Witness name: Dr Ayodeji Onimisi Akerele

Statement No: WITN0204001

Dated: 16.12.2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR AYODEJI AKERELE

I, Dr Ayodeji Onimisi Akerele, will say as follows: -

BACKGROUND

1. I am Dr Ayodeji Onimisi Akerele, an ST6 trainee in Psychiatry.
2. This witness statement is made to assist the Nottingham Inquiry with the matters set out in the Rule 9 request dated 22 September 2025.

3. 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. My qualifications include Bachelor of Medicine and Bachelor of Surgery (MBBS) 2011 and membership of the Royal College of Psychiatrists (MRCPsych) October 2022.
4. I completed my undergraduate medical education from the University of Benin, Nigeria in 2011. I remained in Nigeria until 2014 when I left to work in a mental health hospital in Trinidad and Tobago until 2017. I relocated to the United Kingdom where I commenced my core psychiatry training in Nottingham. I was a core psychiatry trainee, which is general psychiatry training before subspecialising in a specific psychiatry subspecialty. A core psychiatry trainee must have completed an undergraduate medical degree and the foundation year trainings. I completed my core psychiatry training between 2018 and 2022, then joined the higher specialist training scheme in old age psychiatry. I am currently in my third year of higher specialist training (ST6) in psychiatry and I work on Cherry Ward in Highbury Hospital.
5. I have prepared this report from the review of VC's medical records. [NHFT0000168]. I have also drawn on my own knowledge base and from consulting the World Health Organisation's Clinical descriptions and diagnostic requirements for International Classification of Diseases (ICD- 10 &11) mental, behavioural and neurodevelopmental disorders.
6. At the time of my contact with VC, I was in my CT3 extension post with Nottinghamshire Healthcare Foundation Trust (NHFT) and I was working with the City Community Mental Health Team for Older Persons. My only direct contact with VC was on the night of 28th of January 2022 whilst I was the junior

doctor on call in Highbury Hospital. I attempted to take history from VC and made an entry on the core assessment form on the 28th of January 2022 at 23:46; and a progress note entry on the 29th of January 2022 at 12:08am. [NHFT0000186].

INPATIENT MENTAL HEALTH SERVICES

7. The clinical aims of providing inpatient treatment to patients detained under the Mental Health Act 1983 are to enable further assessments of a patient's mental health presentation in a safe hospital environment. Following assessment, the aim is to provide the appropriate treatment that is indicated so that the patient can recover from their illness as much as possible. The restriction from being sectioned under the MHA can then be lifted and the patient discharged safely back into the community.
8. It is my understanding that, when a patient is admitted to NHFT, an initial assessment of both the patient's mental and physical health presentation is conducted by the nursing team and the doctor. This includes the completion of relevant documents on the electronic patient record called 'Rio'. It is worth mentioning that these are usually editable documents that get updated during the admission, as more information becomes known.
9. It is usual practice for new patients to be reviewed by a senior doctor together with other ward professionals at a Multi-Disciplinary Team (MDT) meeting. These are usually conducted weekly until the patient is discharged. These reviews take into account the full details of the patient's history and presentation, risk concerns with the aim of establishing a diagnosis and formulating a

treatment plan. The patient is continuously monitored throughout their treatment and their discharge planned appropriately.

10. For patients detained under s.2 of the MHA (a section of the Mental Health Act 1983 used for admitting a patient to a mental health hospital for assessment), a period of assessment in the safe environment of the ward takes place in order to have time to observe and treat patients who present with a mental disorder. This is done through regular reviews by the ward professionals at MDT meetings, by reviewing the patient's presentation, risks and care plan. For patients who are not yet safe to be discharged from hospital, at the expiry of the section (after 28 days), they may remain in hospital on a voluntary basis, if they are able to and agree to it or placed under s.3 of the MHA (another section of the Mental Health Act used to admit patients to hospital for treatment of mental disorders).

11. The care and treatment of patients detained under s.3 of the MHA is similar in that they are also regularly reviewed by the MDT process, and patients undergo regular reviews of their presentation, risk history and care plan. This differs from a s.2 of the MHA because it is usually utilised for patients with a known mental disorder who are clearly showing signs of relapse of that mental disorder. The duration of a section 3 detention can be up to six months, and it may be renewed subsequently if felt necessary.

