Witness Name: Mr. Clive Chimbi

Statement No: WITN0154001

Dated: 28 November 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF

MR. CLIVE CHIMBI

I, Clive Colin Chimbi will say as follows: -

INTRODUCTION

1. I am Psychiatrist Nurse, currently employed by the Nottinghamshire Healthcare NHS Foundation Trust ("NHFT").

2. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 16 September 2025 (the "**Request**").

3. I have been asked to set out a number of matters in relation to my background and experience, my knowledge of mental health services and treatment, and my involvement with the treatment of Valdo Calocane ('VC').

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

CAREER AND ROLE

5. In 2011, I completed a BSc Mental Health Nursing, at the University of Stirling. I am a Registered Mental Health Nurse, Nursing and Midwifery Council. I have 14 years' experience as a Psychiatric Nurse.

6. Following completion of my BSc, between November 2011 and March 2013, I worked as a Band 5, Acute Care Nurse, The Woodlands Centre for Acute Care, which is part of the Sussex NHS Partnership. From March 2013 to January 2020, I worked as a Band 6 Acute Care Nurse at NHFT. From January 2020 to the present date I have been employed as a Band 6 Crisis Care Practitioner, at Nottingham City Crisis Team CRHT, which is part of the NHFT.

Training and system of work

7. As part of my nurse training at the University of Stirling I received foundational education in risk assessment and risk management. To the best of my recollection, this included lectures that covered theoretical aspects of risk. These sessions explored key concepts such as dynamic and static risk factors, early warning signs, and the importance of multidisciplinary approaches.

8. Following the academic component, I undertook work-based placements where I had the opportunity to observe and participate in risk assessments in real-world clinical environments. These placements helped consolidate my understanding of how theoretical frameworks are applied in practice.

9. While the training provided a solid foundation, much of my practical understanding of risk assessment has been further developed through post-qualification experience and ongoing professional development.

10. When I joined NHFT, I received face-to-face training as part of the Trust's induction programme. While I cannot recall the specific content in detail, I believe this included training on risk and risk management. In addition, NHFT requires all clinical staff to complete mandatory online training annually, which covers various aspects of clinical risk. NHFT also continues to offer face-to-face

training opportunities on risk management, supporting ongoing professional development in this area.

11. Together, these experiences have contributed to my understanding and practical application of risk assessment, particularly in relation to violence towards others in mental health contexts.

Sharing of information

12. Within the Crisis Team, clinicians are typically allocated a list of clients to see during their shift. Each clinician takes responsibility for preparing for their visits by reviewing the patient's electronic notes. While there is no formal handover in the traditional sense, the electronic records serve as a continuous and dynamic handover, providing up-to-date information on a patient's presentation, risk factors, as well as any recent interventions.

13. Occasionally, clinicians may have the opportunity to speak directly with colleagues who are familiar with the patient, which can offer additional context or insights. There are also instances where clinicians participate in multidisciplinary team ('MDT') meetings, during which patients are discussed in detail. These discussions often form a key part of the information clinicians use to guide their assessments and interventions.

14. This approach ensures that clinicians have access to relevant and current information, even in the absence of a structured handover process.

15. In my role, during 2020 – 2022, I had access to the electronic patient record system RIO Local, which I used to prepare for patient visits. This system provides essential information such as the patient's history, current presentation, reason for referral to the Crisis Team, and any specific aims or interventions planned by the team.

16. To the best of my knowledge, there is a separate RIO system used by forensic services (RIO Forensic), which I did not have access to. I did not have access to any other records apart from RIO Local. This is also the situation now.

17. This level of access ensures that I have the necessary information to carry out my duties while maintaining appropriate boundaries around patient confidentiality as well compliance data protection requirements.

18. Before I engage with any patient, I make it a priority to familiarise myself with the key information that will help me understand their current situation and needs. I begin by reviewing the reason they have come to our service or why they are currently under our care, whether it is a crisis presentation, a referral for any other specific reason. This gives me a sense of the context and role for the Crisis Team.

19. I then focus on any documented risks. I pay attention to any indicators of self-harm, suicidal ideation, violence or aggression, and vulnerability.

20. I look at patient diagnosis, previous contacts with the team, and any patterns or significant events that might inform their current presentation. I also check their medication records to see what they are currently prescribed and whether there are any physical health issues that could impact their mental wellbeing or the care we provide.

21. Finally, I review any existing MDT plans. These plans offer valuable insight into the strategies already in place and help guide how I can best support the patient during our contact. This preparation ensures that I approach each interaction with a clear understanding of the patient's needs, risks, and care pathway.

