Witness Name: Dr. Ajith Indran Gurusinghe

Statement No: WITN0102002

Dated: 09 December 2025

THE NOTTINGHAM INQUIRY

SECOND WITNESS STATEMENT OF DR. AJITH INDRAN GURUSINGHE

I, Dr. Ajith Indran Gurusinghe, will say as follows:-

INTRODUCTION

1. I am the Consultant Psychiatrist who treated Mr. Valdo Calocane ("**VC**") during his admission to Priory Hospital Arnold.

2. This witness statement is provided to assist the Nottingham Inquiry (the **Inquiry**) with the matters set out in the Rule 9 Request dated 13 October 2025 (the **Request**).

CAREER AND ROLE

3. I am a Consultant Psychiatrist with Priory Group, a leading independent provider of Specialist Secure Psychiatric care in the United Kingdom. I have a

specialist registration in Forensic Psychiatry and have over twenty-five years of experience as a psychiatrist and caring for patients with complex psychiatric needs. My qualifications include MBBS, MRCPsych and MSc.

4. I was appointed as the Medical Director of Priory Arnold and Priory Hazelwood House Hospitals in 2020. I joined Annesley House (previously managed by Partnerships in Care Group, currently known as Priory Hospital East Midlands) in 2016.

INPATIENT MENTAL HEALTH SERVICS

5. The broad clinical aims of providing treatment to a patient:

   a. in an acute mental health unit, would include reducing a person's distress and suffering urgently. In this process multi-disciplinary assessments are undertaken swiftly with a view to mitigate symptoms and risks, initiation or optimisation of pharmacological treatments, safe discharge and the least restrictive discharge planning in line with the Mental Health Act Code of Practice [**DHSC0000007, chapter 1**] and NICE guidelines.

   b. detained under the Mental Health Act 1983 (the **MHA**) is to deliver the necessary and proportionate treatment that is known to be effective in mitigating risks and promoting recovery without delay. During this process, the legal criteria are reviewed on a regular basis to ensure that

the least restricted options and the individual's rights under the Code of Practice [**DHSC0000007, chapter 1**] are safeguarded at every stage.

c. voluntarily in hospital, are to provide collaborative consent led treatment, support autonomy, shared decisions and to plan a safe discharge drawing on NICE guidelines for capacity and for transition.

6. The general procedure and scope for individuals experiencing an acute and/or severe mental health crisis, detained under section 2 (**s2**) of the MHA include admission for assessment or treatment of mental disorder and risks. In this process multidisciplinary assessment includes physical health examinations, risk formulation, social needs assessment and level of observations which are completed urgently as per NICE guidelines. Furthermore, a decision will be taken within the s2 MHA timeframe (28 days) to discharge or to convert to section 3 (**s3**) of the MHA if further treatment as an inpatient is deemed necessary.

7. The treatment, care and management under s3 of the MHA provides the necessary medical treatment for mental disorder that is available and likely to help, with regular review of the detention criteria, physical health monitoring, structured psychological, social interventions and coordinated discharge planning in line with NICE guidelines.

8. The treatment, care and management for voluntary patients are consent led and recovery focused, with proportionate observation and de-escalation procedures when required, and with transition planning as per NICE guidelines.

9. The relationship between Priory inpatient teams and NHS hospitals and other independent providers which carry out mental health care planning and treatment involve contracted referral pathways, shared care planning, and information exchange so that admissions, transfers and discharges are timely, safe and consistent with local commissioning arrangements.

10. The difference between inpatient services (irrespective of whether it is Priory Hospital Arnold, NHS inpatient services or other independent inpatient providers) and the outpatients services such as the crisis resolution teams and community mental health teams is that, acute inpatient units provide 24 hour multidisciplinary care for high acuity presentations, whereas crisis teams offer intensive home treatment to avoid admission where safe, and the community teams provide ongoing multidisciplinary care, coordination and rehabilitation under the Community Mental Health Framework.

11. The particular service provided by an Acute Mental Health Unit, in comparison with a Psychiatric Intensive Care Unit (**PICU**), is assessment and treatment where risks are significant but manageable on an open and less restricted acute ward. Psychiatric Intensive Care Units provide care for very high and immediate risk patients who require higher level of security measures, staffing and higher level of environmental controls.

12. The role of inpatient providers within the *"Care Programme Approach"* and the *"Community Mental Health Framework"* is to contribute to coordinated assessments, risk formulation, care and discharge planning, allocation of a care

coordinator (**CCO**) and ensuring timely communication of plans and contingencies to community teams.

13. The factors and indicators relevant to an assessment for admission or continued detention under s2 of the MHA include suspected mental disorder, current or foreseeable risks to self or others, severe self-neglect, the need for assessment in hospital, the absence of a safe and more less restrictive option, lack of capacity to consent to inpatient treatment and human rights as set out in the Code of Practice [**DHSC0000007, chapter 14**].

14. The factors and indicators relevant to an assessment for admission or continued detention under s3 of the MHA include confirmed mental disorder, the necessity of hospital treatment, likely therapeutic benefit, imminent risks without treatment, lack of a safe less restrictive alternative and capacity or consent considerations.

15. The factors, indicators and presentations that distinguish admission for treatment from admission for assessment are that s2 of the MHA is used when diagnosis or treatment needs are uncertain and time limited assessment is required, whereas s3 of the MHA is used when necessary medical treatment is indicated, available and proportionate.

16. A patient who is admitted as a detained patient may transition to receiving treatment on a voluntary basis when the detention ends. This can be in circumstances where the criteria are no longer met and the person has capacity

and gives informed consent to ongoing care, with clear explanation, documentation and aftercare planning as per NICE guidelines.

17. The criteria that I use to decide whether there is enough evidence that someone is acutely or severely unwell include a corroborated history and collateral information (such as information from family), a structured mental state examination, significant functional impairment, risk indicators including those in NICE guidelines for self-harm, physical health screening for organic causes including delirium and evidence that community measures have failed or are unsafe.

18. The factors that indicate a diagnosis of psychosis include hallucinations, delusions, disorganised thoughts, abnormal behaviour, negative symptoms and functional decline, with organic causes excluded and the management is guided by NICE guidelines.

19. The factors that indicate a diagnosis of Paranoid Schizophrenia include persistent and characteristic psychotic symptoms with prominent persecutory or referential delusions, abnormalities in thought possession, hallucinations in particular third person auditory hallucinations. This is diagnosed clinically and managed under NICE guidelines

TREATMENT, CARE AND MANAGEMENT OF PATIENTS EXPERIENCING PSYCHOSIS

20. The circumstances that require a PICU bed are more serious and would usually relate to circumstances where there are immediate risks to self or others or severe behavioural disturbance(s) that cannot be safely managed on an open acute ward, consideration of the nature and severity of violence, absconding risk, need for constant containment, and the requirement for higher relational, procedural and physical security.

21. The circumstances for stepping down a PICU patient to an acute ward at Priory Hospital Arnold are a sustained reduction in risk to a level that is safely manageable on an open acute ward, consistent settled behaviour, engagement with treatment, and reduced need for restrictive interventions with an agreed plan for observation and access to leave.

22. The information that I would expect to be provided with a referral or transfer to Priory Hospital Arnold includes legal status and MHA documents, reasons for referral and current risks, diagnosis and formulation, current and recent medications with allergies and prescribed doses, physical health status and observations, safeguarding issues, collateral contacts, and the current care plan including Care Programme Approach or Community Mental Health Framework documentation.

23. The circumstances in which I would seek further information from a referrer would include, where there are any gaps or ambiguities about risks, legal

status, safeguarding or treatment history, since safe care requires verification of these important aspects at the point of transfer, which is standard practice.

24. The circumstances in which I would seek further information from services previously involved in the care or treatment of a patient would include routine historical information, previous risk formulations and response to treatment which would inform current treatment and care planning in line with NICE guidelines.

25. The circumstances in which I would seek further information from the police in circumstances where a patient has been assessed for admission as a result of or in connection with criminal behaviour, or where the police have been otherwise involved in the circumstances of the patient's admission, are where the admission follows criminal behaviour or police involvement and where accurate factual information is needed to assess current risks and legal processes, with proportionate, lawful information sharing as per the Code of Practice **[DHSC0000007, chapter 10.2]**.

26. The factors that determine whether a patient detained under s2 and s3 of the MHA should be held in "seclusion" are the presence of immediate and serious risk of violence that cannot be managed by de-escalation or observation, proportionality and necessity, continuous monitoring and review, and the duty to use the least restrictive alternative in line with the Code of Practice **[DHSC0000007, chapter 26.103]** and NICE guidelines.

27. The types of risk to self and others that I would include in my clinical assessments when setting observation levels for an inpatient are as follows: suicide and self-harm risks, violence and aggression, self-neglect, vulnerability to exploitation, absconding, falls and acute physical health instability as described in NICE guidelines.

28. The circumstances in which observation levels are increased may include escalation of acute risk markers such as intent, planning, associated command hallucinations, uncontrolled agitation or physical health deterioration. The circumstances in which levels are decreased may be a result of sustained improvement in risks and behaviour with engagement and adherence, with all changes documented and agreed by the Multidisciplinary Team (**MDT**).

29. The behavioural or other changes that may inform adjustments to observation levels include: level of agitation, expressed hopelessness or plans to harm, psychotic preoccupation, substance intoxication or withdrawal, physical health instability, positive indicators such as improved insight, consistent engagement and medication concordance.

30. The medical (pharmacological) differences relevant to the treatment and management of psychosis are that Olanzapine is a second generation (atypical) antipsychotic medication that is highly effective for positive psychotic symptoms. It has sedating and significant metabolic properties that require monitoring as advised by British National Formulary and NICE guidelines.

31. In terms of Clonazepam, it is a Benzodiazepine that is commonly used for anxiety and agitation in the early part of admission. It is not an antipsychotic, it has risks of sedation and dependence, therefore it is used over a short term period and with clear indication in order to treat anxiety or agitation that might be associated with psychosis.

32. Lorazepam is a short acting Benzodiazepine commonly used for acute agitation as and when required and as part of rapid tranquillisation protocols with careful physical health monitoring as per NICE guidelines.

33. Zopiclone is a hypnotic used for short term management of insomnia and is not an antipsychotic. It is considered only for sleep problems within a behaviour modification plan to regulate the normal sleep cycle.

