern for his mother may have indicated persecutory delusions or that he was experiencing hallucinations which were validating his concerns. VC's mother's report of her worries regarding her son validated my own concerns of him potentially masking symptoms and not being open with me. VC and the incident were subsequently discussed in RAM where the manager was present and would have been part of the care planning / risk management in this meeting: the discussion was informed by VC's mother's observations as documented in records on page 55 from the call by VC's mother to the Crisis Team.

164. On 14 July 2020 at 4:08pm **[NHFT0000168, at pp.57-58]** the records reflect that an assessment was carried out by Dr Seedat and Jeff Culpin. In that assessment it was noted that VC had stopped taking his medication two weeks following his discharge from his previous admission and that he believed *"he was well" and "did not have mental health problems".* For two weeks he had started to hear voices and had been feeling paranoid. It was noted that he did not fully acknowledge the risk of his actions to others. It was concluded that he had poor insight, was vulnerable to ongoing relapse and a risk to others and was not suitable for community treatment. He was detained (pursuant to s.3 MHA 1983) and restarted on medication. I have been asked but do not remember discussing this case with either of them: sometimes as part of the Mental Health Act

assessment they will call the team / CCO to discuss things, but I do not remember this taking place – and I see that it is not referred to in the notes.

165. As to whether or not I was surprised that VC had stopped taking medication two weeks following discharge, I do not recall my precise reaction at the time, but I do know that this happens fairly regularly with new patients when they come to our service: they may not fully understand the illness and treatment, and therefore make the decision to stop taking their medication. VC had not informed us of his decision to discontinue medication and appeared well; therefore, I would likely have been surprised in this instance.

166. Based on the incident which took place on 13 July 2020, I agreed with the assessment that community treatment was not suitable due to the risk to others due to his psychotic symptoms.

167. A core assessment was undertaken by Rupert Ackroyd on 15 July 2020 **[NHFT0000187].** I did not make any contribution to the assessment as it took place in the early hours of 15 July 2020 when I would not have been at work. I do not recall the exact date that I read the assessment, however, it is standard practice to keep up to date with a patient's Rio records when they are in hospital and under another service so I would have reviewed them within the next working day. This assessment would form part of the ongoing care, treatment and risk management plan as it gives indication into someone's mental health and life at that time.

168. On 16 July 2020 in an entry timed at 11:38am **[NHFT0000168, p.63]** it is recorded that I had attempted to contact VC's mother at 11.30am. She did not

answer, but it is recorded that I spoke to VC by telephone at 11:35am. VC explained he was doing ok and was *"trying to make the best of things"*. I encouraged him to contact me should he need additional support. I do not now recall precisely what was discussed but standard practice would have been to discuss why a patient had been brought to hospital. This was a supportive call to ensure VC knew I was still involved in his case and to offer any practical support in the form of contacting the university or his place of work.

169. The note goes on to record at 11:38am **[NHFT0000168, p.63]** *'Rowan 1 advised I call Monday afternoon following MDT to book in for a ward round'.* It appears an MDT meeting took place on 20 July 2020 **[NHFT0000168, at pp.73-74]**. I cannot be certain, but the records indicate that I was not present at that MDT meeting. This may have been due to not receiving the invitation. Generally, the CCO or a member of the team would attend the ward rounds, whether remotely or in person. However, there can be difficulties with this e.g. not being informed of them, not being invited to them, the ward changing the time and then not being able to attend.

170. I note that I did attend the ward round on 21 July 2020 at 1:15pm **[NHFT0000168, pp.77-81]**. In my view VC was suffering a relapse in psychotic symptoms. I was there to be part of the discussions since he has been admitted and to inform the team of my contact in the community. I read VC's notes prior to that review: I would not have discussed VC with the inpatient team prior to the review as the review meeting itself was the forum for such discussions.

171. The notes state that nursing comments were that VC *"appears to understand the importance of taking his medication when he is discharged [and] appears to have developed good insight into his condition"* **[NHFT0000168**, **p.79]**.

172. VC had appeared to develop insight into his condition. He could reflect on symptoms he experienced when unwell, such as hearing voices; he was able to reflect with the ward manager and acute psychological interventions practitioner Angela Purdue on 20 July 2020 **[NHFT0000168, P.75]** that he stopped taking his medication due to his lethargy and low motivation, but he recognized stopping the medication had led to him becoming unwell again. It is recorded: *"Valdo stated that he now understands that he needs his medication to stay well at this time and that he would not stop taking his medication in the future without consulting his GP first as he realises that this was what was keeping him well."* This would indicate he had developed good insight into his condition. VC did not deny he had been unwell, which is what I might have expected if he had failed to gain any insight into his condition.

173. It is noted, in the section "Family/Carers involvement", that VC's mother was concerned about the risk of relapse prior to his exam and queried whether VC should be started on depot medication **[NHFT0000168, p.79]**. It is recorded that I was *'happy with the plan to go for oral tablets for now'.* I was aware that there was a risk of relapse if VC was non-concordant with medications, which had previously led to this relapse and admission, but I was happy with the plan for oral medication (which was made in discussion with psychiatrist, Dr Seedat) for a few reasons. Firstly, this was VC's second admission to hospital: we work on a least restrictive approach in EIP, and the medication VC had been on

previously was a sub-therapeutic dose that he had been on for only a short time: it was in keeping with the least restrictive approach to try VC on oral medication once more before moving to depot medication. Secondly, as recorded the previous day in his discussion with Angela Purdue, VC appeared to have gained some insight into his mental health and to have appreciated the link between stopping medication and becoming unwell. It felt appropriate, based on this, to support a further attempt at oral medication. This is a standard practice in EIP.

174. Thirdly, VC himself was not requesting depot medication at this time. There is documentation by Dr Seedat during VC's 72-hour review on the ward, referencing discussion about depot on page 79 and the nursing staff on the ward gave him information regarding depot also on page 79. There is no further documentation to state his views on this at that time. The EIP cannot provide depot medication in the community against a patient's wishes. In any event, it was not a final decision at this time and VC still had time to consider depot prior to discharge.

175. In the section "Risk Assessment", it is recorded that there had been *"no incidents of violence yet"* but *"this would be a potential concern if acutely unwell"* **[NHFT0000168, p.80]**. I do consider the incidents prior to admission to have constituted incidents of violence; this was driven by his psychotic symptoms of persecutory delusions, voices, paranoia.

176. A capacity assessment was carried out on the ward regarding VC's capacity to make decisions about admission and treatment **[NHFT0000168, p.80]**. I was not involved in that assessment. It was concluded that VC did not have capacity to

make decisions about admission or treatment at that time. I do not believe that this assessment contributed to or informed the decision regarding depot medication.

177. The plan was to aim for discharge 'next week on Thursday' **[NHFT0000168, 81]**. This was a short admission. I would have expected there to be more clarity regarding his risk, insight and medication concordance before discharge.

178. On 24 July 2020 at 9:33am **[NHFT0000168, at pp.90-91]** and 27 July 2020 at 10:35am **[NHFT0000168, at p.98]** I noted that colleagues Sabrina Edwards or Abi Parsonage would support VC's discharge during my upcoming period of leave. I regularly review the patients' notes when they are admitted to the hospital. I recall that I felt that VC would benefit from a step-down approach from the ward with crisis intervention, to ease him back into the community and monitor his engagement and concordance. Regular appointments with EIP, regular reviews of medication concordance, to offer the EIP interventions as stated by NICE, a community consultant for psychiatrist review.

179. I do not recall having a specific discussion about VC with either Sabrina Edwards and/or Abi Parsonage, however, it is standard practice to discuss caseload cover prior to leave. I would have discussed VC's relapse and admission with the team in meetings so they would have been aware of his presentation and risk.

180. In light of VC's second admission, while I do not recall thinking what EIP may have done differently to prevent a further relapse, I do remember feeling his admissions were short on the ward and that he was on low doses of medication for only a short period of time ahead of discharge to community. I felt he would

have benefitted from longer admissions to review the effectiveness of his treatment.

Post Second Admission, 31 July 2020 – 3 September 2020

181. With regard to the risks of failure to take medication and lack of engagement, risk of relapse, VC had completed some work with ward psychologist regarding psychosis and appeared to understand the link between medication and psychosis. The ward felt that he required crisis visits daily to manage his treatment as a stepdown approach from the ward.

182. On consideration of his notes, it does not appear that the risks of violence/escalation of violence to others and risk of reoffending were specifically identified and assessed, but neither I nor EIP were involved in his discharge meeting from the ward as I was on annual leave and my colleague did not attend - I am unsure of reason for this or whether or not they were invited.

183. After VC was discharged, the plan initially was for the Crisis Team to see him daily for medication concordance appointments. They continued to see him for several weeks after discharge. I saw VC on 14 August 2020 **[NHFT0000168, p.129],** provided him with a month's worth of medication (Aripiprazole, now at 10mg), and made sure he was aware I was going on leave the following week. Crisis discharged him on 15 August 2020 **[NHFT0000168, p.130]** without my awareness or involvement. They were due to call the EIP team on Monday 17 August 2020 but, from my consideration of the notes, it does not look like this happened, and my colleague AP followed up on 21 August 2020. I made him

aware I had further annual leave the following week and advised a colleague to be in touch in my absence.

184. I visited VC on 27 August 2020 **[NHFT0000168, p.131]**. I care-planned on 1 September that I intended to see VC every 1-2 weeks, phone calls were not scheduled. These would be as and when, usually a phone call would follow a DNA or if a face to face was not possible so the frequency of telephone calls would vary week by week

185. On 6 August 2020 I called VC's mother to check in with how she was doing, to offer support and to see if she had any concerns **[NHFT0000168, p.126]**. I did not set a plan of contact but left it open for her to contact me or the Crisis Team if support was needed out of hours when the EIP team are not at work. Patients and carers can contact the Crisis Team out of EIP working hours, even if they do not have an open referral.

186. The EIP took over prescribing VC's medication to ensure he got his medications, and I checked how he was managing with them, whether he was experiencing any side-effects; I would ask how many days of medication he had left to try and work out if he was taking medications as prescribed.

187. The frequency of contact remained the same as it was following VC's First Admission. It was and remained every 1 – 2 weeks maximum.

188. I completed the care plan collaboratively with VC on the 1 September 2020 when I returned from annual leave **[NHFT0000202]**. I put in a plan regarding medication that we would prescribe and have oversight of the medications, the agreed actions and who was involved. I also documented CBT-p therapy and for

a referral to be considered after further assessment. I documented the option for BFT.

189. VC was initially managed by the CRHT following discharge This was part of a step-down approach to the community following discharge from the ward, to support medication compliance when he was discharged as he had quickly stopped his medication after the first admission. CRHT initially saw VC daily; this was reduced based on their clinical assessment. Usually, CRHT and EIP would do some joint visits following discharge; I cannot comment on why this did not take place in VC's case. However, we would read each other's RIO entries and escalate any concerns. CRHT should include or involve EIP on discharge / care-planning / change in risk. It is not clear whether they did contact the EIP team on discharge from CRHT. I was on annual leave at the time of VC's discharge.

190. On 3 August 2020 at 3:20pm **[NHFT0000168, at p.123]** I spoke to VC by telephone. My notes record that VC was polite and pleasant, but his response did appear somewhat delayed – albeit I noted that I was *"unable to establish whether this was related to his current presentation":* I read VC's notes covering my period of absence before making this call. The understanding was that there had been an improvement in his mental state generally, but CRHT were planning to remain in place as he had upcoming stressors with university. I could see that on occasions with the CRHT he said he did not have his medications therefore could not take them in front of them, or that he had reportedly taken these prior to the CRHT visits (indicating that the medication packages had medication dispensed). He did appear reluctant to have staff observing him taking medication.

191. A delayed response is noteworthy because it can be a potential symptom of psychosis. It can be common that positive symptoms of psychosis improve, but it is common that following a period of being floridly psychotic, patients experience negative symptoms or low mood. This could be an indication of negative symptoms of psychosis. However, it could also indicate that he may not have wanted to speak with us. Steps required – ongoing care with mental health services, ongoing attempts to build therapeutic relationships so that VC could feel he could trust and open to me for support, community consultant review of treatment. I cannot recall the exact details of the conversation I had with VC at this time.

192. On 6 August 2020 at 4:40pm **[NHFT0000168, at pp.125-126]** I spoke to VC's mother. She provided some background information on VC's personal history and commented that VC had expressed concern to her during his hospital admission that he was not where he expected to be aged 28 compared to his peers and siblings. She also remarked that she considered he had stopped taking his medication to try and prove that he could lead a normal life off medication and there was a risk this could happen again.

193. I have reflected on this entry. VC did not express the same concerns regarding his progress in life to me: I did try to ask and explore things with him, but he would not open up to me. His reasons for stopping his medication as suggested by his mother seem plausible: this view is common amongst people experiencing FEP. I was of course aware of the risks of relapse, but they were a risk for any patient experiencing FEP. In terms of the steps taken to try and avoid VC attempting to prove that he could lead a normal life by stopping his medication, EIP offers

psychoeducation regarding psychosis, medication, importance of EIP services, instilling hope that people can and do recover, that people can live with psychosis but need necessary adaptations to reduce risk of relapse.

194. As I recorded at the time, and as I expressed in my conversation with VC's mother, I felt that it may be worth exploring previous experiences in more detail and to be mindful of previous risks to others when [VC] has been unwell **[NHFT0000168, p.126]**.

195. In August 2020 VC returned to the flat where his paranoid persecutory beliefs had commenced. I recognised that there was a risk that if he discontinued taking his medications as prescribed, that VC could become psychotic again and the symptoms could re-emerge, thus increasing the risk he posed to others.

196. I tried hard to get to know VC and build a therapeutic relationship in order to explore some of his previous experiences. This is a difficulty faced with FEP patients; it can be very challenging for someone who is paranoid to open up and trust others: it takes time and effort. I asked VC lots of questions to try to get to know him, to build common ground, to be curious and to demonstrate that I was interested in him and his life. I was conscious throughout that there was a history of this risk and was mindful of this in every appointment / contact with VC.

197. I have been referred to a record of 12 August 2020 at 11:20am **[NHFT0000168, at p.128]**: noting an email sent to me by Patrick Crolla regarding the provision of medication to VC – specifically, that VC reported he had three days of medication remaining and the plan was for the local mental health team (LMHT) to provide further meds. I noted that in response to this email, on 13 August 2020, I

contacted VC and stated that I would come and see him and bring medication the following day. I had access to and read Mr Crolla's note of his home visit to VC dated 8 August 2020 **[NHFT0000168, at pp.126-127]** prior to this visit.

198. At that point VC had a month of discharge medication, often referred to as TTOs (meaning "to take out") from the ward at discharge, so had his own stock of medication.

199. As Patrick Crolla's entry of 8 August records, VC denied any issues with medication compliance during the appointment. I assumed VC had the requisite mental capacity regarding his treatment because it was documented that VC understood what his medication was and why it was prescribed; he denied side-effects of treatment. At this point VC was on Green RAG under CRHT which meant he would not have required direct observation to confirm that he was taking medication during his appointments. Green Rag indicates that a patient's risk is low and they are in a stable condition. They have less frequent contact with the Crisis Team, usually less than twice a week and they are ready for less intensive support or discharge. If someone requires support with medication concordance, they would generally require daily or twice daily visits.

200. On 13 August 2020 at 1:19pm **[NHFT0000168, at p.128]** I spoke to VC by telephone and arranged to see him the following morning with medication. I do not recall this conversation specifically, but I note that it is recorded that VC stated that he was happy with the plan and that "everything is fine at the moment". I do not recall whether or not I asked VC directly whether he was taking his medication in this call: it was a courtesy call to let him know when I was coming to see him the following day.

201. I carried out a home visit to VC on 14 August 2020 at 12:00pm **[NHFT0000168, pp.128-129]** My note of that visit records that VC was doing better and was mentally stable. I noted that he was quite reserved, but also that the conversation flowed naturally and that I did not observe any evidence of him responding to unseen stimuli. He told me he had 1 Aripiprazole tablet left and I supplied him with a further 28 days of medication. I did not document that I physically checked his medication box; however, Patrick Crolla recorded on the 12 August 2020 that VC had '3/7 days' of medication left **[NHFT0000168, p.128]**. I saw VC on 14 August 2020, and he indicated he had 1 day left **[NHFT0000168, p.129]**. I concluded compliance with treatment as from his visit with Crisis Team he had 3 days left and 2 days later when I saw him he had 1 day left. It was my general practice, when giving patients medication, to talk about the medication provided, the effects, side-effects and compliance. This is standard practice and I would have had this discussion with VC.

202. I do not recall discussing with VC the issues raised by his mother – namely his concerns regarding his lack of progress in comparison to his siblings etc. It is likely I did not discuss this with VC. In my experience it can be unhelpful to raise issues reported by family/carers directly with the patient: it risks them feeling that they have been discussed behind their back and risks a breakdown in their relationship and trust with the EIP. It is helpful that I am aware of the information provided and I can explore this in a curious manner e.g. by asking the patient about their studies / friendships, asking about mental health & symptoms. It may be unhelpful to say *"I spoke to your mother and she told me you said x; what is your response?".*

203. I visited VC again on 27 August 2020 at 1:30pm **[NHFT0000168, at p.131]**. Prior to this visit I reviewed VC's records which included the note of Ms Parsonage's home visit on 21 August 20 **[NHFT0000168, at p.130]**. I have been referred to her comment that VC may be "masking". There is always a risk that a patient masks symptoms if they are anxious about re-admission to hospital. This was a known past risk for VC. It was something we needed to be mindful of and we were.

204. My note of the home visit reflects that VC appeared well kempt and the flat was very tidy. I noted these facts down because this is the sort of evidence which can indicate that a patient is mentally stable and looking after themselves. I also recorded that there was no evidence that VC was distracted by any on-going psychotic symptoms and that he denied experiencing any auditory hallucinations. I cannot now recall the appointment from memory, however, typical evidence of there being an absence of distraction would include his body language – e.g. good eye contact, concentration in conversation, normal rate, tone and flow of speech; no evidence of seeing VC responding to external stimuli; no evidence of VC looking around the room at something they may be seeing which I could not.