22. In my role as a Crisis Care Practitioner, I am required to record and share patient information using the RIO system. RIO facilitates multidisciplinary collaboration by enabling various professionals and teams to access and contribute to a single, comprehensive patient record. This integrated approach supports continuity of care, ensures timely communication, and promotes coordinated decision-making across services. By documenting assessments, interventions, and outcomes in RIO, I help maintain accurate and up-to-date records that are essential for effective crisis care management.

Multiple admissions under the MHA

23. As far as I am aware, there is no dedicated or streamlined method within RIO for tracking patterns of hospital admissions under the MHA. However, RIO does provide a page where clinicians can view all previous and current referrals. This allows access to historical data, though it requires manual review and interpretation.

24. This page is accessed on the client home page on RIO. On the right panel you can scroll down to **Referrals Information**. Clicking the link opens up current referrals and previous referrals, as can be seen in respect of the screenshot for VC **NHFT0000258**

25. Given that there are several different mental health services, each operating with different remits and criteria, it is typically the responsibility of each service to extract and interpret information relevant to the care they are providing. When a comprehensive understanding of a patient's admission history is deemed necessary, particularly if it could impact ongoing care planning, I would expect that the relevant teams would compile this information from RIO records.

26. My role was to act in accordance with the crisis plan and mandated actions at the time, which I felt I had sufficient information to carry out effectively. As previously stated, if it had been deemed that a detailed awareness of admission history was essential and would significantly impact the care provided, this would have been a matter for the multidisciplinary team ("MDT") to review and determine.

Care planning

27. There are multiple community-based mental health teams, each with its own remit and criteria for involvement. The relationship between inpatient care planning and community teams is largely shaped by these service-specific roles.

28. In my role within the City Crisis Team, we typically do not have an active role while a patient is receiving inpatient care. However, we may become involved when inpatient services are considering early discharge. In such cases, the

Crisis Team can be care-planned into the discharge process to provide intensive home treatment as part of the patient's transition back into the community.

29. Occasionally, we are invited to discharge planning meetings, particularly when our involvement post-discharge is being considered. A senior nursing clinician from our team would attend these meetings to assess the patient's suitability for home treatment and to collaboratively plan the support required on discharge.

30. A senior nursing clinician recorded decisions about VC's suitability for home treatment following his inpatient admission. The notes are contained within [NHFT0000168 p.109-110]. The discharge meeting made clear guidance and aims for the CRHT. It laid out the role as medication concordance along monitoring mental state. The information was entered at 17:39 on 28 July 2020 by Merima Jordan who is Clinical Nurse Lead Band 7.

Risk assessments

31. As a community-based mental health practitioner with previous ward experience, I understand the importance of risk assessments in shaping inpatient care plans. I am not, however, fully familiar the most up to date practices and protocols for how risk assessments used in the formulation and development of an inpatients care plan, as I am a community-based practitioner.

Concerns regarding risk

32. Within the City Crisis Team, we hold regular and structured MDT meetings, which serve as a key platform for raising concerns about risks posed by patients. I actively participate in these discussions and feel confident in voicing any concerns related to risk. The collaborative nature of MDT meetings encourages open dialogue and shared decision-making, which I find supportive and effective.

33. Outside of MDT meetings, I can approach a Clinical Nurse Lead, who is a senior clinician available to provide guidance and support. This offers an additional avenue for raising concerns, particularly when urgent or complex issues arise outside of scheduled meetings.

34. I also make use of clinical supervision to reflect on complex cases and discuss any concerns in a more focused setting. These structures MDTs, senior clinical support, and supervision create a professional environment where I feel comfortable raising concerns, knowing they will be taken seriously and addressed appropriately.

Discharge planning for patients

35. In my role as a crisis care practitioner with the Crisis Team, I have actively contributed to discharge planning for patients under my care. I have not only initiated but also completed discharges when patients have reached a point where intensive home treatment is no longer required. This decision is based on a clinical assessment of both risk and symptom presentation. When symptoms no longer cause significant disruption to daily life and the associated risks are no longer active, I proceed with discharge planning.

36. More recently, I have adopted the term "*transfer of care*" to describe this process, as it more accurately reflects the nature of crisis discharge. Care is rarely ended, it is transferred, often to other secondary mental health services, and in some cases to primary care such as the patient's GP. This terminology acknowledges that care is part of an ongoing journey, and that discharge from CRHT is a transition rather than an endpoint.

37. To the best of my knowledge, I have not been involved in the care of any other mental health patient who has gone on to seriously injure or kill a member of the public following discharge or while in the community.

