Witness name: Jonathan Gibson

Statement No: WITN0205001

Dated: 17.11.2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF JONATHAN GIBSON

I, Jonathan Gibson, will say as follows: -

INTRODUCTION

1. I am a consultant psychiatrist employed by the Nottinghamshire Healthcare NHS Foundation Trust (“the Trust”).
2. This witness statement is made to assist the Nottingham Inquiry (the “Inquiry”) with the matters set out in the Rule 9 Request dated 23 September 2025 (the “Request”).

BACKGROUND

3. I am currently a consultant psychiatrist working at Highbury hospital, although at the time of my involvement with "VC" I was an ST4/ST5 registrar.
4. I graduated from Newcastle University with a Bachelor of Medicine, Bachelor of Surgery (MBBS) in 2013. I completed my Foundation Programme in the Northeast of England, before starting Core Psychiatric Training in the East Midlands in 2016. I completed my Membership of the Royal College of Psychiatrists (MRCPsych) examinations along with my Core Psychiatric Training in 2019. I worked as a specialty doctor in a locked rehabilitation unit during the first year of the pandemic before starting Higher Specialist training, again in the East Midlands, in February 2021. My involvement with VC was during my second rotation as a Higher Specialist Training (HST).

CLINICAL AIMS UNDER THE MENTAL HEALTH ACT (MHA 1983)

5. Since the Mental Health Act 1983 ("MHA"), National Institute for Health and Care Excellence (NICE) guidelines, International Classification of Diseases 11th Revision (ICD-11) criteria and other statutory guidance, are in the public domain and are well known, I will not reiterate them here. Instead, I will give a broad overview and abstract the principles. A peculiar feature of mental illness is that patients often lack insight into its presence, severity, or the need for treatment. This, coupled with the potential for harm to the patient or others stemming from that illness, means sometimes patients require detention against their will and are occasionally forced to have appropriate treatment.

6. The use of state violence to detain someone against their will, and potentially to enforce treatment via injection (often while a patient is physically restrained by nursing staff) is something that should be used judiciously and only when necessary. Since it is not always clear whether someone's liberty should be infringed in this way, section 2 of the MHA allows for detention for the purpose of assessment (potentially followed by involuntary treatment) for a short duration. In some cases, however, a patient has a clear diagnosis and pattern of illness, with an already defined treatment plan. In such cases, section 3 of the MHA allows for a longer duration of potentially involuntary treatment of that illness.
7. Medical treatment is not the only aspect of care in an inpatient setting. Nursing care is invaluable to facilitate patients attending to their activities of daily living, monitoring their physical and mental health, and preventing violence from harming others on the ward. Psychological input is often highly important, although depends on the individual's presentation and ability to engage. Occupational therapy allows for the assessment of and the improvement of their functional skills. Attention should be given to the patient's social situation including occupation, housing, social interactions and substance use. Care should involve members of the patient's family where possible.

<u>INPATIENT SERVICE</u>

8. Patients will be admitted to the ward either informally or detained under the MHA. They will be clerked by a resident doctor, and various assessments will be undertaken by nursing staff as part of the admission process. A senior

review of the patient by a registrar or consultant (or equivalent) should happen within 72 hours of admission during which a holistic sense of the presentation should be gained and an initial management plan formulated, including everything from level of observations, leave, medical treatment, physical healthcare, and contact with external agencies.

9. Multi-disciplinary (MDT) meetings take place weekly, where progress of the patient can be discussed, jobs chased, and new jobs requested. Each patient will be reviewed by their Responsible Clinician ("RC") at least weekly and by their named nurse outside of this. Jobs arising from these reviews (or at any other point) will be completed throughout each week and will be allocated and chased at board reviews each weekday morning.

10. Consideration is given to the causes for admission, mental state, accommodation, required treatment, and community follow-up. Once these have been adequately addressed, as judged by the RC in collaboration with the MDT, a plan will be made to discharge the patient.

