Witness Name: Ms Ella Harrison

Statement No: WITN0198001

Dated: 12 November 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF

MS. ELLA HARRISON

I, Ella Harrison will say as follows: -

INTRODUCTION

1. I am Registered Mental Health Nurse, currently employed by the Nottingham 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 3 October 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. I completed my Degree in Mental Health Nursing at Birmingham City University between 2015 and 2018. I first registered with the Nursing and Midwifery Council ("NMC") on 17 September 2018.

6. I have always worked at NHFT. I began as a Band 5 Nurse, and from 27 April 2020 worked as a Band 6 nurse. I am currently a Clinical Team Leader on Redwood 1 Ward, Highbury Hospital. I was working on this ward, in this role at the time of my involvement with VC.

Training and system of work

7. Whilst undertaking my degree, I received training through attending lectures and seminars and completing tutorials and e-learning. This included theoretical modules that covered biological, psychological and social factors that impact mental health and influence risk, such as the potential for violence and aggression. There were also areas of the course which focused on current legislations and policies. I completed exams, coursework, assignments and Objective Structured Clinical Examinations ("OSCE's"). I was also taught through role play.

8. My degree involved a 50/50 split between theoretical study and practical clinical experience. I attended practical placements where I was able to apply evidence-based learning in a clinical setting.

9. Managing risk is a core expectation under the NMC standards. Nurses are required to assess risks and make autonomous decisions to assess and manage risk.

10. When joining NHFT all employees are required to complete mandatory training. As part of my mandatory training, I completed 'Clinical Risk Assessment and Management' E-Learning.

11. There are ongoing learning opportunities within NHFT to refresh knowledge and skills. I have undertaken de-escalation training, which focused on reducing the risk of violence and aggression, including anticipation,

prevention and de-escalation. I have also undertaken observation policy training, which included the use of and need for risk assessments. I have further undertaken Debrief/Post-Incident Debrief training, which also included consideration of risk assessments.

Information sharing

12. A handover is undertaken at the start of every shift, and it provides comprehensive and relevant clinical information to maintain patient safety. A handover must be completed by a qualified nurse from the outgoing shift (shift ending) or a person judged to be competent for the designated areas being handed over.

13. For a handover to go ahead there must be at least one qualified nurse present. The handover prioritises the discussion of important information that supports discussion on presenting risk. It also supports clinical discussion, including views on patient's risks and needs.

14. At the commencement of each shift, the oncoming nurse will walk the ward with the outgoing nurse to visibly confirm all patients, make notes on wellbeing, including reflection upon mental state and condition.

15. A handover template was used on Redwood 1 to ensure that adequate information was documented. This included:

    a. Patient's name;

    b. Age;

    c. Ward safety (in respect of staffing ratio);

    d. Tasks (allocation of medication, and staff responsibility);

    e. Date and reason for admission;

    f. Diagnosis;

    g. Legal status;

h. Observation level;

i. Section 17 MHA leave status;

j. Key workers; and

k. Handover notes for early, late, and night.

16. All patient information was contained on RIO. This included all core assessments, care plans, risk assessments. I only had access to RIO Local.

17. At the commencement of a shift, I would receive a verbal handover from the outgoing nurse. This information was also available in written format (on the handover sheet). I would ensure to have read the patient's care plan and risk assessment, on RIO. The core assessment is also available to view. I would not review this every time at the start of a shift, but would review for new admissions.

18. Any involvement I have with a patient would be documented on their patient records, within RIO. I also update handover templates, patient care plans and risk assessments and any other relevant core documentations. I would share this information in handovers, Multidisciplinary Team ("MDTs") and ward reviews.

Summary and Care Plan

19. The aim and purpose of a care plan is to promote person-centred care by responding to individuals' preference and needs, reflecting on a holistic assessment, including goals, aims and outcomes. They should empower individuals to have a voice. They should be co-produced with the patient, for example, by using their own words and phrases and using language free from jargon and abbreviation.

20. There is no standardised approach, and the choice of care plan format is adaptive to patient preference, choice and need. However, each plan should be individualised to document and reflect the views and goals of that patient. Patients must be offered a copy of their care plan.

21. Care plans exist for the benefit of the patient and should be formulated around the needs of that person and not simply on the services that are available. They are about being flexible as patients' circumstances can change. Whilst an inpatient, the care plan should direct care and the information included should pull out key areas of focus throughout the admission. This will support and aid discharge.