INTERACTIONS WITH VC

1 August 2020 home visit

38. On 1 August 2020 I carried out a Home Visit to follow-up with VC. I recorded the following information [NHFT0000168 at p.118-119]:

> "[F]rom our assessment we found him to be pleasant and polite […] [H]e engaged well and it was easy to build a rapport with him […] there was no evidence of paranoia or delusional ideas. [VC] showed some insight

into his mental health agreeing that he had been unwell at the time of admission. He feels he has improved a lot since then.

When we arrived this evening, he still had not taken his medications. he agreed to take them in front of us and went to fetch them. [A]fter several minutes he came back and said he could not find them. [H]e said he thinks he might have misplaced them somewhere in his room. [W]e had a discussion about medications [,] he said he knew it's important for him to take his medications. He accepted they were keeping him well and he said he did not have any problems taking meds. [H]e agreed to keep looking for them and take them once he's found them. I informed him we would ring him later this evening to check if he had found them. I informed him we will see him daily for medication compliance. he agreed to this and said he was happy to take his medications. I have told him if he cannot find his meds we will order some more for tomorrow.

Risk: Deterioration in mental state of non-compliant with medications."

39. This clinical note is accurate to the best of my knowledge.

40. With regard to the risk statement, my comment reflected a clinical judgement that VC's mental state was at risk of deterioration in if he did not comply with his prescribed oral medications. This was based on the understanding that medication adherence was a key factor in his stability at that time. The note was intended to capture an ongoing and dynamic risk, which would need to be monitored through continued engagement and daily follow-up to ensure compliance and prevent relapse.

41. This note was not intended to be taken in isolation, but rather as part of an ongoing care summary and risk assessment. This view was meant to contribute to the wider understanding of VC's presentation and inform the ongoing care provision by the team.

42. The purpose of this home visit was to follow up on the discharge plan agreed during VC's discharge meeting on 28 July 2020, which included medication concordance as part of a wider community treatment plan. The visit aimed to

support VC in taking his prescribed medication and to assess his engagement with treatment following discharge.

43. In addition to medication concordance, every contact with the Crisis Team is used as an opportunity to assess mental state and risk, which was also undertaken during this visit.

44. On this occasion, medication concordance was not achieved, as VC was unable to locate his medication at the time of the visit. However, he later contacted the team to confirm he had found the medication. While missed concordance is not uncommon, it is generally not a cause for concern unless it becomes a pattern, particularly when accompanied by reluctance to engage or poor insight into the importance of medication.

45. This visit contributed to the ongoing assessment, and the risk noted was part of a broader, dynamic process of monitoring and supporting VC's recovery in the community. I consider that the purpose of the meeting was achieved.

Information prior to my involvement.

46. As per my usual practice, I believe I would have reviewed VC's electronic medical records on RIO. This provided me with essential background information, including his presentation, recent history, and the discharge plan that had been formulated during his inpatient stay. This information helped guide the purpose of the visit and gave me a clearer understanding of VC's current needs and the expectations for follow-up care.

47. While Mental Health Act assessments are stored within RIO, my focus was primarily on the discharge plan and associated care guidance, as these documents are typically the most up-to-date and reflective of the patient's current presentation and treatment goals. In my experience, the discharge plan often provides a more relevant framework for immediate community-based interventions than earlier MHA assessments.

48. The aim of the visit was therefore shaped by the discharge plan, which included medication concordance and ongoing monitoring of mental state and risk.

49. I do not recall receiving any additional verbal information.

VC's discharge from inpatient care

50. I do not have a specific recollection of my understanding of the reasons that VC had been discharged from inpatient care to the care of the CRHT during his second period under Community Care.

51. My understanding would have been informed by the notes available and actual discharge plan and my awareness of the role of the crisis team.

52. Having reviewed the notes contained within [NHFT0000168 p.109-110] the discharge meeting made clear guidance and aims for the CRHT. It laid out the role as medication concordance along monitoring mental state. The information was entered at 17:39 on 28 July 2020 by Merima Jordan.

53. I was aware that non-concordance with medication could lead to a deterioration in VC's mental health, which in turn could increase the risk he posed to others. This understanding was based on a combination of clinical judgement and information available in his electronic records on RIO.

Multi-agency meetings with VC's treating team at Highbury Hospital

54. I was not involved in any inpatient care for VC in any capacity. If there had been a need for Crisis Team representation at a multi-agency meeting during his inpatient stay, it would typically be a Clinical Nurse Lead who would attend on behalf of the team.

55. I cannot recall attending any MDT meetings specifically for VC with CRHT MDT. However, I was fully aware of the MDT plans and arrangements, as I routinely reviewed clinical notes and care plans on RIO prior to each contact with VC. This ensured I was informed of the agreed treatment goals and any identified risks or support needs relevant to my role in the community follow-up.