34. Haloperidol is a first generation (typical) antipsychotic medication with potent dopamine blockade that is useful for acute psychosis and for intramuscular use, with risks of extrapyramidal effects and potential heart rhythm prolongation that require monitoring.

35. Aripiprazole is a second generation (atypical) antipsychotic medication with partial dopamine agonist that is less sedating, low risk of weight gain and more effective for negative psychotic symptoms and cognitive (concentration) symptoms.

36. Information that would be considered important and relevant to the initial period of observation following admission includes baseline physical observations,

mental state, substance use and withdrawal risk, medication prescribed, legal status, capacity issues, immediate safeguarding or environmental factors and other risks as described in NICE guidelines.

37. Capacity assessments are usually conducted for inpatients when there is reason to doubt capacity. It is decision specific and time specific. Capacity assessments are conducted by assessing a person's ability to understand, retain, use and weigh relevant information and to communicate their decision, in line with the Mental Capacity Act and NICE guidelines.

38. The criteria, factors and information that I use to undertake a *"mental state examination"* include considering the: appearance and behaviour, speech, mood and affect, thought form and content, perception, cognition, insight and judgement, and current risks, recorded systematically and linked to diagnosis and care plans of an individual.

39. The aim of conducting risk assessments for inpatients is to identify foreseeable harms and to guide proportionate, least restrictive management and collaborative safety planning in line with NICE guidelines.

40. The circumstances in which inpatient risk assessments are conducted are at admission, following incidents or change in presentation, before leave or discharge, and at routine review points.

41. The individuals who provide input into risk assessments are the MDT including nursing staff, healthcare support workers, doctors, psychologists, occupational therapists, the patient and carers where appropriate.

42. The frequency of review of risk assessments is as often as any risk changes and at each formal review including daily nursing reviews, MDT ward rounds, prior to leave access or discharge.

43. Risk assessments are conducted so that both immediate and historic risks are captured by combining structured clinical judgement with collateral history, incident analysis and contemporaneous observation, and by documenting antecedents, behaviours and consequences that inform management.

44. The aim and purpose of a care plan and the factors that determine how it is formulated include: a clear statement of needs, goals, interventions, responsibilities and review points, shaped by risks, preferences, capacity and available supports as per NICE guidelines.

45. The frequency with which care plans are reviewed is at least weekly on inpatient wards and whenever needs or risks change, and again at each transition.

46. The matters within the scope of a care plan includes symptom management, psychological therapies, physical health, social needs, safeguarding, observation levels, leave and discharge planning.

47. Where a patient has had multiple admissions, clinicians ensure that any patterns in respect of their presentation and condition are captured within ongoing care plan by capturing patterns across multiple admissions through longitudinal summaries and risk formulations that record previous triggers, responses and engagement, and by incorporating these into current plans and handovers.

48. The relationship between inpatient care planning and post discharge care planning requires continuity and clear handover to the community mental health services with named responsibilities, timeframes and contingencies as per the Community Mental Health Framework.

49. Risk assessments are used in formulating and developing an inpatient care plan which informs observation, leave, treatment choices, environmental adaptations and relapse prevention.

50. The leave plans are established for detained and informal inpatients by taking into consideration the collaborative risk assessment, the purpose and therapeutic value of leave and by stipulating conditions to mitigate identified risks. The leave is reviewed in a timely manner after significant incidents, change in mental state or physical health, and compliance with treatment and management plan consistent with the Code of Practice **[DHSC0000007, chapter 27.10]**.

51. When reviewing risk assessments and care plans, nurses, healthcare assistants and other staff observations are taken into account in reviews of risks

and care plans. These are recorded within observations and behavioural records as core evidence in daily reviews and ward rounds and by documenting in the risk assessment and taking them into consideration when formulating the management plan.

52. The meaning of rapid tranquillisation and the circumstances in which it might be necessary are when calmness or sedation is required in order to reduce immediate risk when other forms of non-invasive de-escalation methods have failed. The medications are administered with close physical health monitoring in line with NICE guidelines.

53. The clinical and medical treatments expected before stepping a PICU patient down to an acute unit include an agreed formulation and diagnosis, established and tolerated antipsychotic treatment with side effect monitoring, a reduction in restrictive practices, engagement in psychosocial work, and a clear risk, observation level and leave plan consistent with NICE guidelines.

54. The clinical and medical treatments expected before considering discharge of an inpatient experiencing psychosis include establishment of an effective and tolerable medication regime, stabilised symptoms, stable physical health, completion of psychoeducation and relapse prevention work as appropriate, involvement of carers where possible and a robust follow up plan in line with NICE guidelines.

55. The observations, behavioural changes and indicators that are prerequisites for considering discharge of an inpatient with a diagnosis of psychosis include

significant improvement in symptoms, absence of violence or aggressive behaviours, consistent engagement and adherence with advice and procedures. Other prerequisites include an assurance that residual risks are manageable with community support, person centred and tailored contingency plans with additional safeguards where there is a history of aggression, violence, non-concordance, isolation, disengagement or masking.

56. For those patients who have a history of violence, are considered by clinicians to be at risk of becoming violent in the absence of treatment, or who are isolating, disengaging or masking psychotic symptoms must have allocated CCOs or support workers to monitor mental state and risks and support treatment compliance.

57. Those with history of non-concordance with medication and disengagement may require additional measures such as community treatment orders (**CTO**) to enforce medication compliance, supervision and swift readmission to inpatient settings.

58. Whilst those with a history of isolation and masking psychotic symptoms may require input from specialised services such as Early Intervention for Psychosis (**EIP**), Assertive Outreach Team, community based psychology services and Crisis and Home Treatment Team input arranged prior to discharge.

59. The particular risks posed by the factors listed in the previous paragraph include: relapse with significant harm to self or others, rapid deterioration due to non-concordance, social isolation, reluctance to seek assistance, in denial, minimising or masking of symptoms and a higher likelihood of crisis readmission, which would require enhanced follow up and risk management.

60. The behaviours and observations that would lead me to consider that a patient remains a risk to themselves and/or others such that discharge should not be considered include a number of factors. Some of the mandatory factors include persistent intent or active plans for self-harm, ongoing command hallucinations to harm, uncontrolled persecutory beliefs with threat, current or very recent serious violence or near misses, frequent boundary breaches, severe disorganisation and inability to meet basic needs despite support. The concerns around current non-concordance with medications and or the expression of non-concordance in the future, expression of distrust in the management plan and lack of capacity to engage with medication treatment plan too are indicators for unsuitability for discharge.

61. The information I expect Priory Hospital Arnold to provide to community mental health teams on discharge is a summary that includes diagnosis and formulation, medication and monitoring plan, risk assessment and safety plan, early warning signs and crisis contacts, legal status and aftercare arrangements, and follow up appointments in line with NICE guidelines.

62. The meaning of *"insight"* in respect of patients who are experiencing or have a history of psychosis is the person's understanding of their illness, the recognition of symptoms and the appreciation of the need for treatment, which informs capacity assessments.

63. The meaning of *"masking"* of symptoms is conscious or unconscious minimising or concealment of psychotic experiences or risks during clinical contact, which requires triangulation with observations and collateral information.

64. The meaning of engaging on a *"needs led"* basis is engagement that occurs mainly when meeting requests or needs of patients or when prompted by staff.

65. The objective factors and independent sources that inform a judgement on the level or lack of insight include collateral reports, observed adherence, concordance between stated beliefs and behaviour, and the outcomes of decision specific capacity discussions in line with Mental Capacity Act, Code of Practice and NICE guidelines.

66. The objective factors that inform a judgement about conscious or unconscious masking include inconsistencies between interview reports and ward observation, abrupt changes in account linked to past events or future plans, contradictory views to external contingencies, third party information, and observed guardedness or rehearsed responses.

67. The information from a patient's history that is relevant to identifying risks on deterioration or relapse includes previous episodes and precipitants, patterns of non-concordance, response to medicines, history of violence or self-harm, forensic and safeguarding records and early warning signs recorded in previous care plans.

68. Discharge plans are formulated with the involvement of the following professionals: inpatient MDT plans with the community team, the general practitioner and where appropriate carers, with clear responsibilities, timeframes and contingencies in line with NICE guidelines.

69. The ongoing involvement that I would have after discharge to community is a formal handover and availability for early follow up advice as agreed at discharge, with day to day responsibility transferred to the relevant community mental health team and the care coordinator (**CCO**).

70. The health service responsible for ensuring the discharge plan is followed is the community mental health team or service that is accepting to manage or lead the patient's mental health care (after care), with the general practitioner (**GP**) and other relevant agencies (crisis resolution and home treatment team) supporting according to the plan.

COMMUNITY TREATMENT ORDERS (CTOS)

71. The circumstances in which a person with psychosis or Paranoid Schizophrenia may not be discharged without a **CTO** are frequent relapses due to disengagement or non-concordance that leads to serious risk to self or others, a history of serious violence or aggression, rapid deterioration after stopping medication, or social isolation and masking that impede engagement, where statutory criteria are met and the CTO is the least restrictive way to ensure safe community treatment.

72. There are no specific criteria for different presentations or historical risks. The decision as to whether CTO is the right option for any patient is taken by the Responsible Clinician (**RC**) and requires the agreement of an approved mental health professional (**AMHP**). As per Code of Practice **[DHSC0000007, chapter 29.10]**, CTO may be used only if it is deemed not possible to achieve the

desired objectives for the patient's care and treatment without it. The Code of Practice **[DHSC0000007, chapter 31.6]** states, that the key feature of the CTO framework is that it is suitable only where there is no reason to think that the patient will need further treatment as a detained in-patient for the time being, but where the responsible clinician needs to be able to recall the patient to hospital if necessary. In making that decision the RC must assess the risk of patient refusing or neglecting to receive treatment. The Code of Practice further states that the risk of patient's condition may deteriorate is a significant consideration, but does not necessarily mean that the patient should be discharged on to a CTO **[DHSC0000007, chapter 29.16]**. The RC and the AMHP must be satisfied that the risk of harm arising from the patient's disorder is sufficiently serious to justify the power to recall the patient to hospital for treatment. Although there are number of conditions that can be applied on a CTO, there are only two mandatory conditions. The first mandatory condition is a patient's availability for medical examination which is necessary to determine if the CTO should be extended and the second mandatory condition is the availability for a Second Opinion Appointed Doctor's review of treatment with the patient. The other conditions may be relevant or important but cannot be enforced includes compliance with oral or depot medications, testing or abstinence of drugs and alcohol and meeting the care coordinator (CCO). In order to recall a patient they must either breach one of the mandatory conditions or there must be sufficient evidence to suggest that they are relapsing in mental illness and posing significant risks to themselves or others.