11. Treatment on the ward at Highbury Hospital is usually followed by outpatient treatment by secondary mental health services of some variety, although occasionally patients are discharged directly to primary care. It is good practice to liaise with the outpatient team, during an inpatient admission, particularly if the patient has one. Ideally, representatives will attend ward rounds. This is sometimes limited by the staffing shortages in outpatient teams.

INVESTIGATING MENTAL HEALTH ILLNESS

12. The phrase "acutely unwell" is not a technical term and does not have set criteria from my understanding. I have a reasonable amount of experience with mentally unwell people, however, and can usually make a judgement whether someone is "acutely unwell" from a combination of reading the notes and conducting a clinical interview.

13. Psychosis is fundamentally a distortion of perception and thought, which can result in unusual behaviour. Common perceptual abnormalities would include auditory hallucinations, tactile hallucinations, or illusions. Distortions of thought can include delusions, thought disorder, and abnormal possession of thought. There are multiple potential causes of psychosis, including stress, insomnia, illicit drugs, prescribed medications, physical illness, or mental disorders such as severe depression, mania, dementia, or schizophrenia. Schizophrenia is a disease in which there is persistent psychosis (often with a relapsing and remitting pattern) alongside cognitive abnormalities, and negative symptoms. The symptoms must be present for one month to qualify for a diagnosis.

14. On admission to an acute ward, a patient is clerked by a resident doctor. They will complete the Core Assessment at this, and no other point. This should be a complete psychiatric history for the patient. As part of the clerking process, the resident doctor should perform a physical examination, take (or delegate) routine bloods, perform (or delegate) an ECG, and complete a VTE form. Nursing staff will observe the patient's behaviour, conduct 1:1 named nurse sessions regularly, support the patient with any queries or difficulties, dispense medications, facilitate mealtimes, and conduct physical health and

psychiatric observations. Other useful information early in admission could include collateral history and a detailed social history.

MENTAL STATE EXAMINATION

15. A Mental State Examination is the standard means of describing a patient's mental state. The headings include: appearance, behaviour, speech, mood, thoughts, perceptions, cognition and Insight. The details of which are in most psychiatric textbooks and known to all but the most junior doctors in psychiatry. The information for the examination is taken only from the clinical interview that preceded it.

SUMMARY AND CARE PLAN

16. Summary and Care Plan documents are completed by nursing staff and should be an accurate and concise representation of the care plan that has been developed by the MDT. Since the care plan is produced by the MDT, it is up to them to ensure that repeated patterns of illness are addressed. In practice, this will come from reading the notes, speaking to family and to community teams. Inpatient and outpatient care plans are clearly related but separated by the fact they are produced by two different teams in very different settings. There should be communication between the two teams sufficient to support care planning, but one team cannot and should not dictate the care plan of another team as they do not have the knowledge or understanding of the setting to do so and cannot change it when

circumstances change. Trivial examples of this might include leave restrictions in a hospital setting, or the process for planning appointments in an outpatient setting, which are clearly only relevant to their respective settings. Recommendations can be made by either the outpatient or inpatient teams regarding care plans in other settings and should be duly considered by the respective team (in practice these are usually agreed unless there is a logistical reason a recommendation cannot be followed or there is a clinical disagreement). Often, one team will develop useful clinical insight from working with a patient for a long period of time. It is good practice to share this with other teams looking after the patient where possible.

MENTAL HEALTH CLUSTERING TOOL

17. The Mental Health Clustering Tool uses a checklist of questions of different symptom and social functioning domains to allocate patients into "Clusters" that supposedly share similar characteristics. This is to aid treatment planning, monitor caseloads, and I believe has been used to allocate funds by commissioners.