205. I recorded in VC's notes that he was continuing with his Aripiprazole every morning and reported having approximately two weeks supply left; I also noted that his mother was calling him daily to prompt his medication. My notes do not record any inspection of VC's medication and I cannot recall from memory whether or not I carried out such an inspection. It is very difficult to monitor concordance in the community. Our patients are under no obligation to take medication in the community (unless on a CTO) and we can only advise,

encourage and provide appropriate psychoeducation regarding psychosis and its treatment. Even if I had inspected medication on a weekly basis, if someone does not want to take it and does not want mental health services to know, it is easy enough to dispose of medication prior to any inspection. If we have enough evidence that someone is not taking their medication as prescribed, i.e if they tell us so or there is evidence of relapse, we would review the risks / capacity and treatment plan and arrange for a more formal assessment via the MHA if necessary.

206. I did not consider that the fact of his mother's involvement with VC's medication compliance – ie her daily prompting – suggested anything regarding VC's own motivations to take medication. Rather, I considered that it was due to his mother's anxieties about his compliance in treatment and her wish to support him and prevent him from becoming unwell again. It is common for families to support patients in this way.

207. My note of that visit records that I spent some time discussing the risk of relapse with VC **[NHFT0000168, at p.131]**. I do not now recall the exact nature of that discussion. However, my practice was to inform patients of the things that could impact relapse e.g. not taking medications or stressors. I would have been open and honest that these could increase the risk of relapse. I remember asking him on many occasions to be open and honest with me so that we could consider alternative treatments if he was unhappy with the side-effects of medications.

208. I also recorded that *"…we would do our best to keep VC out of hospital given that he has unfortunately experienced two very quick admissions"*

[NHFT0000168, at p.131]. I offered this reassurance because it was a worry and fear for VC. If I were to have said we would rush a patient into hospital at any suggestion of a psychotic symptom, this could have reduced the likelihood of VC engaging with support in the future. In this entry VC's risk to others was recorded as "low". This was because he appeared to be mentally stable during this appointment; there was no signs of psychotic symptoms, and he was engaging better in our appointment. It was also reflecting the fact that he appeared to be complying with his treatment at this time, due to his medication finishing when expected.

209. I have been referred to the following documents which were due for review on 31 August 2020

   i. The Risk and Safety Assessment completed by Annette Palmer on 24 May 2020 **[NHFT0000197]**.
   ii. The Risk and Safety Assessment completed by Sindi Ndlovu on 26 May 2020 **[NHFT0000196]**.
   iii. The Risk and Safety Assessment completed by Sarah Rivers on 15 July 2020 **[NHFT0000195]**.

210. I can see that the formal risk assessment was not updated until 31 August 2021. While this is regrettable, it does not mean that I did not review or consider risk during this time when I was working with VC. It is the CCO's responsibility to review the documentation.

211. I completed the "Summary & Care Plan" **[NHFT0000202]** on 1 September 2020. VC needed an EIP care-plan. This could not be completed while he remained

under the ward or crisis care. I was on leave when VC was discharged from the Crisis Team: 1 September would have been the earliest opportunity I had to complete this paperwork.

212. The plan reflects regular contact with his CCO (me) every 1-2 weeks **[NHFT0000202, p.3]**. This was standard EIP practice but, as I recorded, there was scope for it to be changed if VC needed change. I planned to continue my assessment of VC to gain more knowledge of him on the basis that he was a new patient to me and EIP and, again, this was standard practice. I considered that the EIP would provide a resource for building a therapeutic relationship and that we should adopt an assertive approach: that is, we should try actively to engage VC in EIP care and treatment. In terms of psychoeducation work, I planned to provide VC with relapse prevention skills, early warning signs work, safety/crisis planning, psychoeducation re psychosis, medication, and information on how to stay well.

213. The timescale for review and expected outcome was ‘ongoing’? Patients may engage with reviews, but they may not, so we continue to review at times we deem necessary as people may need to reflect on this or change information. There was no strict timeline for such a review: each review depends on the patient and their requirements.

214. The plan also records “review level 2 risk assessment on a regular basis”. Level 2 risk assessment meant the risk assessment used on the core risk assessment forms on RIO which was completed by the ward during VC’s admission. Review on a “regular basis” meant that we would discuss and assess risk whenever we saw/had contact with the patient, and depending on information that we received

from carers/family. If there is a change in risk, this should be updated on the risk assessment form /Rio entries with a minimum update of once per year.

215. In the medication section it was noted that VC had a history of non- concordance, and the action was *"on-going monitoring of concordance due to increased risk of relapse"* **[NHFT0000202, p.4]**. This involved asking VC questions about his medication at appointments, reviewing when his medication was due – ie when he had finished a prescription and aligning it with the due date we were aware of; exploring VC's views on medication generally, asking him if he is experiencing any side-effects, discussing his long-term goals. Sometimes we check a patient's medication box to ascertain whether or not they have been taking medication, but patients can refuse to allow this or can simply pop out or dispose of medications prior to inspections so that it appears that they are being taken as prescribed. I have experienced this in the past and it can make it difficult to assess accurately whether or not a patient is compliant. If we had concerns regarding compliance, we would consider referral to CHRT and for MHA assessment considering hospitalisation if appropriate. I note that the plan refers to VC's GP as being responsible for medication (in addition to me, in my role as his CCO and Dr Lloyd, in her role as Community Psychiatrist). This was an error: when VC was initially discharged post first admission, his GP was involved in dispensing, but this role was subsequently taken over by the EIP team.

216. It was noted in the crisis contingency plan that VC should access his own coping strategies in the first instance. Perceived coping strategies are the things that an individual finds helpful: they differ from person to person and can include things like breathing exercises, going for walks, talking to others. For VC, focusing on

his studies was important and if he was not able to focus on his studies it would cause him worry and stress. He had not engaged in identifying any further therapeutic interventions at this time and it is a patient led document. We completed a collaborative relapse plan together on 18 January 2021 (in Rio uploads folder) where he indicated more therapeutic measures.

217. On 3 September 2020 at 1:28pm **[NHFT0000168, at pp.131-132]** I spoke to VC by telephone. As the record reflects, he was not due a face-to-face appointment this week because he had an outpatient appointment ("OPA") with Dr Burri. It is noted that VC said everything *"was just fine"* which was his usual response, he had just been relaxing and was taking his medication as prescribed. EIP clinicians tend to be part of the medical OPAs and discussions. Given his meeting with Dr Burri, I did not plan to see VC additionally this week, as seeing patients more frequently can be too much and too intrusive as they have already opened up about their experiences in a medical OPA. I do not recall this discussion from memory but assume I had the impression that every was fine, as this is what I recorded in my RIO entry.

218. On 7 September 2020 at 2:24pm and 2:51pm **[NHFT0000168, at pp.132-134]** VC attended an OPA with Dr Bilal Burri at the City South EIP Clinic at which I was also present. Prior to the OPA I discussed VC with Dr Burri, as was my usual practice: I provided him with information on how VC had been, how he was engaging, my involvement with VC as a patient. In terms of the appointment itself, my role was to listen to the plan and ensure the patient's thoughts/feelings were raised if they did not do so themselves. The note of the appointment records that

VC was "compliant with his medication": this would have been based on VC's own reporting.

219. The note also reflects that VC *"mentioned that he would like to try to have medication free trail"* (sic) **[NHFT0000168, p.133]**. I do not recall from memory what his reason was for this was. However, I do note from the record that Dr Burri cautioned against this and recommended that he remain on antipsychotics for at least six months to a year with a view to keeping *"an open mind and having a frank discussion in the future about medication".* I felt it was positive that he was having the discussion about this with us and listening to the rationale as to why we did not feel this was safe at this time.

220. Dr Burri noted – and I agreed - that VC showed superficial insight, but he was not very confident that VC had a *"deeper grasp of his illness in the long term"* and noted that there *"may be some element of minimisation".* Dr Burri's also recorded his impression that "there may be compliance issues on horizon. His CCO will try to do some relapse prevention work with him at first opportunity". Compliance issues are always a possibility: in VC's case, he had discontinued medications previously and had voiced his wish to have a medication free period, so there was a risk he could stop taking his medication and fail to inform us.

221. Dr Burri recorded that I would "try to do some relapse prevention work with him at the first opportunity" **[NHFT0000168, p.134]**. Relapse prevention work is working through psychoeducation around psychosis/medication, to ascertain what may have triggered relapse for the patient (e.g. stress / poor sleep/ drugs / family history), what could be put in place to mitigate the risk of these triggers - e.g. what helps reduce stress. It also involves putting a plan in place should

symptoms begin to re-emerge which will set out both what the patient should do, what the EIP should do, and what any others should do. Patients do not always wish to engage with relapse prevention work but it is something that we review routinely with them in any event.

222. On 15 September 2020 at 3:30pm **[NHFT0000168, at p.134]** I visited VC at his new accommodation and noted that he appeared well with *"no evidence of responding to auditory hallucinations"*: this would have followed a discussion with him on the subject. I also noted that he was *"able to focus on conversation and reflect on what had been discussed during his OPA*". This was significant as it would tend to indicate that he was mentally well and stable: people who are suffering with psychosis generally struggle with concentration and memory.

223. I recorded that I had gone through the care plan and that VC agreed to read through it in his own time and let me know if he wanted to make changes. I have reflected and do not believe that he ever subsequently confirmed that he had read the care plan; certainly, he did not request that any changes were made. He did however report that he was continuing with his medication and understood the importance of concordance given his recent relapse **[NHFT0000168, p.134]**.

224. I do not now recall whether I undertook any checks/inspection of his medication but I have not documented doing so. Checking medication in the community has its own challenges. If a patient wants it to seem like they are taking their medication, it is easy enough to dispose of the tablets prior to any inspection. Even whilst being monitored daily by the CRHT, patients including VC have been suspected of secreting medication following the visit. Secreting medication is covert non-adherence, for example patient's hiding medication in their mouths,

and later disposing of it rather than ingesting it. I cannot now recall from memory whether there were any discussions of VC's remarks about medication at his previous outpatient appointment; I note that I have not documented any. However, I do recall that when we discussed medication and relapse, he would agree verbally or nod to indicate his agreement. My record of the meeting reflects that he had just returned from the supermarket and was busy with putting away his groceries **[NHFT0000168, p.134]**. We did not carry out any relapse prevention work undertaken at this appointment because he was occupied with his groceries and did not want to sit down and speak.

225. VC presented as mentally stable at that time and he was attending university which was his priority. It was concluded that there were no identified risks to self/others: the notes reflect that he presented as mentally stable during this time and we felt risk increased when he was unwell. We wanted to strike a balance between being supportive and not being too intrusive: in those circumstances I thought it appropriate to fix his next contact for two weeks' time.

226. On 25 September 2020 at 1:48pm **[NHFT0000168, at p.134]** I spoke to VC by telephone. He stated he was doing ok and had been working on some of his studies but, as I recorded in his notes, *"didn't disclose that he had been doing anything else with his time".* The fact that VC did not disclose any more information is open to a number of interpretations; it could have indicated that his priority was studying, which can be normal for some students. It could have indicated he was experiencing negative symptoms or a low mood due to lack of motivation to do other things. I did not document a discussion re medication, but

as I have stated before, medication discussions would take part of appointments with patients.

227. On 1 October 2020 at 3:00pm **[NHFT0000168, at p.134]**: I visited VC at home and noted that he appeared well with nil evidence of any overt psychotic symptoms. I recorded that I provided him with a 28 day supply of medication, possibly a few days early. The medication was provided to VC on the Thursday 1st but his next refill was in fact only due on Monday 5th October. I cannot now recall why I provided his medication early, however, I note from having considered the rotas, that I was off work the following week. Where there is an issue over staff availability or absence we may on occasion provide medication a little early.

228. At this visit I would have asked about the symptoms I know him to have previously experienced such as hearing voices, delusional beliefs, and paranoia. I do not recall from memory what checks I carried out with regard to his medication.

229. On 27 October 2020 VC was seen at the Queen's Medical Centre Eye Casualty **[CHCA0000017]**. He was diagnosed with an intra-ocular haemorrhage of the left eye, thought to be traumatic. I was not aware of the incident at the time; it was not something VC discussed with me. We did not have automatic access to this information within Rio, and we do not receive alerts from physical health attendance and appointments within Rio.

230. On 9 November 2020 at 3:08pm **[NHFT0000168, at p.136]** I tried unsuccessfully to contact VC and his mother. I can see from records that I was off work, which

coincided with one of my other patients sadly ending their life. This contact was upon my return when I was trying to check in to make contact, get an update, and arrange our next appointment. My colleagues Abigail Parsonage and Gary Carter had seen and followed up in my absence prior to this call, where they did not raise concerns.

231. I spoke to VC on 10 November 2020 at 11:13am, 12:48pm and 3:30pm **[NHFT0000168, at pp.136- 138]** in response to a text message he sent requesting a face-to-face appointment that day. He had said he had *"something very important to discuss".* I have recorded in the Rio notes that VC appeared very hesitant to discuss the matter over the phone and did not respond to my questioning him as to whether he was concerned for his safety or felt at risk. It was out of character for VC to request an appointment or reach out to me directly for help and support. It did give me grounds for concern, and I immediately emailed Dr Burri to see if he had any capacity to visit VC that day. I had concerns that VC might be becoming unwell or was experiencing potentially distressing psychotic symptoms that he did not feel safe disclosing over the phone.

232. Following my email, Dr Burri visited VC the same day, as described in his note of 12:48pm **[NHFT0000168, at pp.137 – 138]**. I was also present at the visit and have reviewed Dr Burri's note which accords with my own recollection of it.

233. As the note records, VC disclosed that although he had told the ward doctor at Highbury Hospital that he no longer heard voices, this was not the truth: he said it because he was tired of being in hospital. He disclosed that he could still hear voices and see other people; he also said that "the voices that I hear can see other people as well and [I] don't want that other people to get into trouble". He

told Dr Burri that the voices did not give him commands but suggest he should do things to "prove his power". VC expressed the view that these voices were a "real experience" and not the result of mental illness. He was attentive to his care and hygiene and reported a good appetite and sleep; he denied any thoughts to harm himself or others.

234. Reflecting on what VC told us at this meeting and what he had reported immediately following discharge, I came to the conclusion that VC did mask his symptoms and had not been fully honest about his experiences. From his own reports, this was in part because he was "tired of being in hospital" and also referenced "he did not want to get others in trouble" which highlighted his psychotic experiences and fear this could implicate others **[NHFT0000168, p.138]**. This appointment highlighted that VC was able to mask his symptoms and that the previous assessment might not have been accurate.

235. This experience with VC demonstrated both that VC had some insight into his illness as he was highlighting that he was aware of some of his psychotic symptoms. At the same time, it also demonstrated a lack of full insight, because VC stated that he had believed the voices to be real. I remember feeling pleased that VC had been honest with us had shared this information as I knew this would have been difficult for him. I was hopeful that I would be able to ask about this at future appointments and that we would be able to have more open conversations about his experiences.

236. With regard to medication concordance, no physical checks were carried out during that appointment, but VC was asked and reported (as documented,

[NHFT0000168, p.138] that he had missed a few doses due to forgetting the odd days but, for the most part, was taking his medication daily.

237. Dr Burri's impression was that VC came across as psychotic with an escalation of symptoms. My recollection of this appointment was that he was not becoming more unwell necessarily, but VC was describing current symptoms of psychosis. I recall feeling that it was a positive appointment where VC had opened up and engaged well.

238. The plan – with which I agreed - was to "increase Aripiprazole dose and to give some short term Benzo…close monitoring in the community by CCO". It was standard practice for CCOs to complete close monitoring – this would include the actions I had previously taken.

239. Dr Burri noted that the "risks are currently contained" and "if the risks escalate or compliance is an issue then we may need to involve Crisis Team". This meant VC's current treatment plan was working to manage the known risk that he posed.

240. The record reflects that VC gave his consent for this information to be shared with his family. I had frequent contact with VC's mother, Celeste; I was not in contact with any other family members. I have considered my next documented contact with Celeste: it was on 21 December 2020. I do not believe I documented all my contacts with Celeste., I would often take unscheduled calls in between visits in the community, so documenting contacts would not have been easy had I been out of the office at the time. I cannot remember the exact details I shared with her on that occasion.

241. I carried out a second home visit to VC on 10 November 2020 at 3.30pm **[NHFT0000168, at p.138]**. As I recorded in the Rio entry, I provided VC with a seven day supply of Aripiprazole (at an increased dose of 15mg). VC offered assurance that he would remain concordant with his medication and said he felt fine after the appointment that morning. From what I recall, this was a short appointment purely to take the increased medication and we did not have any lengthy conversations. I had squeezed this appointment in and had to arrange to get the increased medication from the pharmacy to him at short notice. I saw him on my way to see another patient but wanted to ensure he had his new treatment in a timely manner. I did not discuss things further as we had spent the morning in the appointment together.

242. On 12 November 2020 at 2:27pm **[NHFT0000168, at pp138-139]** I spoke to VC by telephone. He reported no concerns since the medication increase and confirmed that he felt ok following his recent disclosure. He confirmed that he was continuing to hear voices but denied feeling any more distressed by this. He confirmed he was happy for me to speak to his mother regarding his welfare. The focus of this discussion was on VC's medication and any potential side-effects. I cannot remember from memory the discussion regarding the voices he was hearing, but it is likely I would have asked questions in terms of frequency, who the voices were, if he could identify them, what they were saying etc. The impression I had was that VC had some symptoms of psychosis present, but that he was not floridly unwell or psychotic at this time. He informed me he was taking the medication and was compliant. Albeit that my only contact with VC's mother Celeste was recorded as later in December 2020, I remember frequent contact

with Celeste during this time and that I kept her updated about VC's care and presentation.

243. I next saw VC on 17 November 2020 at 1:00pm **[NHFT0000168, at p.139]** when he attended Stonebridge Centre. I noted that he was relaxed and well presented. I recorded that he expressed feeling that *"a weight had been lifted following his disclosure about being a little dishonest about his symptoms*". He was concordant with his increase in Aripiprazole. In keeping with his usual presentation, he volunteered minimal details about how he was feeling but I noted that he appeared less distracted and more able to focus on conversation than at previous visits.

