Witness Name: Dr Gareth Foote

Statement No: WITN0413001

Dated: 23 February 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR GARETH FOOTE

I, Dr Gareth Foote, will say as follows:

Introduction

1. I am a registered Clinical and Forensic Psychologist and have been working at Nottinghamshire Healthcare NHS Foundation Trust ("the Trust") in various roles since 2000. I provide a more detailed overview of my career history in the section below.

2. I make this statement in response to a request made under Rule 9 of the Inquiry Rules 2006, dated 29 January 2026. In this statement, I discuss my career and role, system of work, and interactions with Valdo Calocane ("VC").

3. This witness statement was drafted on my behalf by the external solicitors acting for NHFT in respect of the Inquiry, with my oversight and input, following discussions in writing by email and by video conference.

Qualifications, Training, Career and Role

4. I am a registered Clinical and Forensic Psychologist with the Health and Care Professions Council and a Chartered Forensic Psychologist with the British Psychological Society. I hold the following qualifications:

    a. BSc (Hons) Psychology, Manchester Metropolitan University 1997
    b. MSc Forensic Psychology, Manchester Metropolitan University 2002
    c. Doctorate in Clinical Psychology, University of Nottingham, 2011
    d. PGCert Professional Practice in Law (Mental Health Law), 2018

5. Throughout my career as a psychologist, I have worked at Nottinghamshire Healthcare NHS Foundation Trust. I trained under supervision for over three years as a Forensic Psychologist to chartered status and a further three years under supervision as a Clinical Psychologist to doctoral level. I have set out a summary of my employment history in the below table:

Date	**Role**
2000-2003	Associate Forensic Psychologist, Mental Health Services Directorate, Rampton Hospital (trainee forensic psychologist)
2003-2005	Forensic Psychologist, Mental Health Services Directorate Rampton Hospital
2005-2009	Trainee Clinical Psychologist, Trent Doctorate in Clinical Psychology
2009-2016	Adult Mental Health Acute In-patient Service Psychologist, Highbury Hospital
2011-2021	Clinical Lead for AMH Nottingham Dialectical Behaviour Therapy Team

2016 – 2021	Lead Psychologist Nottingham and Nottinghamshire Adult Mental Health Acute Care Network
2021 - 2023	Consultant Clinical Psychologist, Adult Mental Health Personality Disorder Service
2022 -2025	Clinical Director, Adult Mental Health Service
2025 - present	Trainee Multi-Professional Approved Clinician

6. As part of my core training and post qualification, I have participated in training and workshops on psychological approaches to understand psychosis including the power threat meaning model of psychosis, cognitive behavioural therapy for psychosis and have contributed to MDT assessment, formulation and treatment planning for inpatients with psychosis. I have also provided individual and team supervision, and reflective practice meetings focussed on understanding and responding to patients experiencing psychosis in inpatient settings.

7. Throughout my career, I have had experience of assessing capacity to make decisions regarding psychological treatment. In addition, I am a doctorate level trained psychologist and therefore bring knowledge and experience in assessing capacity regarding psychological treatment as well as in risk assessment. My knowledge of either of these was not different in July 2020.

8. I have no awareness of having been involved in the care of any other mental health patient who has killed or seriously injured a member of the public following discharge, or in the community.

Psychology at the Trust – on an inpatient ward

9. The role of psychology on an in-patient acute adult mental health ward includes assessment, formulation and brief interventions for acute mental health difficulties, group interventions often aimed at skills development. Psychologists also offer indirect work such as consultation to the Multi-Disciplinary Team ("MDT") by participating in ward rounds, MDT meetings and board reviews, providing staff training, individual and team supervision and reflective practice, staff and patient debriefs following incidents, post-incident reviews with patients and contributing to service development and quality improvement projects such as positive behavioural support and wider aspects of culture of care.

10. Where possible psychologists will attend MDT and ward meetings, and ward rounds. Due to resource limitations, it is not possible for psychology to attend all meetings. A full-time qualified psychologist will typically work across two wards with a case load of individual patients, team and individual supervision sessions and on occasions patient group sessions to attend to. Psychologists do their best to attend ward rounds and team meetings concerning patients they are directly involved with, but this is not always possible. They will write in the notes and give a verbal handover after each patient appointment. They will communicate any concerns or risk issues to the wider team as required.