NON-CONCORDANCE AND DEPOT MEDICATION

73. The behaviours and observations that suggest a risk of non-concordance with medication include negative views of medications, expressed refusal or ambivalence, observation of secreting medications, inconsistent accounts of use, poor insight, and intolerance of side effects, chaotic lifestyle and repeated history of poor concordance.

74. The circumstances in which I would consider that a patient may not be discharged unless medication is given by depot injection are expressed refusal or ambivalence to accept oral treatment, repeated non concordance with oral treatment that has led to high risk relapse or serious harm, previous benefit from depot, and a reasoned view that depot is the least restrictive way to maintain stability and safety and where there is a history of aggression, violence, social isolation, disengagement or masking.

75. Although there are no specific criteria, those with a history of aggression in the community and inpatient settings, those who are considered by clinicians to be at risk of becoming violent in the absence of treatment and those with a history of violence may require their depot medication administered in a community clinical setting or in the presence of a minimum of two staff members (male and female as appropriate) in their home setting.

76. Those with a history of non-concordance with medication, those with a history of social isolation, those with history of disengagement from treatment and

history of masking psychotic symptoms may benefit from depot medication administered in their home setting.

RESPONSES IN RESPECT OF VC'S TREATMENT

TRANSFER TO PRIORY

77. The first occasion I reviewed VC was on the day of admission. He was admitted to Priory Arnold on 01 October 2021 at 17:00hrs. As I recall, my interaction was a brief interview whilst the admission was being clerked in by the Resident Medical Officer (**RMO**) Dr Adamu. I discussed the medication regime and received VC's consent to continue the medication regime he had already been prescribed. I concluded that VC had capacity to consent to the medication regime.

78. Cygnet Victoria House provided the clinical notes of the previous seven days, risk assessment, multidisciplinary team review and detention paper work (s3 of the MHA 1983) **[PAGR0000003, PAGR0000004, PAGR0000005, PAGR0000006]**. The referrer, Nottinghamshire Healthcare NHS Foundation Trust's (**NHFT**) bed coordinator provided additional Rio electronic records as part of the referral information, which would have been emailed across to Priory but unfortunately this information was not uploaded onto VC's care notes/medical records, so I am unable to reference this directly. All of the electronic records that were available at the time of referral were used to screen the appropriateness of admission to an acute ward at Priory Arnold by the Bestwood ward MDT.

79. I understood that VC was admitted to Priory Hospital Arnold as a step down in his care pathway. The purpose of admission to an acute ward was to facilitate gradual transition to the community.

80. I am unable to recall whether I had seen the discharge summary or notification document completed by Cygnet hospital.

81. The source of the background information within VC's "*Keeping Safe*" Care Plan dated 21 October 2021 **[PAGR0000023]** was provided by the referrer, the NHFT's bed coordinator as part of the referral, as explained within paragraph 78 above, I am not able to reference this information directly.

82. VC's Care Plan **[PAGR0000023]** records that VC was *"able to engage in the admission process."* He engaged with the admission procedure on the day of admission and thereafter, for example he engaged in the admission interview, physical examinations, blood testing and ECG tests. The Care Plan also records that VC *'gave a good understanding of his reason for admission.'* VC was able to give a brief account of circumstances of his previous admissions and the admission to Cygnet Hospital **[PAGR0000025, entry: 01 October 2021, 19:14hrs]**.

83. There is a comment within the admission notes **[PAGR0000023]** that states, *"he admits that these were thoughts he was having at the time and appeared to be a symptom of his illness."* I am unable to comment on this extract, as this is a document that I have not authored. Therefore I am unable to comment what is meant by it. However, if VC had acknowledged that they were part of

symptoms of his mental illness, I would consider them as demonstration of insight.

84. The referral paper work indicated that at Cygnet Victoria House, VC had been fully compliant with treatment offered to him **[PAGR0000003, page 3],** engaged in MDT ward rounds and engaged in assessments by the nursing and psychology team. He accessed escorted leave uneventfully, and complied with the general management plan on the PICU ward.

INITIAL ASSESSMENTS AND PLANS

85. A risk assessment was completed on VC's admission **[PAGR0000008]**. I was not involved in the risk assessment document completed at the time of admission.

86. The risks had been rated based on the information the admitting doctor had access to at the time of admission. The historical risks refer to historical evidence of those risks, whereas current risks refer to more recent, relevant to the latest admission period. *"High"* refers to clear and significant evidence of risk, "medium" refers to less certain risks.

87. I have been invited to comment upon key concerns arising from each of the risks within the risk assessment. This includes the presence of all of the risks and the severity of them historically and for that admission period. My main observation would be that non-adherence with treatment had been identified as

"high" for that particular risk assessment, and as currently presenting and observed by the admitting doctor.

88. A referral checklist was completed on 1 October 2021 **[PAGR0000005]** and captured a previous incident where he entered another property as a result of his psychosis but not caused any direct physical harm or intentional emotional harm to others.

89. I expect that the risk assessment was formulated using the information made available by the referrer such as Rio electronic notes maintained by NHFT in addition to the clinical notes provided by Cygnet.

90. The risk management plan that was included in the referral checklist was formulated by the author of the referral screening document. I contributed to that as part of the MDT team.

91. The risk management plan considered the physical health aspect of the admission procedure under point 1. Point 2 refers to the initial level of nursing observations considered as appropriate. Point 3 explains how to manage restricted items on an acute ward and the graded manner he could have access to them later on. Point 4 refers to capacity assessments and his legal rights explanation plan. Point 5 refers to information sharing regarding mental state and management plans at daily MDT handover meetings. Point 6 refers to the psychology input plan focussing on insight, psychoeducation and relapse prevention. Point 7 refers to MDT reviews and how the treatment and management would be optimised. Point 8 refers to individual (one to one)

reviews by the named staff member allocated to work closely with him. Point 9 refers to the support provided by the occupational therapy team. Point number 10 refers to how the care coordinator and the nearest relatives would be involved in planning discharge and care needs. It also refers to VC's consent for such contact or involvement.

92. The risk management plan included a reference to anticipating that he would require a minimum of four intermittent nursing observations within an hour. This is standard for new admissions.

93. The expected benefit of input from the psychology team included the potential for VC to build trusting therapeutic relations with the team, offering opportunities to express his views and share experience and educational information by the team members. The expected benefits and progress is assessed by the level and frequency of his engagement with team members and improvement in compliance and insight into his illness. When patients do not engage in one to one talking sessions, different methods such as engagement in physical activities/games or discussions of patient's preference are trialled as alternative methods of building relations and accessing information.

94. Substance misuse was identified as a potential trigger for VC's mental illness, although it was not identified as a known risk. The psychology team is trained to assess and deliver advice on managing substance misuse using psychological methods.

95. The occupational therapy team provides assessments on activities of daily living, hobbies and interests as well as providing guidance on occupational/vocational opportunities. The progress of benefit is assessed by the level and frequency of engagement with the team.

96. All aspects that were considered relevant to mitigate risks at the time of VC's admission to Priory Arnold have been included in the initial management plan.

97. A care plan was formulated and in place at the time of VC's admission. These are documented in the admission assessments completed by the admitting doctor and nurse.

98. I am satisfied that Priory's admission, transfer and discharge policy was adequately followed in relation to VC's admission.

CLINICAL REVIEWS

99. Following VC's admission to Priory Hospital Arnold, VC had ward rounds on 4, 7, 14 and 21 October 2021, as well as a consultant review on 18 October 2021, before being discharged on 22 October 2021. During my interactions with VC during ward rounds, I recall him speaking with a soft tone, he answered in short sentences and the content was rational.

100. He presented as guarded during the initial interactions. I found him to be more relaxed, open and engaging in the conversation in subsequent reviews.

101. There was no obvious evidence that he was masking symptoms. However, I recall conversations with the MDT members about the potential of him masking symptoms during the initial MDT reviews. This was captured in the risk assessment as an additional risk item.

102. VC demonstrated insight by requesting a different type of medication (Aripiprazole) that he found effective in the past. He was also able to acknowledge previous experiences with auditory hallucinations both second person and third person (first rank symptom of Schizophrenia). He acknowledged and appreciated that the medication Aripiprazole was beneficial in resolving these experiences and agreed for the CCO's continued involvement in his care.

103. There was no evidence or signs of aggression or violence during his admission to Priory Hospital Arnold.

104. Over the course of VC's admission, he presented as more relaxed and engaging in conversations proactively towards the later part of his admission.

105. The feedback from nursing colleagues was obtained during daily handover meetings, MDT meetings and reviews.

106. The most significant aspect of the feedback at each ward round was that he remained calm, polite and compliant with ward procedure and regulations. The aspects of the feedback that I found reassuring was that VC was compliant with

medications, had proactive interactions with staff and presented as much more relaxed comparing to the initial week.

107. There was no concerning feedback received from any of the staff members. They spoke positively about his progress.

108. The feedback changed over the course of VC's admission from guarded, suspicious presentation to more relax and opening up about his circumstances and expressing plans to resume his University degree.

109. The MDT was supportive of trialling leave outside the hospital unescorted and then in the wider community with a view to assist securing accommodation and resuming his studies. VC was allowed to visit his car that was parked at Highbury Hospital and bring items such as his laptop. He was observed working on his laptop often. He utilised hospital grounds leave and community leave access as per authorisation regularly without any concerns. Absence of any concerning behaviours, signs or symptoms of psychotic features assisted in making active discharge plans.

110. There are ward round notes that were documented on 7 October 2021 **[PAGR0000159]**, 14 October 2021 **[PAGR0000160]**, 21 October 2021 **[PAGR0000028]**.

RISK ASSESSMENTS

111. Risk assessments were completed on 4 October 2021 **[PAGR0000009]**, 7 October 2021 **[PAGR0000010]**, 14 October 2021 **[PAGR0000011]**, and 21 October 2021 **[PAGR0000012]**. There are separate records of risk assessments and MDT reviews (ward rounds). The ward rounds were completed during MDT reviews on 7 October 2021 **[PAGR0000159]**, 14 October 2021 **[PAGR0000160]**, 21 October 2021 **[PAGR0000028]**.