22. For inpatient mental health settings, risk assessments and care plans should be reviewed alongside admission, ward/MDT review and discharge agreed timescales.

23. The inpatient care plans generally include the following information:

    a. An overall 'pen portrait', i.e. what is known about the service user as a person – e.g. life story, strengths, weaknesses, coping mechanisms, achievements, family history;

    b. Reason for admission – what led to admissions and including their views;

    c. Current presentation – mental state, mood, thoughts;

    d. Medication – allergies, side effects, compliance, preferences;

    e. Physical health – any physical health diagnosis;

    f. Health promotion needs – smoking cessation, alcohol, substance misuse;

    g. Social circumstances – housing, finances, relationships, work, meaningful occupation and recreational activities;

    h. Spiritual and cultural needs - religious needs, dietary needs, values, beliefs, what helps you combat bad times, where do you look for support, resilience;

    i. Mental Health Act Interventions - e.g. section and section rights, leave;

    j. Family/carers - relationships with family, carers support, carers assessment, 'triangle of care';

k. Patient's Perspective - the patient's perspective for purpose of/ reason for admission; and

l. Crisis contingency plans.

24. There are many different factors that determine the appropriate approach to developing a care plan. These can include the individual's personal goals, preferences, values, and background, as well as their specific needs, strengths, and any risks involved. The approach should be person centred. Where possible this is dependent on the level of engagement and capacity of the patient and/or their motivation to want to make change. If we are struggling to engage a patient, we would consider more of a holistic and collaborative approach and look at the wider picture. We would also include the wider MDT such as doctors, community teams, support workers, psychologists, OT, social worker, dieticians, and education providers, university (if they are a student), and/or family if they consent to this.

25. Specific factors which would determine the appropriate approach to formulating care plans would be dependent on their diagnosis, presenting presentation, functional ability, and risk factors. We would aim to look at what outcomes matter the most to the patient and respect their decisions in regards to the management of their care and treatment, provided any risks can be appropriately managed.

Multiple admissions under the MHA 1983

26. If a patient has had multiple admissions under the MHA, then this would be highlighted upon admission, usually by the MHA assessment or initial assessment which brought the patient to hospital.

27. During the clerking process on the ward - whereby the patient is clerked by medics or the duty doctor - the core assessment is completed. The core assessment included information regarding mental health history.

28. A patient will then have a 72-hour review with their responsible clinician who will also enquire about their mental health history.

29. A patient's mental health history will be included in their risk assessment.

30. During weekly ward review, a patient's mental health history would be discussed as part of the collaboration with team who will be completing the follow up in community, i.e. Community Care Coordinator ("CCO") or crisis team.

31. Their history would also be discussed during named nurse sessions.

32. A patient's history would also be discussed as part of the discharging process.

33. A record of previous admissions would be visible on RIO.

Relationship between inpatient care planning and care planning undertaken by local community mental health teams

34. Care plans are different for community and inpatient teams. Prior to admission, if a patient was under a community care plan, a new one would be created by the inpatient team.

35. If the patient is being discharged to the local community mental health team, then they would then create their new care plan once the patient has been discharged.

36. If the patient is under NHFT for both inpatient and community care, then the care plans are accessible to both inpatient and community teams, so all professionals can access these if they have access to RIO local partnership. I have no experience in writing community care plans so would not be able to comment on the relationship. However, during the discharge planning and discharge meetings the community teams contribute to specific interventions and goals.

Mental Health Clustering Tool

37. The HoNOS PbR is a needs assessment tool which was created to rate the needs of a patent based upon a series of different rating scales. It measures the health and social functioning outcomes in Mental Health Services. It is a

global scale, not just used within NHFT. The clusters describe groups of patients with similar types of characteristics. The clusters are relatively broad in nature therefore there can be a range of presentations within each.

Risk assessments used in the formulation and development of inpatient care plans

38. Risk and safety assessments inform risk formulation to develop risk management plans and care plans.

39. Risks differ from person to person. Clinical risks include suicidality, self-neglect, self-harm, other risks to self, and risks to others.

40. By completing the risk assessment, current and potential risks are identified. Once the risk is identified, a plan for management and/or specific intervention can be created. For example, if a patient is at risk of falls, we are able to create a management plan for mobility and support. If we identify someone with poor food intake, we may need a diet plan and/or weight monitoring.

