Witness Name: DR MONA AHMED
Statement No: WITN0425001

Dated: 12th March 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR MONA AHMED

I, DR MONA AHMED, will say as follows: -

INTRODUCTION

1. I am a fully registered medical practitioner employed by South West London and St George's Mental Health NHS Trust. I am a Consultant Forensic Psychiatrist working at a Medium Secure Unit at Springfield University Hospital. I am also a Consultant Lead for Court Liaison and Diversion in South West London and St George's NHS Mental Health Trust. I began working as a locum Consultant Forensic psychiatrist in the Trust in November 2016 before being appointed substantively in April 2018.

2. Between November 2022 and August 2025 I was the Associate Clinical Director for Forensic Mental Health Services at South West London and St George's Mental Health NHS Trust. I vacated that role in September 2025 to take on the role of Associated Medical Director for Health Inequalities.

3. I have been a member of the Royal College of Psychiatrists since 2011. I am on the General Medical Council Specialist Register for Forensic Psychiatry having received my Certificate of Completion of Training in Forensic Psychiatry in 2017.

4. I am an Approved Clinician, approved under Section 12(2) of the Mental Health Act 1983 (as amended in 2007) as a medical practitioner with specialist expertise in the assessment and treatment of mental disorders. I hold a post graduate diploma in Forensic Mental Health from King's College London.

5. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 16 January 2026 (the "**Request**").

BACKGROUND

6. I have been asked to provide a statement about my role as an independent clinical expert, namely, a Consultant Forensic Psychiatrist, commissioned by the Care Quality Commission ("CQC") in February 2024 to conduct a review of NHS services provided to VC and my contributions to the CQC's s.48 report titled, Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust (hereinafter the "CQC Review").

STATEMENT

7. In early February, South West London and St George's Mental Health NHS Trust ("my Trust") was contacted by Chris Dzikiti, Director of Mental Health at CQC for help to support in producing the CQC Review. The Trust was told, see email dated 7 February 2024 from Chris Dzikiti at CQCM0029114 that the key lines of enquiries were:

1. Review and report on the care, treatment and services provided by the NHS from VC's first contact with services to the time of the offence
2. Review and report on the appropriateness of the treatment of the service user in light of any identified health needs
3. Review and report on the adequacy of risk assessments and risk management, including specifically the risk of the service user harming themselves or others
4. Examine and report on the effectiveness of VC's care plan including the involvement of the VC and the family
5. Review, assess and report on compliance with local policies, national guidance and relevant statutory obligations
6. Establish and report on if this incident was predictable and preventable.

8. My Trust released me to work with CQC on their Review. I was deemed to be a suitable person to carry out this work given my role in the Trust as Associate Clinical Director for the forensic service. I do not recall being asked to provide a CV by the CQC at the time that I was first approached to participate in the Review. The CV was first requested on 8/1/26. My Trust was told that a Clinical Director from East London NHS Foundation Trust had also been commissioned to help with the CQC Review. This was Dr Sarah Dracass, Consultant Psychiatrist, Medical Director for Inpatient and Urgent Mental Health Care at East London NHS Foundation Trust and North East London NHS Foundation Trust.

9. I have been asked to review document CQCM0006060. This outlines the terms of reference for work streams covering all aspects of the review more broadly and is not entirely relevant to what I was tasked with, which is set out above in paragraph 8.

10. Dr Dracass and I were specifically tasked with reviewing the two years of medical records made available to us, focusing specifically on the terms highlighted in

Chris Dzikiti's email of 7 February 2024. I had a Teams conversation with Chris Dzikiti separately to confirm this as well. This was what I referred back to in completing my reports that fed into the CQC Review.

11. I have been asked to review document CQCM0009697. This is one of a chain of emails between myself and Dr Dracass about how we would work together on the CQC Review. I attach WITN0425002which are additional emails as part of that discussion.