11. Psychology is a limited resource, and therefore, it is usual for doctors and/or nurses to make referrals to psychology based on the team's understanding of

patient needs. The type and amount of input is determined through collaboration between the patient, the team and the psychologist.

12. Psychologists have full access to the patient record on RiO (patient information system).

13. As a psychologist on an acute inpatient ward, I would be asked to see more patients with a personality disorder diagnosis than patients who presented with psychosis or depression. This was, in my view, because people experiencing problems associated with personality disorder in inpatient settings are less responsive to interventions such as medication. Psychological interventions are the main treatment for personality disorder, whereas other interventions, such as medication, are limited in their efficacy for these problems, and pharmacotherapy for depression or psychosis is considered to be effective. As psychology was, and to an extent remains a limited resource (numbers of available ward psychologists mean that they are unable to engage with all of the patients on a ward directly), psychologists were asked to see patients who had more limited responses to interventions available to other disciplines.

14. The role of the Lead Clinical Psychologist for Acute Adult Mental Health ("AMH") involves providing line management and supervision to qualified, Assistant and Trainee Psychologists, supporting service managers to understand the resources required for the psychology service, consulting to the service leadership about the role of psychology in the service, as well as being asked to see complex patients for individual work.

Psychology team on Rowan 1 ward – July 2020

15. In July 2020 Rowan 1 ward had one Assistant Psychologist available approximately two days per week and a full time acute psychological intervention practitioner ("APIP").

16. An Assistant Psychologist is a psychology graduate with an interest in pursuing a career as a practitioner psychologist in clinical settings. They are not qualified or registered psychologists but are often working towards securing a training place. Assistant Psychologists work under the supervision of a Practitioner (qualified) Psychologist. Their role on the ward is to attend MDT meetings and ward rounds, offer post-incident reviews to patients of incidents that have occurred during admission to contribute to understanding difficulties and care planning, contribute to the delivery of group interventions, conduct file reviews to understand patients' difficulties and histories, conduct observations of an individual's behaviours on the ward where appropriate, offer limited individual assessment and/or skills based interventions or other interventions during the admission, actively participate in supervision, and support data collection and analysis, for both clinical and service evaluation, as required.

17. The APIP was a role that was developed locally by nursing management to address the shortfall in provision of psychological services within the acute wards. It was introduced onto the wards relatively briefly in 2019, as I recall. As I recall Rowan 1 ward had one full time APIP. At the time I was working three days per week in the inpatient service and there was one other part-time

psychologist working into one ward in Mansfield. The APIP role has since been disbanded. I was not involved in the development of these posts. APIPs were qualified mental health nurses with an interest in and experience of providing psychological interventions.

Role of psychology in risk assessment, assessment of insight, masking of symptoms and risk of future relapse

18. Psychology contributes to the overall MDT risk assessment for patients that the psychologist is involved with. Due to resource limitations, it is not possible for psychology to see all patients on a ward, therefore psychology input is not a requirement or requested for all the patients on a ward. Psychology does not have the same standing nationally as nursing and medicine in that a ward is seen to be able to function without psychologists, although the benefits of employing psychologists in acute mental health settings is widely acknowledged. When involved with a patient directly, a psychologist will aim to develop a shared or collaborative formulation with the patient that will include risk assessment. Psychologists might also contribute to the team understanding of patient risk during ward round, MDT meetings, board reviews, team supervision, team formulation and team reflective practice meetings.

19. Psychologists have a role in helping to clarify a patient's understanding and awareness of their difficulties and risk of future relapse. Where there is a concern about the possibility of a patient masking symptoms the psychologist

can contribute to exploring this directly with the patient, or through consultation to other team members. Psychologists aim to provide patients with a supportive and non-judgemental setting to explore their difficulties. Risk assessment and factors associated with relapse are part of the overall shared formulation developed with the patient, rather than reliance on a standardised risk assessment tool.