41. Care plans allow for shared decision making and collaborative care. They look at how risks can be managed in a holistic manner.

42. Risks are also dynamic and can change over time. Care plans should reflect the current risks, though this will be informed by knowledge of previous risks. As part of the care planning process, it is important to balance any health and safety concerns with a patient's quality of life, recovery, choice and autonomy. It is not always possible to remove all risks completely, and during the care planning it is important to recognise that restrictive practice can also restrict positive outcomes and recovery.

43. Care plans may also include crisis contingency plans which look at ways in which a patient can be supported during a crisis and ways they are able to alleviate stress and stay safe. It identifies those who could be contacted during a crisis and how to access their support.

Reporting concerns regarding risks posed to others by patients

44. I am able to report any concerns to the MDT which would include the patient's responsible clinician or covering consultant if the consultant was absent. I could consult the junior medics, the ward manager, and in the absence of the ward manager, the covering Band 6 or Service Matron. I have no issues with raising concerns and have always felt comfortable raising or discussing any concerns with senior members of clinical teams.

Discharge planning

45. I contributed to the discharge planning of patients under my care.

46. Discharge decisions are made by the MDT collaborating with the patient, carers, care co-ordinators and any other relevant professionals involved.

47. Discharge planning commences at the point of admission. The ward team and care co-ordinator should work collaboratively and identify any issues that may impact discharge at an early stage.

48. When a patient is new to the service or is not allocated to a Local Mental Health Team ("LMHT") the ward inpatient team should refer the patient to the appropriate LMHT or community team as soon as practicable.

49. On the ward, discharge meetings occur prior to discharge. Any nurse can be involved in these meetings.

50. Prior to discharge, nurses on duty will assess the patient's mental state. A patient will generally have increased periods of leave to the community which will assist with the overall assessment process. This information is then fed back, and used to formulate a safe discharge.

51. It is the nurse on duty's responsibility to ensure that a three-day follow up is arranged, and to ensure that the patient's medication is accurately recorded and transferred with the patient. They are also required to ensure that the responsibility for the ongoing prescribing is clear.

52. As a clinical team leader, I also attend meetings such as bed management meetings which consider any delays in discharges. I also attend length of

stay meetings which identify any patient who has had a long admission to again identify any delays.

53. I am not aware of any other patients that I have been involved with having killed or seriously injured a member of the public. I have not been requested to attend any investigation or interview related to such incidents.

INTERACTIONS WITH VC

VC's Third Admission (under s.2 MHA 1983) – Rowan 1, Highbury Hospital, NHFT ("Third Admission")

54. I was not working on Rowan 1 and was not involved in his VC's admission apart from a single seclusion review, on 7 September 2021 which I attended as part of my role as a senior nurse.

55. I have no recollection of this seclusion review.

56. My understanding of VC's psychiatric history, diagnosis and/or condition, treatment and or/care plan, his forensic history and/or past instances of aggression, and the incidents which led to his Third Admissions would all have been obtained from a verbal update Melanie Davies. I have no memory of my actual state of knowledge at the time.

57. I did not discuss any matters with VC during his Third Admission.

7 September 2021

58. On 7 September 2021, I carried out a nursing seclusion review in respect of VC, with another nurse, Melanie Davies. The record of this attendance was completed by Melanie Davies [NHFT0000168, at p.181]. This states:

> 12pm - SECLUSION REVIEW - NURSES REVIEW By TL Mel Davies and CTL Ella Harrison
>
> Seclusion to continue due to risk to others.

Valdo has been observed to have used the bathroom, has drank water and returned back to lie on the bed. Movement and breathing observed. Continue to wait for a PICU bed.

Next review due - Drs review at 2pm.

59. The purpose of a seclusion review is to monitor a patient's behaviour, compliance, communication, mental state, personal hygiene and physical well-being.

60. All nursing reviews are recorded in the progress notes including the outcome of the review. If during the nursing review there are any concerns with the patient's condition then this should be reported immediately to the patient's responsible clinician or to the duty doctor. Although nursing reviews take place every two hours, the patient will be on observations every 15 minutes.

61. I do not recall this seclusion review, but it appears from the notes that the objectives were met, as VC was observed, and his presentation recorded.