12. I began the work by creating a document which brought together all available information in the Progress Notes in RiO electronic medical records. This to me was the only way I could assure myself that we did not miss any contact that VC had had with professionals be it in the community or during his inpatient stays and gain insight into the rationale behind the clinical decision making. This piece of work resulted in the creation of the document titled "Summary of patient presentation/ timeline of engagement" CQCM0010415 and once all this information was collated we could then set about answering the specific questions above around adequacy of risk assessments, appropriateness of care provided and whether the incident was predictable and preventable.

13. Dr Dracass and I liaised throughout with Evan Humphries, a Senior Specialist in Mental Health at CQC and he sent myself and Dr Dracass documents held by CQC.

14. I no longer have access to the documents I received from CQC, but recall that they included VC's hospital records from Nottinghamshire Healthcare NHS Foundation Trust in the form of RiO Progress Notes, care plans and risk summaries, and at least one of the discharge summaries from an independent sector hospital. These records covered the time period from 24 May 2020 until 23 September 2022. I also received the Trust's Initial Management Review document,

15. Dr Dracass and I were working to an exceptionally tight deadline, with only one week from being given access to the documentation to submit our reports. It was not possible to review VC's teams' practice against their local policies (which were not provided), so NICE guidance was used.

16. I have been asked to review certain documents, to confirm whether I drafted or contributed to these and to confirm whether these formed part of the work produced by me for the CQC Review.

17. CQCM0010414: "Review of risk assessments". I produced this document as part of the work produced for CQC. I made it available to Evan Humphries in this form. This was my work and I do not recall if Dr Dracass contributed to this document.

18. CQCM0010415: "*Summary of patient presentation/timeline of engagement*". I produced this document as part of the work produced for the CQC after reviewing records of all of VC's contacts with mental health services (from May 2020 to September 2022) contained in the information provided. I made it available to Evan Humphries in its current form. Dr Dracass made a number of additions to this which are incorporated into the body of the text but the main text was completed by me. To the best of my recollection, the text in blue in this document was added by Dr Dracass.

19. CQCM0010416: *"Incident in June (Index Offence) and whether this was predictable".* I produced this document as part of the work produced for CQC. I do not believe Dr Dracass amended/edited it. I made it available to Evan Humphries in its current form.

20. CQCM0010417: *"Whether the index offence of June 2023 was preventable"*. I produced this document as part of the work produced for CQC. I made it available to Evan Humphries in its current form and I do not believe Dr Dracass amended/edited it.

21. I also produced a document headed Risk Formulation and Appropriateness of Care Provided, which is CQCM0010431.

22. Dr Dracass produced document CQCM0016210.

23. The documents I produced, together with Dr Dracass, were submitted to Evan Humphries on 16 February 2024.

24. On 20 March 2025, Dr Dracass and I received an email from Evan Humphries that was also addressed to me with an update on the CQC Report. A copy of this email is attached at CQCM0013441. This explained that there had been an extension to the final outcome/report. Mr Humphries said:

"There has been an extension given to the final outcome/report of the workstream we were working on. I drafted a report based on the work of yourself, Mona, Des and Andy. However, following contact from the Secretary of State and due to the possibility of us (CQC) requesting and reviewing further information from other sources this has been extended. I am not entirely sure at this stage exactly what the additional ask is and we are waiting on further information about what else may need to be looked at for inclusion in the report. The extension was granted quite late on as I was preparing for the final submission for review.

There will be some information about the review published in the next week or so, these were workstreams 2 and 3 which were related to Rampton specifically and the wider trust (we were working on workstream 1). However, the work that yourself and Mona worked on is likely to be pushed back until early May for publication.

Everything you both provided me with has been extremely helpful and thorough, the extension isn't based around the work you completed (I just wanted to reassure you and Mona that everything you did was spot on and will inform large parts of the report), its more that we may be asked to look at other aspects which weren't in scope when we started the review.