112. At each ward round following the initial admission assessment on 1 October 2021, VC's risks, so far as relevant, were assessed as set out in the following table. The 'historic' risk, which was also set out in each assessment, is included here:

Risk	1 Oct	4 Oct	7 Oct	14 Oct	21 Oct	History
Self-neglect	Medium	Low	Low	Low	Low	High
Non-adherence with treatment	High	Medium	Low	Low	Low	Medium
Violent, aggressive, intimidating behaviour	Medium	Medium	Low	Low	Low	High
Absconsion or escape	Medium	Low	Low	Low	Low	High

The dated risk ratings reflect VC's presentation up to that date. The historical ratings reflect evidence or past history of each category. The dated risk ratings have been updated (downgraded) as per presentation and progress made. For example, there was no evidence to suggest high risk for non-adherence with treatment since VC had been fully compliant with treatment and no evidence of negative attitudes or resistance or requirements to persuade to accept

medication. Similarly no evidence to suggest ongoing concerns for violence, self-care or absconding behaviour.

113. VC's historic risks were rated as per the information recorded related to historical events/incidents and presentations.

114. The risk formulation is usually updated following significant new incidents or concerns during the admission period or if new information is received about historical events/incidents or specific categories. It may therefore appear that the same risk formulation is repeated verbatim at each ward round. However, there were no incidents of violence reported during his admission period at Priory Hospital Arnold.

115. In circumstances where the form provides that the section should set out *"the rationale for the Risk Level assigned",* the risk formulation addresses the background to VC's admission because the formulation attempted to capture the relevant risk categories and rationale in the background history.

116. The contemporaneous records of the rationale for risk assessments include the MDT forms, which captures nursing records of presentation for that particular review period and the presentation during the MDT review (ward round).

117. VC having no family support network or close friends in NHFT remained a concern. However, he did have some acquaintances (university friends) who I believe assisted him in moving his car to and from Highbury Hospital car park. Additionally his mother was in regular contact with VC, she used to contact the

ward and the ward phone was passed on to VC on few occasions (due to mobile phone signal issues). Comparing to other patients in similar situation, VC was quite resourceful, he had access to funds, mobile phone/laptop and clothing and footwear. He was independent in activities of daily living. He came across as intelligent, self-advocating and efficient in resolving matters related to his education, finances and accommodation

RISK MANAGEMENT PLANS

118. Following each risk assessment, a *"Risk Management plan"* is formulated to address identified significant risks. This is shared with the wider nursing colleagues. Level of nursing observation advises the intensity and frequency recommended for monitoring the patient, medications denotes the type of medications that can be used to manage distress/incidents, *'leave'* refers to the restrictions placed on access to leave the ward and *'access'* refers to various items the patient has easy access or restricted.

119. *'Level 2, 2 checks'* means, intermittent observations with minimum of 2 checks within the hour. Level of observations are usually set as 4 checks for new admissions. This is to facilitate close monitoring of symptoms/risks as well as therapeutic relations. The frequency of observations are reviewed as per presentation. In VC's case this was reduced as there was no need for intense monitoring since there were no incidents, risks or management concerns.

120. *'PRN'* is an abbreviation for the Latin term *pro re nata*, and that means *"as the thing is needed"*. PRN refers to medications that can be used as and when

required to manage risk incidents or distressing symptoms, and can include those medications that are prescribed on regular basis too.

121. The agreed plan for VC's leave to be escorted was due to an absconding risk considered at the time, in addition to the fact he was unfamiliar with a hospital environment and local area. This is the standard practice with all of the new patients who are detained.

122. The risk management rating changed on 14 October 2021 as a reflection of the progress he was making. He did not pose any challenges to the ward management procedure, was fully compliant with treatment and was not involved in any incidents. The reason for the reduction of restrictions on his leave access was to facilitate recovery and independence.

123. There was insufficient evidence to change the risk management plan on 4 October 2021 as it was only few days since his admission.

124. The management plan described in the initial checklist to involve VC's CCO and his family was actioned. VC's CCO was notified about the ward rounds and sent emails inviting her to join in person or remotely using electronic links. The CCO attended the ward round on 14 October 2021 **[PAGR0000160, page 4]** (although the records states CPN attended, this refers to Ms. Claudia Birtles who was both a CPN and CCO), was given an update of progress and possible discharge plans for the following week and agreed to attend the next MDT review and remain involved in his care. VC's CCO was also informed of the planned discharge on 21 October 2021 when she phoned the ward to get an

update. VC declined to give consent for his mother to be involved in his care or to attend MDT reviews remotely. He declined his mother's input stating she would worry unnecessarily. I contacted VC's mother on her mobile phone to gather background information and briefly update the progress and discharge plans. During this conversation I recall informing VC's mother about his accommodation status and possibility of moving to a supported accommodation (Beacon Lodge) if there are delays securing tenancy for suitable accommodation. She was appreciative of the telephone conversation.

125. As per the management plan occupational therapy (**OT**) and psychology input was offered. His progress notes indicate that he declined OT input. It is not clear whether the psychology team invited him for any sessions or assessments. During the admission period VC was able to demonstrate that he was competent in activities of daily living and required no additional assistance by the OT team. He declined OT physical activity sessions when offered.

126. All relevant measures to reduce risk were included in the risk management plan. Consideration for depot medication administration and CTO could have been included in the initial management plan. However, these were not considered appropriate as he demonstrated insight into benefits of medication and motivated to continue oral medication.

127. I am satisfied that VC's risk assessments whilst at Priory Hospital Arnold appropriately captured, addressed and managed the risks that VC posed to himself and to others while acutely unwell based on the information known to Priory. I am satisfied that the general principles and guidelines of Royal College

of Psychiatrists Good Practice Guide for the Assessment and Management of risk to others have been adhered to when assessing, formulating and managing VC's risks. The good practice guide emphasises on patient-centred care and holistic approach to risk assessment, requiring clinicians to gather information from multiple sources in relation to key historical risk factors and involving the patient and carers in developing the management plan. In line with this principle his risks and management plans have been reviewed on several occasions. In addition to the available historical information, VC and his mother's views and wishes have been taken into consideration, triangulating the risks and formulating the risk management plan.

128. The Priory's policy on *"Clinical Risk assessment and Risk Management"* **[PAGR0000038]** stresses the fact that the risk is a dynamic process changing over time in response to a number of factors that include the patient's previous history, their current mental state, and the environment, particularly stressful points of transition such as admission, transfer or discharge from the ward. The policy highlights the importance of updating risk assessments after each significant change in the patient's presentation, including responding to any incidents or change in mental state. I am satisfied that the policy that was in place at the time of his admission was adhered to when gathering information, assessing presentation and formulating risk profile and safe discharge planning.

CARE PLANS

129. VC had care plans in relation to *"Keeping Safe"* **[PAGR0000023]** which was first formulated on the day of admission, 01 October 2021, by Staff Nurse Emelia Parton. *"Keeping Healthy"* **[PAGR0000174],** "*Keeping Connected"* **[PAGR0000171]** were completed on 2 October 2021, and *"Keeping Well"* **[PAGR0000167]** *on* 3 October 2021 by Emelia Parton as` well.

130. All care plans were last updated on 21 October 2021. Earlier versions of each care plan also exist for the following dates, in respect of each care plan:

- Care Plan "Keeping Safe" dated 1 October 2021 **[PAGR0000164]**
- Care Plan "Keeping Safe" dated 7 October 2021 **[PAGR0000165]**
- Care Plan "Keeping Safe" dated 14 October 2021 **[PAGR0000166]**
- Care Plan "Keeping Safe" dated 21 October 2021 **[PAGR0000023]**
- Care Plan "Keeping Healthy" dated 2 October 2021 **[PAGR0000174]**
- Care Plan "Keeping Healthy" dated 7 October 2021 **[PAGR0000175]**
- Care Plan "Keeping Healthy" dated 14 October 2021 **[PAGR0000176]**
- Care Plan "Keeping Healthy" dated 21 October 2021 **[PAGR0000022]**
- Care Plan "Keeping Connected" dated 2 October 2021 **[PAGR0000171]**
- Care Plan "Keeping Connected" dated 7 October 2021 **[PAGR0000172]**
- Care Plan "Keeping Connected" dated 14 October 2021 **[PAGR0000173]**
- Care Plan "Keeping Connected" dated 21 October 2021 **[PAGR0000021]**
- Care Plan "Keeping Well" dated 3 October 2021 **[PAGR0000167]**
- Care Plan "Keeping Well" dated 5 October 2021 **[PAGR0000168]**
- Care Plan "Keeping Well" dated 7 October 2021 **[PAGR0000169]**
- Care Plan "Keeping Well" dated 14 October 2021 **[PAGR0000170]**
- Care Plan "Keeping Well" dated 21 October 2021 **[PAGR0000024]**

131. All care plans had been updated regularly until the date of discharge.

132. Care plans take into consideration important aspects of a patient's care. For example *"Keeping Safe"* covers areas concerning patient's and other's safety

aspects. *"Keeping Connected"* with patient's support network, social circle, and accommodation and employment aspects. *"Keeping Healthy"* covers physical well-being and *"Keeping Well"* covers mental health and general well-being.

133. The care plans included various objectives, goals and expected actions. They summarise key aspects of VC's different care needs and management plans.

134. All aspects that were considered important and relevant have been captured in the four care plans.

135. The role of VC's family and mother's name have been captured in the "*Keeping Connected*" care plan which was formulated initially on 02 October 2021 **[PAGR0000171].**

136. *"Talk Time"* refers to individual (to one to one) nursing sessions offered to each patient. These sessions are offered to patients on regular basis, the purpose is to facilitate therapeutic relations, carry out accurate assessments and provide necessary support.

Feedback from the external teams were received by way of referral information **[PAGR0000003, PAGR0000004, PAGR0000005, PAGR0000006]**. Certain aspects of those information had been shared and clarified with VC during his reviews by MDT members at various points. He was given feedback about concerns around medication compliance, external team's views about circumstances of admission and psychotic features **[PAGR0000159]**. VC was reassured that the bed management team was happy for him to leave his car

that was parked at Highbury Hospital car park until he is discharged from hospital **[PAGR0000160]**.

137. The rationale for the various objectives and actions to be included within VC's care plan was to capture as many care needs and provide necessary support to VC to ensure that his care needs were met.

138. Most of the objectives and actions as prescribed within the care plans were completed throughout the admission period except the objectives on OT and psychology input. The care plans were regularly reviewed during one to one sessions and at MDT reviews (ward rounds) by nursing staff with the input of other clinicians of the MDT team.