RISK ASSESSMENTS

18. Risk assessments are conducted implicitly in every interaction a clinician has with a patient. This can range from simple things such as setting up a room in a particular way or asking for another staff member to be present in a meeting, to synthesising all the information a clinician knows about a patient when

making a decision regarding discharge from hospital. Every decision that a clinician makes regarding a patient involves a risk assessment of some sort, including seemingly trivial investigations or treatments (all of which have a non-zero risk of harm and need to be weighed against competing interests such as potential benefits and tolerability to the patient). As such, clinicians have vast experience in conducting risk assessments. This is especially true in psychiatry, where the lack of objective biological testing means all diagnoses are essentially syndromes characterised by clusters of symptoms that co-occur rather than a known defect in a biological process that can be perfectly characterised and treated with minimal uncertainty. Decision making is therefore made in a relatively low information environment (compared to other specialities) and a probabilistic approach to information and risk assessment is therefore required. This is often not formally acknowledged due to people's psychological need for certainty, but that does not make it untrue. Some of these risk assessments will be formalised and written down, although the majority will not. The act of writing down a risk assessment has little use other than to communicate information regarding risk that may be relevant to other professionals. It is also important to note that there are no risk assessment tools that are shown to be more accurate than specialist mental health clinical judgement.

19. In my practice, I read as many notes as appear required to have a good understanding of the patient's risk history. I combine this with collateral information (where relevant) from sources such as family, carers, and police (although information is not always forthcoming), before interviewing the patient clinically. Risk assessment is a dynamic process and more information

may come to light from any source at any point during the inpatient admission, or indeed any time during a patient's care. That information is evaluated for its relevance and veracity, before being synthesised into the overall assessment. Behavioural changes are one such source of information, with violent cognitions, threats, or outright violence being particular features that would affect the risk assessment.

20. All types of risk are included, with harm to self, others, from others, and neglect. Formal risk assessments should be updated at points of care transition (such as admission or discharge) and if any new relevant information comes to light.

INSIGHT

21. Insight is the degree to which a patient understands that something is "*wrong*" with their experience followed by the degree to which they identify this as a mental illness. This can lead to treatment, if recommended, although a patient could have full insight regarding their condition and still refuse treatment if the subjective side effects of which are worse than the condition itself.

22. Insight is not a binary, but on a spectrum ranging from a patient having no idea that anything is even wrong, regardless of any attribution of cause, to someone fully understanding their symptoms as part of a mental illness, the nature of which they intimately understand; and which would likely lead to the desire for some form of treatment. Most psychiatric patients lie somewhere

between these two extremes, although psychotic patients who are detained under the MHA overwhelmingly skew to the lower end.

MASKING

23. Often patients with psychosis attempt to “mask" their symptoms, sometimes more effectively than others. When patients have sufficient insight to recognise their symptoms as abnormal, they will often try to hide them from others in order to fit in. This process of presenting a socially acceptable facade is normal behaviour that most people (whether mentally ill or not) will engage in. When patients realise their symptoms are related to their detention in hospital, they will sometimes try to hide these symptoms from professionals in order to avoid detention or to gain discharge. This is a common situation for psychiatrists who have a lot of experience in dealing with the matter. A patient’s ability to mask their symptoms is inversely proportional to the degree of their symptoms, so paradoxically, successfully masking symptoms can be viewed as a sign of improvement. Not all patients will accept the formulation of mental illness from their mental health team and will continue to mask symptoms as best they can. These patients can still be discharged from hospital, assuming their risks can be adequately managed in the community.

PAST CONDUCT AND FUTURE RISK

24. The greatest predictor of future behaviour is past behaviour, therefore if a patient has a history of violence, they are more likely to perpetrate it in the future. Other important risk factors for violence include being young, male, having a severe mental illness, having multiple mental health diagnoses (especially including personality disorder), and substance misuse.