25. On 10 April 2024, Dr Dracass and I received an email from Evan Humphries with a further update on the CQC Report. This is CQCM0013652. He said:

I have completed my draft of the s48 review relating to VC and the ten cases reviewed. I have used the information you helpfully provided to me to complete the report.

I was hoping if you have time available you would be able to take a look to ensure you are happy with the way I have presented your work. I would welcome any comments/suggestions/amendments that you may have.

It is likely I could get this to you early next week to review. My line manager and a member of the editorial team will be looking at it between now and then.

If you are able to review the report I would need comments back from you by 5pm on Monday April 22nd . The report will then be reviewed by various layers of CQC personnel including our Chief Executive, Chair, legal team etc before it is shared with a range of stakeholders (including the victims families, VC's family, the trust, police etc) and then finally the secretary of state before publication. We anticipate it will be published on our website during mid June, which may seem far away, but this is due to the significant layers of quality assurance and briefings that will be required (and allowing time in between each stage so comments/amendments can be made).

If you could let me know if you would have time to review the report it would be much appreciated.

26. In fact I did not receive the draft CQC Report until 15 May 2024 with a request to provide any "thoughts/comments" by 20 May 2024. Unfortunately, I was not able to do this as I was on leave at the time. I do not know whether Dr Dracass was able to do this.

27. In his email of 15 May 2024, a copy of this email can be found at attached at CQCM0029112, Mr Humphries stated:

It is important to note all the information you initially provided was incorporated into the first draft. The report has been reviewed by various colleagues in legal and engagement and gone through various versions. There are restrictions on certain things that we cannot publish due to GDPR which may not have made it into the report. However, I wanted to assure you all the work you did initially was in the first version and has all been considered for the final version.

28. I have been asked, with reference the version of the CQC Review which is publicly available, to specify which part(s) of the CQC Review incorporate or rely on the analysis undertaken by myself and Dr Dracass as well as the conclusions reached by me/us.

29. I have reviewed the overall conclusions reached in the CQC Review. For each conclusion, I indicate which parts of my own analysis underpin that conclusion and the reasoning that appears to have been incorporated from my reports. The most clearly incorporated elements from my analysis appear to be:

a) the analysis of the risk assessments and deficiencies within those

b) the formulation linking untreated psychosis and imminence of relapse on discharge and the attendant violence risk to others

c) the conclusion that depot medication and CTO were missed opportunities

d) the conclusion that discharge from secondary services to the GP did not adequately mitigate relapse risk

30. The report concludes that the outcome resulted from a combination of shortcomings across risk assessment, care planning, decisions around treatment planning and discharge process. Although the report does not refer to these as 'failures' it broadly reflects the overall structure of my analysis in 'Risk Formulation and Appropriateness of Care Provided', where I identified multiple interacting failures including inadequate risk formulation, insufficiently assertive treatment of psychosis, missed opportunities to use legal frameworks such as a Community Treatment Order (CTO), and failures to ensure consistent engagement with services. This is outlined in the "Risk Formulation and Appropriateness of care provided document.

31. Conclusion that risk to others was not properly recognised or managed

32. The CQC Review concludes that the seriousness and immediacy of VC's risk to others were not sufficiently identified or articulated within clinical documentation. This reasoning reflects the analysis contained in my 'review of risk assessments' and 'risk formulation'. These describe omissions of key risk incidents, inadequate recording of the seriousness of risk, and most crucially the absence of a structured risk formulation describing risk scenarios, how risk might escalate, and towards whom. My analysis also concluded that the information available about VC's previous violence did not adequately inform treatment planning or risk management strategies.

33. Conclusion that violence risk was closely linked to untreated psychosis

34. The report emphasises that VC's risk to others increased when his psychotic illness was not effectively treated and that relapse was associated with violence to others. This reflects the core formulation set out in my report on risk formulation, which identified untreated paranoid psychosis as the primary factor mediating violence risk (which underpins the arguments that the offences could have been preventable). I concluded that his systematised persecutory delusions and auditory hallucinations led him to believe that others posed a threat to him or

his family, prompting confrontational and violent behaviour during acute relapses hence the importance of ensuring effective and consistent management of his psychotic disorder. In my opinion there is evidence that VC was labouring under residual paranoid beliefs and auditory hallucinations throughout a substantial proportion of his time in the community.