139. VC engaged and developed positive relationships with most members of the MDT team who had direct interactions with him, particularly with the nursing and medical members of the team. He did not take part in occupational therapy activities offered. I could not find any evidence that VC had engaged with members of the psychology team. It may be that the admission period was short and he was occupied in other activities that were important to him at the time such as resolving his accommodation and resuming education that meant that he was unavailable to engage when they were present on the ward.

140. Most objectives in the care plan were met as evident by the recovery he made, medication compliance, family contact established, connection with his community psychiatric nurse, accommodation resolved, absence of incidence

and successful and safe transition/discharge back to the community to resume his education.

141. VC's *"Keeping Safe"* care plan (1 October 2021) **[PAGR0000164]** included the following objectives set by the MDT: non-compliance, violence and aggression, psychosis, paranoia and harassment of neighbours. These were considered current risks at the time, as they were relevant to the circumstances of the admission.

142. All of the previous risks mentioned in the preceding paragraph to this statement were considered significantly reduced over the admission period to be considered low risk at the point of discharge. They were monitored during one to one sessions by members of the clinical team and at MDT ward round reviews.

143. All previously mentioned areas were taken into consideration when gradually reducing restrictions placed on VC's freedom, for example access to certain items such as laptop/cables, community leave access and his detention under s3 of the MHA and subsequent discharge planning.

144. VC's *"Keeping Well"* care plan **[PAGR0000024]** included the needs or goals as expressed by him. The needs and goals were expressed by VC during meetings and/or discussions with members of the MDT team from the time of his admission at various points. The care plans were formulated with VC's cooperation.

145. I consider acknowledging abnormal experiences such as hearing *"multiple voices"*, being able to express his concerns about some of the medication side effects and suggesting alternative but effective medications as significant turning points of VC's recovery.

146. When VC said he had *"been informed that it is called psychosis,"* in my opinion this reflects some level of acceptance of his psychotic experiences and a change of position held previously.

147. When VC said, *"the only problem I have is salivation,"* I understood him as referring to a side effect he experienced with medications, which was attributed to a known side effect with medication Haloperidol that he was prescribed at the time.

148. When he mentioned *"only problem"*, in my opinion this was in reference to the only complaint he had regarding medication he was on (Haloperidol) at the beginning of his admission to Priory Arnold.

149. The *"warning signs and possible triggers"* referred to in the care plans were the warning signs and triggers previously identified and therefore understood by the team. The objectives were for the MDT members to be aware of them and for VC to have a better understanding of them. Some of the warning signs were presenting as stressed, responding to hallucinations or abnormal believes, negative attitudes or resistance to accept medication, presenting as suspicious, irritability, verbal and physical aggression. There were regular monitoring and exploration of these during nursing reviews and MDT ward rounds. The

significant improvement showed in these areas assisted decisions regarding management of care, treatment and safe discharge plans.

150. During the course of the admission I would consider that VC's *"warning signs and possible triggers"* were understood by VC. He acknowledged the presence of a mental health problem and the benefits of receiving treatment. In terms of *"warning signs and triggers"* he was able to discuss previous experiences with abnormal voices. He reported relief of these experiences and feeling better when he was receiving his medication (Aripiprazole) in the past and requested change of his medication to that. There were regular discussions during MDT ward rounds about signs and symptoms and stressors, and he was able to articulate them better towards the later part of his admission.

151. I believe VC understood the importance of medication as he himself suggested change of medication to Aripiprazole, stating it was more effective and tolerant in the past in terms of relieving his symptoms. I was satisfied that he would remain concordant with a medication of his choice. I was reliant on his community team (EIP) which is a specialised team with resources and expertise to continue to build trusting therapeutic relations to ensure his medication concordance.

152. The importance of VC continuing to take his medications was addressed during each MDT ward round. I was satisfied that he understood and acknowledged the relief of symptoms when he was receiving medication in the past and that this would motivate him to remain concordant if it is a medication of his choice, effective and more tolerant with fewer or no side effects. Increased salivation

and sedation or tiredness were his main concerns with medication (Haloperidol). As there were no concerns of his medication compliance during admission period and no reported increased salivation or tiredness or sedation, it was decided to discharge him on the same medication and the same dose strength. The community team was advised and expected to review medication/treatment as appropriate during post discharge and follow up assessment meetings.

DIAGNOSIS, TREATMENT AND MEDICATION

153. On 7 October 2021, the diagnosis of Paranoid Schizophrenia was **[PAGR0000027]** confirmed on the basis of clear description of previous experiences with *"third person"* auditory hallucinations, which is a first rank symptom (characteristic feature) of this condition.

154. Depression and other types of psychotic illnesses were considered prior to confirming this diagnosis, however they were excluded on the basis of absence of adequate clinical evidence.

155. Paranoid Schizophrenia itself is a psychotic illness and the treatment remains the same. Had VC presented with significant clinical features of depression, additional medications such as antidepressant medications could have been included in his medication regime.

156. As to VC's capacity, the capacity assessments were carried out by providing information about his treatment and assessing his understanding of rationale

for such treatment, assessing his ability consider pros and cons of such treatment and assessing his ability to convey his decision/agreement.

157. The source of information came from Cygnet's clinical notes, risk assessments and MDT ward round notes **[PAGR0000003, PAGR0000004, PAGR0000005, PAGR0000006]**.

158. As per Cygnet MDT form dated 21 September 2021 VC lacked capacity to consent to treatment. My observation on 01 October 2021 was that VC had capacity to consent to recommended treatment.

159. My initial assessment of his capacity was on the day of his admission 1 October 2021. I had a conversation with him while he was being admitted by the admitting medical officer and the nurse.

160. VC's capacity to recommended care and treatment was assessed at the point of his admission and at subsequent MDT ward rounds.

161. His capacity to consent to care and treatment was taken into consideration when assessing progress, recovery and planning treatment and discharge

MEDICATION

162. VC was prescribed Haloperidol 5 mg **[PAGR0000007]** oral tablets three times daily at the time of his admission to Priory Arnold. This is a first generation strong antipsychotic medication. This was prescribed at a comparatively higher

dose to manage the level of violence and aggression displayed during the early part of his detention. He was nursed in seclusion for nearly a week at the 136 suite of Highbury Hospital, Nottingham prior to his admission to Cygnet.

163. VC complied with his medication treatment (Haloperidol) during his admission at Priory Hospital Arnold.

164. VC reported problematic side effects with his treatment (Haloperidol) such as increased salivation and tiredness. As previously mentioned, he himself suggested alternative antipsychotic medication that had been effective and tolerable and agreed to continue during the admission and in the future.

165. In VC's *"Keeping Well"* care plan (7 October 2021) **[PAGR0000169],** it was noted that VC said he would *"like to switch to Aripripazole."* VC wanted to change his medication due to problematic side effects, namely hyper salivation and tiredness which was likely to impact on his plans to resume university education and possibly driving too.

166. His medication was changed to Aripiprazole. The dose was cross tapered; while the Haloperidol dose was gradually reduced the Aripiprazole dose was gradually increased.

167. VC's medications were changed with a view to facilitate his compliance with medication. Aripiprazole is a second generation (modern/refined) antipsychotic with similar effectiveness in treating psychosis in the longer-term with a better safety profile in terms of potential harmful side effects.

168. VC reported better tolerance and reported improvement of hyper salivation and tiredness in subsequent reviews. He continued to improve in terms of his mental stability and activities. He was able to use his laptop, make contact with external parties, accessed community leave, secure a tenancy on his own and made plans to resume university education upon discharge.

169. VC was happy to continue the recommended Aripiprazole dose and agreed to remain engaged with the community psychiatric nurse and the early intervention team.

170. The *"Discharge entry"* in VC's care record **[PAGR0000025]** on 22 October 2021 provided that VC was *"given 14 days TTO – Aripiprazole."* TTO refer to *"To Take Out",* meaning take home when discharged. Patients are given 14 days of their medication regime when they are discharged. This was to ensure that he would have an adequate quantity of his medication until he received a repeat prescription from his GP surgery.

MHA DETENTION

171. On 18 October 2021, VC was discharged from his s.3 MHA detention **[PAGR0000014]**, as there were no further indications to restrict his freedom. He remained fully compliant with care and treatment plans and made significant progress and improvement of his mental illness signs and symptoms. Furthermore, there were no imminent concerns around his safety or safety of others, he managed to resolve issues regarding accommodation and there were no further hindrances to his discharge plans.

LEAVE

172. Towards the end of VC's admission, he took relatively lengthy periods of leave. His care records **[PAGR0000025]** provide that, on 16 October 2021, VC *"utilised 6 hours community leave and returned appropriately*". On 18 October 2021, he also *"utilised his 6hr unescorted community leave".* On 20 October 2021, VC spent *"the majority of the day… out of the hospital perimeter".* VC's leave was considered appropriate and it was to facilitate his wishes and plans to resume his university course. As I recall, he utilised the leave to visit his new accommodation, move his belongings from his car to the new accommodation, visiting university and meeting with his friends and acquaintances.

173. There were no concerns reported upon VC returning from leave. He was compliant with leave conditions and returned to the ward in time, complied with medications and attended to his meals and personal care unprompted.

174. VC had extended periods of leave only towards the last stages of his admission, in particular after rescinding his detention. Prior to that he had access to unescorted hospital ground leave access. There were no concerns reported during pre-leave or post leave observations. Assessments and observations concluded up to that point raised no concerns of relapse signatures or signs of distress. Extended periods of leave were authorised to facilitate his transition and re-integration into the community.

175. I am satisfied that Priory's *"Assessment, Diagnosis and Treatment"* policy **[PAGR0000141]** was adequately followed in VC's case.

176. I am also satisfied that Priory's *"Care Programme Approach/Care & Treatment Planning"* policy **[PAGR0000037]** was adequately followed in VC's case.

INSIGHT AND ENGAGEMENT

177. In VC's 1 October 2021 **[PAGR0000008]** and 4 October 2021 risk assessments **[PAGR0000009]**, under *"Patient Views and Involvement"*, the following comment was provided: *"Patient is engaging with staff. He requested to know when he will be discharged, but willing to stay to get better."* The basis for the comment that VC was engaging with staff was in relation to his cooperation with admission assessments, consenting to treatment, remaining calm and being polite, not showing any negative attitudes or behaviours towards staff or management plans.