244. Reflecting on this meeting, I felt that VC had improved: he was less distracted and more able to focus on conversation; he had also opened up about his experiences, which would indicate he was more trusting of me. Though I documented that he had volunteered minimal details about how he was feeling during the appointment, he had opened up about his experiences in more detail in the recent OPA and his acknowledgement of his previous dishonesty felt significant. In terms of insight, my view remained at this time that VC had partial insight as described in his recent OPA review.

245. It is recorded in this entry that VC had not observed a change in frequency or intensity of the voice experiences. I have not documented any questions I asked in this regard, but I can confirm that it was my practice to ask questions about the nature of his voice hearing experiences – although I remember he would not always respond or give answers. My concern was whether he was experiencing

command hallucinations: I remember him denying that this was the case and confirming that he felt in control of his actions. I remember focusing on the impact of his experiences and how this affected him, but not always getting much information back.

246. I have recorded that I provided VC with information on psychosis from the BPS. On the 17th November 2020 I emailed the document "Understanding Psychosis and Schizophrenia" to VC **[WITN0348002] [WITN0348006]**. It was my practice to share information in a range of different ways depending on the patient's needs. Some patients prefer verbal information; some prefer written materials. I provided this information at this time due to VC's recent disclosure and discussion with me and Dr Burri regarding his experiences. I felt this was an appropriate time to supplement his understanding. He demonstrated to me a willingness to engage with me / EIP on a deeper level, but I wanted to work through this in a meaningful way. VC opening up to us demonstrated some level of trust and I wanted to support him with his experiences and understanding of psychosis. He was an educated individual engaged in a university education so I took the view written material would be accessible to him.

247. I also discussed the option of CBT with VC. Previously he had not opened up much about his experiences. CBT-p is helpful only if someone wants to engage and is willing to be open / work on their mental health, the patient could only be referred to CBT-p, if they consented to the referral, I could not refer on his behalf.

248. I sent an email on November 19th 2020 with information on CBTp, I am not aware of an email reply from VC regarding this. I cannot recall whether information was

shared on voice hearing in particular with VC at the time **[NHFT0017993, NHFT0017894]**.

249. On 24 November 2020 at 4:20pm **[NHFT0000168, pp.139-140]** I noted that VC did not attend a scheduled appointment at the Stonebridge Centre; at 2:00pm, a text was sent and I recorded that "it appears he [forgot] the appointment time".

250. I conducted a home visit at 4:20pm that day. VC reported he was doing okay and remained concordant with his medication. I do not recall carrying out any medication checks on that occasion.

251. With regard to the voices he was hearing, VC initially reported that the voices were much the same but then reported they were a little quieter. However, he also confirmed that he "hears them pretty much all day without a break" **[NHFT0000168, p.140]** albeit that he maintained they did not interfere with his sleep and that he felt able to concentrate on his daily tasks.

252. Hearing voices is not an unusual symptom for EIP / FEP patients to experience. VC had not been on the increased dose of medication for very long and had benzodiazepines to reduce distress. As he disclosed to me that he was able to concentrate on his daily tasks such as working and finding work and was sleeping well this indicated to me that they were lower intensity voices. Had he informed me he could not function or was finding this very difficult, I would have felt the severity of his condition was worsening.

253. As I recorded, VC's mother had been in contact with me earlier in the week and had expressed concern that he might be struggling with his studies. I knew that VC had in fact deferred his course but intuited from this that his mother did not. I

do not now recall the full detail of our discussion: I spoke with Celeste often and did not document every interaction. I do not know why I did not document it, but I assume this would have been due to capacity. I did however record that VC agreed to speak to his mother in order to reassure her **[NHFT0000168, p.140]**.

254. At 3pm on 1 December 2020 I saw VC for an in-person appointment at the Stonebridge Centre **[NHFT0000168, at p.140]**. VC stated that he had not observed changes in the voice experiences but felt they were generally quieter. He continued to believe they were "quite powerful and remained unsure whether they were symptoms of psychosis":

255. I assumed from the reference to their being "*powerful*" that the voices were persistent and that he was not getting a break from them. My view was that VC had ongoing, partial insight, he would consider what we would say to him regarding his symptoms, but he did not feel that it made sense and wanted to look for an alternative reason for his experiences other than psychosis symptoms. He was no longer denying that he was having unusual experiences but was trying to find out the explanation for these experiences. I felt that he had some insight as he was coming to see me for appointments and coming to base, and if he had had no insight at all, I did not feel he would come to see me.

256. With regard to VC's observation that the voices might not be symptoms of psychosis, I note that when he discussed them with Dr Burri, he had raised the thought that they were real (see entry **[NHFT0000168, p.138]**). I note that it is recorded that VC stated that the voices would stop if he went back to hospital but that he thought they were saying that to punish him **[NHFT0000168, p.140]**. I offered reassurance that we as a team did not want him to go back to hospital

either. I do not recall from memory what I said and it is not documented, but it is normal for us to support and offer reassurance to our patients as psychosis is a frightening experience and most do not want to return to an inpatient admission. The aim of EIP services is where possible to keep people out of hospital and to provide them with support in the community. This conversation and my reassurances did not mean I would not escalate concerns if necessary.

257. In terms of our discussion regarding CBT, I would have reviewed the information regarding the nature and practice of CBT-p; asked VC if he had seen the email information, if this is something he would be interested in. I wanted VC to engage with CBT-p as I did feel this would support him in his recovery; however, I remember that VC would often appear uninterested in this.

258. I note that it is recorded that I provided VC with a two week supply of medication; further, that VC thought he had medication left over and thought that he had been given more than the seven days shown on his medication card. I note that I encouraged him to go home and check the box; I do not now recall whether or not I followed this up with VC. I do remember that I questioned him about concordance in the appointment, but he denied it being an issue. It was something I was aware of for ongoing reviews / appointments.

259. At 4:45pm on 7 December 2020 **[NHFT0000168, at pp.140-141]** VC attended an in-person appointment with Dr Burri at the City South EIP Clinic. As the record reflects, I was also present at this meeting. I have reviewed Dr Burri's note and can confirm that it accords with my memory of the event.

260. Dr Burri notes that VC continued to experience second and third person auditory hallucinations but remained able to *"keep his calmness"*, had secured a warehouse job, was speaking to his mother more often, had a good mood, and was taking his medication regularly. Dr Burri's noted impression was *"slow but steady progress with much better presentation, gained significant insight with better functioning, compliant with medication*" **[NHFT0000168, p.141]**. This was also my impression at the time and I agreed with Dr Burri that there was no acute risks to self or others.

261. It is noted that although VC would benefit from CBT psychotherapy, he *is "not keen at the moment"* [NHFT0000168, at p.141]. I considered that CBT would help VC to understand his symptoms and triggers and provide support for new ways of thinking, to challenge his thought processing. Unfortunately, VC never showed any interest in CBT and the EIP in Nottingham did not and does not have access to alternative interventions – all of which would require the engagement of the patient in any event.

262. On 15 December 2020 VC cancelled a planned home visit **[NHFT0000168, at pp.141]**. I subsequently tried to make arrangements for him to collect his medication but on 17 December 2020 he texted to say he had plenty of medication left and requested a visit the following week **[NHFT0000168, at pp.141]**.

263. I see from VC's records that I noted it was possible he had been using the lower dose or Aripiprazole before starting the higher dose and I planned a home visit the following Monday (21 December 2020) to monitor concordance and deliver medication **[NHFT0000168, at pp.141]**. VC would have had extra medication

from his previous dose at this time, so it was plausible that he could have been using this. However, there was a concern that he may not have been concordant and this was fitting with past presentation of non-concordance with medication.

264. I spoke to VC's mother at 11am on 21 December 2020 **[NHFT0000168, at pp.142]** it is noted that she reported that VC had sounded anxious when she first spoke to him by telephone but appeared to relax as the call went on. She reported that he was concerned about a loss of weight and that he was waiting to hear back from his university about returning to his studies. I agreed to offer VC support regarding liaising with his university. I note that it is recorded that VC's mother said she would value a call following my visit to VC later that day. I do not now recall whether or not we spoke later that day. I can say that I spoke to her frequently but may not have documented every contact.

265. I visited VC at home later that day **[NHFT0000168, p.142]**. I have recorded in my notes that he appeared *"perhaps a little preoccupied at times during the conversation*" and that he confirmed he was continuing to hear voices and did not feel there had been much improvement since increasing the dosage of Aripiprazole: **[NHFT0000168, p.143]**. I was concerned that VC's condition was not improving. Although I have not documented this, I would have asked – as was standard practice – if VC was open to an increase or a change in medication. I also observed, however, that VC had been more open with me in recent weeks and was in regular contact with his family, both of which were positive developments.

266. I have recorded that VC showed me *"that he had four remaining tablets left and believes that he has had a slight overlap at some point which has left to surplus*

supply" **[NHFT0000168, p.143]**. I believe he thought he had been given his medication early on one occasion and therefore had a surplus of medication.

267. I provided a further 14 days of medication and reminded him of the importance of being concordant with his medication. I recorded in his notes that I had *"reiterated the importance of concordance"* because this was something we discussed frequently. I often had conversations with him about the importance of medication and made clear to him the risk that, if he did not take his pills, he would be at risk of relapse of his illness. I wanted to ensure he understood its importance and that he would consider this when making decisions about whether or not to take his medication.

268. Diazepam had been prescribed as a PRN (pro re nata) medication: to be taken as and when needed. The Diazepam was to help reduce any distress or anxiety he might experience. This was discussed with him in his OPA's and reviewed with him at his appointments with me. We would encourage him to use PRN when needed to help reduce distress, but it was a regular daily use prescription. I noted, however, that VC was not using diazepam.

269. This appointment was shortly before Christmas: I reminded VC that I would be away on leave over the Christmas break. As I recorded in his notes, VC appeared isolated in Nottingham: he was far away from his family in Wales and not in contact with friends. However, as I recorded at the time, VC himself did not seem concerned by this and reported that he was eating and sleeping well. He was also in regular contact with his family and had opened up more over the last few weeks.

270. Isolation in any patient is obviously not ideal. VC was, however, a quite introverted and private individual in any event. His isolation was also arising in the context of the Covid epidemic where there were restrictions on socialising more generally.

271. I did however consider the fact of VC's increased contact with his family to be a positive sign. It indicated that VC was beginning to trust others more, which suggested an improvement in symptoms, levels of functioning, and, potentially, insight. If we see people pull away or disengage with family and friends, this can indicate that someone is becoming unwell.

272. It is recorded that VC was considered to pose no new risks to self / others at this time. This was on the basis that there was no change in his presentation, and he did not say there had been any changes in risk when asked about his thoughts.

273. It was also noted that VC was keen to get back on with his life without too much interruption. It is quite common for patients under our care to not want us to intrude on their life. This is especially common with those patients aged 35 and under, in early adulthood. We work within a recovery model and try to find a balance between our involvement and respecting patient wishes in regards to contact with our team. Clearly this depends on the assessment of risk at the time. Building a strong therapeutic relationship is central to effective engagement within the EIP service. Establishing trust, consistency and collaboration provides the framework for assessment, supports adherence to treatment plans and enhances recovery outcomes. This was something that I consistently tried to balance with VC's engagement.

274. On 4 January 2021 at 3:15pm **[NHFT0000168, at pp.143-144]**: VC attended the Stonebridge Centre for a scheduled appointment with me. I noted in his records that he was continuing to hear voices but that he *"denied that the auditory hallucinations interfered with his work"*. I also noted, however, that VC hesitated slightly when I asked him about whether or not he was experiencing any current command hallucinations.

275. My view at the time was that VC's symptoms were not too loud, disruptive or distressing in his life. VC had informed me previously that the voices do not like it when he speaks about his experiences: I interpreted his hesitation in responding as a potential indication that he was frightened to talk about his experiences. He continued to deny any command hallucinations, and stated that he was able to *"continue to ignore the voice experiences"* **[NHFT0000168, p.144]**. On this basis I reached the conclusion that he was, on current form, able to continue living his life and engaging with tasks (work).

276. VC also stated that he felt his short term memory and recall had deteriorated over the last 2 years: we spent some time discussing some of the common symptoms of psychosis and agreed to look at early warning signs during the next appointment and to begin the development of a relapse plan.

277. I cannot recall which symptoms of psychosis exactly were discussed, but my general practice would be to discuss the positive (ie active) symptoms of psychosis e.g. delusions, hallucinations (different types), disorganized thinking, change in behaviours as well as the negative (ie passive) symptoms such as affect, apathy, anhedonia, alogia, avolition, and asociality.

278. VC's reported memory loss could have been associated with the negative symptoms of psychosis, which are often the more difficult symptoms to treat. It could have indicated a longer-term illness but this was still too early to say. I also recorded that *"[VC] denied any feelings of agitation or anger saying that at most he has only ever felt 'apprehensive'"* and that *"he felt quite content at the moment"* **[NHFT0000168, p.144]**. He did of course have a history of appearing to experience both anger and agitation when unwell, but this was the interpretation he gave and I did not see signs that he was agitated or distressed in the course of this appointment. He continued to see me and engage, he was happier as he had work which gave him purpose.

279. I next saw VC at the Stonebridge Centre on 18 January 2021 at 3:00pm **[NHFT0000168, at pp.144-145]**. I have recorded in his notes that at this point we started to explore "Early Warning Signs and Relapse Prevention". We began this work in January 2021, several months after his first engagement with the EIP, because it was only at this point that he was willing to engage with this work. I had spent the preceding months building a relationship with VC and he was opening up about his experiences. Patients need to be in a certain place in recovery to engage with the Early Warning Signs ("**EWS**") relapse prevention work.

280. In my entry of that day I listed a number of early warning signs that VC identified **[NHFT0000168, p.145]**:

   i. Having unusual thoughts, beliefs and ideas;
   ii. Thinking he was being watched;
   iii. Thinking he was being laughed at or talked about;

iv. Noticing co-incidences;

v. Feeling depressed or low;

vi. Feeling violent/angry/aggressive/pushy;

vii. Feeling distressed;

viii. Thinking that he might be controlled;

ix. Feeling tense/anxious and afraid; and

x. Being preoccupied with things.

281. VC noted that while he identified the early warning sign of feeling violent/angry/aggressive/pushy, he "never acted on those feelings". I recorded that he was unable to identify anything specific that had triggered this episode but that he did that feel stress, especially university workload/exams may have contributed to it. I felt that study-related stress was a factor within this particular cohort of patients – albeit that there may of course be other factors, such as biological influences, too.

282. I recorded that, if he became unwell again, VC would like to avoid hospital, using the "least restrictive practice" – this reflects the Mental Health Act Code of Practice which stipulates that any restrictions placed on a patient should be the minimum necessary to safely provide the care or treatment required. This principle applied to all patients we cared for and it was standard practice to discuss it with them. As part of these discussions, I would make it clear that where possible we would treat people at home with the support of the Crisis Team. However, making it clear there are occasions that people do need to be admitted due to risk factors or if people lack insight. I told VC that we would

continue to have open and honest conversations about this and should I have any concerns, I would be open with VC about this.

283. I note that VC stated he would like "to remain on Aripiprazole". I do not recall from memory his reason for this or what alternative treatments were discussed.

284. I reflected in VC's notes that he had moved back to his previous flat in Lenton and was living with one other student. I never saw another housemate in Lenton. I would ask whether his housemate was in the property when I visited (due to confidentiality / concerns that we could be overheard in a communal area) however VC consistently advised that he was alone.

285. On 18 January 2021 I completed a relapse prevention plan for VC **[NHFT0000270]**. Its completion was one of the actions identified in the care plan I had created for VC on 1 September 2020 **[NHFT0000202]**. I do not believe it was updated. Several months had passed since I had identified the relapse prevention plan as a necessary action but I used this time to build a relationship with VC and it was only in January 2021 that I felt I was really beginning to build a relationship with VC and that he was really opening up to me about his experiences. Patients need to be in a certain place in recovery to engage with the EWS relapse prevention work, hence the passage of time prior to its completion.

286. I did not then see VC again until 13 April 2021, a gap of around three months. I made telephone contact with VC on 1 April 2021 and arranged a visit for 12 April 2021 **[NHFT0000168, at p.149]**. I spoke to VC again on 12 April 2021 and rearranged our appointment to the following day **[NHFT0000168, at pp.149-**

150]. I was away from work for a period of time in the spring of 2021 due to having suffered a miscarriage. I attempted to make contact with VC very soon after my return to work and my first contact with him was on the 1 April 2021. I do not know or remember why there was a gap between the appointments.

287. On 13 April 2021 at 2:00pm **[NHFT0000168, at p.150]** I visited VC at home. I recorded in his notes that he appeared well presented, relaxed and that there was no overt evidence of psychosis: VC was asked and denied experiencing troubling thoughts or ongoing anxiety. There was limited spontaneous conversation, but VC did respond to questions appropriately. I have been asked about my recall of VC. This was a very difficult period for me in my personal life, and frankly, I do not remember or recall very much from memory. However, from the documentation I can see that I have recorded the difference in VC was that his hair and beard were longer. As I noted at the time, while this could have been due to self-neglect it could equally have been because of the covid lockdown and the lack of access to barbers etc.

288. I recorded that VC continued to work and was studying in his spare time but did not appear to be participating in any leisure activities **[NHFT0000168, at p.150]**. This was normal functioning for VC. I also noted that VC had spoken to Dr Burri regarding his memory concerns and was reassured following a memory assessment that there were no obvious issues with his memory; he also felt there had been a slight improvement since the increase in Aripiprazole **[NHFT0000168, p.150]**.

289. At the meeting of 13 April, VC and I discussed an email I had received from PC Gail Collins [**NHFT0017933**] in which she explained that the landlord of the flat

where the previous incident in which VC had been involved was seeking £600 compensation. As I recorded at the time, VC was taken aback by the cost and I was *"mindful that discussing events leading up to his admission is quite difficult for [VC], I sense that there is an element of shame and embarrassment surrounding this and he doesn't particularly benefit from being reminded of the incidents especially now he is doing a bit better"* **[NHFT0000168, p.150]**.