Understanding of VC's psychiatric history, diagnosis and/or condition, and capacity

56. I cannot fully recall the extent of my awareness of VC's complete psychiatric history at the time. However, it is my standard practice to review all relevant and available information on RIO prior to any patient contact. This includes reviewing recent notes, referral reasons, discharge summaries, and care plans. While I do look at a patient's history, this is often limited due, to the volume of records, especially for individuals with long-standing involvement in mental health services.

57. I would have been aware of VC's diagnosis, as this is essential information for providing safe and effective care. As a practitioner, I aim to be familiar with a patient's diagnosis, symptoms, prescribed medications, and current treatment plan in order to offer appropriate support and interventions.

58. At the time when I first reviewed VC on 1 August 2020, based on the documents that would have been available to me, I believe that I would have understood that VC's diagnosis was one of a psychotic illness with paranoid ideas. This is documented within [NHFT0000168, p.105]. The entry was made by Dr Hakam Ibrahim at 16:57 on 28 July 2020, in the last ward round before discharge. At this time, in respect of his capacity, I considered that he had full capacity. He appeared to be fully aware of the purpose of our visit and demonstrated an understanding of the issues discussed. There were no indications or concerns that he lacked the capacity to engage in decisions related to his care.

<u>3 August 2020 Home Visit</u>

59. On 3 August 2020, I carried out another home visit to VC. I recorded the following information [NHFT0000168 at pg.122]:

> [VC] said he had already taken his morning meds. [He] showed me the meds with evidence of tablets having been dispensed. I informed him we need to do medication concordance with him. He said it was a bit excessive of staff to come in and watch him take meds. He prefers to take his meds between 8 and 9. He said he did not want to take it any later. He would not give a valid explanation why."

60. This clinical note is accurate to the best of my recollection.

61. While I cannot recall my exact thoughts at the time, on reviewing this entry, VC's comments during the visit suggested a possible reluctance to fully engage with the medication concordance plan that had been agreed upon at discharge. His resistance to being observed while taking medication, and his unwillingness to provide a clear reason for this preference, may have raised some concern about his willingness to adhere consistently to the treatment plan.

62. That said, while I was worried about the possibility non-concordance, I do not believe I was immediately alarmed, as VC was presenting as symptom-free and his functioning appeared adequate. This stability in his mental health was a reassurance that he was likely to have been taking medication. Based on my concerns I suggested education on the importance of medication concordance, and I also raised the issue with the MDT, indicating that I was monitoring the situation and seeking team input.

63. Within the same entry at [NHFT0000168 at pg.122], under the heading "Plan" I recorded:

> MDT today for a plan. What is the next step should he continue to refuse meds concordance? […] If he refuses meds concordance, please explain the risk of relapse and possible hospital admission."

64. I consider this entry to be accurate to the best of my knowledge.

65. At this time, whilst VC was refusing medication concordance, he was not refusing to take his medication altogether. VC expressed a preference to take his medication independently and at a time that suited him, typically between 8 and 9 a.m. He had demonstrated insight into the importance of medication and acknowledged its role in maintaining his mental health during our meeting a few days earlier.

66. My concern was that if VC were to stop taking his medication entirely, there was a significant risk of deterioration in his mental state, which could lead to an increase in symptoms and associated risks to himself or others. If such deterioration became severe enough to impact his functioning or made home treatment no longer viable, hospital admission would need to be considered.

67. At this particular time, I felt it was appropriate to escalate the issue to the MDT for further discussion and guidance. I documented my clinical assessment and flagged the need to explore next steps, including how to respond if VC continued to resist medication concordance. This collaborative approach ensured that any decisions were made with input from the wider team and aligned with best practice in risk management and patient care.

VC's care and treatment plan

68. I cannot recall whether I was directly involved in formulating VC's care and treatment plan during his second period under the care of the CRHT. However, any documentation I completed would have contributed to the wider clinical picture and may have informed decisions made during MDT discussions.

69. It is standard practice within the team to ensure that all clinicians' observations and assessments are considered when reviewing or updating treatment plans. My notes would have supported the MDT in shaping and refining VC's treatment approach.

Risk posed by VC

70. I cannot recall the full extent of what I was aware of at the time regarding VC's risks to himself and others. However, it is my usual practice to review relevant clinical notes, risk assessments, and care plans on RIO prior to any patient contact.

71. My understanding of VC's risk profile would have been informed by historical notes detailing previous presentations and incidents. Discharge summaries and MDT discussions. Risk assessments completed during his inpatient stay and updated during community care. My own clinical observations during home visits.