12. The inpatient teams at Highbury Hospital work very closely with the Crisis Resolution and Home Treatment Team and the various Local Community Mental Health Teams in ensuring smooth and safe transitioning of patients' care between the inpatient wards and community. This is done via patients'

information sharing between these teams in ward MDT meetings and handover of patients' care to the community teams during discharge planning.

13. Inpatient mental health services provide treatment, care and management to patients admitted to mental health hospitals. The crisis resolution team will assess and manage patients who are experiencing an acute mental health crisis. They provide a risk assessment and will coordinate the admission of unwell patients if required. The community mental health team provides longer term treatment, care and management to mentally unwell patients in the community rather than as an inpatient.

14. Inpatient service providers play a key role in ensuring the smooth transitioning of patients into the community, after discharge from hospital. This is required to help improve the continuity of care of a patient with complex needs on the Care Programme Approach pathway. The inpatient service is specifically valuable in the area of initiating the assessment of the mental health and social needs of an inpatient, formulating a multi-disciplinary care plan and ensuring the appointment of a care coordinator for the patient, before the patient is discharged from hospital.

ILLNESS AND PSYCHOSIS

15. A person will be considered acutely mentally unwell if they present with features suggestive of a disorder or disability of the mind, causing significant disruption of their functioning and in such a way that they either put themselves and/or others at risk of harm. The assessor must be satisfied that these signs and symptoms are not attributable to any identifiable physical health cause, but

instead, one's mental health. For example, a person may restrict or stop eating and drinking because of their strong belief of their food being poisoned, in the absence of any evidence. Such person can put themselves at risk of malnutrition and dehydration and then struggle to function.

16. Psychosis is a disability of the mind that causes distortion of reality or loss of touch with reality. According to the World Health Organisation's International Classification of Diseases (ICD) [WITN0204002], psychotic symptoms comprise of delusions (fixed false beliefs held with certainty), hallucinations (perceptions in the absence of an external stimulus), passivity experiences (experiences that one's feelings, impulses, actions or thoughts are being controlled by others) and disorganised thinking. Other psychotic symptoms include negative symptoms such as withdrawal from people, disorganised behaviours and psychomotor disturbances (restlessness, agitation, catatonia). Catatonia is a state of marked disturbances in movement, behaviour and responsiveness.

17. When at least two of the symptoms of psychosis listed above are present for a period of at least one month, it is referred to as schizophrenia. In paranoid schizophrenia, the predominant symptom is a delusion of persecution, where someone firmly believes, without evidence that they are being targeted, conspired against or attacked by others. This can be associated with the need for the sufferer to take actions to protect themselves, which can sometimes lead to violence towards others.

18. The initial period of observation following admission involves reviewing and gathering relevant information as much as possible about the patient's past

medical history, current presentations including reasons for admission, risk history, initial close nursing observations of behaviours and physical health assessments (physical observations checking the pulse rate, blood pressure, respiratory rate, temperature, oxygen saturation, physical examination, blood tests and ECG). These can formulate the initial care plan until a time when a more robust formulation of the care plan is completed by the MDT.

CORE ASSESSMENT FORM

19. The core assessment form is recorded on the electronic patient record called 'Rio', used in NHFT for recording information when reviewing new patients. [NHFT0000187]. It has different sections capturing the patient's presenting complaint, past psychiatry history, physical health history, medication history, family history, drug and alcohol history, forensic history, record of consent and capacity for assessment, personal history, social history, mental state examination, family/carer views and physical health examination. The completion of the core assessment form commences on admission. It can be updated as new information becomes available and also be used by the community mental health team for the same purpose.

RISK ASSESSMENT

20. Risk assessments are an integral part of inpatient care plan formulations. They help inpatient teams better understand the risks the patient poses to themselves, to others and the potential for other people to harm the patient. It will also take

into account the risk of damage to property. All of these risks are considered when formulating the inpatient care plan and during discharge planning.

MENTAL STATE EXAMINATION

21. Mental State Examination reflects the patient's appearance and behaviours, the mood (the patient's subjective emotional state), affect (the objective emotional expression of the patient to the examiner), the tone, volume, rhythm of speech and whether speech is rational or not. It also captures the content and the flow of the patient's thinking and presence of any perception in the absence of an external stimulus referred to as hallucinations, cognition in terms of the patient's orientation and memory and finally, insight which checks how much they are aware of their symptoms being related to a mental disorder and their understanding of the need for treatments. The findings from a Mental State Examination are used collaboratively with the patient's history to formulate diagnosis.