290. As I recorded in an email I sent to PC Collins subsequently **[NHFT0000168, at pp.150-151]**, VC was shocked and surprised at the proposed compensation sum, given his view that he has only damaged a single door. I observed to PC Collins that VC found it very difficult to talk about what led up to his admission, having never really felt able to discuss it. I noted that VC was trying to move on from the events leading to his admission and observed to PC Collins that I was worried that discussion of the incident, could be triggering for him. I had in mind in particular the financial stress and shame/guilt that I considered VC would associate with the incident.

291. Personally, I did not think the difficulties discussing events leading to admission were fully due to lack of insight. VC did have some awareness of what had happened on reflection of when he was unwell. It is normal for people to have an experience like this and to feel shame, embarrassment and guilt when they are better.

292. My next home visit to VC was on 13 May 2021 at 9:59am **[NHFT0000168, pp.151-152]**. This was a month after my previous home visit and was followed, a month later, by a further visit. Following this meeting I recorded in his notes

that VC appeared relaxed and well presented, having had a haircut after the easing of the covid restrictions. VC reported that he felt things were going well; he also informed me that the voices were *"quieter and much more in the background"* than they had been previously and he again denied any command hallucinations **[NHFT0000168, p.152]**. He remained unconvinced that medication had improved his hallucinations but said he was concordant with medication.

293. I noted in his records that he appeared *"much less distracted",* had a *"less blunted*" affect, and his conversation was *"less stilted".* I do not recall writing this entry directly, but from a review of records I note that VC was presenting as stable, engaging better in conversation with me and not reporting concerns associated to psychotic symptoms; though he was still experiencing some background voices, they were not disturbing him.

294. This entry reflects that I provided VC with a further 28 days of medication. There is no reference to a medication concordance check and I cannot now recall whether or not I checked or inspected VC's medication supply or otherwise verified his medication concordance at this visit.

295. I then had a period of annual leave. On my return on 14 June 2021 at 3:03pm and 17 June 2021 at 9:50am **[NHFT0000168, at p.154]** I exchanged texts with VC's mother. I observed that Celeste Calocane had had some worries while I was on leave. I had reviewed VC records on my return to work and saw the contact with Crisis Team. I initially tried to call her but did not receive a response so I texted her. In a response received on 17 June 2021, VC's mother said there were *"some things that wasn't adding up which made me worried";* but she

clarified that *"the team assessed him over the phone and thought he was fine also the (sic) went to see him which put my mind at rest. I spoken to him couple time I think he's okay."* **[NHFT0000168, p.154]**. This was the extent of the concerns raised and suggested to me that they had been looked into by my colleagues - CPN Abigail Parsonage and CPN Adele Pinder had conducted a follow up EIP visit in my absence on 2 June 2021 **[NHFT0000168, PP.154-5]** and had recorded that in their view VC had not relapsed and appeared *"well in himself".*

296. In any event, on 18 June 2021, the day after my text exchange with his mother, at 10:30am I visited VC at home **[NHFT0000168, at p.154-155]**. As I noted in his records, he "*appeared well, relaxed and well presented".*

297. He stated he was unclear why his mother was concerned he might be relapsing but was *"…reassured and was appreciative that it only involved a call from the crisis team and follow up from EIP just to check everything was okay".* I noted that there was *"no overt evidence of psychosis observed"* and that VC's *"risks remain low".* From my records I assessed that he was well and there was no evidence to suggest otherwise.

298. On 28 June 2021 at 2:00pm **[NHFT0000168, at p.155]** I discussed VC's care plan – updated from the version created on 1 September 2020 - with Dr Burri. This was part of VC's annual CPA review. The care plan remained the same as that created in September 2020, despite the events of the previous nine months. His medication and the frequency of appointments had both changed and should have been updated: I do not know why this did not happen. Often time is the biggest constraint to completing the paperwork documents. VC did not attend

this review; therefore, I updated the care plan with an update of the past year under services. It would always be my preference to update the care plan in collaboration with the patient. We were still offering the same interventions as set out for the EIP pathway.

299. I next tried to contact VC on 2 July 2021 at 9:51am **[NHFT0000168, at p.155]**. I did not receive an answer and left a message asking that he return the call. I do not now recall from memory whether or not VC did return my call, but given I have documented a response, I would assume he did not.

300. On 5 July 2021 VC assaulted a flat mate. I was not made aware of this incident at the time and I note that there is no reference to it in VC's Rio notes. If we receive information regarding any concerning incidents with our patients we would prioritise further exploration and assessment of their mental health and any associated risks. Without knowing what the details of the incident were, it would be difficult to say what I would have done however the information would have been shared with the wider team / in MDT to decide on an appropriate course of action. The risk assessment would also be updated.

301. I visited VC at home on 8 July 2021 at 3:00pm **[NHFT0000168, at pp. 155-156].** I noted that he appeared *"less blunted"* and reported himself *"100% back to his usual self"*. He denied any current concerns regarding his mental health and reported that the voices were *"barely noticeable"*. He reported taking his medication everyday with no immediate wish to "come off the tablets" although he noted that he would like to be off medication eventually. We discussed and agreed that his negative symptoms were much improved since the increase in his Aripiprazole dose.

302. I do not recall from memory, but it is standard practice to ask the reason as to why people miss appointments, as this may mean additional support is required in future or reasonable adjustments need to be made. On that basis I assume that I would have asked why VC had failed to attend an appointment with Dr Burri the week previously. I made a note to re-schedule the OPA **[NHFT0000168, p.156]**.

303. I cannot now recall my views on VC's assertion that he was *"100% back to his usual self"*. I had never met VC before his initial episode of psychosis so it was difficult to assess what his *"usual self"* might have been. On reflection I do not feel that VC had full insight into his presentation and this was an overestimation. I do not recall from memory and it is not documented that I physically checked VC's medication supply. I did record, however, that we had a discussion regarding his medication. He recalled the length of treatment advised by Dr Burri, stated he did not want to be on long-term medication but confirmed he had no plans to discontinue at this time.

304. I have recorded that *"we also acknowledged that the negative symptoms appears much improved since the increase in Aripiprazole"*. **[NHFT0000168, p.156]** This observation was based on the fact that his affect was less blunted, he was more spontaneous in his speech; he appeared more able to engage in conversations about activities and his family. At the time of this meeting, I was unaware of the incident involving VC's flatmate on 5 July 2021: as a result I did not bring it up with VC and we did not discuss it.

305. On 14 July 2021, VC attempted to enter a flatmate's room. Again, I was not made aware of this incident; it was not recorded in VC's Rio records and VC himself did not tell me about it. If I had known about the incident, I would have followed the steps I have outlined at paragraph 300.

306. It is imperative that the EIP is made aware of any incidents involving our patients in order that we can assess any risk or potential decline in their mental state. Health Care Professionals ("**HCPs**") can also inadvertently be put at risk visiting patients at home without the full relevant information.

307. On 29 July 2021 at 5:56pm I received an email explaining that VC had been offered a conditional caution **[NHFT0000168, at p.156]**. I spoke to VC the following day, 30 July 2021 **[NHFT0000168, at p.157]**. He confirmed he had been seen by PC Collins and had declined an offer of a conditional caution; further that he did not want to undertake the three sessions offered by the Liaison and Diversion ("L&D") team, even though his refusal could lead to a criminal record. I noted that he reported that he was "doing fine" and appeared to understand the implications of declining the offer (risk of a criminal record) but that I myself was "unsure what has led him to the decision" and felt that it warranted further exploration. I recall him saying that he "wanted his day in court": he wanted to contest the charges. This is reflected in the note authored by PC Gail Collins.

308. My colleague Gary Carter saw VC on 6 August 2021 **[NHFT0000168, at p.157]**, he described VC as *'a little abrupt… irritated… quite short… not very friendly or sociable as I've known in the past'.* I recall a verbal conversation with Gary regarding how VC had been on this appointment and he was making me aware.

I would not be able to recall the exact date and time as this is not documented and we would often catch up with each other.

309. I was aware of the note entered into the system by Dr Tuhina Lloyed on 9 August 2021, prior to my scheduled meeting with VC on that day **[NHFT0000168, at pp.157-158].** I was the CPN who had advised Dr Lloyd of my concerns regarding a potential relapse for VC. He subsequently failed to attend his out patient appointment scheduled for that day so I telephoned him.

310. On considering my note of this conversation **[NHFT0000168, at p.158]** I am struck by the fact that VC was delayed in answering and did not greet me: this was a notable change in presentation as he would usually be pleasant and polite on interactions. VC stated that he *"wasn't aware"* of the outpatient appointment that morning even though he would have received a text reminding him of the appointment that morning. I remember him presenting as cold and unlike his usual self. He was not apologetic for missing his appointment. This to me was an indication that he might be starting to disengage due to his illness.

311. VC said he could not attend an appointment the following day because he was busy, without explaining what he was doing. I noted that he appeared to be *"avoiding appointments currently";* I was concerned that this might be evidence that he was starting to become unwell or was unwell, as disengagement was a sign of relapse. Signs of disengagement / avoidance were potential signs of relapse. From memory at this time he was not presenting as floridly or overtly psychotic, however, there was evidence of subtle changes in his presentation which would indicate relapse. It was in light of this that I immediately took steps

to have VC reviewed by a medical colleague: I made a provisional booking for a home visit by a medic on 19 August 2021 **[NHFT0000168, p.158]**.

312. I note from the Rio entry that my plan was to contact VC's mother to see if she had any recent contact and to discuss VC's case at an MDT meeting. I cannot now recall whether I did discuss this with VC's mother. There is no entry or documentation reflecting such a call, but it is possible I did have contact as these are things I would liaise and speak with VC's mum about.

313. I cannot recall on which date VC's case was discussed at the MDT. However, I am certain that would have raised the case for discussion due to VC's signs of relapse. It is likely we discussed VC during our MDT on 12 August 2021 following the medical review home visit on the 10 August 2021. The purpose of this would be to update the team regarding our assessment on the 10 August.

314. On 8 August 2021 I completed a "Mental Health Clustering Tool" **[NHFT0000180],** also known as a HoNOS form. Every patient requires a HoNOS form: it provides a standardised way of assessing a patient's mental health needs and a mechanism for assigning them to the most appropriate care cluster. However, within EIP every patient must be allocated to a cluster 10 which indicates -Psychosis First Episode regardless of their HoNOS score. Usually the specific patterns of scores across the 12 domains, combined with clinical judgement determines the appropriate cluster allocation.

315. I would have completed this document at this time as it was due for an update. This document needs to be updated a minimum of yearly or if there were any major changes. Prior HoNOS had been completed by Crisis Team and the ward

staff. Upon discharge from hospital, HoNOS should be updated to reflect appropriate care pathway, in this case for VC Cluster 10 First Episode Psychosis. I should have changed VC's cluster when he came out of hospital but did not.

316. I scored VC 4 in current ratings. These were as follows:

   i. 0 ("no problem") for current non-accidental self-injury, problem drinking/drug taking, cognitive problems, physical illness or disability problems, problems with depressed mood, other mental and behavioural problems, problems with activities of daily living, problems with living, problems with occupation and activities, and strong unreasonable beliefs in non-psychotic disorders.
   ii. 1 ("minor problem requiring no action") for current overactive, aggressive, disruptive or agitated behaviour and problems with relationship.
   iii. 2 for current problems associated with hallucinations and delusions ("mild problem but definitely present").

317. I scored VC 5 in historical ratings, these being:

   i. 3 ("moderately severe problem") for agitated behaviour/expansive mood.
   ii. 1 ("minor problem requiring no action") for engagement and vulnerability.
   iii. 0 ("no problem") for repeat self-harm and safeguarding children and vulnerable dependent adult – on the basis that this was not an issue for VC.

318. A HONOS tool is based off the previous 2 weeks. Whatever the score comes in as for a patient, as the EIP we must overrule and change to a cluster 10 which is the score used for FEP. This score was based on the information I knew about VC at this time. This tool would not have influenced my management of VC because, whatever the outcome was, I was told it needed to be overridden and all EIP patients put on a cluster 10 FEP.

319. This tool was not completed again until 10 August 2022 when CPN Gary Carter completed it as part of its annual update.

320. On 10 August 2021 at 3:35pm **[NHFT0000168, at pp.158-159]** I conducted a home visit for VC in the company of Dr Sasidharan. As I recorded in VC's notes, VC himself reported that he has been doing fine and was spending his time going to work and engaging in his studies. Dr Sasidharan recorded that VC was engaging in his usual activities; there was no reference to any distress from his symptoms and he denied any delusional thoughts or risk factors. There is nothing recorded as to why he did not attend his prior appointments, however, it is relevant that VC did not see mental health support as a priority in his life whereas work / studies were important to him; Dr Sasidharan recorded that VC *"does not believe that he has mental health problems however he is happy to follow medical advice"* **[NHFT0000168, p.159]**.

321. I have been asked for my views on this Rio record and whether the respective policies with regard to missed appointments - **[NHFT0004725]** and/or **[NHFT0000417]** were followed. I note that I was not responsible for completing this entry but i was in attendance at this appointment with Dr Sasidharan. I did

not document my own entry in the Rio records as Dr Sasidharan had completed her entry. If I had disagreed with any of the assessment at the time, I would have documented this in the MDT records. I do not recall whether the reasons for missed appointments were discussed during this appointment.

322. On 31 August 2021 at 3:09pm **[NHFT0000168, at pp.161-162]** Gary Carter and I conducted a home visit. VC had been visited by Abi Parsonage and Adele Pinder in the intervening weeks. Gary Carter and I carried out this home visit because we had concerns that VC may be relapsing and we also needed to deliver his further supply of medication.

323. As is recorded in his Rio records, VC was noted to be *'not particularly welcoming like his usual self but not aggressive…slightly confrontational from the start and appeared suspicious of our [intentions]'* **[NHFT0000168, p.162]**. He reported that *"he was no longer taking his medication and had no intention of continuing treatment",* he would not say when he stopped medication other than saying it had been 'days'. He proceeded to "rant" about not taking medication – primarily because, in his view, he was not currently psychotic and never had been. As I recorded in this entry, VC presented with a complex delusional system: he believed you were working in collaboration with the judicial system and the hospital (Highbury) and had created technology to cause his voice experiences / monitor him. He refused to answer my questions about his current voice experiences.

324. My impression was that he was relapsing. I also noted that it was "*unlikely that VC is going to engage with home treatment*" **[NHFT0000168, p.162]**. I noted

there was no evidence of current risk to self. In respect of risk to others I recorded:

"[VC] is usually a very personable, kind, polite and gentle man however when unwell he did break down a neighbours next door because he believed he could hear voices of someone in trouble next door. Lack of insight, [VC] doesn't appear to recognise that he has ever been unwell, behaviour can be unpredictable when unwell. We did not feel it was safe to continue to push the assessment at this time as [VC] appeared increasingly frustrated and mistrusting of us… I was also concerned that it was potentially quite difficult to get out of the flat due to a long corridor / hallway to the exit should we have needed to leave promptly."

325. As I observed in a subsequent NHFT interview conducted in January 2025, this was the only time that I met him VC and thought *"'Oh my goodness', this chap is not very well"* **[NHFT0004906, at p.5]**. I recall that I felt uncomfortable being in his presence as he had never presented like this with me before. He also referenced me in his delusional belief system remarking 'you know, you know'. I felt like I wanted to get out of his property and he did not think we were helping him; we were simply making him more angry. In terms of risk I felt that he could be a risk towards others / from others, as I had never seen him this unwell and angry before. As I remarked in a subsequent NHFT interview, VC was not aggressive but did present as quite agitated **[NHFT0004707, at p.2]**. I was aware from his previous admissions that he was a risk to others due to his hallucinations and delusional beliefs. I called for an MHA assessment as I felt this was the only way to keep both VC and others safe at this time. He could have been at risk from others in terms of retaliation if he was accusatory towards others.

326. As I recorded in the notes, my plan was to discuss the case with Dr Lloyd and the CRHT; I also noted that an MHA assessment might be required *"due to lack of insight"* **[NHFT0000168, p.162]**. I spoke to Dr Lloyd straight after the appointment with VC.

327. To be clear, in my mind I felt that VC did require an MHA assessment, but this was something that needed to be discussed with the CRHT team, consultant psychiatrist and AMHP. In Nottinghamshire HC CRHT are required to gatekeep all Mental Health assessments. I escalated these actions as above and it was agreed and an MHA assessment was planned as by this stage it was clear that VC would not engage with the home treatment process. I finish work at 5pm and the action to arrange the time was left with the Crisis Team.

328. From considering the records, I note that I tried to call VC's mother at 4:20pm; CPN Gary Carter tried again on 1 September 2021. At 4:18pm on 31 August 2021, I had a telephone call with Rachel Masterson **[NHFT0000168, at p.163]**. As she recorded in the Rio notes, I observed that I believed VC had been deteriorating for several months and that the risk he posed was primarily to others on the basis that he had broken into a neighbour's house during his last episode of mental ill health.

329. I called for a Mental Health Act assessment to be carried out on 31 August as I was concerned about VC's presentation and the potential risk he posed towards others: I felt he needed admission to hospital. Subsequently, on 1 September 2021, Gary Carter described the situation as not an "*absolute emergency*" and stated that an MHA assessment was *"considered the way forward in the near*

future" **[NHFT0000168, at p.163]**. My view was that he needed urgent assessment and admission to hospital.

330. On 31 August 2021 I updated VC's Risk and Safety Assessment **[NHFT0000194]**. This was the first time I had updated this document: I acknowledge that I should have updated it when VC was discharged from the hospital / Crisis Team.

331. I noted in the assessment that VC appeared to be relapsing, was quite suspicious/paranoid, and *"a little bit confrontational"* **[NHFT0000194, p.2]** although he did not display any evidence of aggression. I also recorded that VC had stopped treatment abruptly, probably far longer than the three days ago that he had suggested; that he was presenting with complex delusional beliefs, displayed "*nil insight"* and did not believe he had ever been unwell. I noted that he had no support network in Nottingham and was at risk of further deterioration of mental state.