62. I have no independent memory of why it was recorded that VC remained a "risk to others". However, from review of the RIO records it appears that the risk to other was based upon the severity of the incident which led to admission, and the need for seclusion and a Psychiatric Intensive Care Unit ("PICU") bed.

63. VC had been reviewed by a consultant medic review prior to this nursing review. It was felt that VC lacked insight into his mental health as he did not seem to believe that he was suffering from a mental illness. He did not engage in the assessment and refused treatment, therefore IM haloperidol was given under restraint.

64. I do not remember what information I received in advance of my involvement with VC. I believe I would have followed my normal practice. I was the senior nurse that day and was called to the 136 Cassidy Suite to complete the seclusion review. On arrival, I would have received a handover of what led to the seclusion and a handover of the last 24 hours. I cannot remember the

specific details. I would have received this from Melanie Davies. I would not have read any further information. My clinical judgement would have been based on how VC was presenting at that time.

65. I cannot recall my clinical impression of VC following this review.

66. I cannot recall what my assessment was of VC's capacity to consent to his treatment. There is an assumption of capacity, unless proven otherwise.

67. Based on information that would have been available, I understood that risks that were associated with VC's presentation to have been violence and aggression, given the incident in the community that led to the admission involving assaults on the police and use of a taser and tear gas. Other risks at the time would have included lack of insight and non-concordance with medication.

68. I did not undertake a risk assessment or participate in any other aspect of VC's care during the Third Admission. I was only visited the ward for the specific purpose of a seclusion review.

VC's Fourth Admission at Redwood in Highbury Hospital, NHFT (under s.135 and then s.2 of MHA 1983) ("Fourth Admission")

69. Whilst VC was an inpatient on Redwood 1, I was a Band 6 Clinical Team Leader. At the time I worked full-time on the ward, so worked on average 37.5 hours per week. I would have nursed VC from admission to discharge.

70. The role of a Band 6 is to provide care and treatment to those who present with significant mental problems/disorders in an inpatient setting. A Band 6 will also provide clinical and managerial leadership skills within the team, providing education and supervision to junior staff and other professionals within multidisciplinary teams. One of the Clinical Team Leaders will also deputise for the Clinical Ward Manager in their absence.

VC's presentation

71. VC originally had a MHA assessment on 18 January 2022. This was due to lack of engagement, missed appointments, concerns over medication concordance and a report that VC had assaulted a fellow student/flatmate. The flatmate had called the police, and a crime number was given. The flatmate reported that VC physically assaulted him and refused to let himself and another flatmate leave which is why they called the police.

72. During the MHA assessment VC remained calm and with no overt signs of psychosis observed and no imminent risk to self or others were identified. Therefore, it was agreed that the least restrictive plan should be imposed, namely home treatment in the community. This consisted of daily reviews and medication was being administered to support adherence. During this period of home treatment, it appeared that VC had engaged to an extent, but it was believed that he was still not fully concordant with medication. There were concerns that he was not swallowing medication, and refusing to take fluids with medications, leaving promptly after taking medication, and one incident of spitting medication in the bin.

73. VC continued to present as guarded and lacked insight, and was denying mental ill-health. Due to home treatment no longer being a viable option, another MHA assessment was sought. A warrant was sought, however, was not executed as VC agreed to go to Highbury for MHA assessment and was taken there without any issues.

74. I understood, at this time, that VC's diagnosis was Paranoid Schizophrenia.

VC's psychiatric history and condition

75. I understood that VC had had three previous admissions under the MHA under s.2 and s.3. He had had one admission to PICU.

76. His first admission was in May 2020 when he was arrested by the police after gaining unlawful entry to a female neighbour's flat leading the female to jump out a first-story window to escape the property. VC reported hearing his mother being raped and screaming. He also experienced persecutory beliefs

people were after him. This was a short admission lasting two weeks and he was discharged on aripiprazole 5mg with crisis support.

77. In July 2020 VC was readmitted with a similar incident, when he unlawfully entered the flat above to confront a neighbour whom he believed was talking about him. He reported hearing voices at the time. After admission he was discharged with crisis support and EIP support with aripiprazole 10mg prescribed.

78. In October 2021 he was subject to a s.3/PICU admission after entering a neighbours' property, causing distress. Police attended the incident and tasers and tear gas were required to manage VC. VC assaulted a police office in the process. During this admission, VC was reported to have 'complex delusional beliefs'. He believed his CCO and care team were conspiring against him with the police and judicial system. He also believed that mental health services created a technology that caused voices and this meant that they were able to monitor him. His medication changed from haloperidol to aripiprazole 20mg. He was discharged with EIP support.