DISCHARGE PLANNING

25. Discharge planning is advised to start as soon as a patient is admitted to hospital. There are no specific criteria that determine when a patient is approaching discharge. On a broad level, the problems that led to a patient being detained would no longer be present or at least would be diminished to the degree that the patient could be safely treated in the community again. While there are no specific criteria, a large proportion (possibly a majority) of psychotic patients in inpatient settings have histories of aggression, risk of violence, previous non-concordance with medication, social isolation, previous disengagement, and attempts to mask symptoms. This is so much the case, I would be surprised to see a psychotic patient in my practice who did not have any of these factors. As such, most psychiatrists have vast clinical experience dealing with such issues.
26. Some factors clearly militate against discharge in psychotic patients. These would include anything that suggests significant risk of harm to the patient or others, or reasons to believe the patient would immediately disengage from treatment and rapidly deteriorate. Some factors might include ongoing

violence to others, threats of violence (particularly to people other than ward staff), refusing medication on the ward, or stated intent to stop medication outside of hospital. These factors would not mean that "*discharge planning*" should not take place. However, as this is a process that should be undertaken throughout admission, instead, it should inform discharge planning and could potentially affect the discharge pathway. This depends on the cause and endurance of said factors.

27. Discharge plans are formulated by the relevant members of the MDT. This will always include the RC and a nurse, but may include occupational therapy (OT), psychology, pharmacy, drug and alcohol liaison, police, GP, and outpatient teams as appropriate. Responsibility for different parts of the plan will reside with different people or agencies. For instance, the resident doctor may be responsible to complete a discharge summary requesting a GP to follow up a patient's physical illness, but the GP would be responsible for reading and actioning the request. In some cases, the patient may be responsible for some aspects of their discharge plan, such as taking their medication, or attending follow-up appointments.
28. Assessments into a patient's needs will take place throughout the whole of their admission. It will usually include observation of their socio-occupational functioning on the ward, their ongoing symptoms, their insight, their ability to manage medications, their social supports, and housing situation. Their risk is similarly assessed over the course of the admission and will include information from notes, collateral sources, nursing observation, other MDT input, and clinical interviews with the patient. A community care package should seek to meet the needs and manage the risks identified.

29. Once the patient has been discharged, the ward does not have responsibility to follow-up whether a discharge plan has been followed. It is expected that the receiving team will either follow the plan or amend as required. For instance, if the ward team requests an outpatient team continues prescribing a medication following discharge, the assumption will be that this will happen, and it will not be followed up. If there are issues with following the request, for e.g. the medication becomes out of stock following discharge, it is expected that the receiving team find a solution. This is standard practice for handover of care in all healthcare settings.

30. Community Treatment Orders (CTO) provide a framework to increase the likelihood of compliance with treatment plans of patients who have been detained on Section 3 MHA. This is due to the conditions of the CTO that the patient must comply with or face the risk of recall to hospital should their community RC believe their mental state to be sufficiently affected by their non-compliance. As such, it can incentivise patients to follow their treatment plan, assuming they are able to understand it and the consequences of not doing so. In order to be effective, compliance with the treatment plan needs to be objectively assessable, rather than relying on subjective reports of compliance from the patient.

31. I consider CTO for psychotic patients who have recurrent admissions, poor concordance with medication, limited insight into their illness, with associated risks sufficient to justify the restriction of their liberty in the community. For patients who are actively refusing required medication and therefore requiring coercion (physical or implied) from the MHA, a CTO is generally required on discharge. This, of course, assumes that the patient will follow the conditions

in order to avoid recall to hospital. There are no specific criteria for who should be placed on a CTO, although you could not place a patient on a CTO who did not meet the criteria laid out in the MHA. Many patients could be argued to meet the criteria laid out in the MHA, although the word "*necessary*" does a lot of work in this instance. Clinical judgement tends to be the arbiter of when it is "*necessary*" for the RC to be able to exercise the power of recall in order to protect the patient's health, safety, or for the protection of others.

32. Psychotic patients are often ambivalent at best about taking antipsychotic medication, for various valid reasons. Antipsychotics have many side effects, some of which can be unpleasant, they attract stigma, are a sign they are mentally unwell and are often seen to be imposed upon them by others, particularly when the patient lacks insight and is detained under the MHA. If patients are observed to secrete medication on the ward (and spit it out later), this suggests an increased risk of later non-compliance. Similarly, if patients outright refuse to take medications, or make strong protestations about them, requiring significant persuasion from staff. Sometimes, patients will deteriorate in the mental state on the ward for no obvious reason, leading to a suspicion of non-concordance.