35. Conclusion that medication management and treatment were not sufficiently assertive.

36. The CQC Review concludes that treatment approaches were not adequately reviewed or optimised despite persistent symptoms and repeated relapse. This corresponds with my analysis that antipsychotic treatment was not assertively optimised during much of the two-year period of care, including periods in which VC continued to report persistent hallucinations and paranoid beliefs without a comprehensive review of medication strategy or consideration of alternative treatments and modes of administration. Again, this is described in the 'Risk Formulation and Appropriateness of Care Provided' document and the documents addressing the question of whether the offences were preventable.

37. Conclusion that a more robust and assertive package of care was required.

38. The report concludes that after multiple admissions and persistent disengagement, VC required a significantly more assertive approach to treatment and supervision than was provided. This reflects the conclusion in my risk-formulation analysis that, after four admissions in two years and repeated evidence of medication refusal and poor engagement, and attendant risk to others when unwell, a more robust package of care (eg consistent supervision of treatment adherence with use of long acting depot medication and the legal framework of a CTO) would have been necessary to manage both his illness and the risk he posed to others.

39. In conjunction with the above, the report highlights missed opportunities to consider depot antipsychotic medication and the use of a Community Treatment

Order, particularly given VC's repeated medication non-compliance and disengagement from services. My reports identified the same issue, concluding that by the time of the later admissions there was very clear indication for depot treatment in conjunction with the legal framework of a Community Treatment Order so as to ensure consistent treatment adherence, community supervision and recall to hospital if necessary.

40. Conclusion that there was insufficient multi-disciplinary team thinking including consideration of a forensic assessment

41. The report discussed missed opportunities for closer multidisciplinary team thinking particularly ahead of his discharges from hospital. The multidisciplinary meeting would have enabled the views of the care co-ordinator and EIP consultant to be considered together and to share their concerns. A more cohesive MDT approach would have also informed the understanding of his risk formulation and the decisions around medication management. Along similar lines, a specialist forensic assessment would have helped with understanding the level of risk and supporting a risk management plan, but this was not considered. These points are covered in the risk formulation and appropriateness of care provided document.

42. Conclusion that discharge decisions did not adequately consider the risk of relapse and violence.

43. The CQC Review concludes that the decision to discharge VC from specialist services back to primary care did not adequately account for the high likelihood of relapse and associated violence. This reflects the reasoning in my report addressing predictability, where I concluded that given VC's history of medication non-compliance, poor insight and repeated relapse, it was highly likely that he would discontinue treatment and experience further psychotic episodes, which historically had been repeatedly associated with violent incidents towards others.

44. The report also highlights the fact there was no updating of the risk summary/reformulation of risk ahead of discharge to the GP in September 2022 which would have been crucial in highlighting the risk of non compliance with treatment, relapse and potential for violence to others. This reflects the conclusions in my 'Review of Risk Assessments' document.

45. <u>Conclusion that there was no evidence of a structured approach or explanation of capacity assessments for VC</u>

46. This is reflected in the 'Risk Formulation and Appropriateness of Care Provided' document. However I was more explicit in my concluding that his profound lack of insight would have significantly impaired his ability to understand and weigh up the information regarding the antipsychotic treatment and on that basis he very likely lacked the capacity to consent to treatment. More accurate and consistent assessment of his capacity to consent to treatment in different care settings were crucial and knowledge of his impaired capacity would have then been factored into the decisions around more coercive treatment interventions such as the long acting depot antipsychotic that he required.