79. I am not able to recall if I ever discussed any of these previous admissions with VC.

Nursing reviews

80. VC's medical records include two entries which relate to nursing reviews where I am listed as the originator, on 7 February 2022, at 7:35pm [NHFT0000168, p.233] and on 22 February 2022, at 7:47pm [NHFT0000168, p.257]. To the best of my recollection, these entries are accurate.

81. Prior to these reviews, I would have reviewed VC's notes for the day. I would have had handover as normal practice. I also would have read his care plan and risk assessments. The Risk and Safety Assessment was 7 of 9 [NHFT0000191]. The Summary and Care Plan number was 9 and 10 [NHFT0000199] [NHFT0000198].

82. The purpose of these nursing reviews is to assess a patient's mood/mental state within their running records three times per day (early shift, late shift, night shift). This will allow treating staff to identify any improvements, changes or deterioration in a patient's mental state. The progress note will include an overview of mental state, mood and thoughts, observation level, appearance/personal hygiene, interactions, therapeutic activities/engagement, other needs, i.e. food/fluid, sleep, any physical health concerns, as well as any risks. Progress notes enable good communication among the healthcare team, and oversight of a patient's condition.

Capacity

83. I deemed that VC had capacity in respect of both interactions. A person is always presumed to have capacity unless there is evidence to suggest otherwise. Capacity must be assessed for a specific decision at a particular time. VC was very articulate and understood information that he was presented with.

84. Whilst on the ward, VC accepted his prescribed oral medication, without any refusals. There was no evidence of a deterioration of his mental state, or any overt psychosis, and he denied psychotic phenomena. He did not present a risk to himself or others during his period of admission and he was not violent or aggressive. He was prescribed prn lorazepam, however, this was not required.

85. I would consider that VC had partial insight into his condition during reviews. It was recognised that VC was not always accepting of his mental illness. However, he did have some awareness of presenting problems and had an intellectual understanding. He recognised that he had heard voices in the past and correctly attributed experiences to such hallucinations. During the admission VC also did not appeal his detention in hospital.

Entry dated 7 February 2022 at 7:35pm

86. The entry dated 7 February 2022 at 7:35pm [NHFT0000168 at p.233] includes the following information:

"…Valdo has been low profile on the ward throughout the day […] minimal interaction with staff and peers, appears to be quite guarded on approach. Declined 1.1 with staff. No concerns highlighted at time of writing note. Staff to continue to try and engage to further assess mental state."

87. VC was described as "low profile", meaning that he was largely bedroom-based and generally only approached staff on a 'needs basis'. VC was guarded and did not wish to speak to staff regarding his mental state. He did not give any reasons for declining the 1-1 from what I recall. It was known that VC had difficulties building rapport/sustaining therapeutic relationships with mental health staff due to trust and previous persecutory beliefs.

88. 1-1s allow for patients to build rapport with staff and sustain therapeutic relationships. It creates a safe place for patients to be able to express their thoughts and feelings and to focus on a recovery focused treatment plan.

89. An inpatient's mental state is assessed by a mental state examination. The components of a this includes assessment of their mood and affect, speech, thought process and content, perception and cognitive function.

90. A patient's mental state will be assessed during named nurse sessions/1-1's, patient reviews, psychology sessions, during their engagement in activities, and will be assisted by collateral information, care plans/risk assessments, and collaborative approaches with the wider MDT.

91. Within the same entry from 7 February 2022, under the heading "risks" the following information is recorded: "Low risk of self-harm currently. Violence and aggression (assault on police), hostage taking (held flatmates hostage)."

92. These risks were identified from historic medical records which all staff need to be aware of.

93. This was not an exhaustive list; it was a snapshot so professionals were aware. Further details would be contained within the risk assessment.

94. If there were any new risks identified for that shift, then it would have been documented in the patient notes that I wrote. However, the risks identified were historic from previous medical records.

95. I believe that I had reviewed historic medical records, including previous care plans, risk assessments, and Approved Mental Health Professional ("AMHP") reports. I cannot recall having reviewed any information from the police in respect of these incidents. I know the Community Care Coordinator CCO had tried to liaise with the police who refused to give information. I cannot recall the specific AMHP reports that I reviewed.