332. I ticked the box "risk to others". I did not complete the risk and action section that followed **[NHFT0000194, p.2]**: I remember feeling rushed to get the Mental Health Act assessment planned following seeing VC and my priority was getting the key points written in the risk assessment which I believe I accomplished.

333. The risk was that he was not engaging, had no insight, did not want to take medication again, was displaying an increase in agitation, had a complex delusional belief system. He had previously presented as a risk towards others when unwell and I believed on this assessment he could be a risk to others again.

This was why I escalated the matter to Dr Lloyd and requested a further Mental Health assessment.

334. On 3 September 2021 at 1:58pm **[NHFT0000168, at p.164]** I spoke to VC's mother by telephone. She reported that the previous night VC had spent much of an hour-long phone call taking about the government monitoring him and she had found it difficult to challenge those beliefs. VC had told her he had seen the EIP Team on Tuesday; he had been polite but had told them he did not what to see them again. He had not told her he had stopped medication. She wanted to speak to a social worker. Following this phone call, albeit that it is not documented, I recall speaking to a social worker and discussing the need for social care to contact VC's mother.

VC's Third Admission (under ss.136 and then s.3 MHA 1983) – Cygnet and Priory ("Third Admission"): Relevant dates: 3 September 2021 – 22 October 2021

335. VC's notes from 3 September 2021 record that whilst the police attempted to execute a s.135 warrant, VC punched an officer with significant force three times; assaulted other officers; headbutted an officer; and wrestled handcuffs from an officer to use as a weapon **[NHFT0000168, p.167]**.

336. Owing to this incident happening late on a Friday night, I did not find out about it until the following Monday morning. I do not believe I received an oral update – I merely obtained the information from reading VC's notes. My obvious conclusion was that VC was unwell and did not want to go to hospital. Although I would have

expected him to be reluctant to go to hospital, I was surprised by how much the situation escalated.

337. On 7 September 2021 at 1:45pm **[NHFT0000168, at p.181]** I spoke to VC's mother. I noted she was upset VC had been admitted but understood why it was necessary: she too was very shocked by his reaction to the police. We both agreed that this was *"very much due to him being unwell and having no insight".* In my view VC held no insight into his mental state, his illness, his need for medication or his need for hospital support at this time. This is why he acted out with such aggression, because he did not want to go to the hospital and did not trust the health professionals or police, both of which he believed were conspiring against him.

338. On 9 September 2021 at 3:00pm **[NHFT0000168, at p.187]** I engaged in a number of telephone calls in relation to VC's belongings as he was due to move out of his flat.

339. VC had been moved to an out of area hospital. This posed a number of additional challenges. There are many challenges when working with out of area bed providers: we do not have same access to notes / records so cannot see how a patient is presenting; they cannot see our records for patients; we do not always get invited to ward reviews, when we do, we can only join online / via phones which can involve poor connections and communication difficulties; ward reviews also often overrun, leading to us being unable to attend; out of area beds can also be at some geographical distance from our Nottingham base, meaning we are unable to travel to see patients physically. This also makes it difficult for

families to visit patients. Unfortunately, it was relatively common for patients to be sent out of area due to the lack of beds in Nottingham.

340. On 13 September 2021 at 1:00pm **[NHFT0000168, p.190]** I exchanged messages with VC's mother. She reported that VC seemed "*good*" following a video call she had had with him. At this point VC had been placed out of area with a private provider, Cygnet, so my contact with him was through attendance at virtual ward rounds and from receiving updates via email from the hospital. I also had some contact with VC directly via telephone call regarding his tribunal request.

341. On 17 September 2021 I emailed John Laverick Senior Nurse **[WITN0348005]**: *'Is a depot being considered? This was discussed following his second admission however he declined at the time. This is obviously his third admission and concordance remains an issue. Reflecting on things now I don't think VC has ever truly acknowledged that he has a mental health issue and insight has remained poor.'*

342. John Laverick responded later that day at 2:12pm **[NHFT0000168, at p.190]**. He reported that VC was settled and had remained low profile but his insight remained poor. It was stated that there were no plans to commence depot and that this would be best discussed *"when [VC] is stepped down from PICU and consideration is being given to what his needs will be in the community"* **[NHFT0000168, p.190]**.

343. My view was that it would be sensible for a depot to be commenced now: we had tried oral compliance in the community; VC had discontinued and had clearly not

been honest about when he had stopped this treatment. He had said he would not take oral medications whereas before he said he would /did take them. I believed he would not take medications orally willingly and felt depot was needed to ensure his treatment. However, I also did not feel VC would have willingly accepted a depot in the community. From my perspective, I considered that this meant he would have needed to be on a CTO to ensure recall to hospital in the event that he did not accept medication. I advocated for this at his Mental Health Tribunal: in my view this resulted in a further breakdown in my relationship with VC.

344. I have not worked in PICU personally so could not comment on exact procedures, but it seemed to me that it would have been appropriate to commence depot medication while VC was in PICU.

345. I am not aware of any further discussion with Mr Laverick in respect of VC: none is recorded in the notes.

346. On 17 September 2021 at 2:17pm I spoke to VC via telephone. As I have recorded in his notes, **[NHFT0000168, p.191]** VC reported that he did not have a psychotic illness and there were no issues with his mental health. He considered the admission, and previous admissions, had been unnecessary and that he thought I was involved in a *"cover up"*, claiming that he was unwell when he was not. My telephone call to VC on that day was for the purpose of discussing his imminent Mental Health Tribunal to which I was required to submit a social circumstances report. This report requires direct contact with the patient to support its completion. Following this conversation, I formed the view that VC had no insight at this time; he had fixed delusional beliefs which included me.

347. I remember this being a very unpleasant conversation. VC was accusatory towards me; he fixated on his beliefs that he was not unwell, had never been unwell and I was involved with the hospital in fabricating his illness. I believed he was very unwell at this time and required PICU support.

348. I spoke with VC about what a depot medication is, why we suggest this and the positives of having a depot injection vs oral medication e.g. to support compliance, not needing to remember to take medication every day, depot medication helping to keep people well in the community and reducing the risk of relapse. It would not have been for me as a nurse to suggest which medication in depot form, so side-effects would not have been discussed as the specific medication was not yet prescribed. However, I would have informed VC of the potential side-effects in terms of an ache around the injection site.

349. That same day, 17 September 2021, I completed VC's "Social Circumstances Report" for the mental health tribunal **[NHFT0000275]**. A social circumstances report is a statutory requirement for a Mental Health Tribunal. It provides up-to-date information to the tribunal about a patient's social circumstances and the level of support they are likely to be provided with in the community including information like a chronology of previous involvement with mental health services, details of any offences or forensic history, a summary of their progress and compliance etc.

350. I recorded in VC's social circumstances report that he had *"no prior history of violence and aggression towards others"* **[NHFT0000275, at p.5]**; however, I did also record that he had previously broken into a neighbour's flat and had

seriously assaulted police officers while being detained on a s.135 warrant **[NHFT0000275, p.9]**

351. On reflection, I should have documented this differently: VC was violent in his admission to hospital to staff and the police. However, in the community, as far as I was aware at this time, although he had acted in an aggressive / intimidating nature towards others when unwell, there were no known episodes of physical violence.

352. I also recall that I had spoken to VC's mother and that she felt a monthly injection might be beneficial given issues with concordance **[NHFT0000275, p.7]**. This was based on a telephone conversation I had with VC's mother: I informed Celeste of what depot medication is versus oral medication. Neither did I suggest which medication in depot form would be provided nor did I provide any information regarding side effects (as this was not agreed at this point). However, I informed her of the positives of depot as I had with VC: she felt this would be a good option.

353. VC initially said that he too was 'willing to explore it further' **[NHFT0000275, p.6].**

354. On 21 September 2021 at 3:45pm I attended the PICU ward round at Cygnet via a remote link **[NHFT0000168, at p.191]**. My role in this round was simply to listen to feedback on VC's progress, engagement, current care-plan and risk assessment. It was also to fill in any gaps in their knowledge on VC's history that the ward might have; his engagement with EIP in the community; the incidents leading to admission; and our view on what we felt would help post-discharge in terms of treatment planning and risk management.

355. The ward round included discussion of events prior to VC's First Admission. VC is recorded as having carried out research into psychotronic harassment which, in my view, was part of his delusional belief system. I believed he was still unwell and lacked insight into his condition and capacity to make decisions about the care he should receive. From memory I do not recall whether he had difficulty discussing the events that led to his detention; however, I documented that he did engage in conversation regarding the events prior to his 1st admission and gave his account of what he believed he was experiencing.

356. It is recorded that VC said *"he was likely to be more guarded with me going forward given that information had been shared"* **[NHFT0000168, p.191]**. At this point VC believed me to be a key part of his delusional belief system: I understood why he would have found it more difficult to speak with me openly; I had also broken his trust because I had for his Mental Health Ac assessment, something which he did not agree was necessary. I considered that he thought I had broken his trust by sharing information regarding his thoughts and beliefs at the time with the social care team in order to request a Mental Health Act assessment. Although patients are aware that confidential information will be shared with other professionals if we have any concerns regarding risks to self / others or by others, I think they can sometimes feel blindsided or let down by their care team when they are then exposed to the associated processes such as the Mental Health Act / safeguarding / or criminal proceedings. This is more challenging when a patient lacks insight and doesn't agree with their care team's assessment.

357. I also had to write and assert my views in the tribunal, via the Social Circumstances Report, that VC was not well and had no insight. I wrote that that he did need support and longer time in hospital for treatment / assessment. I felt a depot would have been necessary to keep him well, which he disagreed that medication was necessary.

358. VC was unhappy with me and the views I had expressed. The key part of our role as mental health professionals, and particular as care coordinators, is to establish a trusting therapeutic relationship in which the patient feels they can trust and open up. This relationship between VC and me had been broken and was one of the reasons why we later changed CCO.

359. I attended VC's section 2 Tribunal remotely on 23 September 2021 at 1:30pm **[NHFT0000168, at p.191]**. I was there to provide comment on my social circumstances report and to answer any questions which the Tribunal had, based on my experience of working with VC and my recommendations for his future care.

360. At 6.30pm that evening, I spoke to VC's mother. **[NHFT0000168, at pp.191-192]** She did not object to the mental health assessment planned for the following day. She did, however, express concern at the lack of contact from Cygnet and observed that she felt she did not have a full understanding of VC's current difficulties. I have recorded that I passed her concerns on to the social worker, Alison Jacques. I cannot, however, remember speaking with Cygnet: I cannot from memory say why I did not speak to Cygnet. I do not recall having any further contact with Cygnet after this point. VC was stepped down to a private acute ward in Nottingham five days later.

361. On 1 October 2021, VC moved from Cygnet Hospital to the Priory Calverton where he was detained under s.3 Mental Health Act 1983 on Bestwood Ward. On 14 October 2021 at 3:36pm **[NHFT0000168, at pp.192-193]** I attended a ward round at the Priory via an Microsoft Teams Link:

362. As I recorded in VC's notes for that day, the Priory did not feel VC needed to stay on a Section 3 and were actively planning his discharge. I remember feeling this was premature; I felt depot treatment would have been helpful in providing treatment / care. I feared that we would have the same difficulties as we had experienced previously if VC was discharged in these circumstances.

363. As I observed in my subsequent NHFT interview, I believed the Third Admission was the only real opportunity to arrange a CTO [**NHFT0004707**, at p.1]. This was VC's first time on section 3, therefore it was the first opportunity that a depot injection could have been prescribed under a CTO. I felt that if a depot commenced, we would have required a CTO to enforce treatment. I cannot see this clearly documented but I had raised this during the ward review. I do not believe depot was discussed directly during this ward round as the clinicians at Priory were indicating that in their view, VC was well and stabilised on his treatment, planning discharge. I did feel depot would have been helpful for VC; however, I do remember him saying he would think about it but was not keen. The ward did not pursue this and went with oral treatment. There is only so much I can advise and advocate, ultimately, the ward holds the care and treatment plan.

364. I have been directed to my NHFT interview conducted in January 2024 in which I stated that by VC's Third Admission the EIP team had "firmed up our views" on depot but that by this time VC was adamantly against it **[NHFT0004707, at p.1].** Similarly, in my Theemis interview **[TCLT0000748, at pp.27-28]** I remarked that: *"…by the third admission when he went in and then he went on a three I remember thinking, "Oh this might be the opportunity now to talk about a depot in more detail now he's on a three." But unfortunately that didn't happen and he went to a private hospital somewhere. And I think I remember asking them and they said they weren't considering it … […] he was technically on his third admission so it felt that that time was probably a good time to think about it…".* I conveyed these views on Depot injections in my MHT Social Circumstances report, in the Ward Round; I also discussed them with VC and his mother, both of which were entered on VC's Rio records.

365. In the week of 21 October 2021 I was on leave. It is recorded in VC's notes that I was contacted by the Priory and informed that the plan was for VC to be discharged the following day **[PAGR0000028, at p.4]**. The discharge summary **[PAGR0000029, at p.3]** also states that I (CPN) was informed that VC had been discharged to his new flat with a 14-day supply of Aripiprazole.

366. This was an error. As the Rio notes reflect, I was away on leave that week (see entry **[NHFT0000168, p.193** *"informed the MDT that I am due to go on leave next week, I will see whether a colleague can attend the next ward round in my absence").* As my colleague Abi Parsonage CPN recorded in an entry dated 22 October 2021 **[NHFT0000168, p.195]**, she rang the Priory that day and was

informed: *"[VC] discharged this morning, mum rang, and was annoyed she had not been informed. Neither had we…. Claudia (CCO) is back Monday….".*

367. I was not at work when VC was discharged, as a result I did not write in VC's notes or share the information regarding his discharge with the rest of the EIP Team at that time. My colleagues did, however, follow the matter up in my absence.

Post Third Admission 22 October 2021 – 28 January 2022

368. When I returned from my period of annual leave I reviewed VC's notes, including Abi Parsonage's entry of 22 October 2021 at 4:00pm **[NHFT0000168, at p.193-194]** noting the fact of VC's discharge. Given my absence on leave, the timing of VC's discharge, and the fact that the EIP had not been informed of it, I was not involved in the discharge meeting. It was discussed at the ward round I attended on 14 October 2021 that the Priory were "actively planning discharge" but no date was set. I asked colleagues to attend VC's next ward round in my absence but I was not aware this would be a discharge meeting. As a result, VC was discharged from the Priory without EIP involvement and we only found out by chance because his mother contacted the EIP.

369. I planned to see VC weekly and to speak to him by telephone weekly. I was in frequent contact with VC's mother in any event and proposed to maintain this whenever she or I had updates or she was in need of support. I planned to monitor VC's medication concordance through dialogue with an increased frequency of contact to that which followed the First and Second Admissions

because of my concerns regarding his engagement – but this was not set out in a care plan at the time of VC's discharge because the EIP was unaware that it was taking place. It was not updated subsequently due to my workload: I recognise that it should have been.

370. I called VC on 25 October 2021 at 12:13pm **[NHFT0000168, at pp.194-195]** to carry out a three-day follow up. This was my first opportunity for contact following my period of leave. I noted in VC's records that he was *"largely monosyllabic",* declined a face-to-face appointment, and would not commit to a time to meet. He reported his mental health was *"perfect"* and *"back to normal".* He was not sure how many tablets he was discharged with. My view was that his presentation was the same as his baseline prehospital admission. He was calmer and less aggressive; however, he was not engaging well, to the extent that he was engaging at all, it was superficial: I was concerned he could disengage again. I also thought he lacked insight: he said everything was 'perfect' and 'back to normal': this did not seem entirely accurate. I was also concerned about his compliance with medication. The fact that he was not sure how many tablets he had been discharged with suggested an ambivalence on his part: I was concerned he may become non-concordant again. He would not commit to anything or be honest with me.

371. As VC's Rio notes record, I tried and failed to contact him on 29 October 2021 and left a message to arrange a face-to-face visit **[NHFT0000168, p.195].** VC failed to attend a subsequent appointment at the Stonebridge Centre on 1 November 2021. I then made contact with VC's mother who reported that she had been in contact with VC briefly over the weekend: she reported that he

seemed ok and was focusing on university work and happy to have found new accommodation **[NHFT0000168, at p.195]**. She also reported that VC had confirmed he was taking his medication, and that she would encourage him contact me. Nonetheless, I was concerned by VC's level of engagement at this stage. He was not showing signs of wanting to engage with the EIP service; he did not see us as a priority, which fed into what he had raised previously that he was not unwell and didn't see the need to engage with us.

372. I attempted to call VC again on 4 November 2021 at 2:59pm and 3:03pm **[NHFT0000168, at p.197]**. He did not answer. He did, however, send me a text message saying that he had *"…'plenty of tablets left'"*. I noted in his records that he believed he had two weeks' worth left. I noted that if he was taking his medication correctly, he should run out on the coming Friday. Again, I was worried that there were potential indications of non-compliance or a failure to take his medication correctly. This in turn led to a risk of relapse and further risk to others/from others. I booked a further review by way of outpatient appointment and attempt to actively engage VC in appointments. I continued to discuss his case in MDT and kept in contact with his mother.

373. I saw VC in person for the first time following discharge on 5 November 2021 at 2:05pm **[NHFT0000168, at p.198]**. We met at the Stonebridge Centre, I recorded in his notes that VC appeared well presented and relaxed although he was fairly abrupt, did not appear keen to engage in conversation, his responses were *"largely monosyllabic".* The impression I got from this meeting was that our relationship was breaking down – or had already broken down. I did not feel that VC fully trusted me any longer. He answered my questions in monosyllables and

I sensed he did not want to be there and did not like me or want to speak with me. His engagement was superficial but also had a new sense of abruptness.

374. As I recorded in his notes, VC reported to me that everything was ok and he was not experiencing hallucinations; he also disagreed with medical professionals that he had been unwell. He felt the admission to hospital was *"awful and unnecessary*" and he was taking his medication *"because he [had] to"* rather than out of necessity **[NHFT0000168, at p.198]**.