47. Elements that have not been as clearly incorporated include:

48. CQC Review refers to relapse risk but does not provide explicit assessment of predictability (as outlined in my "whether predictable" report)

49. A theme in my analysis that is largely absent from the CQC Review is the role of criminal justice processes in risk management and deficiencies in liaison with the Criminal Justice System. I highlighted the repeated violent incidents where criminal charges were not pursued, the effect this had in minimising the seriousness of the behaviour and the missed opportunity for MAPPA involvement and police liaison.

50. I have been asked to consider whether the CQC Review accurately reflects the analysis and conclusions that I came to in undertaking the work that I did to contribute to the CQC Review. I believe that the CQC Review broadly reflects the work done by Dr Dracass and myself, however I would make the following comments.

51. The report does not refer to me as a forensic psychiatrist (specialising in the treatment of mentally disordered offenders) but as a community psychiatrist. Indeed, the report mentions two community psychiatrists.

52. More fundamentally, the CQC Report concludes that there was no single point of failure. In my opinion there were a number failings which include the following:

53. Developing an appropriate management plan that adequately treated the symptoms of his illness: VC was essentially labouring under distressing symptoms of psychosis throughout much of the two years he was under mental health services (due to both his non adherence to treatment which was strongly suspected but also lack of appropriate antipsychotic prescribing). There was a lack of assertive management of his mental illness as evidenced by the need for 4 detentions under the Mental Health Act in a very short space of time associated with a series of violent incidents which were to a substantial degree motivated by his psychotic symptoms.

54. Medical treatment was not optimised in my opinion and much needed medication changes (the antipsychotic agent used as well as dosage and mode of administration) did not take place despite evidence that he remained unwell and was not accepting oral treatment. This is further detailed below beginning paragraph 69.

55. Deficiencies in continuity of care, communication and information sharing between the community team and inpatient teams to inform his treatment plans on discharge from hospital (particularly during admissions 2 and 3 when he was

detained on Section 3 of MHA which could be converted to CTO). His treatment planning and risk management whilst he was detained on Section did not appear to take into account his presentation and the challenges he posed whilst in the community. Inpatient clinicians appeared to rely on his presentation as an inpatient detained on Section (assuring staff that he would engage in the community and accept treatment) without taking into account a more longitudinal view of his previous risks in the community setting namely his propensity to disengage and his poor compliance with treatment (which had also been corroborated repeatedly by his family).

56. The community team more effectively outlining the rationale for depot and CTO whilst he was detained on Section, coupled with Inpatient clinicians taking a more longitudinal approach to understanding his risk (both risk of relapse and risk of violence to others), would have enabled more robust treatment on discharge. It does not appear however that the inpatient teams utilised the experiences of the community team to inform their management plans. This was particularly evident during admissions 3 exacerbated by his transfer to independent bed (on this occasion he was detained on Sec 3 which could have been converted to CTO) as well as admission 4 where he was discharged whilst still actively symptomatic and insightless and with concerns raised by his neighbours just prior to discharge regarding his mental state. Ultimately his risk history including the seriousness of his violence when unwell did therefore not appropriately inform the treatment plans.

57. Additionally whilst patient autonomy and collaboration ought to be preserved where possible, there was inappropriate emphasis on this at the cost of providing much needed treatment and more assertive risk management. Ultimately the balance of need for assertive management to treat his illness and manage risks versus VC's own autonomy and need for least restrictive interventions was misjudged.

58. Managing this difficult balance between autonomy and the more coercive interventions (such as use of depot medication which could be more reliably

monitored and CTO) would require collective multi-disciplinary team thinking/risk formulation bringing together the experiences and concerns of all those working directly with VC and overseen by the team consultant. *Based on the information provided*, this did not happen.

59. Such decisions would have additionally required regular assessments of his capacity to consent to antipsychotic treatment which do not appear to take into account his profound lack of insight and resultant inability to understand and weigh up information regarding his treatment, the consequences associated with treatment non-adherence and the level of risk he posed to others when unwell.