Other risks

96. From the care plans, risk assessments, section paperwork, AMHP paperwork, core assessments, 72-hour reviews, patient reviews and collateral information I considered that the risks to be associated with VC's presentation were:

a. Poor engagement;

b. Fluctuating insight;

c. Non concordance with medication leading to further decline of mental health;

d. Violence and aggression;

e. Damage to property; and

f. Recent Eviction.

97. I reviewed the "Risk and Safety Assessment", dated 28 January, that was updated at the start of VC's Fourth Admission [NHFT0000191].

Entry dated 22 February 2022 at 7:47pm

98. The entry dated 22 February 2022 at 7:47pm, [NHFT0000168, at p.257] includes the following information: "[VC was] Reluctant to engage with staff.

Appeared euthymic in mood. No overt signs of psychosis. No management concerns highlighted."

99. By using the term "euthymic in mood", I meant a normal, calm and stable mental state which is balanced. He was neither depressed nor manic.

100. I cannot recall a reason as to why VC was reluctant to engage with staff.

Awareness of Fourth Admission

101. I was fully aware that this was VC fourth admission in less than 2 years. This was clear from his records.

102. In all ward reviews we spoke of the pattern of non-concordance with medication. I cannot say if it was specifically if that topic was brought up by me, however this was a noted pattern which the MDT were aware of.

14 February 2022 updated Summary & Care Plan

103. VC's record shows that on 14 February 2022, I updated VC's "Summary & Care Plan" [NHFT0000198]. This document failed to highlight, under the heading 'Mental Health History' that this was VC's Fourth Admission to NHFT over a period of less than 2 years. Aside from this, I believe that this document accurately reflected VC's presentation, condition and the risks associated with his condition at that stage. It was well known that this was his fourth admission.

104. I cannot remember which sources of information I used to update the information within the Summary and Care Plan. However, I would generally review RIO patient records, core assessments, AMHP reports, section paperwork, previous care plans, and risk assessments.

105. Where time allowed, we would review a patient's full history of admissions, including any information from other hospitals. However, the purpose of a care plan is about the current presentation and current treatment goals/outcomes. I cannot recall whether you reviewed notes entered by clinicians from VC's Crisis Resolution and Home Treatment Team ("CRHT")

team and/or from his Early Intervention Psychosis – Local Mental Health Team ("EIP-LMHT") team.

106. VC did not wish for his nearest relative to be involved in care at the time. However, the CCO had a good relationship with his mum so she would liaise with her.

107. The CCO tried to seek further information from police regarding the incident prior to the Fourth Admission but I understand that the police refused to disclose information.

108. The Reference to VC reported that he "was taking aripiprazole 5mg OD consistently" was historic, as the title suggests, this was part of his "Mental Health History". This was the account provided by VC taken from a previous admission.

109. Prior to his admission he was on 20mg aripiprazole. Further details of medication and patient view was listed further down on care plan

110. The section entitled Diagnosis [NHFT0000198, at pp.1-2] states that VC had "First Episode Psychosis". I understood that VC had diagnosis of Paranoid Schizophrenia. The Summary and Care Plan Form says 'Only fill in diagnosis and ICD-10 code if qualified to do so'. As such it would not be myself who would be inputted this entry. Diagnosis and ICD-10s are made by consultants.

111. Under the section titled "Care Plan Details" the following information is recorded [NHFT0000198, at pp.3–4]:

> MY VIEWS ON MENTAL STATE:
>
> Valdo said that he had 'one recognised episode' which was the first admission and that was 'totally rational' to be admitted to hospital. However he said that the following ones were not rational. He said that during the first admission, anyone would have noticed that something uncharacteristic was happening but only a health professional was able to say that it was a psychotic episode. He accepts that his behaviour

leading up to his first admission was uncharacteristic as but not prior to the following episodes as the experiences never reappeared. When asked what he meant by experiences, he would not further expand and said that he had given detailed notes in the past. An explanation was given as to why its important that we as a team understand what he experiences however he did not further expand.

Valdo reports that he has a particular understanding of what happened and the subsequent events. He denies feeling suspicious of the people around him and said that he doesn't have irrational thoughts around this. He said that if it wasn't for his first admission, he wouldn't have been sectioned this time.

CAPACITY/CONSENT:

Valdo currently does have the capacity to understand, retain and weigh information provided to make an informed choice about his care and management of mental health condition, including prescribed medication.