TREATMENT

22. It is difficult to generalise treatment strategies for all patients experiencing psychosis, as individual patients' care needs usually differ therefore, treatment strategies should be tailored to these individual needs. In general, patients experiencing psychosis should receive a holistic approach to their care, taking into account their antipsychotic medication needs, addressing any psychological factors and as well as their social needs.

23. Antipsychotics are medications used to treat psychosis. They can be given orally and as well as in injection forms. The inpatient ward environment usually helps to ensure compliance to medications because it provides for supervised administration of medications. This environment may also enable better monitoring for side effects to medications as well as responses to treatment. The reduction of the symptoms of psychosis is a good indicator of response to treatment.
24. Psychological formulations capturing the factors that increase the risk of developing psychosis including any specific psychological therapies such as Cognitive Behavioural Therapy for Psychosis (CBT-P) may be beneficial for patients experiencing psychosis. Addressing social needs which contribute to the patient's stressors in the community such as homelessness, unemployment, financial difficulties, are also part of the treatments offered to patients.
25. People who experience psychosis may have partial or lack insight into their experiences. These could impact on their ability to comply with treatment but, the return of insight, reductions in psychotic symptoms and the behavioural disturbances including risks associated with psychosis, are good indicators for discharge planning to commence.

DISCHARGE PLANNING

26. I am not aware of any specific criteria for commencing discharge planning for patients with a history of aggression in the community and inpatient settings but, based on clinical experience, it is likely that if the mental disorder is treated to a reasonable extent, there is also likely to be some mitigation of this risk to a level

that can be safely managed in the community and with strategies put in place to detect future relapses in a timely manner.

27. These patients will benefit from strategies to ensure compliance with treatments and follow up care with the community mental health teams. These may involve addressing factors such as any medication side effects that may contribute to difficulties in continuing medications, psychological approaches to improve their education about their illness and treatments. They may also benefit from changing their oral medications to depot. Depot is antipsychotic medication in injection form that is given either weekly, once in two weeks, once in three weeks or monthly, depending on the patient's needs. It helps to improve compliance as patients do not have to remember to take tablets daily.

28. The use of a Community Treatment Order (CTO), which is a legal framework under the MHA 1983, allows a patient detained under section 3 of the MHA to be discharged from hospital into the community, with specific conditions that the patient must adhere to, otherwise such patients can be recalled back to hospital if they breach the conditions. Advice and inputs from the community forensic psychiatry team may also be helpful for such patients.

29. Patients with a history of violence may require multi-agency collaboration in the risk assessments and management strategies with other relevant agencies such as social care, the police, forensic psychiatry services, primary care services and any other relevant agencies. Patients with a history of non-concordance with medication will require close monitoring by the community mental health teams, addressing any factors that may be contributing to medication non-concordance, use of depot medications to improve compliance and considerations for the use of CTOs. Patients with a history of social isolation

may benefit from inputs of community support workers, personal assistants and social prescribers, who may be able to introduce them to and assist in accessing relevant group activities in their localities, day centres and recovery colleges.

30. Patients with a history of disengagement from treatment may require CTOs which are usually instigated by the inpatient teams together with an Approved Mental Health Practitioner (AMHP), before discharge. Such patients will require close monitoring and regular reviews by the community mental health team, following discharge from hospital.

31. Patients with a history of masking psychotic symptoms may benefit from consideration of the combination of their history and presentation taken from other people who know the patient very well. This approach will help in formulating diagnosis and treatment care plans. From clinical experience, psychosis can impair a patient's awareness and insight about their symptoms, but patients with partial insight (patients who have some awareness of their symptoms) may be able to mask their symptoms, with the intention of possibly avoiding the perceived stigma associated with mental illnesses.

When determining which patients detained under the MHA 1983 still present a risk to themselves or others and therefore should not be considered for discharge planning, there are a number of factors that will need to be considered. These factors include patients who have not been complying with their recommended treatments and who exhibit persistent or worsening symptoms, including continuous lack of insight. A patient who has not successfully had a leave trial off the ward may not be suitable for discharge straight away. It may also be considered that the patients who remain a high risk

for aggression and violence with multiple aggression and violent incidents on the ward may not be considered for discharge.