178. The statement that VC was noted to be willing to *"stay to get better"* was in reference to his questions during admission and subsequent reviews. I considered this significant as it indicated that he had some insight of the process and was consenting to treatment and care plans.

179. The basis for the comment that VC was willing to stay in hospital was, in my opinion, his agreement to cooperate with treatment and management plans when the admission process was explained to him at the time of admission and during subsequent reviews.

180. A nursing admission assessment was conducted on 1 October 2021 by Emelia Parton **[PAGR0000017]**. The assessment form included the following comments:

> *"Valdo spoke about the reasons for admission and showed insight into his mental health illness, he recognised that he has psychosis and he stated that he didn't mind taking medication (However notes suggest that he has been non-compliant before in the community)."*

I was aware of the comments VC made at the time of admission regarding his illness (psychosis).

181. I agreed that VC showed some level of insight into his illness at the time of his admission to Priory Arnold. This, in my view, was a demonstration of insight on the part of VC, particularly the nurse's comments about history of non-compliance in the community. The basis for my conclusion was the fact that VC was able to acknowledge his psychosis, improvement of his symptoms and his consent to comply with medications/treatment.

182. VC's 14 October 2021 risk assessment **[PAGR0000011]** included the following comment:

> *"Patient is engaging only on needs basis, remains guarded - likely to be personality - keen to be discharged and appears to be minimising the severity of illness."*

My basis for the observation *"patient is engaging only on needs basis, remains guarded"* was as a result of the nursing feedback received during the MDT ward review, that he approaches them only to request for something or for his meals and he was observed to spend a lot of time in his room.

183. My observation that VC remains *"guarded"* was made by his interactions and responses during MDT ward rounds. I suspected that he is a quiet and a private person by nature and his presentation could be explained by an introverted personality.

184. VC's 21 October 2021 risk assessment **[PAGR0000012]** included the following comment:

> *"Presenting as relaxed, engaging better during ward review, showing insight but appears to be in denial of the severity of illness."*

The reason for my comments that he was *"engaging better"* and *"showing insight"* relates to my observation at the time, that he was presenting as much more relaxed and conversing more comparatively. He was able to acknowledge the benefits of medication on his recovery and willing to continue the recommended medication and comply with follow up plans with his community team.

185. Other comments such as, VC was *"minimising"* indicated that he was not acknowledging the seriousness of his illness and the comment *"denial"* was made to suggest that he may be aware but struggling to accept the seriousness

of his illness. Both these aspects were taken into consideration when assessing risk and planning care and treatment. It is very common for intelligent and young persons (university students) to come to terms with their mental health diagnoses. As a result they have tendency to minimise the seriousness of illnesses. Denial is part of a defence mechanism to defend their ego, in my opinion.

186. I did not have ongoing concerns that VC was minimising or in denial of the severity of his illness at the time of his discharge on 22 October 2021. He presented as having made a sufficient recovery by virtue of the way he interacted at the last MDT ward round on 21 October 2021. He agreed with my suggestion to remain on the ward overnight and leave the following morning. He did not show any negative views when discussing the importance of complying with medications and acknowledged he was tolerating medications without any side effects and was happy to continue them. I was hopeful that he would continue to engage with his community mental health team (the early intervention team) and form trusting therapeutic relations with his community psychiatric nurse similar to the relationships he made with certain staff members of Priory Hospital Arnold. It was my view that he had implied that he had had a positive experience during his recovery by remaining incident free and being polite to all categories of staff.

187. VC's level of insight was taken into consideration when deciding treatment, care and risk management planning. He was able to acknowledge improvement of his symptoms and suggested his preferred option in terms of medication.

188. I did not have ongoing concerns of lack of insight at the time of his discharge. I am of the view that a patient suggesting appropriate medication for his illness is a good indication that he is appreciating benefits and is likely to comply with that particular medication. Since he was tolerating the medication better without significant side effects, and since it was not affecting his activities of daily life, I was convinced that he would remain compliant with treatment in the foreseeable future. In terms of potential non-compliance in the future, I was satisfied that he had adequate wrap around service in terms of the monitoring and supervision by the specialised team. The EIP team has adequate resources and expertise to manage/intervene medication non-compliance issues. I believed that the CCO would form therapeutic relations and be able to address any concerns with regards to compliance issues.

189. I am unable to recall forming an impression that VC was engaging with OT and psychology during his admission at Cygnet Victoria House. I did not expect him to have engaged proactively in therapy sessions as he was very unwell in the early part of his admission there.

190. In terms of lack of engagement with occupational and psychology therapy services, my focus was to get him stabilised in his mental state and building trusting therapeutic relations with him in the first instance. It is expected that when patients are new and unstable they would remain unengaged in the initial weeks. The approach with VC was to build trusting relations at the earliest opportunity so that he would feel comfortable engaging in therapy sessions.

191. Patients do not engage in recommended therapy sessions for a number of reasons. Some of these include ongoing symptoms of mental illness (low mood, paranoid beliefs, and hallucinations), anxiety/tension, lack of motivation, lack of self-confidence, lacking energy and many other reasons or factors. These matters were taken into consideration during reviews when planning care and discharge planning. We did not emphasise occupational therapy as he was independent in activities of daily living, maintained a good level of personal care, and was resourceful and intelligent enough to advocate for himself. In terms of psychology input, I am unable to recall or find evidence whether he was offered or declined any psychology sessions. VC's main focus was getting discharged in order to resume his university degree as he was very close to completing and obtaining qualifications. The MDT facilitated access to his personal belongings (laptop, mobile phone, books), community leave with a view to reduce his frustration and anxieties around being detained in hospital for long period and also to assist securing a new tenancy and his transition back to the community.

192. I was satisfied that he had made adequate progress in order to be considered suitable to stepdown to an acute mental health service. The referral information suggested that his interactions with staff and peers were appropriate.

193. VC presented as isolating in the initial part of his admission at Priory Hospital Arnold. Staff respected his privacy and approached him with compassion and assisted meeting his needs. He started forming trusting relations with certain members of staff and engaged in meaningful conversation about his

background and future plans as evident by nursing clinical entries **[PAGR0000025, page 5, 13 October 2025, 16:57hrs]**.

194. Patient's non-engagement with staff or peers is a concern in any service. It is vital to promote engagement so that patients are likely to form trusting relations. Delivering therapy and exploration of risks becomes more accurate when patients begin engaging with both staff and peers. VC's engagement with staff improved slowly but more meaningfully as he progressed with recovery.

FAMILY ENGAGEMENT

195. VC's *"Keeping Connected"* care plan **[PAGR0000021]** included the following comment, noted to have been expressed by VC: *"I don't want my mum to be bothered with my illness as she always worry about me,"* was mentioned on 7 October 2021 during a care plan review with staff nurse Mia Gel. Staff regularly facilitated telephone contact with VC's mother whenever she phoned the ward. I understand that the mother was given brief updates on his recovery by staff who handled those calls. The ward mobile phone was passed on to VC during those occasions and he was observed engaging in cordial conversations. VC's mother was contacted to obtain information about his background and history and for reassurance purposes. No information that was considered confidential such as circumstances of his admission or details of his mental disorder or treatment were discussed.

196. VC declined consent to invite his mother to attend MDT ward rounds or share information when this was discussed during the MDT ward review on 7 October

2021 **[PAGR0000159]**. I am unable to recall whether this was revisited again in subsequent MDT ward rounds. I understand that his mother regularly contacted the ward and contact with VC was facilitated.

197. I myself contacted VC's mother on one occasion. My intention was to obtain background information and concerns and providing reassurances that he was safe and making progress in his recovery whilst respecting VC's wishes not to share information that could make her worry unnecessarily. The information was helpful to understand VC's background, upbringing in different cultures/countries, his personality features (quiet, respectful and considerate) and confirm his psychotic diagnosis.

198. It should be noted that VC's CCO is referred to as CCO and as his CPN within records (as she held both professional titles).

199. VC's CCO attended the MDT ward round on 14 October 2021 **[PAGR0000160]**, also referenced in VC's clinical records **[PAGR0000025]**. I discussed his presentation, medication changes, progress made and plans to rescind his detention order as there were no active indications to justify detention further. Furthermore, I discussed the possibility of discharging the following week and advised nursing colleague(s) to order discharge medication at the earliest in preparation for this discharge. As far as I can recall and as per minutes of the MDT meeting there was no objection to this plan. The CCO was sent an email and electronic link to take part in the discharge MDT ward round on 21 October 2021. The clinical notes have recorded a conversation by a nurse that the CCO contacted the ward on the phone and made inquiries of the outcome of the

discharge MDT meeting shortly after it was concluded **[PAGR0000025, page 1 and 2, 21 October 2021, 19:19hrs].** The CCO was informed that VC was discharged and that he will be leaving the ward the following day and to make necessary follow up arrangements.

VIOLENCE AND AGGRESSOIN

200. Each of VC's risk assessments – 4 October 2021 **[PAGR0000009]**, 7 October 2021 **[PAGR0000010]**, 14 October 2021 **[PAGR0000011],** and 21 October 2021 **[PAGR0000012]** – included the following comment: *"Circumstances of current admission has been serious and violent."* VC gave a brief account of circumstances of his admission during admission interview and in the initial MDT ward round on 07 October 2021. He was of the view that it was not a relapse of his mental illness, rather an over-reaction when police got involved. Later in the conversation he acknowledged it was a psychotic episode related to stress.

201. I believe VC did express regret for his reaction.

202. VC did demonstrate insight into his previous psychotic episodes but not violence or aggression. He was able to report previous psychotic experiences and gave details of auditory hallucinations.

203. It was not clear whether VC did not appreciate the seriousness of circumstances of his admission or whether he was intentionally downplaying the severity of violence. I believe denial played a part in minimising or

normalising and moving on with his life goals. I was not particularly concerned as he did not present as hostile or intimidating towards staff or engaged in any form of violence during the admission period at Priory Hospital Arnold. In fact he presented as polite, calm, patient and well mannered.

204. His capacity for violence was taken into account during planning his care, treatment and discharge. I considered his violence was a result of psychotic experiences and my objective was to treat him effectively so that this aspect of the risk profile could be mitigated significantly towards a safe discharge process into the community.

205. I was aware that VC had brought a hammer with him after going out on community leave on 10 October 2021. The entry that makes reference to this in VC's care record stated that *"it is unclear as to whether he picked this up by accident or whether it was intentional"* **[PAGR0000025]**.