72. Having reviewed the relevant clinical records again recently, I consider that VC posed no imminent or acute risk to himself, but there was a risk of possible deterioration in his mental health if he did not engage with medication concordance. I consider the risk he posed to others was none at this given time.

He had not given any indicators to suggest that he had any thoughts or ideas to hurt other people. In addition to this, his mental state appeared stable, and he was free of overt symptoms of a psychotic illness.

6 August 2020 Home Visit

73. On 6 August 2020, I attended a further home visit with VC. I recorded the following information, recorded in [NHFT0000168 at pg.125]:

> "Valdo continues to appear stable in his presentation [...] no overt signs of psychosis [...]
>
> [H]e states he is happy to continue with current medication regime with no side effects reported. [W]e again spoke of the importance of being compliant to reduce the chances of a relapse.
>
> [...]
>
> **Comment:** Since discharge Valdo has engaged with the crisis team. [H]e has presented as free of psychotic symptoms and no negative effect on his mood and affect. [H]e has denied paranoid and delusional ideation. [T]here has been no evidence to dispute this. [I]f there are any symptoms, they are probably well managed and not causing and distress. [O]n the grounds of mental state and risk, [VC] does not meet the CRHT admission criteria. [H]e is not presenting as admission vulnerable. Risk is low in all areas and does not warrant crisis input. [I]t is worth noting that Valdo in the recent past has deteriorated rapidly after discharge. The original plan agreed with crisis at point of discharge was to offer support to avoid another rapid deterioration.
>
> **RAG:** This has been changed to Green in line with the above plan."

74. This entry is accurate as far as I am aware.

75. The decision to reduce VC's Red, Amber, Green ("RAG") rating from Red to Green was based on a series of clinical observations and ongoing assessments. VC had consistently presented in a stable and coherent manner, with no overt signs of psychosis, paranoia, or delusional ideation. His mood and affect were appropriate, and he appeared free from any distressing symptoms.

76. VC had expressed satisfaction with his medication regime, reported no side effects, and demonstrated insight into the importance of medication compliance as a preventative measure against relapse. These factors indicated a positive level of engagement with his treatment plan.

77. Importantly, VC had engaged well with the Crisis Team, and there were no behaviours or symptoms that met the threshold for continued CRHT involvement. His risk profile appeared non-imminent across all domains, and he did not present as vulnerable to hospital admission at that time.

78. While it was acknowledged that VC had previously deteriorated rapidly following discharge, his presentation during this period did not warrant crisis input. The original plan to offer short-term support, post-discharge, remained valid, but based on his mental state and risk assessment, it was appropriate to reduce his RAG rating and begin the process of transferring care to his longer-term community mental health team.

79. This decision reflected the CRHT's role as a short-term intervention service, and the transfer ensured VC would receive ongoing care from a team better placed to provide specialist, long-term support tailored to his needs in line with his diagnosis.

80. Between the home visits on 1 August 2020 and 6 August 2020, VC continued to express a general willingness to take his prescribed medication, though there were some signs of ambivalence regarding the process of medication concordance.

81. On 1 August, VC was unable to locate his medication during the visit but expressed insight into its importance and agreed to take it once found. He later contacted the team to confirm he had located the medication, which suggested a level of engagement and responsibility.

82. By 3 August, VC stated he had already taken his morning medication and showed evidence of dispensed tablets. However, he expressed discomfort with staff observing him take medication, describing it as "*excessive*." While he did

not refuse medication outright, his reluctance to participate in concordance raised concerns about potential non-adherence.

83. On 6 August, I do not recall directly observing VC take his medication during the visit. However, VC's presentation remained stable, with no overt signs of deterioration, and he continued to engage with the team.

84. I therefore do not believe that I ever observed VC taking his medication during the period of 1 – 6 August 2020. Please note that I did not see him daily during this period. Other clinicians would have seen him as well.

85. Overall, while VC did not demonstrate clear refusal, his preference for privacy and resistance to concordance, and the fact I had not seen him take his medication, suggested a need for continued monitoring. These behaviours were discussed within the MDT to ensure appropriate risk management and care planning.

15 August 2020 Home Visit

86. On 15 August 2020, I attended a further home visit with VC. Within my note of this attendance, I stated "[o]bjectively I found him to have a masked expression and euthymic in mood." [NHFT0000168 at p.129-130].

87. By "masked expression," I was referring to a flat or blunted affect. His facial expressions appeared neutral and lacked emotional intensity. This kind of presentation can sometimes be associated with underlying mental health symptoms, particularly within psychotic disorders. However, it did not indicate any significant deterioration or acute distress.