375. This was a 1:1 meeting between VC and me and he was abrupt in his responses throughout. I tried to ask questions to gain insight into his current mental state and thoughts. I did not actively challenge him, however: firstly, because I was alone and had to keep myself safe, but also because I was trying to salvage a relationship with him in the hope of encouraging engagement. If I had disagreed with him this could have led to further deterioration in the therapeutic relationship. VC knew my views - that I felt he had been unwell and hospital was necessary because I called for the MHA assessment and reported this in his ward rounds / tribunal report. I believed VC did not have insight into his condition.

376. VC reported that he was now taking his medication and that he *"realised he has been taking just one tablet (10mg) rather than the two tablets he is prescribed."* I noted that this error appeared to be an oversight. He was taking medication which appeared to demonstrate some willingness to take treatment but I recognised the importance of continually reviewing his concordance by asking him and observing his presentation / behaviours and ascertaining his mental state / thoughts. I reiterated the importance of medication concordance, because it was apparent he did need treatment to stay well: this was his third admission

and he did become unwell when non-compliant. VC clearly did not want to go back to hospital and I advised taking medication as prescribed would help to keep well and reduce the risk of relapse.

377. VC did appear to listen to me, but he was passive in response: although he did not argue with me or become angry, he also did not appear very interested or concerned. I did, nonetheless, record that there was *"some improvement in mental state"* **[NHFT0000168, p.198]**. This reflected the fact that he was no longer accusing me of being part of the conspiracy against him, and that his outward presentation was calmer, more relaxed and not agitated. He remained abrupt but he was no longer presenting with florid symptoms of psychosis.

378. I next contacted VC on 12 November 2021 at 11:23am and 2:00pm **[NHFT0000168, at p.198]** about collecting his medication. He did not attend to collect on this day.

379. VC subsequently failed to attend an appointment on 15 November 2021 at 8:59am **[NHFT0000168, at p.198].** I did not document and do not now recall what actions were taken as a result. It may have been that I attempted to call in between other appointments however didn't get a response however I can't recall whether this happened on this occasion. Due to the nature of community work, much of our day is conducted away from base and access to patient notes, it is possible that I forgot to document an attempted follow up call on the Rio records. I was however, aware of the NDA guidance **[NHFT0004725]** and/or **[NHFT0000417]**. My usual practice following a failure to attend would be to call the patient / loved ones, follow up, re-arrange, ascertain the reason behind the DNA.

380. VC next attended the Stonebridge Centre on 19 November 2021 at 1:26pm **[NHFT0000168, at p.199]**. As I recorded in his notes, VC remained very guarded and would not engage in conversation: he was monosyllabic, hostile, and unfriendly. I did not observe any overt psychotic symptoms and VC denied any auditory hallucinations. His leg appeared restless however and I noted my impression that he was reluctant to engage with mental health services and was doing *"the minimum required".* At this point I considered it unlikely he would ever open up about his experiences given *"this has led to an admission previously"* **[NHFT0000168, at p.199]**. What I meant by this was that VC had opened up about his delusional belief system which he believed to be true and we did not: this had led to a Mental Health Act assessment and admission to hospital. Given he still believed his delusions were "*true*" rather than a manifestation of his illness, that fact that I had called for the assessment which led to his hospitalisation broke any trust he may have had for me.

381. VC's reluctance to open up made it very hard to provide support. He was no longer open with services; he was suspicious and did not trust us. It is very difficult to work with people who refuse to speak or open up or only engage minimally. Therapeutic work requires engagement.

382. At this point VC still believed that we were conspiring against him. He did not trust us and I did not feel he had full insight into his condition. He was abrupt with me and annoyed, which I considered to be as a result of his anger arising out of his previous admission. In terms of prognosis, I reached the view that this was likely to be a longer term illness.

383. His level of risk at this point was very difficult to assess. He did not share information with us. I tried my best to elicit information from him and assessed what I could see, but if someone does not want to speak and will not open up, it is hard to engage with them beyond observing for the signs of relapse, which would indicate hospitalisation needed for treatment.

384. VC advised that he was taking 10mg doses of Aripiprazole rather than the 20mg prescribed. He said he would take the higher dose **[NHFT0000168, p.199].** We reviewed his medication prescription, the tablets, and the dose required him to take this. I did have concerns he may stop his treatment again as this had happened previously. This was an ongoing risk for him: as an EIP our way of combatting this risk was providing monitoring and observation of his concordance and encouraging him to take his medication.

385. At the conclusion of this entry it is recorded *'PA for review of mental health'* **[NHFT0000168, p.199]**. This is a typographical error: it should read *"OPA for a review of mental health*", meaning an outpatient medical appointment with consultant. This was necessary because VC had failed to attend several appointments. It was a routine review, rather than a response to a particular concern arising out of this appointment. The entry on the records was a reminder to myself as a plan.

386. I spoke to VC again on 16 December 2021 via text message and he called me in response to a text message **[NHFT0000168, p.201]**, but this was the last occasion on which I saw VC in person prior to his Fourth Admission. We attempted to visit him at home and to arrange meetings with him but he consistently failed to attend.

387. On 29 November 2021 at 2:00pm **[NHFT0000168, at p.199]**: I spoke to VC's mother. I reiterated the importance of VC attending outpatient appointments She advised me that VC had said he was going to contact me to rearrange an appointment due to a study deadline but there had been no contact. VC's next appointment was for an outpatient appointment at home on 6 December 2021. Unfortunately, he was not home when Dr Lloyd and I arrived for this meeting **[NHFT0000168, p.199]**.

388. Following the failed home visit of 6 December 2021, we discussed VC at the MDT meeting of 9 December and agreed to continue to attempt contact. I remained in contact with VC's mother who confirmed that she would try and reach VC to find out *"what's going on"* **[NHFT0000168, p.200]**.

389. I next spoke to VC by telephone on 16 December 2021 at 5:00pm **[NHFT0000168, at pp.200-201]**. As I recorded in his notes, VC was very confrontational and angry throughout this conversation. He questioned why I had tried to make contact through his mother and said that *"under no circumstances could I have any contact with his mum as it was 'stressing her out' and was totally unnecessary".* He told me he was *"cutting of this contact completely"* and said I was never to speak to her again, albeit that he agreed to me contacting her to explain his decision rather than just ceasing contact out of the blue.

390. This was obviously an indication that VC had withdrawn his consent for any contact with his mother. I was aware of the relevant NHFT, NICE, and MHA Code of Practice guidance on this issue. This provides that we can continue to have contact with carers to offer support, and listen to information but there are

limitations on what we can share with them about the patient due to patient confidentiality. These limits depend on risk and mental capacity however: if a breach of confidentiality is necessary because of risk, a patient's wishes can be overruled; similarly, if a patient lacks mental capacity to make decisions regarding with whom information can be shared, it can be shared with others in the patient's best interests. I am aware of the confidentiality policies within the trust and Information Governance training is completed regularly. I discussed VC's case with my manager and supervisor, and with Emma Robinson in supervision and with the MDT. I was not advised to overrule VC's decision on this occasion.

391. I did not have an opportunity to conduct a formal assessment of VC's mental capacity at this time because contact was poor. His reasons for ending contact were due to his mother being stressed: he did not voice any delusional beliefs by asking contact to end, there was no evidence of paranoia or suspiciousness of his mum. He was simply annoyed that I was speaking to his mother to try and engage with him. This was frustrating but it was rational.

392. In terms of the decision to prevent contact between me and his mother, I had no evidence to rebut the presumption of mental capacity that I know the Mental Capacity Act 2005 establishes. If, for example, VC had voiced delusional beliefs which drove him to tell me to end contact with his mother, my response would have been different.

393. I note that I did seek VC's permission to inform his mother of his change of heart regarding contact between us. And while I have not recorded it, my recollection

is that I did text VC's mother to update her about this decision. Regrettably, I no longer have these texts. I do not believe I received a response to this message.

394. VC said in his discussion with me that he had not missed appointments because he did not want to see mental health professionals **[NHFT0000168, p.201]**: the implication was that he was simply too busy. He confirmed that he would attend an OPA in January 2022. I arranged an OPA for VC on 10 January 2022, however, I still planned to attempt contact in the interim.

395. VC was angry with me regarding my contact with his mother. I needed to ask when he planned to collect his treatment but given he did not wish to engage in further conversation with me at this point, I did not explore the issue further.

396. It was difficult to fully assess VC's insight and risk at this juncture. He was angry that his mother was stressed and did not want her to be. he was also more abrupt than usual with me. I do not recall that he was floridly unwell at this time, and I did not note any evidence of delusional beliefs or voicing psychotic symptoms, but he was more abrupt than usual. He was always very protective of his mother and wanted the best for her.

397. On 17 December 2021 at 11:59am **[NHFT0000168, at pp.201-202]** VC attended EIP to collect his medication. It is recorded that he was 'very curt' with the receptionist and asked who had come to his house "the other day". He asked to see me but I was out on a visit.

398. CPN Abi Pinder updated me about this attendance when I returned from my appointments. I read the entries and noted the comments regarding VC. I was on annual leave the following week and returned to work on New Year's Eve,

2021. I attempted to call VC but he did not answer. I anticipated that he was still annoyed with me due for contacting his mum, so I was not overly surprised by his frustration. I also noted that VC had come out of his way to collect his medication in person: if he did not want to take his treatment he would not have come out of his way to collect it independently.

399. I again attempted contact with VC on 31 December 2021 at 9:51am **[NHFT0000168, at p.202]**. I recorded that we had discussed him in an MDT meeting the previous day and the plan was to try a further home visit the following week. We did not minute MDT meetings at that time so I cannot now recall who was present and what exactly was discussed. I can say, however, that our general practice was to discuss new patients, provide feedback on new assessments, and raise patients on our respective caseloads for discussion. VC's lack of engagement would have been raised; I would have informed the MDT of my actions so far and asked for advice and input on next steps. I do not recall particular details of the discussion we had, but from the Rio notes recorded around this time, I anticipate it would have been regarding VC's lack of engagement and his abrupt / curt nature. I cannot now recall whether anything was planned beyond the home visit that was scheduled for the following week.

400. I attempted to call VC on 6 January 2022 at 10:40am and 3:30pm and 7 January 2022 at 9:41am **[NHFT0000168, at p.202]**. I also attempted to visit him at home with my colleague, CPN Abi Parsonage: there was no answer at the address we had on file. As I recorded in VC's Rio notes, I was concerned that he had disengaged from support. Poor engagement meant it was challenging to assess VC's mental state, his current risk, or medication compliance. This in turn could

lead to a risk of relapse which could increase risk to selfor to others. The 7th January was a Friday and the EIP team does not work on the weekends. VC's apparent level of disengagement did not warrant a referral for CRHT to follow up at this point.

401. On Monday 10 January 2022 VC had a further OPA booked. I prompted him to attend via text as recorded in his Rio entries: see the entry of 7 January 2022 at 9:41am **[NHFT0000168, at p.202]**. I texted VC stating *'I've been trying to get in contact to see how you're getting on. Are you still okay to come to your appointment with Dr Lloyd on Monday at 12'.* I do not believe I received a response to that text.

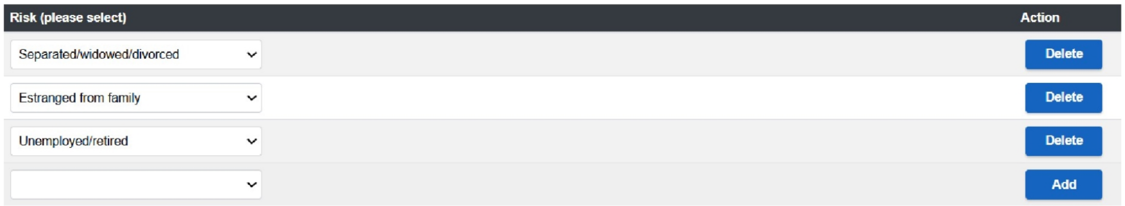
402. I sent a further text message to VC on 10 January 2022 at 9:35am **[NHFT0000168, at p.202]** asking if he could make his appointment and noting that his medication was due that week. He replied on 11 January 2022 **[NHFT0000168, p.203]**, *"Got exams".* It was a possibility that VC genuinely could not attend at this time or did not have time. It was exam season; we work with a lot of students and this can be a normal response / pattern of behaviour around exam periods: VC valued his studies and wanted to do well. It could also, of course, have been an excuse for VC not to engage.

403. I tried to call VC a further time on 17 January 2022 at 4:31pm **[NHFT0000168, at p.203]**. He did not answer, nor did he respond to my subsequent text message. Dr Lloyd earlier that day noted that VC had missed an appointment for the fifth time and that consideration would need to be given to discharging VC because *"...[VC] has essentially disengaged and we have not been able to monitor him. Perhaps a conversation with his mum and course tutors to see if*

there are any concerns currently before considering discharge". As I recorded, the plan was to discuss the matter at MDT *"on Thursday"* (20 January 2022).

404. On 18 January 2022 CPN Adele Pinder was informed by Ellie Turner at the University that VC had held his housemate hostage **[NHFT0000168, p.203]**. I updated VC's Risk and Safety Assessment in response **[NHFT0000192]**. I identified a risk to others, of damage to property, and of past violence towards people/property. I also noted that VC had disengaged and was suspected to be non-concordant. I have reflected on why no actions are identified in respect of the risk to others on the form. I did add in options from the drop down list in terms of risks I was aware of. However, you cannot add actions into the drop down list as it views. Below I have provided an example of a current risk assessment which can be edited: the only option is to select the risk and then click under action to add or delete.

405. The action agreed is documented in the formulation section of the risk assessment document. The action, due to a change in presentation and risk, was that a Mental Health Act assessment was required. VC was not engaging and there were concerns regarding the potential risks he posed towards others. It was documented that a warrant and police assistance would be required to support the assessment. Actions are not documented risk assessments: they do not have an active "action" section; rather, actions are identified in the care plan or running records.



Risk (please select)	Action
Separated/widowed/divorced	Delete
Estranged from family	Delete
Unemployed/retired	Delete
	Add

406. I reviewed the note of 18 January 2022 at 9.30 **[NHFT0000168, at p.203]** describing a telephone conversation between Ellie Turner and my colleague Adele Pinder. From my reading of the entry, there was no clear reason documented as to why VC assaulted his housemates. The entry includes the personal account of the housemate, who reported that VC had *"intent to hurt me"* but was prevented from doing so, as a result of which police neither arrested nor removed VC from the property.

407. I have considered the following entries:

    i. The note of 18 January 2022 at 11:16am **[NHFT0000168, at p.204]** by Miss Victoria Green that VC had been disengaging and was no longer concordant with his medication.
    ii. The note of 19 January 2022 at 3:40pm of an MHA assessment **[NHFT0000168, at p.205]** when it was decided not to detain VC but it was observed that the overall picture was of poor engagement with the team, "being guarded".

408. My view, having considered these entries, is that the recent altercation suggested he was relapsing. CRHT intervention was appropriate but in the absence of medication concordance, engagement, or further risks becoming apparent, hospital admission would be the next step. VC did have some stresses which may have been exacerbating things – university exams – but ultimately, he was unwilling to countenance the suggestion of looking at an alternative

antipsychotic medication. He denied symptoms of psychosis and his insight was relatively low.

409. On 20 January 2022 at 2:00pm **[NHFT0000168, at p.206]** we received a telephone call from Ellie Turner (University of Nottingham) informing us that VC was due to be "kicked-out" of student accommodation due to the risk he posed to others. Ellie reported that in her view VC was unwell and was not meaningfully engaging with the support service.

410. I shared this view. A review of VC's Rio at this time indicated that he was not engaging well with EIP. We had not seen him despite many attempts and were therefore unable fully to assess his mental state. We maintained, nonetheless, that he required treatment to manage his symptoms. The motivation behind his "hostage" incident was unclear and the MHA assessment entry was not detailed.

411. I have been asked whether or not there was an MDT meeting on 20 January 2022. I do not recall whether or not I attended this meeting and there is no record from which I can refresh my memory. I do recall, however, that my view on discharging at this point was that, notwithstanding the difficulties with engagement, discharge was *not* an appropriate option.

412. I kept up to date with VC's records throughout my time as his CCO and I reviewed the following documents at the time they were made.

    i. The note of 21 January 2022 at 11:00am **[NHFT0000168, at pp.206-207]** in which it was recorded that VC met a CPN for medication concordance and appeared to take medication from his mouth and put in the bin as he walked away.

ii. The note of 21 January 2022 at 4:22pm **[NHFT0000168, at p.207]** in which Ellie Turner (University of Nottingham) raised with my colleague Nathalie McPherson that a mental health admission should be considered if there was another failure at medication concordance.

iii. The note of 22 January 2022 at 3:45pm **[NHFT0000168, at pp.207-208]** in which VC recorded as having dry and cracked lips but declined to drink any water when taking his table.

iv. The note of 23 January 2022 at 11:22am **[NHFT0000168, at pp.208-209]** when VC was again noted to present with cracked lips, was observed to be monosyllabic and guarded, and shrugged when asked about his views on requirements for medication.

413. I read all of these entries around the time they were made – I do not recall being verbally updated regarding their contents. Together they confirmed my view that VC had poor insight into his condition and did not want to engage with our service. I considered they demonstrated evidence of secreting medication during medication compliance visits with the Crisis Team; his cracked lips could be construed as evidence of self-neglect which could in turn have indicated negative symptoms of psychosis. VC was guarded and clearly did not want to open up to people. However, each Crisis Team appointment was held with different staff members making a broad assessment difficult to carry out. VC continued to see

CRHT on appointments: he did not disengage entirely, but his engagement was poor or, in my view, superficial.

414. On 24 January 2022 at 11:39am **[NHFT0000168, at p.210]** I spoke to Ellie Turner (University of Nottingham). She was concerned that VC was not fully engaging with community or student support, was struggling with his studies, was at risk of losing his accommodation, and was failing to engage with student support. VC was already in the red RAG rating at this time: we agreed that if his engagement continued to be as poor, we would refer him for a Mental Health Act assessment. This in fact took place a few days later on 28 January 2022 **[NHFT0000168, at p.213]**, following VC's repeated failure to attend appointments.