[…]

MY VIEWS ON MEDICATION:

When asked about his thoughts about taking medication in the long terms he said that he had already been taking it for a long time. He denies being non-compliant with his medication prior to admission and reports that he was taking his 20mg OD. He said that he was getting his medication from Cripps Medical Centre weekly.

When asked whether he had forgotten to take tablet, he said 'that's incorrect'.

Valdo said 'no' to starting a depot. He said that he was satisfied with the mediations as it is, he has been on it for a while. He said that when he had changed medications in the past, he had experiences side effects.

It was explained that the depot would be the same medication. Valdo expressed again wished to stay on the tablets rather than the depot."

112. VC's level of insight would have been assessed at the time of admission. It is common that an individual's insight fluctuates. The potential and historic risks associated with VC were non-concordance with medication, so if he lacked insight into his history and condition, and acceptance that he had been unwell, he might not take his medication which might, in turn, lead to violence. The fact that he had not accepted that he was unwell during some of his previous admissions, was relevant to the assessment of insight.

113. If there were concerns with an individual not taking medication, a specific care plan would be put in place. However, there were not concerns that VC was not taking his medication whilst on the ward. As such, the Summary and Care Plan did not have specifically address this. I am not aware of what steps that were taken during VC's Fourth Admission to improve VC's insight into his condition and the risks associated with it.

114. With regard to capacity, a person is always presumed to have capacity unless there is proof otherwise. Capacity must be assessed for a specific decision at a particular time. VC was very articulate and appeared to understand the information he was presented with. He was able to engage with, understand and participate in his care planning. I did not have any reason to think that he lacked capacity.

Entry on 14 February 2022 at 1:14pm

115. VC's medical record includes an entry dated 14 February 2022 at 1:14pm which I entered [NHFT0000168, at p.245]. It records the following information: "CARE PLAN UPDATED. Patient declined copy of care plan and refused to engage."

116. If someone declines to engage this does not automatically mean they lack capacity. It may be a conscious/personal decision they are making. Patients might not engage due to a variety of reasons such as not feeling it is necessary to be in hospital, not have a therapeutic relationship with the

nurse, feeling overwhelmed, tire. They may just not wish to participate. Because he refused to engage, we would use other evidence to consider capacity, such as engagement in ward reviews, attendance at the gym, unescorted leave, collateral information from others, and observations of his presentation/metal state.

Depot medication

117. The Request asks me to state why I "considered that VC may have required or benefitted from depot medication." Nowhere within the care plan does it state that I felt that VC would have benefited from depot medication.

118. VC had capacity to make informed decisions about his treatment, he was accepting of oral medication on the ward. He had not refused any medication while being on the ward. There was no evidence of deterioration of his mental health, so there was no increased risk.

119. I know that previously he had stopped complying at times in the community, but while on the ward he was reassuring us that he would continue to engage post discharge, and he would accept the medication. It would be hard to rationalise the decision to enforce treatment upon a patient who was complying with treatment on the ward. I therefore did not think that depot medication was justified at the time.

120. I cannot recall giving him information about depot medication. It would be a pharmacy colleague who would have had a discussion with a patient regarding new medication.

Responsibility for confirmation of accuracy of information

121. As part of MDT and ward rounds, information given by a patient would be followed up by liaising with the community teams and the Patient's GP. VC was collecting his medication from Cripps Medical Centre up until they had concerns regarding non concordance with medication, so to monitor compliance, the community team took over responsibility of dispensing his medication (from the Stonebridge Centre). Although VC said that he was

attending at Cripps he was in fact attending Stonebridge to pick up his medication. I think it is unlikely that this discrepancy would have made any material difference to VC's care or treatment.

Summary & Care Plan - Crisis Contingency Plan/Safety Plan

122. Within VC's "Summary & Care Plan", under the section titled "Crisis Contingency Plan/Safety Plan" [NHFT0000198 at pp.5-6], the following information is recorded: "Current risk to Others: Low"

123. This is recorded under AWOL ("absent without leave") risks. VC was compliant with medication from the ward. He has undertaken unescorted leave and there had not been any incidents of violence or aggression. Accordingly, the current risk was assessed as low.

124. I don't specifically recall whether I reviewed any of the entries within VC's RIO records prior to updating his Summary & Care Plan. However, it is my normal practice to do so. I have no reason to think that I would not have reviewed these entries on this occasion.