88. His mood was euthymic, meaning it was stable and balanced, neither elevated nor depressed. This observation, combined with his overall presentation, suggested that VC was maintaining a level of mental stability. It was important to recognise that recovery from a psychotic episode does not necessarily mean the complete absence of symptoms. Residual signs, such as a masked expression, may persist even as the individual stabilises.

89. This impression reinforced my view that VC required ongoing support, particularly from a specialist service equipped to manage the subtleties of his presentation. For this reason, I felt that Early Intervention in Psychosis ('EIP') team was appropriate. EIP services are specifically designed to support individuals experiencing symptoms like those VC was presenting with, and they could offer the longer-term, tailored care he needed.

90. Ultimately, this observation strengthened my conviction that he remained in need of structured mental health support.

91. Under the heading "Risk", at [NHFT0000168 at p.130] I recorded:

> "*at the current time risks appear low in all areas. He's not a risk to himself and is not a risk to people. It is worth noting the crisis team got involved as it was feared that he may not be compliant with his medications. [W]hile at the present time he expresses that he is happy to continue with medications there is a possibility that he could become non-compliant. This will possibly lead to another relapse*."

92. My judgement of the risk posed by VC was based on a combination of clinical observations, engagement history, and review of his electronic records.

93. VC had consistently presented as mentally stable throughout his contact with the Crisis Team. He showed no overt signs of psychosis, paranoia, or delusional ideation. His mood was euthymic, and his affect, while somewhat masked, did not suggest emotional distress or instability. Importantly, VC had demonstrated insight into his condition and the role of medication in maintaining his wellbeing. He reported no side effects and expressed a willingness to continue with his prescribed treatment.

94. Throughout his engagement with the team, VC had not exhibited any behaviours or made any statements that would indicate a risk of self-harm, suicidal ideation, or aggression toward others. His interactions were cooperative, and he maintained appropriate boundaries and communication. While there had been some ambivalence around medication concordance earlier in the support

period, this did not escalate into non-compliance or refusal, and his mental state remained stable.

95. I was also mindful of VC's history, including previous rapid deterioration following discharge. However, at this stage, there were no clinical indicators suggesting an imminent relapse. The original plan to provide short-term support post-discharge had been fulfilled, and VC's presentation did not meet the threshold for continued CRHT involvement.

96. Based on my involvement with VC and having reviewed the medical records, I considered that we would continue to take his medication. I had not seen him take his medication, however he had said all the right things to suggest that he had a full awareness of importance of medication concordance. He was not refusing medications, but only opting to take the medication at the times that he personally preferred.

97. There are occasions when it becomes necessary to request a patient take their medication in front of a clinician. This practice, known as medication concordance, is used selectively based on clinical judgement and the individual's risk profile.

98. Supervised medication is typically introduced when there are concerns about a patient's adherence to their prescribed treatment. This may be due to a recent history of non-compliance, limited insight into their condition, or a high risk of relapse if medication is missed.

99. The rationale behind supervised administration is to ensure that the patient is taking the correct medication at the correct time, and to allow clinicians to observe any side effects or changes in presentation. It also serves as a way to reinforce the importance of treatment, particularly during the early stages of recovery or immediately following discharge from inpatient care.

100. In VC's case, supervised medication was part of the discharge plan agreed during his transition from inpatient care to community support. This information was entered at 17:39 on 28 July 2020 by Merima Jordan and can be seen at [NHFT0000168 at p.108-109].

101. While the Crisis Team carries out medication concordance, not every interaction results in a successful medication concordance for various reasons. It then falls on the MDT to work out if, generally, the plan is being successful. A few missed concordance meetings will not immediately indicate an area of concern if on the whole stable mental health is maintained. This decision was informed by his previous rapid deterioration following discharge and the need to ensure stability during this period. While VC expressed discomfort with being observed, the plan was clinically justified and aimed at preventing relapse and maintaining his wellbeing.

102. Ultimately, supervised medication is a short-term intervention used to support patients during vulnerable periods. It is always reviewed in the context of the patient's presentation, and evolving needs, with the goal of promoting autonomy and transitioning to less intensive forms of support

VC's Third Period in Community Care – Stonebridge Centre, NHFT ("Third Period under Community Care")

24 January 2022 Home Visit

103. On 24 January 2022, I attended a home visit with VC. I noted the following information [NHFT0000168 at p.210]:

> "[VC] engaged briefly to the purposes if taking his meds. Interaction was brief but he was pleasant and polite. There were no obvious signs of psychosis."
> […]
> **Risk**: Risk of non-compliance, this could lead to a further deterioration. approaching neighbours due to persecutory ideas/auditory hallucinations (neighbour needing to jump [from] window to leave on one occasion), verbal hostility.
>
> **RAG**: Red- Daily visits for the purpose of med concordance and monitoring of mental state/risks."