20. Due to resource limitations psychologists cannot work with all the patients on a ward. Psychologists may be asked to contribute to the team's understanding when there are concerns about the possibility of masking symptoms, although this is not an absolute requirement as other disciplines are able to assess and explore such presentations. Some of the things psychologists will explore with regard to the possibility of patients masking symptoms include incongruities in the patient's self-report, they would consider information provided by other team members or by others to the team, and may ask patients directly about what is happening, for example if a patient is observed to be responding to unseen and unheard stimuli but denies experiencing hallucinations.

21. It is not in my experience standard practice for psychologists in adult mental health settings to liaise with the police to seek information. Regarding other third parties, such as social services or other healthcare providers who have been involved with the patient, psychologists or other team members would approach the third party to seek information if needed.

VC's second admission – July 2020

22. Prior to 30 July 2020, I recall that I had received a verbal handover on 17 July 2020, from George Jackson, Assistant Psychologist, during his weekly supervision meeting of the reasons for VC's admission to hospital and the precipitating events, including involvement of the police and incidents of aggression. I accessed VC's RiO record on 17 July 2020 and 24 July 2020 to further understand the circumstances of his admission.

23. The Inquiry has referred me to an entry in VC's RiO record, made by Dr Rupert Ackroyd, regarding "*psychoeducation re treatment when able*" [**NHFT0000168, p.59**].

24. It is my experience that colleagues in the nursing team would lead on the provision of psychoeducation regarding treatment. Colleagues from pharmacy or medicine can also provide this psychoeducation regarding medication. Psychology can have a role in providing psychoeducation about psychological interventions and recovery more broadly. This is typically offered during a psychology session once a shared formulation has developed to the extent that psychological treatment is indicated.

25. If sessions are ongoing during admission, discussion might continue over several sessions, for example if there are several options and the patient is unsure what to do, or if the patient is ambivalent about psychological intervention, space can be provided for them to reflect on their recovery goals and how they could be achieved. The period over which psychoeducation would be provided varies by patient and according to current need. In some cases, such psychoeducation can be ongoing over many years as part of a wider

ongoing therapeutic relationship with a community worker, such as a peer support worker, Community Psychiatric Nurse, or team.

26. I can see from the RiO record that at the ward review on Redwood 1 on 16 July 2020, one part of the plan was "*Ward Team/APIP?Psychology please work on Psychoeducation and 1:1 around insight/psychosis*" [**NHFT0000168, p.66**].

27. Psychoeducation and 1:1 work on insight into experiences of psychosis would not necessarily be undertaken by psychology. The nursing team are also able to provide this. When this is a feature of psychology sessions, the number of sessions would vary according to individual need. The content of the psychoeducation provided by psychology would aim to link the individual's shared formulation of their problems with models of psychosis and therapeutic techniques, such as sharing information about the stress-vulnerability model of psychosis and individualised techniques to monitor and cope with psychotic experiences.

28. I am not aware that the psychology team on the ward delivered psychoeducation and 1:1 work on insight into psychosis. I believe that this was provided by the nursing team. I was unable to see VC until the day before his planned discharge. I am aware that VC saw the ward APIP during this admission.

29. At the time of VC's admission to Rowan 1 ward the psychology provision on the acute adult mental health wards was inadequate. Following criticism in 2017 from the Care Quality Commission [**WITN0413002, p.31**], about the lack of psychology in the adult mental health acute inpatient wards, there had been

recent investment into the service, aiming for one qualified and one Assistant Psychologist to work across two wards each. At the time of VC's second admission to hospital some of the clinicians recruited to the qualified posts were yet to start working in the service. Since this time the Assistant Psychologist posts have increased to one whole time equivalent per ward.

30. At the time I was working across several wards, supervising and supporting the Assistant Psychologists who were without a qualified psychologist on their ward. I was working in that capacity three days per week as I was also leading a team delivering a therapeutic intervention in another treatment pathway. Due to limited resources I was unable to become involved in VC's care sooner or have more contact with him than the one session provided, but I was aware that George Jackson was present at the 72-hour ward review on 16 July 2020 **[NHFT000168, p.63-64]**.