INSIGHT AND MASKING

32. Insight demonstrates how much awareness a patient has about their symptoms and how those symptoms relate to their mental disorder. Insight will also demonstrate if the patient has awareness and understanding of the need for treatment and their willingness to accept treatment. Therefore, a patient may have full insight, partial insight or may completely lack insight.
33. Masking is when a patient is able to act as though their psychotic symptoms are not present, when indeed they are. Such patients are unlikely to seek help on their own. Masking also poses huge challenges to healthcare professionals in detecting symptoms of psychosis. Ultimately, masking can lead to these patients receiving no treatment and the worsening of their psychotic symptoms.

PAST BEHAVIOUR

34. When assessing a patient's risk of harm to themself or other people during an acute deterioration in mental health, a number of past factors will be considered. A past history of self-harm or suicidal ideation, a previous history of aggression and violence towards others or a past history of damage to property including arson will be contributing factors. The risk from others posed to the patient through either retaliation and/or vulnerability of the patient also helps in predicting future risks posed by the patient. A history of lack of insight

which also contributes to medication non-concordance is also helpful in predicting future risks.

OTHER ISSUES

35. I have not given any interviews or made any public comment regarding this case.

INVOLVEMENT WITH VALDO CALOCANE ("VC")

36. I was on call as the junior doctor covering Highbury Hospital on the night of 28th of January 2022, following VC's admission to hospital. This was my only contact with him. I have no recollection of my interaction with VC on the said night. I have relied on my notes [NHFT0000186 and NHFT0000168 at p216]

37. I attempted to take a history from VC on the night of 28th of January 2022, after he was admitted under section 2 of the MHA. I cannot remember the specific information on his records that I viewed before attempting to review VC on that night, but I know that it is my usual practice to review the medical records of patients and make a summary of the interaction with the patient on the medical records. I can see from my records on the core assessment [NHFT0000186] and progress note [NHFT0000168 at p216] that I may have consulted some of the notes recorded by the Crisis Resolution and Home Treatment Team (CRHT)/ the Early Intervention in Psychosis – Local Mental Health Team (EIP-LMHT), the Mental Health Act (MHA) Assessment recorded on the progress note and previous admission core assessment.[NHFT0000186]

38. As VC did not engage with the assessment that I attempted to undertake on that night, it was difficult to form a full clinical impression of his presentation at that time. However, given his presentation of noncompliance with medication, his disengagement from the EIP-LMHT follow up, his recent referral to CRHT following the incident in his accommodation, his decline of food and fluid similar to previous presentations, his irritability, unpredictable behaviour with risk of escalating behaviours, I had concerns that he was mentally unwell.

39. According to my entry on core assessment [NHFT0000186] I could not ascertain if VC had capacity or not to consent to or participate in his treatment because of his non engagement with the assessment. I may have also thought that due to the time of the night that it was, it might not have been the best time for capacity assessment. Based on the combination of his presentation, refusal of admission and seeming failure to appreciate concerns regarding his mental health (as reported on his MHA assessment notes) [NHFT0000168 at p215], I doubted that he had insight into his own mental health presentation.

40. I can safely assume that my knowledge of the incident where VC held his flatmates hostage came from his records. [NHFT0000168 at p215.] I cannot remember the details of the information I had about this incident. I do not think that I sought further information from the police or VC's housemates that night. If I had, I would have made an entry of such encounters on his records. I cannot say why I had not sought such information, but I can only assume that it may have been felt that such information would be better collected during the daytime, given the time of the night my encounter with VC was. I cannot also remember if I sought information from the Approved Mental Health Professional

(AMHP)'s referral that night, but I do know that AMHP's report can sometimes take several days to be available.

41. From a clinical perspective, it would have been helpful to know the exact details of the incident. In particular, it would have been useful to explore what VC's intentions were and whether he had been responding to a hallucinatory experience or exhibiting signs of paranoia. It would also have been helpful to know what his own views about the incident were. However, this was not possible since VC did not engage with the assessment that night.

42. I cannot remember what my understanding of the VC's diagnosis was at that stage, but my notes [NHFT0000186 and NHFT0000168 at p216] did suggest that he has a history of a psychotic illness and that he was likely experiencing a relapse of his illness.

43. I cannot remember the extent of what was known to me at that time when I reviewed VC, but my note [NHFT0000186] does suggest that he had past history of violence towards the police and others, including confronting a neighbour. This is mentioned in the MHA assessment notes [NHFT0000168 at p215.] and previous core assessment [NHFT0000186]. I appear to have lifted this reference into my own core assessment entry, although I am not sure how I may have interpreted this information on that night.