104. At the time of the home visit on 24 January 2022, my understanding of VC's psychiatric history would have been informed by a combination of previous

clinical notes, risk assessments, and my own observations during prior contacts. VC had a documented history of psychotic episodes, which had previously led to concerning behaviours—such as approaching neighbours in distressing ways and exhibiting verbal hostility. These incidents were noted in his records and formed part of the rationale for ongoing CRHT involvement.

105. I cannot fully recall how much awareness I had at the time of VC exhibiting any behaviours, including violence. I had full access to RIO and I want to believe I would have been aware of any information on relevant risk assessments. My usual practice is to familiarise myself with risk assessments and whatever care plans in place.

106. VC's diagnosis was consistent with a psychotic disorder, and his presentation during this visit aligned with that understanding. Although he engaged only briefly, he was polite and showed no overt signs of psychosis during the interaction. However, the brevity of the engagement and the context of recent risk behaviours particularly those involving neighbours suggested that his mental state required close monitoring. The risk of non-compliance with medication remained a significant concern, as it had previously led to deterioration in his condition and increased risk to others. My understanding was that he was presenting with a psychotic illness and there was no indication of any other symptoms other than that of the condition he was receiving treatment for.

107. Regarding capacity, VC appeared to retain the ability to engage meaningfully with the purpose of the visit and understood the importance of taking his medication. While his engagement was limited, there was no indication during this contact that he lacked the capacity to make decisions about his treatment or care. That said, capacity is dynamic and context-dependent, and in cases like VC's, it is continually assessed in relation to his insight, engagement, and risk behaviours.

108. I witnessed VC taking his medication. The entry "[VC] engaged briefly to the purposes if taking his meds" contains typographical errors. It should read "[VC] engaged briefly for the purposes of taking his meds". This contact lasted a few

minutes in which I observed him taking his medications. There were no other activities carried out.

Formulation of VC's care and treatment plan

109. I do not recall having a direct role in formulating VC's care and treatment plan during his third period under the care of CRHT. However, as part of routine clinical practice, any assessments, observations, and documentation I completed during my contact with VC would have contributed to the wider clinical picture and informed the team's decision-making.

110. Within CRHT, care planning is a collaborative process, often shaped through MDT discussions. While I may not have been involved in drafting the formal care plan, my input, particularly through clinical notes and risk assessment, would have supported the team in reviewing and refining VC's treatment approach.

Risk Assessments

111. During VC's third period with CRHT, I do not believe I formally updated the core assessment documents within the electronic record system. However, risk assessment is part of every clinical contact, and I routinely carried out informal, dynamic assessments during my visits.

112. These assessments were documented within my clinical notes following each visit and reflected my observations of VC's mental state, engagement, and any emerging concerns. For example, during the home visit on 24 January 2022, I noted that VC was pleasant and polite, with no overt signs of psychosis, but also highlighted the risk of non-compliance with medication. This was based on both his presentation and historical behaviours, including incidents involving persecutory ideation and verbal hostility toward neighbours.

113. The risk assessment at that time concluded that VC required daily visits to support medication adherence and monitor his mental state. This was reflected in the RAG rating being set at Red, indicating a level of clinical concern and the need for intensive support. While not recorded in a standalone risk assessment

form, these observations and conclusions were captured in the clinical notes and contributed to the team's ongoing understanding of VC's risk profile and care needs.

Risks posed by VC

114. During VC's third period with CRHT, my understanding of the risks VC posed to himself and others would have been informed by a combination of clinical documentation, historical records, and my own observations during home visits. I do not however have a specific, independent recollection of my assessment of these risks.

115. Referring to VC's medical records, at the time of my visit on 24 January 2022, VC was presenting as polite and cooperative, with no overt signs of psychosis during the brief interaction. However, the risk assessment documented that day reflected concerns that extended beyond his immediate presentation. VC had a known history of psychotic symptoms, which had previously led to troubling behaviours such as approaching neighbours in distressing ways and displaying verbal hostility. One incident noted in his records described a neighbour needing to jump from a window to avoid an encounter with VC, which highlighted a risk when his mental health deteriorated.

116. The primary concern at this stage was the risk of non-compliance with medication, which had previously been a key factor in VC's relapse. Non-adherence could lead to a resurgence of psychotic symptoms, increasing the likelihood of behaviours that posed a risk to others. While VC was not actively expressing intent to harm himself or others, the potential for deterioration based on his history necessitated a crisis input.