31. The psychology provision for the adult mental health acute wards is now better established, and it is now possible for psychology to have greater input into the care planning and treatment of patients on the wards. However, the psychology provision currently is not adequate to be involved in all inpatients' care directly.

My involvement with VC– 30 July 2020 - background

32. VC's RiO record states that I attended a psychology session with VC at around 3:30pm on 30 July 2020. I confirm that this record is true and accurate to the best of my knowledge. Other than this session, I did not have any other dealing or interaction with VC. I attended this meeting as per the record, and I was

accompanied by George Jackson, who made the relevant entry on RiO. The full record is reproduced below:

"*Clinical Psychology appointment with Valdo (V.C) today on the ward. Attendees: Valdo, Dr. Gareth Foote (Lead Clinical Psychologist for Acute AMH) and George Jackson (Assistant Psychologist).*

The meeting started at 3:30pm and lasted for approximately one hour, Dr. G. F lead the appointment. Dr. G.F initially asked V.C if he had seen a Clinical Psychologist in the past but V.C said that he had not seen a Clinical Psychologist before.

V.C mentioned that he is going home tomorrow and following discharge, he intends to go back to his flat and he feels fine about this. V.C says that he has room mates at his flat and mentioned that they are not aware of the extent of his mental health in recent months – this is what V.C expressed to us. V.C elaborated on his time in hospital and said that 'it hasn't been too traumatic'. V.C mentioned that he has felt as though he has had a place to unwind, a place of reflection and that it wasn't safe for him to 'be outside'. He expressed that he wasn't 'in the best place' and felt 'paranoid and unsafe'. V.C talked about feeling as though he had come a long way and feels that the medication has been helping him. He also recognised the support of the CRHT team – V.C said they were supportive and reassuring. V.C went on to tell us that he isn't aware if he needs input from the Clinical Psychology Team.

Dr. G.F went onto ask V.C what his plans were 'to stay well in the future' – V.C states that he will comply with medication advice, work towards visiting family in Pembrokeshire, Wales and maintain a good diet and exercise regime, he enjoys cycling. V.C talked about currently studying for an exam – he is an Engineering student in Nottingham – Dr. G.F encouraged V.C to seek support and help from the university regarding his mental health as V.C said that he had not communicated with them about it in-depth. V.C spoke about 'Making sense of his Psychosis' – V.C says that he had 'heavy studying schedules', anxiety, poor diet, stress and this compounded into an episode of psychosis. V.C spoke about anxiety and his expression of this – V.C spoke about having 'career anxiety' and wanting a 'good career' which means getting good grades. Thus, he can experience anxiety. Dr. G.F encouraged V.C to take breaks from studying to reduce stress and anxiety that he is experiencing due to his studies. Dr. G.F asked V.C about playing sports and/ or going to the gym – V.C mentioned that he does go to the gym to reduce stress. V.C spoke about his diet being poor because of a lack of fruit and vegetables but aims to improve this when he is discharged. V.C was very reflective throughout the session and expressed evident progress in understanding his mental health throughout his time in hospital.

V.C said he does not use drugs.

He said he has not had any 'strange experiences' or voices in recent weeks.

We spoke about recognising signs of his mental health and deterioration and V.C said that he will be able to do this by recognising that he is paranoid, feeling a 'lack of control' over himself, feeling as though people might be following him, and feeling very irritable can be a warning sign for him struggling with his mental health. V.C said that if anything does arise, he will contact the CRHT team / family/ his G.P.

V.C is being discharged on 31-07-20 and no recommendation for further Clinical Psychology input has been made at this point." [**NHFT0000168, p.114-115**]

33. I recall the purpose of the session was to see if VC would benefit from referral to psychology in the community. My recollection is that I was asked to undertake the session by George Jackson. As set out earlier in my statement, I recall that I had received a verbal handover from George Jackson, of the reasons for VC's admission to hospital and the precipitating events, including involvement of the police and incidents of aggression.

34. I did not perform any type of risk assessment with VC. I became involved near the end of his admission and believed that the wider MDT had assessed the risks leading to a decision to discharge VC.