206. My recollection of his explanation is that he picked this up as he was moving to a new property and needed a hammer to hang items. The hammer was detected during a search upon returning from communality leave, this was removed and kept in his locker as it was a banned item on the ward.

207. I cannot recall whether I had any concerns at the time. I was satisfied that he remained calm and was cooperating with the staff members prior to and post leave assessments and searches.

208. I was aware that VC had sustained a cut to his nose on 20 October 2021 in the morning, and him reporting a fall in his room. I cannot recall him reporting during the MDT review but was mentioned in the nursing feedback **[PAGR0000025]**.

209. I cannot recall observing a cut or a plaster on his nose when I reviewed him during the MDT ward round on 21 October 2021.

210. I cannot recall having concerns about him sustaining a cut to his nose and not eluding to how it was caused.

211. I did not have ongoing concerns about VC's risk of violence and aggression at the time of discharge on 22 October 2021. He remained free of violent incidents during the admission period. He was calm, cooperative and polite to staff throughout.

212. I did not anticipate that he would present as aggressive or violent as he was considered ready and safe to step down to an acute ward by Cygnet intensive care unit. However, I was fully aware of his capacity to become violent during episodes of psychosis. My objective was to treat his mental illness with effective and tolerable medication, provide care with respect and compassion and build a trusting therapeutic relationship that would assist risk assessments, treatment and safe discharge planning.

213. I was familiar with VC's delusional beliefs that was documented in Cygnet MDT review dated 21 September 2021 **[PAGR0000006]** about the CCO being part

of a conspiracy by the NHS and the Judiciary to punish him for breaking lockdown rules by way of transmitting voices to his mind that he is psychotic. Additionally I was aware of his delusions at another occasion where he was convinced that someone was being raped next door **[PAGR0000025, page 9]**, clinical entry 01 October 2021I had experience managing patients with similar type of beliefs.

214. VC did not discuss or report ongoing abnormal beliefs whilst at Priory Hospital Arnold.

215. I explored evidence of ongoing abnormal beliefs and experiences when I reviewed him during MDT ward rounds. He denied any concerns working with his community team or his CPN. He was happy to continue to engage with his CPN and her attendance at MDT ward rounds

DEPOT MEDICATION

216. I did not have any direct communications or discussions with any of the Cygnet Victoria House MDT in relation to depot medication.

217. I agreed to prescribe Aripiprazole readily as it is a medication that I have used widely, a medication that has less side effects in particular sexual side effects and it is available in depot format for administration should a need arise. I did not consider administering the medication in depot form as there were no concerns regarding compliance during his admission period at Priory Hospital

Arnold. Furthermore, Aripiprazole was a medication of his choice and he reported no side effects.

218. I cannot recall whether I discussed depot medication with VC.

219. The nursing feedback indicated that VC was fully compliant with his medication and there were no concerns regarding negative views expressed, side effects reported, secretion of medication or non-compliance during his admission period. Absence of ongoing psychotic features and concerning behaviours supported the view that the medication was effective and he was compliant.

220. I cannot recall any particular discussions I had regarding prescribing medication in depot format with VC's community treatment team. However, had his community team made such a request, I could have persuaded VC to accept a depot injection prior to discharge, as I had established a positive therapeutic relationship with him during the course of the admission.

221. The need for commencing depot medication is not based exclusively on VC's community team's request. I would have considered the depot option if there was any evidence of non-compliance during the admission period, if he had expressed negative views of medication or if there was any evidence or suspicion of secreting medication. The oral medication Aripiprazole was his choice of medication, therefore I was convinced that he would remain compliant following discharge. Furthermore, I was satisfied that he has a CCO and he was under a specialised team to follow him up in the community.

222. On 7 November 2024, Nicola Harrand, Priory's Senior Investigations and Inquest Manager, wrote to Amber Sargent of Theemis Consulting Ltd in relation to the latter's investigation **[PAGR0000088]**. I agree with the comment that VC *"had a good response"* to Aripiprazole (tablet format) and that VC confirmed that he would be willing to continue this method upon his discharge back into the community. VC did not present with signs or symptoms of ongoing psychotic experiences whilst he was being treated exclusively with this medication. In fact, what were considered possible negative symptoms of psychosis (isolation, low mood, motivation and activeness) improved significantly. He was observed using his laptop, attended to his personal care unprompted, was observed in communal areas more often, accessed community leave regularly and presented as more relaxed. I was satisfied that he would continue to take his medication after discharge, as it was his choice of medication and it was not causing any side effects and he was appreciating benefits of receiving this medication.

223. I was satisfied that VC would continue taking Aripiprazole following discharge. I was reassured that he had a CCO and he was under a specialised team EIP who have experience as well as expertise dealing with patients who are non-concordant in the community.

224. The depot medication option was available to the community team had they considered managing him on a depot. The community team could have made such a request and even requested discharge on a CTO if they anticipated compliance to be an imminent management problem.

DISCHARGE AND ONGOING TREATEMENT

225. VC's *"Keeping Connected"* care plan **[PAGR0000021]** included the following comment in relation to his discharge plan:

> *"Valdo was admitted on 1st October 2021 as a step down from PICU. He made very good progress during his admission to PICU so now on an acute ward, Valdo will be supported to work towards an appropriate discharge plan."*

The basis for the comment VC made *"very good progress"* was in reference to being considered ready for step down to an acute ward within 3 weeks, absence of violent presentation, concordance with medication, accessing community leave without any concerns and improvement of his psychotic symptoms.

226. The following entry was made in VC's care record **[PAGR0000025]** on 4 October 2021: *"Discharge to Beacon Lodge was discussed and Valdo was keen on this option."*

Beacon Lodge is a transition hostel managed by NHFT to support discharge of patients who do not have access to suitable accommodation or support network and who are considered would benefit being in a supported service prior to retuning to live independently.

227. Discharge to Beacon Lodge was discussed as an option as VC had no accommodation to return to at the time of his admission to Priory Hospital Arnold.

228. No further steps were taken to pursue discharge to Beacon Lodge as VC had managed to secure tenancy during the course of his admission at Priory Hospital Arnold.

229. He was discharged to the community as VC was keen to settle down in his own accommodation and resume his education.

230. Each of VC's risk assessments – 4 October 2021 **[PAGR0000009],** 7 October 2021 **[PAGR0000010],** 14 October 2021 **[PAGR0000011],** and 21 October 2021 **[PAGR0000012]** – included the following comment: *"May be able to mask symptoms to get discharged".*

The comment was made at my initial assessment on 04 October 2021 and identified as an additional risk. This had been repeated to remind the care team to remain vigilant of all potential risks. The risk assessments are only edited and updated at each stage, they are not re-written entirely as new documents.

231. As per the preceding paragraph, the statement was taken into consideration when assessing risks, planning care and discharge.

232. The possibility that VC may be masking his symptoms resulting in being discharged was no longer a concern in the latter part of his admission and certainly not at the time his discharge.

233. VC was regularly reassured that his admission would not be a long one during my interactions with him. This was based on the improvements he had already made and the progress he was making in his recovery and towards discharge.

234. VC's accommodation needs were taken into consideration during discharge planning in the initial stages of his admission at Priory Hospital Arnold. For example, he was considered for Beacon Lodge Hostel, had he not managed to secure private renting. There was no need to delay his discharge process given that he had secured a new tenancy. VC had the option to remain in hospital for further period if he required more time for transition.

235. In terms of my expectations for VC's ongoing management care and treatment following discharge, I was hopeful that VC would receive adequate care and follow up support to meet his treatment needs from the community team, EIP. I expected them to arrange follow up reviews on a regular basis to ensure compliance with his medication and monitoring for his symptoms. I also expected them to facilitate psychoeducation and relapse prevention support in the community.

236. The circumstances of VC's admission was shared with his CCO, the Crisis Team, the bed management team as well as his GP. All of these individuals and agencies were sent a detailed discharge summary **[PAGR0000029]**

subsequently. There is an audit trail to confirm that these actions were completed on 22 October 2021 **[PAGR0000163]**. The information shared on 22 October 2021 included a risk assessment dated 21 October 2021, MDT ward round notes and a copy of the medication card. The CCO and the Crisis Teams were given a verbal handover and requested to arrange a 72 hour follow up. There is a record on Priory's electronic care notes that the CCO was given information of his discharge by a nurse when she contacted the ward on 21 October 2021. **[PAGR0000025].** There is an audit trail to confirm that the Crisis Team was requested to arrange follow up **[PAGR0000163]**. I believe this action (contacting the Crisis Team) was carried out over the phone by then ward administrator. The electronic records were shared using secure email. I gave an update of circumstances of admission and VC's presentation on the ward, medication changes, plans to rescind s3 MHA detention and imminent discharge plans to the CCO when she attend the MDT ward round on 14 October 2021 **[PAGR0000160].** She was sent an invite to attend the MDT ward round on 21 October 2021. Unfortunately she did not attend but did contact the ward to get an update of the outcome shortly after the MDT ward round.

237. VC's presentation since admission to Priory Hospital Arnold was discussed with the CCO on 14 October 2021.

238. His engagement with ward staff and medication change too was discussed during the meeting on 14 October 2021.

239. During this meeting on 14 October 2021, it was discussed that there were no incidents or evidence of violence or aggression.

240. His medication, including concordance was also discussed. I cannot recall however, and there is no record whether a conversation regarding depot medication was discussed during this meeting.

241. As per Priory's *"Admission, Transfer and Discharge"* policy, at paragraph 7.10(c) **[PAGR0000033],**

> *"A verbal handover, which must be documented, should be given to those professionals to whom care is being discharged to assist in ensuring that key risk information is conveyed promptly and effectively."*

I was expecting to give a complete verbal handover to the CCO at the discharge MDT ward round on 21 October 2021. Unfortunately she did not join the meeting. There is a record that a verbal handover was provided to the CCO when she contacted the ward shortly after the MDT ward round on 21 October 2021 **[PAGR0000163].** There is a record that the ward administrator contacting the Crisis Team to update patient's discharge plan and to arrange the 72 hour follow up **[PAGR0000163]**.

242. I was not personally involved in receiving a handover from the Cygnet team when the patient was admitted. I believe the nursing colleagues were involved in verbal handover at the time of receiving the referral. There was a further verbal handover at the time of his admission by the staff members who escorted VC to Priory Arnold on 01 October 2021.