VC's Fourth Admission at Redwood in Highbury Hospital, NHFT (under s.135 and then s.2 of MHA 1983) ("Fourth Admission"): Relevant dates: 28 January 2022 – 24 February 2022

415. On 28 January 2022 Akerele Ayodeji completed a Core Assessment **[NHFT0000186]**. This was part of VC's initial ward assessment clerking in, and took place late in the day after the EIP had finished work. this took place late in the day when we do not work. I read this assessment at the time – although I cannot now be certain of the exact date - as part of my general practice of keeping up with the records of patients on my case load.

416. On 3 February 2022 at 10:05am I attended a ward review **[NHFT0000168, at pp.224-226]**. As per the Rio entry, I shared that his mother reported that he remained independent and had not seen his family since the Covid epidemic –

Dr Gibson had also spoken to her and she had reported that, in contrast to previous admissions, she had not detected any signs that VC was unwell prior to this admission. I shared that I had been VC's CCO since summer 2020 but that our relationship had deteriorated over recent years as VC felt persecuted by mental health services. I also fed back that I had spoken to Ellie Turner at the university and she had reported that VC had been submitting work late and arriving late for supervisions. I stated that we were unsure about VC's medication concordance and considered he would be better off with a depot injection. Finally, I noted that VC had been evicted from his accommodation but observed that he tended to move quite frequently and was likely to be able to manage the practicalities of a move by himself.

417. My view remained, as per the previous admission, that VC would be better treated and managed on a depot medication. I considered that he was in a cyclical pattern and the current care-plan / risk management plan was not working. I raised the prospect of depot with those on the ward round: they discussed it with VC who said it was "*easy*" to take his medication and that it *"[made] no difference to him"*. He did not agree to a depot injection however, on the basis that he did not like needles **[NHFT0000186, p.226]**.

418. On 10 February 2022 at 10:15am I attended VC's ward round review. As is recorded, I commented **[NHFT0000168, at pp.237-240]:** that I *'[wished] that he had the depot during his last admission due to risk of non- compliance with medication'*. I expressed this view because I felt depot was needed to keep VC well. I knew that as he was not keen on depot, however, we would be likely to need a CTO to monitor and/or enforce one.

419. In my view, his existing care and treatment plan was not working. As is recorded, I *"emphasised that there were multiple times in the past that he didn't attend appointments with his consultant and expressed her opinions that a depot would be beneficial in the long term"* **[NHFT0000168, p.239]**. I felt that VC was suitable for a depot treatment as this would give us a better chance of treating him and would provide him with an opportunity to gain insight into his condition, to attain capacity over his treatment decisions, and allow him to improve engagement. In my view, however, depot would only be effective if supplemented by a CTO because I considered VC would be likely to decline injections once discharged into the community. A CTO would give us the tool to recall him to administer depot injections against his will if necessary.

420. VC's treatment plan was not changed at this time, however: the rest of the team agreed to see if he relapsed again and then consider depot **[NHFT0000168, p.240]**. I cannot recall from memory what the views of each of those present at the meeting were. From consideration of the records, I believe the proposal of a depot injection was rejected as an immediate step because VC did not want one, further he stated that he **would** be compliant with treatment. In my view, however, he had said this previously and consistently failed in his concordance: I felt depot was needed at this time.

421. Similarly, with regard to the CTO, my view was that it would be helpful to have the MHA backing to recall VC to hospital if he did not engage nor accept depot. He had told us he did not want a depot, so we could infer from that that he would be unlikely to have accepted one in the community: enforcement would require a CTO. I felt the CTO would have been a positive addition to VC's treatment, and

risk management plan. We had already tried the least restrictive approaches, and they were no longer working for VC. In my view he was a risk to others when unwell; he became unwell without treatment; he needed treatment to remain well. A CTO would have provided us with the necessary tools to support his compliance and engagement.

422. Unfortunately, the decision reached was that a depot would only be considered if VC 'relapsed again'. A CTO could not be commenced unless VC's detention under the Mental Health Act 1983 was extended from 28 day detention for assessment under s.2, to a detention for treatment under s.3 of the MHA 1983: the ward did not feel he met the criteria for detention under s3 MHA 1983.

423. I observed in my subsequent Theemis interview that, in my view, VC's fourth admission *"was very different to the previous admission, I think that would have been probably the best opportunity to argue the case for maybe a CTO and a depot but he didn't want to depot…"* **[TCLT0000748, at pp.29-30]**.

424. I made my views regarding the desirability of a depot and CTO clear but they were not shared by the rest of the ward staff.

425. The records reflect the fact that while we suspected poor/non-compliance with medication, VC denied this **[NHFT0000168, p.239]**. We did not have concrete evidence he was non-concordant with treatment: even the two episodes in which CHRT observed him appear to secrete his medication were not definitive. VC said no to starting a depot and said he did not like needles; he also said he was willing to take his tablets which removed some of the justification for enforced depot injections **[NHFT0000168, P.226].**

426. There was a discharge meeting on 24 February 2022. I attended remotely by Microsoft Teams **[NHFT0000168, at pp.259-260]**. It was noted that no psychotic symptoms had been observed and that VC was compliant with medication. VC reported that he had no issues with medication. The plan was for him to be discharged with 14 days of medication, and for me to do a follow up the following morning, and to manage his medication. My role was to discuss plans for discharge and consider what we could put in place with EIP. I messaged VC at this time but I do not recall receiving a response.

427. The ward did not feel further detention under s.3 MHA 1983 was warranted. They denied current concerns regarding VC's mental state and risk. I had raised my view regarding both depot and CTO. VC was able to reflect on some of his delusional beliefs therefore showing some signs of improvement / insight. In light of this, despite my concerns regarding both his engagement and likely concordance with medication in the community, I could not argue that VC met the statutory criteria for detention for treatment under s.3 MHA 1983.

428. I remained of the view that there would be ongoing difficulties managing VC in the community in the absence of either a depot or a CTO, but there was nothing further I could adapt in his care-plan / risk management plan without these additional tools. There were, as a result, limitations to what more the EIP could do to prevent further relapse. There was no set plan in place for how I could monitor concordance beyond how it had been monitored previously: through engagement, support, and questioning. I have previously documented the difficulties in this model of concordance monitoring in VC's case.

Post Fourth Admission 24 January 2022 onwards: upon discharge

429. Consideration was given to how the risks of failure to take medication, lack of engagement and relapse when not taking medication identified could be managed after VC's discharge. The plan was to see VC more frequently for appointments, albeit that he was not happy about this. I also planned to discuss and review his medications with VC and to book community outpatient appointments for review. It is relevant of course that VC was adamant that he did not, in fact, miss medication.

430. In his updated risk assessment completed after discharge, dated 28 February 2022 **[NHFT0000190]**, I highlighted the risks I was aware of regarding violence/escalation of violence to others and the risk of reoffending in the risks towards others section. I noted the specific risk of damage to property, past violence towards people/property and concerning signs of anger/frustration **[NHFT0000190, p.3]**. I have been asked to comment why no action continues to be identified in respect of the risks. As per my previous response and the screenshotted risk assessment I have provided, the system did not at this time permit the inputting of an 'action' in the risk assessment document. Actions were documented in the care plan and running records.

431. Following discharge, I planned to see VC face to face for a three day follow-up and we discussed increasing frequency of contact to weekly. At this time VC had withdrawn consent for me to speak with family, but communication lines remained open and I welcomed contact from them for updates / concerns.

432. In terms of medication concordance, the plan was to discuss this in appointments, to ask VC about his concordance, and for the EIP to continue to issue medications to ensure he received these. In the event we had further concerns regarding VC's mental state, the plan was to reconsider CRHT /further admission.

433. I was clear with VC that I wanted and expected to see him more frequently than before. He remained opposed to this, however, I wanted to see him weekly

434. At the time of his discharge, I did not update the care-plan on the core documents form. This should have been updated, I cannot be certain of the reason for this not being completed but would assume it was due to limits on my time and capacity. These documents were not audited at this time, and I was not notified of the need to provide an update this following discharge. There is now an oversight of this. In any event, I continued to see VC and discussed with him in appointments about his care and plan.

435. I met with VC on the day following his discharge, 25 February 2022, at 10:20am **[NHFT0000168, at pp.261 – 262]**. As I recorded in his Rio notes, minimal rapport was established. VC avoiding usual greetings like hello and goodbye: he was abrupt and largely monosyllabic, appearing guarded and reluctant to engage. As I recorded in my notes, however, this appeared to be because of a reluctance to engage with the service, rather than as a result of any psychosis. VC again denied missing any medication prior to admission (it had been due on 14 January 2022 but he had made not attempts to collect).

436. My assessment of VC at this meeting was that he was at high risk of disengagement. He demonstrated poor, superficial engagement and clearly did not wish to talk or engage in support. Our relationship had effectively broken down because he was very angry at me regarding his admission. He denied ever having experiences or missing medication, which exacerbated my concerns regarding his lack of insight.

437. This is not an uncommon presentation for patients, however. Many fear talking about or admitting to past failures to take medication as it has perceived consequences for hospital admission.

438. On 1 March 2022 at 10:55am **[NHFT0017913]** I received an email from Ellie Turner (University of Nottingham). She noted that VC had declined input from the University team but had agreed that the university team could "*sit in the background*" – ie not engage proactively – as long as he remained in communication with the EIP and I remained in communication with her. I replied to her email on 1st March 2022 with the following;

Hi Ellie

Yes he was discharged Thursday and came to see me Friday morning. I would say engagement with me remains on a very superficial level but I think he appreciates he needs to engage to try and avoid any further admissions.

His new address is [REMOVED], I believe it is a house share but as is usual VC hasn't shared any information about this.

Happy with that plan, as long as he remains concordant I shouldn't expect we will have too many concerns but we will just have to see how things go over the next few months…

KR

Claudia Birtles

439. On 11 March 2022 at 10:30am **[NHFT0000168, at p.263]** VC attended the Stonebridge Centre to collect seven days' worth of medication. As I noted in his records, he advised that he did not have time for an appointment at this time and expressed his unhappiness at having to collect his medication weekly. His unhappiness with the plan aside, I did not notice any obvious signs of self-neglect or psychotic symptoms.

440. I had changed VC's medication schedule to every 7 days as a means of compelling him to see me more frequently. He was not happy about this and I recognised there was a risk he would disengage with me as a result.

441. On 14 March 2022 at 12:30pm [NHFT0000168, at pp.263-264] VC attended the Stonebridge Centre and was supplied with 14 days' worth of medication. This change in frequency was affected following his OPA review with Dr Lloyd. He was unhappy with the plan of more frequent visits and did not wish to see us weekly: he had stressed that he had a dissertation due in April as part of his masters degree and that he wanted his contact with EIP to be as *"low key as possible*" **[NHFT0000168, p.263]**.

442. Engagement is difficult to manage and balance and cannot be forced. We had no additional tools such as a CTO, so we had no option other than to work with the patient. While it was not ideal, we did not want to push VC too far and risk full disengagement from our service: fortnightly engagement through medication collection was better than no engagement at all.

443. On 1 April 2022 at 10:23am **[NHFT0000168, at p.264]** a 14 day supply of medication was supplied to VC. Due to a Covid-19 outbreak, VC could not enter

the building. I did not observe VC or have any interaction with him and have nothing to add to this record.

444. VC's next collection of medication was scheduled for 15 April 2022. This was Good Friday so I contacted VC and asked him to attend the previous day as we would be shut on 15 April. He did not respond to me **[NHFT0000168, p.264]** however I noted that he subsequently spoke to my colleague Gary Carter and agreed to attend on 14 April 2022.

445. From review of VC's medication card document (**GRO-D**) **[NHFT0000410**] it appears that VC was provided medication by CPN Gary Carter on the 14 April 2022, which would have indicated VC did receive medication when due. However, the note from CPN Gary Carter is not written until the 20 April 2022. I cannot be certain if Gary wrote this in retrospect, however, we would not sign the medication card unless medication had actually been provided on that date. I next provided medication on the 29 April 2022 from the medication card

446. I spoke with VC on 19 April 2022 **[NHFT0000168, p.265]**. He advised that he *"was trying to get some information",* but he did not come in and collect his medication until 20 April 2022, by which time it would have been five days late. In our conversation of 19 April 2022, VC requested an in-person discussion with me about his treatment '*having done some research*'. I escalated this issue to my Team Leader Emma Robinson: we agreed that *'given the historical risks of violence and aggression and hostage taking, home visits were not appropriate unless absolutely necessary and it would be better to continue with plan to offer appointments at the Stonebridge Centre'* **[NHFT0000168, p.265]***.* I offered VC an appointment at the Stonebridge Centre on Thursday or Friday of that week.

He suggested he might have some availability the week following and would check and come back to me. VC subsequently attended the Stonebridge Centre the following day, met with CPN Gary Carter, and collected his medication from him.

447. VC continued to see EIP and come to Stonebridge centre at this time for appointments, where we would review and discuss risk. At this time, there was no known risks to the general population – risks to others were directed towards those we knew such as housemates and the police, however, we did feel there was more of a risk towards health professionals / police / government at this time due to us being intertwined in his delusional belief system and his anger at us due to his admissions. VC never to my knowledge voiced a risk towards the general population.

448. On 26 April 2022 at 2:00pm **[NHFT0000168, at pp.265-266]** I received an email from Ellie Turner (University of Nottingham) reporting that, on 21 April 2022, VC had followed someone into student accommodation and entered his old flat without knocking. He had reportedly remained on site for an hour afterwards and had given a false name when questioned by security. It was reported that VC was not aggressive or confrontational when entering his old flat.

449. I replied to Ellie, cc'ing my TL and VC's Consultant Psychiatrist TL the following [**NHFT0017809**];

Hi Ellie

Thanks for the update. I'm assuming it was still agreed that he shouldn't be returning there at all following the incident? He should be attending SBC Friday to collect his medication so I will try and discuss this with him then.

> *His engagement remains very superficial at the moment but he is attending for his medication on a two weekly basis. I can believe he was perhaps looking for mail, he has alluded to trying to find out some information recently (although I've no idea what for), he's still very guarded and probably quite disillusioned with MH services so he shares very little. Really difficult to assess to be honest but I think full disengagement from services is likely to be our only indication that things have deteriorated further.*
>
> *I am pleased he has completed his course. When is graduation usually?*
>
> *KR*
>
> *Claudia Birtles*

450. I recall discussing this issue in the MDT. On 28 April 2022 at 11:00am **[NHFT0000168, at p.266]**, following a risk assessment and discussion in MDT, it was agreed that it would be appropriate to transfer VC to a new care co-ordinator, preferably two community psychiatric nurses ("CPN"). The plan was that I would see VC on 29 April 2022 to discuss matters with him directly – which I did.

451. As I confirmed in my subsequent NHFT interview I completed a risk assessment with my manager because I was pregnant: given VC's history of assault on police officers prior to detention, it was thought appropriate to transfer him to a new CCO **[NHFT0004707, at p.2]**. We followed this agreement up in the MDT with the wider team. The MDT meeting took place on 28 April 2022. There were weekly meetings held at 10:30am every Thursday. I do not recall the full attendance list as this was not documented. However, we raised concerns about the risk of breakdown in relationships with me as CPN over time. It was felt necessary to hand VC's care over to a new CPN to see if this would improve his engagement: sometimes a new CPN and a fresh start for patients can be beneficial. It is not always effective, but we considered it was something that we ought to try.

452. With regard to the preference for 2 CPNs, this was because two members of staff would be required for home visits / cold calls. CPNs was expressed as a preference rather than a requirement: equally, VC could have been allocated a CPN and a support worker.

453. Ultimately only one CPN (Gary Carter) became VC's care co-ordinator. I have been asked for my view on this. My view is that the documentation should in fact be read as indicating two CPNs *as needed* ie where home visits/cold calls were anticipated. I did not understand there to be a requirement that VC's case be managed by two CPNs at all times.

454. I have been referred to my NHFT interview in which I suggested that GC was chosen because he was a male, due to the risks around violence and aggression **[NHFT0004906, at p.10].** I do not recall having reached the consensus that it was unsafe for VC to have a female CCO or for other female colleagues to have refused to work with VC. Rather, a male was suggested because it would be a different model of care: I, a woman, had tried to work with VC and we did not have a good relationship anymore; he had lost trust in me. We felt it may be worth trying a male, to see if he could / would build a better relationship with them. With regards to my involvement with VC, I was pregnant and it was standard policy that pregnant women **[WITN0348004]** would be removed from working with people with a known risk to others and I was conscious of this.

455. In my experience of working with VC, I was never frightened of him. I did feel uncomfortable at times as he was unhappy with me and did not want to be at appointments but this was not because he had threatened or intimidated me.

456. I have been referred to my Theemis interview in which I remarked that *in "… the last few months leading up to me handing him over things had got increasingly difficult in our relationship. I just felt at that point he'd lost… that that therapeutic side had gone almost, he was finding it difficult to engage with me after that tribunal*" **[TCLT0000748, at pp.11-12].**

457. I was pregnant and it was policy to change CCOs in case of risk; furthermore, our relationship had broken down. Ultimately a change was necessary, but also I also considered it would be supportive to see if VC could build a relationship with someone new; to improve engagement and support. VC himself never asked for a change in CCO, but he also did not feel it necessary to see services.

458. In terms of the reasons I gave VC for the change in care coordinator, as I noted in my Theemis interview, *"I told him, I said, "I'm moving… my capacity's changing within the team". I didn't tell him I was pregnant… I just said, "there's been some changes"* **[TCLT0000748, at pp.23-24]**. I do not recall him giving any particular response to the change in CCO. I made the decision not to share with him the fact that I was pregnant. I did not want him to know about my pregnancy and did not and do not feel I was under any obligation to share that information with him.