35. I was not aware of a plan then or now for VC to have been offered psychological input prior to the admission in July 2020 to Rowan 1 ward. As I recall VC was responding to a direct question from me as to whether he had seen a psychologist before. This is a question that I usually ask when meeting a patient for the first time.

36. I do not recall knowing any information from VC's family. My usual practice regards liaising with family to obtain background information was attendance at ward round where on occasions I would be part of a team interacting with the

family members. It was my understanding that colleagues from the nursing team and medical team would be the most usual discipline to have conversations with family members.

37. As I recall VC presented as well kempt, made eye contact and was able to engage in the session in a reflective manner. I recall that he looked somewhat uncomfortable at the outset. I attributed this to VC being in a novel situation with two people he had just met and would be unlikely to meet again (as he was being discharged the next day) while experiencing shame about his recent experiences.

38. In terms of VC's relevant history as regards his accommodation, as I recall, I was aware that VC had been aggressive and violent in student accommodation while experiencing psychosis.

39. The RiO record states that during our appointment, VC communicated that "*it wasn't safe for him to be outside*", and that he "*wasn't in the best place*" and felt "*paranoid and unsafe*" [**NHFT0000168, p.114**]. As I recall, VC communicated these matters in relation to being asked about what had led to this admission to hospital. He was talking about his mental state leading up to admission, not his current mental state at the time of the psychology session.

40. The RiO record further states that VC stated he "*will comply with medication advice*" [**NHFT0000168, p.114**]. I was aware that VC would have the support of

the crisis team on discharge and a community mental health team on an ongoing basis to monitor compliance with medication after his discharge.

41. In addition, the RiO record states that VC "*spoke about 'Making sense of his Psychosis' – V.C says that he had 'heavy studying schedules', anxiety, poor diet, stress and this compounded into an episode of psychosis.*" **[NHFT0000168, p.114]**. My recollection is that I thought this statement from VC showed insight into factors that had contributed to a deterioration of his mental health.

42. The RiO record also states that it was noted that VC said he had not had "*any strange experiences or voices in recent weeks*" **[NHFT0000168, p.114]**. As I recall this information was prompted by a specific question. I did not explore VC's previous voices/hallucinations, or any ongoing delusional beliefs. My appointment with VC was after a decision had been made that he would be discharged from hospital, and therefore my remit as I understood it, was to explore whether he would benefit from referral for psychology in the community and VC declined this. The appointment was the day before he was due to be discharged. There was not the time available to develop the therapeutic relationship necessary to explore his experience of delusions and hallucinations. From the information provided during the appointment there was no apparent need to explore these matters.

43. Based on the limited interaction that I had with VC I thought that he had demonstrated insight into his mental illness and factors that would contribute to a risk of relapse. VC reported that he had been paranoid and felt unsafe pruior

to admission and had used the time in hospital to reflect and make sense of his experience of psychosis, and he recognised that he had benefitted from medication and would follow advice about this. VC reported that he recognised that he needed to manage stress and anxiety due to studying, and that having a good diet, taking exercise and seeing his family would be important in order to stay well. In my view VC further demonstrated insight through awareness of signs that his mental health could be deteriorating in future. He identified paranoia, feeling that he was being followed and being irritable as warning signs that his mental health was deteriorating. Additionally, he reported having had a positive experience with the crisis team and in my view demonstrated a willingness to contact them or his GP should he have any difficulties.

44. I did not consider the support structures that VC had in place in depth. It was evident I believe that he planned to keep in touch with family and would contact the crisis team if needed. I also recommended to him that he contact the University of Nottingham student mental health support team. I had no reason to doubt that VC would seek support at this point in his admission history.

45. I was not consulted by other professionals about VC's discharge. I was not based in that team at the time, so it was not usual for me to be consulted about discharge plans for each patient on the ward. Had I been consulted after my appointment with VC on 30 July 2020 I would have supported discharge from hospital. It appeared that his experience of psychosis leading to this admission had responded well to medication. It was apparent that VC believed that he had benefitted from the admission and to my mind, according to recovery principles prevalent in mental health services, he should be supported to get back to

university and to attend to the things that were important to him, namely completing his studies and pursuing a career in engineering.