117. This understanding was based on a review of VC's electronic records on RIO, including previous risk assessments, care plans, and documentation from earlier CRHT involvement. It was also shaped by MDT discussions and the collective clinical knowledge of the team. As a result, VC's RAG rating was appropriately set to Red, indicating a high level of concern and the need for daily visits to support medication concordance and monitor his mental state.

118. In summary, while VC was not actively posing a risk at the time of contact, his history and the potential consequences of non-compliance warranted close monitoring and intensive support to mitigate the risk of harm to himself or others.

119. I do not recall having any specific discussions with colleagues regarding risks VC may have posed to others during this third period. If I had concerns about risk particularly those that could impact care planning or safety it is my usual practice to raise them within the structure of the MDT meetings. These meetings provide a formal and collaborative space to share observations, escalate concerns, and agree on appropriate interventions.

120. Outside of MDTs, I do not recall having any informal conversations with colleagues about VC's risk profile. However, any concerns I had would have been documented in my clinical notes and flagged for team awareness.

121. I have always felt comfortable raising concerns about risks posed by patients under my care. The team operates within a structured and collaborative framework, where MTD meetings provide a safe and professional space to discuss clinical observations, risk factors, and care planning.

122. These meetings are designed to encourage open dialogue and shared decision-making, and I have consistently found them to be supportive environments where concerns are taken seriously and addressed appropriately. If I had any concerns about a patient's risk to themselves or others, I would raise them within the MDT to ensure a collective response and to access the expertise of senior clinicians and other team members.

123. Outside of formal MDT settings, I also felt confident approaching senior members of the clinical team, such as the Clinical Nurse Lead, for guidance and support. This was particularly important when urgent or complex issues arose outside of scheduled meetings. Additionally, clinical supervision provided another avenue for reflecting on challenging cases and discussing risk in a more focused setting.

REFLECTIONS

124. Learning of the attacks carried out by VC, was deeply distressing and sobering. As a practitioner who was involved in his care during earlier periods of community support, I find myself reflecting seriously on the clinical decisions I made, the observations documented, and the systems in place at the time.

125. During my involvement with VC, he presented as stable, cooperative, and largely symptom-free. While there were concerns about medication concordance and the potential for relapse, these were managed through daily visits, risk monitoring, and MDT discussions. At no point during my contact did VC exhibit behaviours or express thoughts that would have indicated an imminent risk of serious harm to others. My assessments were based on his presentation at the time, his engagement with the team, and the information available in his clinical records.

126. That said, what happened forces a reflection on the limitations of risk prediction in mental health care. Risk is dynamic and can escalate rapidly, particularly in individuals with complex psychiatric symptoms. It also highlights the importance of continuity of care, robust information sharing across services, and the need for ongoing vigilance even when a patient appears stable.

127. I am reminded of the weight of responsibility that comes with this role, and the importance of maintaining a high standard of clinical curiosity, documentation, and communication. While I acted in accordance with the information and protocols available to me at the time, this tragic event underscores the need for continual learning.

128. The events surrounding VC's attacks, have had a profound impact on me both personally and professionally. While I was not involved in his care at the time of the incident, I had previously worked with VC during earlier periods of community support, and the outcome has prompted deep reflection on my clinical practice.

129. In light of these events, I have become even more vigilant in my approach to risk assessment and documentation. I now place greater emphasis on identifying

and exploring subtle signs that may indicate emerging risk, even when a patient appears stable. I continue to be more proactive in raising concerns within MDT discussions, ensuring that any uncertainty or unease is shared and explored collectively.

130. Additionally, these events have also reinforced the importance of continuity of care and the need for clear, coordinated communication between services. I am more mindful of how transitions between teams such as from CRHT to longer-term services can be points of vulnerability, and I advocate more strongly for robust handovers and follow-up planning.

131. Ultimately, while I acted in good faith and within the scope of my role at the time, this tragedy has deepened my commitment to reflective practice, collaborative risk management, and the continuous improvement of care delivery within mental health services.

RECOMMENDATIONS

132. I recognise the importance of the Inquiry in understanding what happened and identifying any areas for improvement across services.

133. At this stage, I have no recommendations. I believe it is appropriate to await the outcome of the Inquiry, which is being led by the Chair with access to a full range of evidence, perspectives, and expert input. I trust that the Inquiry will carefully consider all relevant factors and make informed recommendations that will help ensure lessons are learned and future risks are minimised.

Statement of Truth

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

Signed: GRO-B

Dated: 28 November 2025

Index to First Witness Statement of Clive Chimbi

No.	Inquiry URN	Document Description
1	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary
2	NHFT0000258	Screenshot of VC's RIO records