33. There are few circumstances in which I think a patient should never be discharged from a ward without a depot antipsychotic. One would be if the patient were acutely psychotic, dangerous, and refusing to take oral medication. I would consider a history of violence (particularly in the absence of treatment), history of non-concordance, and history of disengagement from services to be risk factors that would weigh in favour of the use of depot medication, but would not alone mandate it. This should be weighed

alongside the patient's current presentation, the patient's (and family's) wishes, perspective of the community team, level of insight, dynamic risk, concordance with current treatment plan, their social setting, and community support. I would not consider social isolation or a propensity to mask psychotic symptoms as strong indicators that depot medication should be used.

34. The decision to enforce depot (often with the use of significant state sanctioned violence of restraining a patient by multiple staff members while they are forcibly injected) needs to meet a high bar and should always be following a balanced appraisal of risk. It will always be traumatic for an individual, will usually impair the therapeutic relationship in the short term, and can sometimes irreparably damage a patient's relationship with mental health services, thus leading to poorer engagement and concordance in the long term. I think there is a danger when using euphemistic phrases such as "*unless they agree to accept their medication through DEPOT*", that we obscure the brutal but sometimes necessary realities of coercive treatment. "*Acceptance*" of depot in an inpatient setting under the MHA is always in the shadow of such coercion.

INVOLVMENT WITH VALDO CALOCANE ("VC")

35. I was the Higher Specialist Trainee (HST or "registrar") to Dr Thangavelu on Redwood 1 at the time of VC's fourth admission. Since I started my HST training in February 2021, I progressed from ST4 (first year of higher specialist training) to ST5 (fifth year of higher speciality training in psychiatry). As an

HST, I was essentially an apprentice to Dr Thangavelu. I completed many parts of the consultant role under direct or indirect supervision, although did not have the legal powers of an RC, which resided with Dr Thangavelu. As such, I conducted senior reviews of new patients, attended or led ward rounds, attended or led MDTs, liaised with families and other agencies, completed some MHA work, gave some supervision to junior colleagues and would review patients on the ward in an ad-hoc basis.

FOURTH ADMISSION

31 January 2022

36. I conducted a senior review with VC on 31st January 2022. [NHFT0000168 at p.218]_ This is a standard process after a patient has been clerked by a more junior doctor and is sometimes referred to as a "72-hour review" as it is intended to take place within 72 hours of a patient's admission to the ward. The purpose of this is to provide a more senior perspective on a patient's history and admission, before formulating an initial management plan.
37. I do not recall the specific Rio notes I read prior to conducting my senior review with VC. It will have included all notes sufficient to write the summary I did and most likely some more notes that were not included in that summary. Similarly, I do not recall my specific understanding of his diagnosis at this stage. I have clearly written about multiple psychotic episodes, and the subtext of my entry implies a diagnosis of schizophrenia.
38. From memory, I was puzzled that this man's presentation was different from what I had expected, having read the notes. His notes suggested periods of

relapse into acute psychosis with significant positive psychotic symptoms, agitation, and risk, whereas the man sitting in front of me was calm and did not appear to display any psychotic symptoms. I had expected to see prominent hallucinations, delusions, thought disorder, and irritability (or even aggression) but saw none. I wondered whether he was good at masking his symptoms, and these would become evident in time, or there had been some kind of misunderstanding and he had been inappropriately detained. This does occasionally happen in psychiatry, so it is important to keep an open mind with patients, especially those detained against their will. In this case, I wondered whether he was truly asymptomatic, or simply mildly symptomatic but not meeting the threshold for detention. There is also the risk of diagnostic overshadowing, where all issues in someone's life are attributed to a diagnosis (in this instance schizophrenia). As such, I wondered how much of the incident with his housemates had been a "normal" disagreement over domestic issues that became exaggerated and misinterpreted due to his somewhat literal interpretation of right and wrong.