459. I handed over the role of care co-ordinator to my colleague, GC. He had already been on visits to VC in my company during VC's pathway with EIP; GC had also seen VC on a number of occasions when I was on leave or otherwise absent from work, including on occasions when VC had arrived, unannounced, at the Stonebridge Centre and I was engaged on a visit with another client. GC has also been present at a number of MDT meetings where VC was discussed. GC

had also been present with me as the second person during the appointment when VC was floridly psychotic, leading up to his third admission. I cannot provide a set date regarding the handover conversations, but the process was agreed collaboratively as a team. Part of the logic behind allocating CPN GC to VC was to see if the allocation of a male, rather than female CCO would better support VC's engagement: it was an option we had yet to try.

460. I saw VC for an appointment on 29 April 2022 at 12:00pm **[NHFT0000168, at pp.266-267]**. He reported that everything was fine: there were no issues with medication, and he denied any psychotic symptoms. He declined my invitation to discuss the issues he had raised with me on 19 April 2022 – at which time he had suggested he was *"trying to get some information"* which we should discuss in person. He said this was no longer necessary and he did not need to discuss things further.

461. I informed him that the university had made contact with the EIP regarding his attendance at his old accommodation. He expressed surprise about this and admitted that he had been back but maintained that he *"had spoken to reception and collected his mail with no problems"* **[NHFT0000168, p.267]**. He denied any knowledge of having been previously asked not to return to the accommodation.

462. I was concerned by VC's explanations. They did not marry up with the information I had received from Ellie Turner: though both reports were about collecting his mail, VC did not admit to having entered his accommodation, he also denied any awareness of having been asked not to return to the accommodation, which was contrary to the information I received from Ellie.

463. I was concerned that VC was not being completely honest with us, and while he appeared to be stable and well kempt, he was not expansive in conversation and his responses remained monosyllabic. He was vague and did not engage in much conversation, it was driven by my questions. This was my last direct involvement with VC. I emailed Ellie Turner at the University with an update regarding the contact with VC, the discussion around his attendance at University accommodation and the plan for a change in CCO **[NHFT0017809]**.

> *Hi Ellie*
>
> *I briefly saw VC today, no change in presentation evident but he remains guarded.*
>
> *I asked about his attendance at Rayleigh Park, he said he wasn't aware that he couldn't return and said he had spoken to reception and there had been no issues obtaining his mail.*
>
> *I have strongly encouraged him to consider redirecting his post if he is continuing to have things sent there and not to return and collect in person.*
>
> *He said he might contact the Uni to discuss this as he wasn't aware that there was an issue with him going.*
>
> *I am going to be handing him over to a new CCO – Gary Carter due to the risks with me being pregnant. I have cc'd him into this email.*
>
> *Let us know if you have any contact with VC, hopefully he understands that he shouldn't be going back to his old accommodation.*
>
> *KR*
>
> *Claudia Birtles*

464. On 9 August 2022 at 3:59pm **[NHFT0000168, at p.270]** VC requested access to his notes. This was an issue to be dealt with by the team leader, Emma Robinson. This request underlined that VC was not living at the address he had provided to the EIP on discharge. His current CCO, GC, was informed.

465. The records record that GC was informed of VC's address by email. I also remember a verbal conversation with GC ensuring he knew of my email and

information, as I thought the conflicting addresses were strange. I cannot now be certain of the date on which this was discussed as it was not documented.

466. I understand that a decision was made to discharge VC from the EIP at an MDT held on 22 September 2022 **[NHFT0000168, p.271]**. I can say with certainty that I was not at work on this date: my son was born on the **GRO-B** and I was on maternity leave. It follows that I was not part of the discussions regarding VC's discharge.

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

My contributions to investigations into VC

468. I have been involved in the following investigations into VC and exhibit the following transcripts:
    i. an interview with Theemis on 7 June 2024 **[TCLT0000748]**.
    ii. an interview with NHFT on 8 January 2024 **[NHFT0004707]**.
    iii. an interview with NHFT on 17 January 2025 **[NHFT0004906]** in a conduct investigation into Gary Carter.

469. I have nothing to add to these transcripts which are all accurate reflections of my responses given. I have not given any other interviews or public comments on VC's actions or the matters under investigation by the Inquiry.

Reflections

470. I was devastated to hear of events in Nottingham on June 13 2023, both as a healthcare professional, as a parent to two children, and as a long-standing resident of Nottingham, having moved here to attend university at the age of 18.

471. I was deeply shocked and saddened by the loss of life and the harm inflicted on others by VC. I have reflected endlessly on events prior to June 2023 and on whether there was anything I could have done or said, perhaps even one small thing, that would have changed the outcome.

472. I feel that working through the various investigations into VC's care under NHCT has highlighted many of the challenges and difficulties healthcare professionals face, especially working with the more challenging to engage patient group. I am hopeful that lessons will be learnt going forward and I believe that our services have already changed and improved for the better.

473. Nottingham EIP and Nottinghamshire Healthcare have changed a number of practices in response to events.

474. Improved documentation: MDT discussions are now recorded and a template has been produced. There is administrative support to prompt completion of documents in timely manner, note templates to aid and prompt thorough documentation of records, and daily risk meetings to escalate concerns and formulate plans.

475. I will always work to improve my practice, including risk assessment and documentation of risk. I feel well supported with risk management under our current team structure.

476. Reflecting on 2020/21, following the amalgamation of community mental health services into the LMHT, I maintain the opinion that this had a negative impact on the EIP / FEP pathway and care that could be provided at that time.

477. Whether positive or negative, going forward, I feel I will remain hyper aware of risk. It is now more challenging to take therapeutic risks with patients: this is likely to lead to more restrictive practice in the future.

478. As a wider service, there have been improvements which have supported me and the team e.g. clearer routes of escalation of concern, updated policies with clearer guidelines, audits, better supervision procedures, daily meetings with management services to escalate concerns and risks. All of which have led me to feel more supported in my role.

My relationship with VC

479. I have reflected on my interview with Theemis on 7 June 2024 in which I made the following comments:

"…I suppose in the first yearish I felt like we had a fairly decent therapeutic relationship…he was very pleasant and would happily arrange to meet with me… I felt like there was enough there, it felt positive and like I said, he would answer my calls and things and would arrange to meet up in the first year or so. There was a point midway through that first year I think it was where insight I thought was slightly better and he worked on a relapse plan…" **[TCLT0000748, at p9].**

…"from [the point of the social circumstances report] onwards things got a little bit more difficult because I think he felt that I'd betrayed him in a way and he was much less forthcoming…" **[TCLT0000748, at p.10]**.

"I think he did mask it well, I think he… I think he felt he had to" **[TCLT0000748, at p.30]**.

"I had a relationship with him, but it was superficial from the start. Never really knew him. Guarded from the start, but also in general…" **[NHFT0004707, at p.1]**.

"He was so hard to engage… was determined to keep us at a distance" **[NHFT0004707, at p.3]**.

480. During the three previous investigations, I have always tried to describe some of the difficulties I experienced trying to maintain a positive therapeutic relationship with VC, especially following the MHA Tribunal during his 3rd admission. To this day, I still do not know how VC felt about his care team, whether he felt we had helped him or whether he ever had full insight into his condition. I am clear that VC did experience persecutory delusional beliefs at times; that he believed that mental health services, including myself, were conspiring against him and were colluding with other government agencies to cause him harm by infiltrating his mind.

481. This was probably a very complex and fixed delusional belief that, understandably, had a negative impact on our therapeutic relationship. On reflection, it seems likely that given his beliefs at the time, VC would have been very wary about sharing any information with anyone involved in mental health services. At times it was evident that he mistrusted me and my colleagues and

was suspicious of our intensions, this was due at least in part to a lack of insight into his condition.

482. VC often appeared quite guarded. This, in itself, is not unusual for someone experiencing a psychotic illness. I was also aware that VC was naturally quite an introverted and private individual; furthermore, some people do not feel comfortable sharing private information about their personal circumstances. Reflecting on whether VC was able to mask some symptoms, I think that it was likely at times that a combination of mistrusting services due to delusional beliefs and a reluctance to share experiences to avoid further potential admissions to hospital led him to conceal the true nature of his symptoms.

483. I am not aware of VC's circumstances or mental state immediately prior to the events of 13 June 2023. I always felt, however, that VC's behaviour was driven by a strong belief that he needed to protect those close to him; by a fear that the people he cared about most, like his family, were at risk of harm. Unfortunately, despite my best attempts, this was not something VC shared with me.

484. I remarked in one of my NHFT interviews that "*Apart from the admissions, I suspect that [VC] was never fully concordant with the oral medication*" **[NHFT0004707, at p.2]**. Aside from the occasion where surplus medication was found in VC's flat and the time when VC stated to myself and my colleague GC that he had stopped his medication prior to his third admission to hospital, my view that VC was non concordant with medication was always speculative. I do feel there were occasions where VC *was* concordant with his treatment in the community: it is possible to experience psychotic symptoms whilst being fully concordant with anti-psychotic symptoms. However, VC' s ambivalence towards

treatment and frequently fluctuating insight led me to the conclusion that he was unlikely to be fully concordant at times.

485. The NHFT's Level 2 investigation observes that *"It was the view of his CCO that the periods of concordance in hospital were probably driven by a desire to be discharged from hospital"* **[NHFT0000451, at p.15]**. While this was not something that VC ever said to me explicitly, I agree with the sentiment behind this observation.

486. VC maintained (certainly after the first admission) that hospital was unnecessary and unhelpful and that he wanted to go home to resume his studies. That said, by virtue of the fact that he was detained in hospital under ss.2 or 3 of the Mental Health Act 1983 (rather than being, for example, a voluntary inpatient), VC would have been obliged to be concordant with his medication in hospital in any event.

487. The NHFT's Level 2 investigation concludes that too much emphasis was placed on complying with VC's priorities for his education. Supporting people to remain engaged in education and or employment is a core component of EIP practice. Research shows that continued involvement in meaningful activities supports social functioning, routine, confidence, self-esteem and long term recovery. One of the main rationales for introducing a specialist EIP service was to try and protect social and role development for young people experiencing a first episode of psychosis by trying to limit the disruption to schooling, careers and social roles by keeping people engaged and offering vocational educational support. Staying connected with University or work helps individuals retain their identity and purpose, promotes optimism and hopefully reduces the risk of relapse or decline in social functioning. We felt VC's goal and aspiration of remaining in Nottingham,

at university, engaging in his studies should be acknowledged and supported with the hope that this would have a positive impact on his recovery.

488. As a CPN, it would not be within my role to diagnose any mental health condition formally. I have however worked within the EIP service for many years and I have witnessed the detrimental impact of the stigma associated with mental health labels or diagnoses, particularly schizophrenia and other psychotic disorders. This does mean that we should be cautious about using diagnostic labels early on in the pathway, but it would not mean diagnoses should be withheld entirely if someone is displaying symptoms of a longer term schizophrenia type illness. I am aware that stigma can deter individuals from help seeking help, can lead to social isolation, discrimination in work / education / housing and patients themselves can internalise public stereotypes leading to feelings of hopelessness and a reduced sense of self-worth. This can consequently have a negative impact on recovery, potentially limiting an individual's aspirations and goals in life. I would say that it is a difficult balance between the benefits and risks of using labels for this particular client group and decisions are made on a case by case basis, focusing on individuals' needs, symptoms and their own narratives.

489. At the time that I was VC's CCO, I was aware of concerns about the disproportionate overuse of MHA 1983 restrictive measures with black African and black Caribbean patients which had been publicised in the context of Mental Health Act Reform. However, it was not within my role to make final decisions regarding the use of restrictive practices, such as the use of the MHA. Part of my role was and is to request a MHA assessment, following a discussion with the

MDT, if it was felt necessary. This was something I called for in VC's case at what I felt was an appropriate time.

Recommendations

490. The Chair of this Inquiry should consider making the following recommendations to ensure lessons are learned from these tragic events and to prevent similar attacks in the future.

   i. Improved access to information from other agencies / better communication streams / updates and clear guidelines on confidentiality: a lot of people are afraid of sharing information due to confidentiality.

   ii. EIP services across the UK work differently and not all have the desired model – this needs to be reviewed and quality-assured: full MDTs should be required as per NICE guidelines.

   iii. Assertive outreach services – we did not have access to one in Nottingham and EIP were left to work with AO patients, without having the clear guidance, pathway, MDT, or support for an AO pathway

   iv. Locally and nationally there have been and remain ongoing pressures for mental health beds. It is difficult to get people into hospital informally anymore; in most cases patients need to be detained on a section of the MHA 1983. People are left too long in the community, meaning the community staff work with much higher levels of risk than when I first qualified, but we are not equipped to do this safely. Until this changes further incidents will happen:

services need to move nationally to proactive rather than reactive models.

v. All mental health services should use the same IT systems to ensure that records regarding patients' mental health can be read by professionals regardless of where they are in UK. Currently we cannot read patients' records if they have had contact elsewhere in UK: we are restricted to the Nottingham area only (NHS / private beds)

vi. As mental health practitioners, our powers are constrained by the MHA 1983: consideration should be given to MHA Act reform.

vii. Clear national guidelines on how to manage patients with an SMI / AO presentation; what is expected in terms of engagement, frequency of contact; what to do if someone fails to engage; what to do / what is expected if someone is non-compliant with medication

491. In terms of local and national improvements that could be made to multi agency working to increase effectiveness in preventing similar outcomes in the future, I have the following recommendations to make.

i. Improved access to information from other agencies / better communication streams between different agencies;

ii. Better risk and core assessment tools: the tools currently available are not effective in completing comprehensive risk assessment / care-planning;

iii. Improved systems/notifications as to actions outstanding for patients e.g. systems for notifying practitioners when patients have been discharged, notifications that risk plans, care plans, Honos etc require updating;

iv. Access to more local NHS beds, to reduce the use of out of area beds and foster better continuity of care;

v. Ward staff to be encouraged and educated to listen to and collaborate with community teams who know patients well, and have good knowledge of how patients are in the community; who have a more longitudinal assessment of a patient rather than seeing the snapshot of them during a period of MHA detention;

vi. Access to full MDT for our EIP – e.g. Psychology, Occupational Therapists, Speech & Language Therapists, dedicated EIP medics;

vii. Additional care coordinators: over time, our caseloads have grown, meaning staff are working constantly, with no down time, are always firefighting, and risk being burnt out;

viii. Greater administrative support freeing up more practitioner time to work with patients;

ix. Establish an AO pathway within Nottinghamshire with clear guidelines on how we manage patients with a serious mental illness AO presentation. What is expected in terms of engagement, frequency of contact, what to do if someone fails to engage, what to do / what is expected if someone is non-compliant with medication – some of the polices are still not clear or direct enough and remain open to interpretation.

Statement of Truth

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

Signed: GRO-B

Dated: 29/01/2026

Index to First Witness Statement of Claudia Birtles

No.	Inquiry URN	Document Description
1	NHFT0004012	Early Intervention in Psychosis Service Operational Policy of NHFT
2	NHFT0004725	Not Attends (DNAs)/Cancellations & Management of Patients Who Fail to Engage with Services or Seek to Disengage from Care in an Unplanned Way Procedure
3	NHFT0000417	Policy Document, Re: Cancellations and Management of patients who fail to engage with services or seek to disengage from care
4	NHFT0004906	NHFT investigation interview dated 17 January 2025
5	NHFT0017942	Letter from Claudia Birtles [NHFT] to DR Centre Cripps Health [Cripps Health Centre], re: Valdo Calocane
6	NHFT0000202	VC Summary & Care Plan completed by Claudia Birtles on 1 September 2020
7	NHFT0000168	VC RIO medical records
8	NHFT0000197	Risk and Safety Assessment completed by Annette Palmer on 24 May 2020
9	NHFT0000196	The Risk and Safety Assessment completed by Sindi Ndlovu on 26 May 2020
10	NHFT0000207	Summary & Care Plan completed by Mtetwa Campbell on 26 May 2020
11	NHFT0000188	Core Assessment completed by Anna Ludvigsen on 27 May 2020
12	NHFT0000206	Summary & Care Plan completed by Susie Ip on 3 June 2020
13	TCLT0000748	Theemis interview of Claudia Birtles
14	NHFT0000187	Core assessment was undertaken by Rupert Ackroyd on 15 July 2020
15	NHFT0000195	Risk and Safety Assessment completed by Sarah Rivers on 15 July 2020

16	CHCA0000017	Queen's Medical Centre Eye Casualty record dated 9 November 2020
17	WITN0348002	Understanding Psychosis and Schizophrenia
18	WITN0348006	Email from Claudia Birtles to VC re understanding psychosis, dated 17 November 2020
19	NHFT0017993	Email from Claudia Birtles [NHFT] to VC re CBT for Psychosis Leaflet dated 19 November 2020
20	NHFT0017894	Cognitive Behaviour Therapy for Psychosis (CBTp) leaflet
21	NHFT0000270	Relapse prevention plan for VC
22	NHFT0017933	Email from Claudia Birtles [NHFT] to Gail Collins [NGPF], re: Valdo Calocane
23	NHFT0000180	Mental Health Clustering Tool dated 9 August 2021
24	NHFT0004707	Claudia Birtles NHFT interview
25	NHFT0000194	VC's Risk and Safety Assessment dated 31 August 2021
26	WITN0348005	Email from CB to John Laverick on 17 September 2021
27	NHFT0000275	Social Circumstances Report for VC dated 17 September 2021
28	PAGR0000028	Priory records for VC
29	PAGR0000029	Priory discharge summary for VC
30	NHFT0000192	VC's Risk and Safety Assessment dated 18 January 2022
31	NHFT0000186	VC's Core Assessment completed by Ayodeji Akerele on 28 January 2022
32	NHFT0000190	Updated Risk and Safety Assessment for VC completed after discharge by Claudia Birtles on 28 February 2022
33	NHFT0017913	Email from Claudia Birtles [NHFT] to Eleanor Turner [UNIN], Re: Student dated 1 March 2022
34	NHFT0000410	VC Medication Card
35	NHFT0017809	Email from Eleanor Turner [UNIN] to Claudia Birtles [NHFT] and Gary Carter [NHFT], Re: V.M.C
36	WITN0348004	Protecting Pregnant Employees and new birth parents, Risk assessment guidance
37	NHFT0000451	NHFT Level 2 investigation report