60. In relation to the question of MDT involvement and absence of risk formulation, the degree of violence that he presented with warranted a specialist forensic assessment (which is mentioned in the report) or discussion at a borough 'risk forum' which would have supported the team in understanding his risks and agree risk management interventions and based on information provided this did not happen. I am not aware however whether these services would have been made available by the Trust to the community team.

61. Ultimately throughout his time under services there was failure in formulating his risk as a team to enable risk management procedures to be put in place.

62. VC had little appreciation of the risk he posed when unwell and there was avoidance of discussing this with him directly. In fact there is evidence of discouragement of discussing past risk incidents due to distress it might cause him which meant opportunities for developing insight and collaborative crisis planning/ risk management were missed and he was not supported to understand the relationship between his symptoms and how these precipitated serious violence to others.

63. By admission 3 when a series of violent incidents had occurred as well as criminal damage, there needed to have been closer liaison by the community team with the Criminal Justice System. However it does not appear that a referral to MAPPA (Multi-Agency Public Protection Arrangements) was considered. He

met criteria for MAPPA involvement on the basis that he was assessed as posing an imminent risk of causing serious harm and requiring active management. This would have provided a forum for mental health and police services to come together to understand risk and put risk management process in place.

64. This was made all the more relevant given his ability to evade Criminal Justice System involvement – evidenced by the failure to attend the three appointments with Court Liaison and Diversion under the terms of the conditional caution he received after forcing entry to his neighbours flat prior to first admission.

65. There was limited consideration given to potential use of psychoactive substances eg urine drug screening or clear exploration of this with him or counselling around associated risks. There is very limited evidence of his being questioned about this and his self-reporting was known to be unreliable.

66. There was inadequate communication of the imminence and seriousness of risk on discharge from the community team – the discharge planning should have involved the family, GP, university liaison officer and local police.

67. Based on what was known of VC's symptoms, illness trajectory, frequent relapses in the context of medication refusal necessitating 4 detentions under the MHA, there was clear risk of violence in the context of untreated psychosis and this risk was not communicated appropriately.

68. I confirm that I did not make these comments prior to publication of the CQC Review because, as stated at paragraph 15, above, I did not have time to review the draft within the timescales provided. I do not know whether CQC would have agreed with me or amended their Report.

69. <u>Medication</u>

70. I have been asked to consider whether a different anti-psychotic medication should have been considered and if so, which one and to provide the rationale for this.

71. According to the guidance (NICE Guideline CG178: Psychosis and schizophrenia in adults), if an antipsychotic does not produce an adequate clinical response, clinicians should first review the following:

    a) Adherence – confirm the person has been taking the medication as prescribed.
    b) Dose and duration – ensure the antipsychotic has been taken at a therapeutic dose for at least 4–6 weeks.
    c) Side effects – check if adverse effects are limiting adherence.
    d) Substance use or other factors worsening symptoms.
    e) Regarding long-acting injectable depot antipsychotic these should be considered where there are concerns about adherence to oral medication for example where previous relapse has been associated with stopping oral medication.

72. Turning first to the question of non-adherence, this is particularly applicable in the case of VC, where evidence of non-compliance provided a clear clinical rationale for the use of a long-acting depot antipsychotic. Whilst decisions regarding use of long acting depot injections should be made collaboratively taking into account the person's preferences and attitudes to regular injections, it is appropriate to conclude that by Admission 3 and certainly by Admission 4, it had been well established through multiple sources that VC was not reliably accepting oral medication in the community secondary to his poor insight and residual paranoid symptoms, that this was a factor in the poor control of his psychotic symptoms and a driver of the frequent relapses observed.

73. Strong suspicions around nonadherence to treatment were persistent throughout his two years in the community and this comes across clearly from the RiO medical notes of those working with him. These concerns appear to have been widely acknowledged by the individuals that were involved in his care.

74. VC's resistance to accepting oral medication was also flagged by his family. On a number of occasions, as early as the period following his first discharge from hospital, his mother reported concerns that he was not taking his medication and indicated that VC had disclosed to them that he was not doing so.