39. I was clearly aware of some of VC's forensic history around his admissions due to my documentation, but do not recall the extent of what I was aware of further than what I wrote. I certainly considered he had a risk of violence given his history and other static risk factors. Everyone (except for the most physically disabled people) poses a risk of aggression or violence to others, so risk is always relative. My perception was that VC's risk of perpetrating violence was higher than average for the population, although by no means exceptionally high, and similar to many patients with psychosis. His historic violence appeared related to periods of acute psychosis and his presentation

at the point of admission appeared very different to what had been described during previous admissions. I did not formally assess VC's capacity to consent to his treatment plan as he was both detained under the MHA and consenting to treatment.

40. I cannot recall which treatments I considered at this point, although given the fact I suggested depot medication to him at subsequent reviews and the subsequent MDT states he is refusing depot, it is likely I had suggested depot to him during my senior review: NHFT0000168, p220. Since he was accepting oral medication though, I clearly thought it reasonable to continue at this point and did not require immediate discussion with Dr Thangavelu to initiate depot urgently.

41. My main focus at this point was not on treatment, but instead on the assessment aspect of section 2 MHA. This included understanding what drivers led to admission, what exactly was his psychopathology (if any), and whether admission itself was required. This is why I wished to gain a collateral history from his family. Understanding this would help inform treatment in the future.

42. I do not recall asking VC about social support other than his family, although in my usual practice I will ask a patient who in the community knows them best, when I wish for a collateral history. In practice, this is usually their family. I am conscious of the supportive role families play for my patients, especially when they have regular contact and generally attempt to persuade patients to involve their families in their care. VC's refusal to have his family involved would have limited this, but I thought he may change his mind in time. I replied to an email from the Mental Health Legislation Team which

asked about consent to write to his nearest relative [NHFT0000287] on 1st February 2022. I explained that VC had declined involvement from his family generally, although I had not specifically asked about writing to his nearest relative under the act. I did this to be helpful and inform those messaged of my interaction.

43. At no point did I consider whether his mother should be displaced as Nearest Relative. None of the conditions laid out in the MHA Code of Practice were met, and even in hindsight, I cannot see a rationale for displacement.

44. I do not recall the details of the discussion I had with Dr Thangavelu about contacting VC's mother, however, given that I contacted the mother later, I can infer that the recommendation was simply to contact her to gain collateral history and not share any information with her. This is a common practice in the early stages of admission when a patient is not consenting to contact with their family.

02 February 2022

45. I made a record on 2 February 2022 at 16:12 [NHFT0000168 at p.223] that VC's mother "*expressed some frustration about our lack of ability to share information based on confidentiality, but accepted explanations*." This note was written contemporaneously and I have no reason to believe it was not an accurate record of the conversation. I was aware that his mother had previously been involved in his care and knew him well, hence why I called for collateral history. I appreciate the value that collateral information from family provides, especially when relationships with statutory services are more strained. I put some weight on her reports that he did not appear unwell as

she had been able to identify this in the past and was in regular contact with him prior to admission. I also took on board her suggestion that he felt scared and persecuted by mental health services, especially as I had already been wondering whether the current detention was required. The sense of being persecuted could have been a symptom of psychosis. However, it could also have been the understandable response of a man (who was concordant with treatment and not unwell) to repeated – and from his perspective - inappropriate intrusions into his life. Given this, I wished to avoid reinforcing his perception as much as was reasonable.

46. I do not recall speaking to VC's CCO (care coordinator) about the need for him to be supported by his mother during admission. I expected VC to be persuaded to involve his family in his care during the admission, as is often the case for similar patients, and as he had involved them in the past. I do not recall conducting a specific capacity assessment regarding this, instead I respected his wishes after discussion with others. In hindsight, I do not even believe it would have been in his best interest to break confidentiality at this point should he have been found to lack capacity to make this decision.