243. Dr Helen Aziri completed a discharge summary which is noted was sent to VC's CCO and GP **[PAGR0000029]**. I am unable to recall whether I had input into Dr Aziri's discharge summary.

244. I am satisfied that Dr Aziri's discharge summary provided an accurate summary of VC's progress at Priory Hospital Arnold.

245. I do agree that VC's admission at Priory Hospital Arnold was relatively brief.

246. VC's admission was brief at Priory Hospital Arnold due to multiple reasons. He was initially treated at Cygnet intensive care unit for 3 weeks prior to his admission to Priory Hospital Arnold. He was treated with powerful antipsychotic medications in relatively high doses. He remained concordant throughout the admission in both hospitals. He responded very well to his treatment and made a rapid recovery as evident by absence of obvious psychotic features including paranoid delusions, hallucinations or thought disorder and absence of violence, aggression and any type of challenging behaviours or concerns during his admission to Priory Hospital Arnold. He presented as an intelligent young man whose intellectual functions were well preserved and at a good level at the time of relapse on that occasion. Furthermore, he remained highly motivated to return back and complete his university education.

247. The basis for the comments within Dr. Aziri's discharge summary, that VC had *"settled well on the ward"* was due to the fact that he was fully compliant with ward procedure without displaying any challenging behaviours or psychotic features and accessing leave and being compliant with medications. He did

engage in meaningful and proactive conversations with his named nurse and contributed to care plans. VC himself reported that he was tolerating Aripiprazole and that he did not have any side effects.

248. The basis for the comment within Dr. Aziri's discharge summary that there were *"no psychotic features noted, nor risk to self or others noted"* was due to no psychotic features having been reported, elicited or observed by the staff who had direct and indirect interactions with him. There was no evidence of risk incidents or challenging behaviours. These comments were in relation to his presentation during the admission period and not a reflection or impression formed of his past or potential risks in the future when becoming unwell.

249. In relation to CTOs, I did not have any communication or discussions with Cygnet Victoria House in relation to a CTO.

250. I did not consider the possibility of a CTO with VC during his admission at Priory Hospital Arnold.

251. I cannot recall a conversation of the possibility of a CTO with VC.

252. VC was not discharged with a CTO, as there were no strong indications or justification to continue detention under s3 MHA.

253. I cannot recall any communication or discussion with VC's community team in relation to a CTO.

254. In the circumstances of VC's admission and bearing in mind his history of violence and non-concordance previously, VC's discharge to the community was considered appropriate as he made a significant recovery of his psychotic presentation and was not posing any concerns to indicate imminent or foreseeable risks to himself or others in the community. Furthermore, he was under the specialised team EIP who had adequate experience and expertise in managing patients with histories of non-concordance, violence and aggression. In terms of his risks, I did not have information or reasons to suspect VC had been involved in using a weapon or causing harm to anyone when stable in his mental illness. I was satisfied that he made a sufficient recovery and remained stable in mental state for number of weeks, when the decision was made for his discharge.

255. Looking at VC's inpatient admission to Priory Hospital Arnold as a whole, and in considering whether any further action could or should have been taken to address the risks associated with VC when acutely unwell, I consider that during VC's admission the MDT could have been more proactive in promoting his engagement in psychology sessions to address concerns around risks when unwell, medication concordance, symptom awareness and relapse prevention. VC was pre-occupied with normalising his life, resolving his accommodation issues and resuming university education. He did not show any particular interest in engaging in routine occupational activities and therapies offered to other patients on the ward.

FOLLOW UP

256. On 27 October 2021, I contacted VC over the phone and the details of the call are as noted in his care record **[PAGR0000025]**. It is my standard practice to make follow up calls and inquiries to patients who do not have easy access or adequate family support or input post discharge.

257. I recall VC engaging in a cordial discussion. He reported being in the university and attending lectures. He answered my questions calmly, with a soft tone, his speech was normal in rate, volume and flow and the content was rationale. There was no evidence of thought disorder by the content of his speech.

258. I was satisfied that he was taking his medication since he confirmed the medication stock he had. I felt he was honest when he acknowledged that he was busy and that he did not have the opportunity to meet with his CCO the previous couple of days. I was satisfied that he had the intention to engage with the community team.

259. I cannot recall having further discussions with VC's community team following his discharge. I was satisfied that they would remain engaged as they were a specialised team with training and resources.

THEEMIS INTERVIEW

260. I was interviewed by Theemis as part of their investigation into the care and treatment provided to VC on 19 August 2024 **[TCLT0000403]**. I believe the Theemis Investigation interview notes are accurate.

261. I do not have any additional comments I would like to make in relation to the interview. However, I do not agree with the comments made in the report prepared by Theemis that suggested we (the inpatient team) have not taken seriously the concerns of CCO and the EIP team while VC was on s3 of the MHA to explore a CTO **[TCLT0000403, pages XV11 and XV111]**. I wish to confirm that no such concerns were raised with me by the CCO or the EIP team during his admission at Priory Hospital Arnold.

RECOMMENDATIONS

262. I have been invited to share any recommendations I think the Chair of the Inquiry should make to ensure lessons are learned and to prevent similar attacks in future. In my view, those patients who are considered high risk of relapse and/or non-compliant must be managed by specialised services such as an Assertive Outreach Team. Currently, the EIP teams accept and manage patients only for a period of 3 years from the onset of the psychosis. I recommend that this period be extended to a minimum of 5 years. VC could have been referred and brought under an Assertive Outreach Team. If such a service was not available a referral could have been made for forensic service input.

263. I have been invited to comment on what improvements could be made locally and nationally to multi agency working to increase effectiveness in preventing similar outcomes in the future. In my view, more resources could be provided to specialist services such as EIP, Assertive Outreach Teams and forensic services so that they can accept and manage a larger case load.

STATEMENT OF TRUTH

264. 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
Dr. Ajith Gurusinghe

Dated: 09 December 2025 | 12:00 GMT

INDEX TO SECOND WITNESS STATEMENT OF DR. AJITH I GURUSINGHE

No.	Inquiry URN	Document Description
1	DHSC0000007	Mental Health Act 1983: Code of Practice
2	PAGR0000003	Cygnet Risk Assessment Tool for Acute/PICU form of Valdo Calocane
3	PAGR0000004	Medical Records of Valdo Calocane, from 16/09/2021 to 23/09/2021, Cygnet, Victoria House, Albert Ward
4	PAGR0000005	Priory Hospital Arnold, Referral Checklist form of Valdo Calocane dated 1 October 2021
5	PAGR0000006	Patient Review - Adult Acute/PICU form of Valdo Calocane
6	PAGR0000023	CAREnotes form *"Keeping Safe"* dated 21 October 2021
7	PAGR0000025	Medical records of Valdo Calocane, from 01/10/2021 to 7/10/2021, Nottingham University Hospitals NHS Trust
8	PAGR0000008	Risk Assessment of Valdo Calocane dated 1 October 2021
10	PAGR0000159	Multi-disciplinary team ward round notes of Valdo Calocane dated 7 October 2021
11	PAGR0000160	Multi-disciplinary team ward round notes of Valdo Calocane dated 14 October 2021
12	PAGR0000028	Multi-disciplinary team ward round notes of Valdo Calocane dated 21 October 2021
13	PAGR0000009	Risk Assessment of Valdo Calocane dated 4 October 2021

14	PAGR0000010	Risk Assessment of Valdo Calocane dated 7 October 2021
15	PAGR0000011	Risk Assessment of Valdo Calocane dated 14 October 2021
16	PAGR0000012	Risk Assessment of Valdo Calocane dated 21 October 2021
17	PAGR0000038	Policy Document, re: Clinical Risk Assessment and Risk Management, Priory Healthcare
18	PAGR0000174	Care Plan *"Keeping Healthy"* dated 2 October 2021
19	PAGR0000171	Care Plan *"Keeping Connected"* dated 2 October 2021
20	PAGR0000167	Care Plan *"Keeping Well"* dated 3 October 2021
21	PAGR0000164	Care Plan *"Keeping Safe"* dated 1 October 2021
22	PAGR0000165	Care Plan *"Keeping Safe"* dated 7 October 2021
23	PAGR0000166	Care Plan *"Keeping Safe"* dated 14 October 2021
24	PAGR0000175	Care Plan *"Keeping Healthy"* dated 7 October 2021
25	PAGR0000176	Care Plan *"Keeping Healthy"* dated 14 October 2021
26	PAGR0000022	Care Plan *"Keeping Healthy"* dated 21 October 2021
27	PAGR0000172	Care Plan *"Keeping Connected"* dated 7 October 2021
28	PAGR0000173	Care Plan *"Keeping Connected"* dated 14 October 2021

29	PAGR0000021	Care Plan *"Keeping Connected"* dated 21 October 2021
30	PAGR0000168	Care Plan *"Keeping Well"* dated 5 October 2021
31	PAGR0000169	Care Plan *"Keeping Well"* dated 7 October 2021
32	PAGR0000170	Care Plan *"Keeping Well"* dated 14 October 2021
33	PAGR0000024	Care Plan *"Keeping Well"* dated 21 October 2021
34	PAGR0000027	CAREnotes form re: Diagnosis dated 7 October 2021
35	PAGR0000007	CAREnotes form of Valdo Calocane dated 1 October 2021
36	PAGR0000014	Memo from Dr A I Gurusinghe to The Hospital Managers of Priory Arnold Hospital re Mental Health Act 1983 - Section 23(2)(a) Responsible Clinician Discharge of a Patient From Detention - VC
37	PAGR0000141	Policy Document, re: Assessment, Diagnosis & Treatment, Priory Healthcare
38	PAGR0000037	Policy Document, re: Care Programme Approach / Care & Treatment Planning, Priory Healthcare
39	PAGR0000017	CAREnotes form of Valdo Calocane: Nursing Assessment dated 1 October 2021
41	PAGR0000088	Letter from Nicola Harrand to Amber Sargent re: Priory response to the extracts from the draft independent investigation report (the "Report") regarding the care and treatment of VC that relate to Priory
42	PAGR0000029	Discharge Summary of Valdo Calocane dated 24

		October 2021
43	PAGR0000163	Report compiled by Priory Healthcare Re: VC - Discharge Audit Tool, Discharge Information from Priory Hospital Arnold dated 22 October 2021
44	PAGR0000033	Policy Document, re: Admission, Transfer and Discharge, Priory Healthcare
46	TCLT0000403	Transcript of interview of Priory Group Consultant Forensic Psychiatrist by Theemis, 15 August 2024