125. VC's records from his Fourth Admission include an entry dated 3 February 2022 at 6:50pm [NHFT0000168, at p.227], which indicated that VC was seen near his old accommodation by his former housemates on that day.

126. I can recall discussion of this incident. This, however, would not have been discussed in regards to updating VC's care plan. We would not have disclosed the information given by his old flatmate as it could have put the flatmate at risk. VC had already denied being at the accommodation but had admitted, during one of his reviews, to being in the local area.

127. VC's records also include an entry dated 4 February 2022 at 10:41am, [NHFT0000168, at p.228] which was originated by one of the junior doctors involved in VC's care. It records further information obtained by this doctor from VC's university and housemate.

128. VC's housemate had reported to the doctor that "...there had been some concerns about Valdo's presentation for about a month. Short screams were

heard intermittently from his room, which were thought to be him. He also reportedly entered another flatmate's bedroom in the middle of the night and asked "can you hear that screaming" (referring to a different scream, potentially hallucinatory).

129. I was aware of this information prior to updating care plan, however, did not think it was clinically appropriate to disclose this conversation to VC or discuss the concerns raised by VC flatmates due to incident which had occurred prior to VC's admission. This would have been relevant to VC's risk assessment.

130. I cannot recall whether I contributed to or reviewed any risk assessments in respect of VC during his Fourth Admission.

MDT discussions

131. I cannot recall if I discussed the risks associated with VC's condition with any other member of VC's MDT during his Fourth Admission.

132. I cannot recall If I provided any feedback about VC's condition, mental state and presentation to VC's wider MDT during his Fourth Admission.

133. I noted that VC's medical record includes an entry dated 21 February 2022 at 4:02pm [NHFT0000168 at p.255], which relates to an MDT discussion which I attended.

134. An MDT meeting is when professionals meet to discuss each patient and any outstanding jobs/tasks for that next week, i.e. referrals. It is also to discuss any new admissions or planned discharges. All professionals work together to make decisions regarding the care and treatment of patients. On the ward this is usually led by a consultant, and each professional will then give an update on the past week.

135. I cannot recall the specific details. However, it would be normal practice to handover nursing feedback which would include things such as a patient's mental state, observation level, engagement in activity, food and fluid intake,

attending Activities of Daily Living ("ADLs"), and medication concordance, etc.

136. I cannot recall whether I was involved in any specific aspect of VC's discharge or/and planning.

137. I do believe it was appropriate to discharge VC at this stage of his fourth admission. VC had accepted prescribed medication on the ward and agreed with compliance within the community. He did not present with any risk to others on the ward, there was no incidents of violence and aggression. VC was utilising s.17 leave to community. The family also did not oppose his discharge. It would have been unlikely that VC would have met the requirements to be detained on under s.3. Therefore, the least restrictive approach of community treatment was appropriate at this time.

138. I cannot recall having any communication with VC's CRHT or EIP team following discharge. However, this would not be normal practice once a patient is discharged from the ward. Contact with the inpatient team would normally stop at that point.

139. Whilst on Redwood 1, VC did not present with any overt psychotic symptoms, he continued to accept prescribed medication. VC was low profile on the ward, spending most of his time in his bedroom. His mental state remained stable and at point of discharge there were no psychotic symptoms identified.

140. I did not witness VC display aggression or violence at any time.

141. I cannot recall discussing any risk VC posed to others with any other colleagues.

REFLECTIONS

142. It came as a shock to find out about the attacks by VC because of his presentation on the ward. When I nursed VC, he was a quiet and reserved individual.

143. I am sending my condolences to the families of the victims. It is incredibly sad for everyone involved.

144. These events have not caused me to change my practice.

145. I have not given any interviews or otherwise made any public comments about the actions of VC.

146. I do not have any recommendations for the Chair of the Inquiry.

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: 12/11/2025

Index to First Witness Statement of Ella Harrison

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	NHFT0000191	Medical Records of VC dated from 28/01/2022 to 02/02/2022, NHFT, Re: Risk and Safety Assessment
3	NHFT0000198	Medical Records of VC dated 14/02/2022, Nottinghamshire Healthcare NHS Foundation Trust, Re: Summary and care plan
4	NHFT0000199	Medical Records of VC dated 02/02/2022, NHFT, re: Summary and Care Plan