47. Breaking confidentiality (even in a patient's best interest where they lack capacity to refuse contact) is a serious matter and should only be undertaken in very strict circumstances. The therapeutic relationship (and trust in mental health services more generally) can be severely impaired if confidentiality is not routinely respected. If patients feel that the information they give is likely to be communicated to others without their consent, they are unlikely to share information in the first place. I did not believe there was an "overriding public interest" in disclosure of the circumstances of his detention to his mother as

there was no direct threat to her. Instead, I believed I could gain all the required information from her without breaking confidentiality. His mother was aware of his previous history, so as far as I was aware, information about the current admission was all that was being withheld.

48. I confirm attendance of an MDT in respect of VC's treatment during his fourth admission on 31 January 2022. The record [NHFT0000168, at p.220] notes: *"Valdo is currently doing [a] mechanical engineering course, he has had three previous psychotic episodes and has been prescribed risperidone. He has had altercations with other students. Dr Gibson plans to gain collateral history from his family. No historic substance misuse. He has previously punched police. On the ward appears paranoid and wide-eyed. He has been sitting in communal areas using his phone. Valdo doesn't wish to have depot and has been concordant with current medication. We need to gain further details about his mental health history from CPN and collateral to justify depot."*

49. There appears to be an error in the documentation, as he was prescribed aripiprazole, not risperidone. Otherwise, I have no reason to believe other aspects are inaccurate. I don't believe there would have been any difference in his care if his diagnosis had been listed as paranoid schizophrenia.

50. I do not recall whether there was discussion of the events leading to his first admission during the MDT. The notes taken by resident doctors are necessarily a summary rather than a transcription, so it is possible (but unlikely) this was discussed and simply not recorded. I do not believe any further information was sought from police regarding the incident of assault towards them in the past. This is likely because our documentation around it was deemed sufficient and we had no reason to believe there were active

criminal justice undertakings regarding the incident. I do not believe his medical records from Priory were requested.

51. From my summary at my senior review, it was clear that VC's relapses were associated with poor medication concordance and disengagement from services. The question from my perspective during this admission was whether VC had in fact relapsed and had been non-concordant with medication in the community. I cannot say for sure what was meant by "has been concordant with current medication" [NHFT0000168, p220] in the MDT notes. However, I suspect this was referring to him being concordant with oral medication on the ward. A depot was suggested as there was suspicion from community teams that he had not been concordant with medication in the community and the use of the phrase "to justify depot" implies that someone, likely myself, had already discussed this with him and he had declined.

52. I do not recall whether I reviewed a Risk and Safety assessment on 28 January 2022 at 23:26 in respect of VC [NHFT0000191] as part of formulating VC's treatment plan. It appears to contain much of the information that will have been known to the treating team though. It is the responsibility of the member of nursing staff assigned to update the risk assessment to ensure it is accurate and up to date and there are processes on the ward to ensure staff are allocated to this task. Overall, it would be the responsibility of the MDT and ultimately the RC (Dr Thangavelu) to ensure that information contained in the risk assessment was reviewed as part of the care and treatment plan. However, if new information came to light, it would be the responsibility of whoever acquired the information to communicate it appropriately.

53. Risk assessments are conducted by clinicians at every encounter with a patient, whether or not there is a formal written risk assessment produced. As such, I and the wider MDT would have been constantly weighing the information available to us (and gleaned through each clinical encounter) to assess VC's risk and inform his treatment.
54. All people pose some risk of violence and aggression. Given VC's history and static risk factors, he will certainly have been considered to pose a higher risk than the general population. His presentation on the ward was, however, calm with no clear psychotic symptoms. Given this and the clear relationship between his psychotic symptoms and violence in the past, his dynamic risk would have been viewed as lower than in the past.
55. I do not believe I contacted VC's family for further collateral history other than what is documented on 2nd February 2022 [NHFT0000168 at p.223].
56. A Summary and Care Plan was completed in respect of VC on 28 January 2022 [NHFT0000199] by a mental health nurse. Unfortunately, I do not recall which specific entries I read during VC's admission. Having reviewed the summary, I do not believe it contains any information I was not aware of at the time. I note it is written in a format of discreet entries at specific time points, rather than an integrated summary of the history and care, which makes some information out of date or context. It also contains some omissions that I would consider relevant.
57. I cannot recall all the information and risks I considered to be key at the time, but I can give an approximation with a combination of hindsight and imputation. This would include the history of barging into neighbour's properties in response to hallucinations and delusions (including a neighbour