Recommendations

46. I respectfully submit that the following may be considered by the Inquiry as potential recommendations. It has been my experience that because psychologists do not typically have the statutory status of nursing and medicine in the enactment of the Mental Health Act 1983 (as amended 2007), services have not been able to prioritise funding for psychology posts when funding across the service is constrained. I recommend that the provision of psychology posts on the inpatient wards be increased and consider that this should not be at expense of posts from other disciplines as staff shortages remain an endemic issue across services.

47. It is important to recognise the differences in pace, intensity, role demands, activity and patient turnover between acute inpatient and more traditional community-based psychology roles in adult mental health services. Currently there is one whole time equivalent (wte) qualified psychologist to between 32 and 36 beds across the service, meaning that there is one whole time equivalent qualified psychologist (Band 8a) across two wards, supported by an Assistant Psychologist. There is also a Consultant Psychologist providing strategic and clinical leadership across eight wards and a psychiatric intensive care unit, as well as the Crisis teams and residential and locked rehabilitation units.

48. I support the recommendations made in 2021 by the British Psychological Society (BPS) and the Association of Clinical Psychologists (ACP) workforce development plan (*Psychological services within the Acute Adult Mental Health Care Pathway: Guidelines for service providers, policy makers and decision makers*) **[WITN0413003]**. To provide a comprehensive psychology service that provides a full range of indirect interventions and increase access to psychological interventions to most service users, they recommend the following staffing levels for each 18-20 bedded ward:

    a. 1.0 wte Band 8c Consultant Psychologist, potentially Approved Clinician, 1.0 wte Band 8b Principal Psychologist, 1.0 wte Band 8a Senior Psychologist/ Psychological Therapist, 1.0 wte Band 6 Clinical Associate Pychologist, 0.5 wte Assistant Psychologist, with an additional 1.0 wte Band 8c Consultant Psychologist to provide strategic & operational role across up to 4 wards.

49. Adopting the BPS and ACP workforce plan would allow time to adequately develop a psychological assessment, formulation and treatment plan for each patient in addition to the other necessary demands of the role. At the current rate of 1:32-36 there is little provision for cross-cover when psychologists attend training as part of necessary continuing professional development, take annual leave, sickness absence, or deliver training.

50. Individual psychology appointments typically last for one hour and will be associated with approximately an additional hour to ninety minutes of activity reading records, taking a handover and planning a session, then afterwards

handing over to others, writing in the notes and reports, scoring and interpreting assessment materials, making referrals, liaising with others, seeking consultation, and reflecting on patient progress in assessment, formulation, or treatment. Adopting the BPS and ACP workforce plan would allow for each patient to be offered weekly direct psychological assessment, formulation or treatment sessions with additional extensive indirect work.

51. The psychologist's contribution to team meetings about patient care will be enriched through their direct work with patients and allow for there to be a psychologist present and contributing at all ward rounds, MDT meetings and board reviews where risk is discussed and treatment and management plans made. This will be in addition to the other roles and functions of the qualified psychologist. These include team supervision and formulation sessions, patient and staff debriefs, service development, audit and evaluation, training, supervision of Assistant Psychologists, Clinical Associate Psychologists, qualified psychologists, and supervision of colleagues from other disciplines.

52. When considering resources for this staffing level it will be important not to create qualified posts at the expense of Assistant Psychologist posts. These are traditionally development posts and are crucial to the qualified workforce pipeline. Equally, it will be important not to rely on less costly Assistant Psychologist and Clinical Associate Psychologist posts as these are limited in scope of practice, professional autonomy and competence to work with complexity and risk independently of the supervision and oversight of a qualified, HCPC registered practitioner psychologist.

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: 23 February 2026

Index to First Witness Statement of Gareth Foote

No.	URN	Document Description
1	NHFT0000168	Patient Record Summary of VC
2	WITN0413002	2017 CQC report
3	WITN0413003	Psychological services within the Acute Adult Mental Health Care Pathway: Guidelines for service providers, policy makers and decision makers