44. I believe I must have understood from the note [NHFT0000186] that, when VC becomes unwell, he disengages from his treatment and follow up care. He also tends to pose a risk of aggression and violence towards others. I believe I must have considered VC posed a risk of agitation and aggression to others, hence the reason I initiated "as-and-when-needed" lorazepam (a medication used to manage agitation and aggression due to his calming effect) on his medication

card and with a plan to the ward team to escalate any concerns to the doctor, as an initial management measure. [NHFT0000168 at p216.]

45. I believe my identification of VC's risks of irritability and unpredictable behaviours that could escalate, as documented in my entries on both core assessment and progress note under the heading 'Inpatient Admission Clerking', was an initial risk assessment. [NHFT0000186]. These informed my decision to prescribe as-and-when-needed lorazepam to manage aggression. I believe that I also noted a risk of poor food and fluid intake, hence the mitigation around this risk as stated in my plan.

46. I cannot remember if I specifically reviewed the risk assessment completed by the nurse or if I had conversations with the specific nurse who completed the risk assessment that night. [NHFT0000191]. I am aware that it is usual practice for the staff on the ward where a patient has been admitted to, to provide the doctor with a handover of the patients who have been admitted. It is also a usual practice for me to handover my plan, after reviewing a patient, to the ward team.

47. Core assessment form is one of the several forms and sections on Rio where patients' information and history can be accessed. Just like the other forms and sections on Rio, it contains useful patient information relevant for formulating diagnosis and treatment plans.

48. I had no further involvement in VC's care and treatment during his fourth admission.

49. I had no further contact or input into the care of VC other than to take a history from him on the night of 28th January 2022.

50. I have not been involved in the care of any other mental health patients who have injured or killed a member of the public to the best of my knowledge.

REFLECTIONS

51. Reflecting on my contact with VC on the night of 28th of January 2022, when he was admitted, I wondered If I would have been able to get more relevant information that would have assisted in uncovering any existing psychotic symptoms and undertake more detailed risk assessments, if I had persisted some more with trying to engage him in the assessment. I wondered if there would have been a struggle on my part with balancing this with the risk of escalating him, if I had persisted.

52. I have also reflected on the importance of having all the relevant information when reviewing a patient, including seeking information from anyone or agency that may hold useful information about a patient in the care and management of the patient. I can also see how important it may be to have a system with easier accessibility to useful patient information.

53. There has been improvement in my practice. I have improved my skills of identifying sections on Rio such as the core assessments forms, risk assessment forms, summary care records, the inpatient discharge forms, uploaded document section and other necessary sections, that hold useful patient information when reviewing patients. I have also significantly improved my skills in using this information in undertaking a holistic review of patients' presentations, formulating management and risk management strategies. These are reflected in my documentations of patients' assessments. I believe

this has come from my experience of continuous reviews of patients with various complex presentations.

54. I have not given any interviews or public comments about the actions of VC.

55. The findings and learning points from this inquiry should be made well known to every NHS trust and if possible, should be incorporated into local academic teachings of every trust and as well as incorporate it in both the undergraduate and postgraduate medical curricula. This will ensure continuous learning.

56. Improving the accessibility to relevant patient information in a timely manner across multiple agencies that are involved in the care and management of patients with mental disorders will help in the overall coordination of patients' care. This may be in the form of having a unified database with access granted to all relevant parties.

NOTE

57. 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. I also sought advice from my Medical Defence Union.

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.

GRO-B

Signature...

Dated……16/12/2025……………………………………………….

Index to First Witness Statement of Dr Ayodeji Akerele

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.	WITN0204002	World Health Organisation's Clinical descriptions and diagnostic requirements for ICD-11 mental, behavioural and neurodevelopmental disorders
3.	NHFT0000186	Medical Records of VC dated from 28/01/2022 to 29/01/2022, NHFT Re: Core Assessment (CPA and non-CPA)
4.	NHFT0000191	Medical Records of VC dated from 28/01/2022 to 02/02/2022, NHFT, Re: Risk and Safety Assessment
5.	NHFT0000187	Medical Records of VC dated 15/07/2020, Nottinghamshire Healthcare, NHS Foundation Trust Re: Core Assessment (CPA and non-CPA)

List of supporting references not exhibited

1.	World Health Organisation's 'ICD-10 Classification of Mental and Behavioural Disorders', available online at: https://icd.who.int/browse10/2019/en