75. On discharge following Admission 2 he had claimed to have lost medication and then subsequently refused to allow the Home Treatment Team to supervise the administration of his medication. He then again requested a medication free trial in Sept 2020 and his care coordinator notes that medication non-compliance was "on the horizon". There were instances of him failing to collect medication (or not needing to replenish it as frequently) and statements to his care coordinator that he did not believe he needed it.

76. Indeed, VC himself acknowledged that he had discontinued medication shortly after discharge from hospital. In July 2020, prior to Admission 2, he reported that he had stopped taking it because it made him feel low and lethargic. He again admitted to not taking medication in August 2023 prior to Admission 3. Prior to Admission 4, despite the involvement of the Home Treatment Team in supervising medication administration, his adherence was described as "sporadic at best," and on one occasion he was observed spitting the medication into a bin after walking away from staff.

77. On this basis a depot antipsychotic treatment should have been more assertively pursued. This would have been made all the more necessary given the level of violence displayed in the context of past psychotic relapses and the need to prevent recurrence.

78. The decision should also have considered whether his poor insight resulted in impairments in his capacity to consent to depot treatment, in which case referral for authorisation by Second Opinion Approved Doctor could have been sought to help support the team in making this decision.

79. Prior to converting to depot treatment there needed to have been assurance around the effectiveness of an antipsychotic agent however there is evidence that oral aripiprazole was additionally not fully controlling his symptoms:

80. Following discharge from his first admission, he was reviewed by the Home Treatment Team, who documented that he continued to experience auditory hallucinations and was likely to downplay his symptoms. This assessment took place shortly after discharge from an inpatient admission, during which medication administration would have been closely supervised and adherence assured.

81. Similarly, in the period immediately preceding discharge from Admission 4 in February 2022, there was evidence that he continued to hold paranoid beliefs and that symptoms of passivity were elicited. This occurred following a four-week inpatient admission during which medication adherence would have been closely monitored. At that point if not earlier it would have been appropriate to conclude that the aripiprazole, even at an increased dose of 20mg was not managing his symptoms effectively. Consideration should have been given to switching to an alternative antipsychotic. Once an antipsychotic agent that effectively controlled his symptoms had been identified, conversion to a depot preparation should then have been pursued which his care coordinator had explained was the preferred option (ward round on 10/2/22).

82. Even prior to this there had been evidence that the aripiprazole even at increased doses was not fully managing his symptoms. Following Admission 2 (14th -31st July 2020) where he was discharged on Aripiprazole 10mg there were concerns by clinicians in the community (care coordinator and Specialty Trainee Doctor) that he was still symptomatic. Following assessment in Nov 2020 where he was reported as “psychotic with an escalation in symptoms” the dose was increased to 15mg. On review 4 weeks later, voices were described as present “pretty much all day without a break”. On review 2 weeks after that, he was still reporting the voices as “powerful” and the progress note states that he “continues to hear voices on a daily basis and

does not feel there has been much improvement since increasing the Aripiprazole dose".

83. The deterioration in his presentation continued into February 2021 despite increasing the dose of aripiprazole to 20mg. Concerns were also raised by his mother in May 2021 that he was relapsing. At that stage, consideration should have been given both to strategies for monitoring medication adherence (eg supervision by HTT) but also to the possibility of trialing an alternative antipsychotic agent.

84. In the period preceding Admission 3, there were clear and documented concerns regarding both treatment adherence and the adequacy of aripiprazole in managing his symptoms. These concerns ought to have informed the treatment decisions made by the inpatient team during Admission 3.

85. However, he was discharged on the same medication, namely 15 mg of oral aripiprazole. This again happened on discharge following Admission 4 where just prior to discharge there were concerns regarding ongoing symptoms and yet he was discharged on the same antipsychotic agent.

86. According to the RiO medical notes, the only documented trial of an alternative antipsychotic appears to have been haloperidol, which was initially administered intramuscularly due to VC's refusal of oral medication. He received oral haloperidol during the first five weeks of Admission 3. However, the medication was subsequently changed back to Aripiprazole prior to discharge after VC reported experiencing hypersalivation while taking haloperidol. Full awareness on the part of the inpatient treating team in Admission 3 of his limited response to aripiprazole in the community may have been limited by the fact that he was placed out of area in an independent bed. This may also have been compounded by VC's known propensity to mask or downplay his symptoms. In addition, the fact that he was discharged without the knowledge of the community team may have

meant that they were not able to contribute fully to the discharge planning process.

87. By the time of Admissions 3 and 4, the inpatient and community teams would have by then been aware of the challenges in managing him, his difficulties with treatment adherence, and the persistence of symptoms despite treatment with Aripiprazole. In that context, it would have been appropriate to trial an alternative antipsychotic. Either a first or second generation antipsychotic could have been offered, crucially one with the option of subsequent conversion to a depot preparation once its effectiveness in managing symptoms was confirmed.

88. Establishing consistent medication administration is necessary in order to properly evaluate the effectiveness of an antipsychotic being prescribed. Without this, it is difficult to determine whether the persistence of VC's symptoms reflected genuine treatment resistance or was the result of inconsistent adherence to oral medication (urine drug screening would also have been helpful to exclude illicit substance use). A depot formulation would have allowed clinicians to ensure that the medication was being received as prescribed and therefore to accurately assess its therapeutic effect. If symptoms had persisted despite assured adherence and an adequate trial at therapeutic dose, this would have supported the conclusion that the illness was treatment resistant, at which point a trial of Clozapine should have been considered.

89. I would like to extend my sincere condolences to everyone who has been affected by this case.

90. **Recommendations**

91. An appropriate body, such as the Department of Health and Social Care, NHS England or CQC should produce guidance or minimum standards for NHS Trusts and other providers to incorporate in order to increase the

robustness of their local disengagement policy and strengthen their processes for the discharge of patients, particularly those with Severe and Enduring Mental Illness.

92. There should be a formal memorandum of understanding between the NHS and policing bodies to establish and/or strengthen police liaison functions with mental health providers. This should identify roles and responsibilities for ensuring that people who present with risks are appropriately discussed with risk management plans formulated where necessary – whether this is within the context of MAPPA or not.

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
Dr Mona Ahmed

GRO-B

Date 12/3/26

Index to First Witness Statement of Mona Ahmed

	Inquiry URN	Document Description
1	CQCM0029114	Email from Chris Dzikiti, dated 7 February 2024
2	CQCM0006060	Terms of Reference: Section 48 commission for a special review of Nottingham Mental Health Services (undated)
3	CQCM0009697	Email Dr Dracass to Dr Ahmed, dated 9 February 2024
4	WITN0425002	Emails between Dr Ahmed and Dr Dracass dated, 9 February 2024
5	CQCM0010415	Summary of patient presentation / timeline of engagement (undated)
6	CQCM0010414	Review of Risk Assessment (undated)
7	CQCM0010416	Review of Incident in June (Index Offence) and whether this was predictable (undated)
8	CQCM0010417	Review: Whether the Index Offence of June 2023 was preventable (undated)
9	CQCM0010431	Risk Formulation and Appropriateness of Care Provided (undated)
10	CQCM0016210	Review of the involvement of services into Valdo Calocane's care to identify if the care and treatment he received was appropriate and in line with trust policies and national guidance or if there were missed opportunities to manage his care (undated)
11	CQCM0013441	Emails Dr Dracass and Dr Ahmed with Evan Humphries, CQC, dated 16 February 2024 and 20 March 2024
12	CQCM0013652	Email Evan Humphries, CQC, to Dr Dracass and Dr Ahmed, dated 10 April 2024
13	CQCM0029112	Email Evan Humphries, CQC, to Dr Ahmed, dated 15 May 2024