jumping out a window in response), significant assault on police requiring PICU (Psychiatric Intensive Care Unit), repeated non-concordance with medication, poor engagement with community services, and poor insight into his illness. The summary also includes the diagnosis as First Episode Psychosis, which I would consider to be incorrect, and should instead have been schizophrenia. I am also unaware of any instance in which he declined medication during admission.

03 February 2022

58. I have seen VC's medical notes, including a record of a Ward Review which took place on 3 February 2022, which it is recorded that I attended [NHFT0000168 at p.224]. In hindsight, VC's insight had not improved at this point as he remained of the opinion that he was not unwell, and had been concordant with medication. At the time, our main concern was whether he was in fact unwell or had been non-concordant with medication. If what he had been saying was true, this would have been his perspective and he would not have lacked insight (bar the reports that he had not been unwell prior to his third admission).
59. A main focus of this admission was trying to assess VC's mental state and understand the events leading to his admission. As previously discussed, if there had been a "misunderstanding" with mental health services and he had been both concordant with medication and not experienced any psychotic symptoms, then little further would have been required to manage his risks. Despite this, there were sufficient concerns about non-concordance that the prospect of depot medication and CTO was broached on multiple occasions.

There were also multiple discussions surrounding the importance of engaging with outpatient treatment.

60. VC's medical records include an entry dated 3 February 2022 at 9:15 am [NHFT0000168, at p.224]. Board reviews are 30 minute meetings from 0900 to 0930 to handover any significant developments in a patient's presentation and allocate outstanding jobs. Since there are 16 patients on the ward, this leaves less than 2 minutes to discuss each patient (less if there has been an incident involving another patient which requires more discussion). It is unlikely that subtle changes in a patient's mental state will be discussed in such a meeting. From reading the note, I do not believe the board review on 3rd February 2022 would have contributed much to formulating VC's care and treatment.

61. The second MDT discussion took place at a Ward Review on 3 February 2022[NHFT0000168 at pp.224-225]. The aim of the ward round on 3rd February 2022 was to assess VC's mental state and synthesise with information from other sources such as historical notes and CCO, in order to develop a treatment plan. I do not recall the feedback I provided or risks discussed during this meeting, so can only rely on the written notes. While not explicit, it is highly likely that I would have summarised the interactions I had with VC, his mother and my own understanding of the historic notes. At this point, I believed we still needed to get a better understanding of VC's current psychopathology (if any) and the events prior to admission. I do not recall any member of the clinical team raising concerns about the safety of discharge.

04 February 2022

62. VC's medical records include an entry dated 4 February 2022 at 10:39 which records that I questioned VC about his attendance at his old accommodation [NHFT0000168, at p.228]. The note records that VC denied that he had gone to his old accommodation, but I concluded that "*it is likely that VC did not adhere to his leave requirement*" and VC's leave was restricted as a result. I believed the coincidence of a complaint coming from the university that VC had been spotted at his accommodation with his time on leave from the ward outweighed VC's denials. I did not consider there to be any motivation for his former flatmates to lie about this, and it would be unlikely they were mistaken about who he was. On the other hand, I considered VC would have significant motivation to lie about his whereabouts if he had not adhered to his leave conditions.
63. I checked the section 17 leave records (leave of absence from hospital under the MHA) [NHFT0014974], which were unfortunately incomplete. I therefore raised an IR1 [NHFT0007527] incident form (a general incident reporting form used within the NHS) to document the matter. This could have helped corroborate either story depending on how long he had been off the ward. As a result, I had to make a decision based on my reasoning. During this interaction, I recall VC presenting in a similar way to previously. He had conviction about his denial but appeared guarded about any further questions. I do not recall detecting any psychotic symptoms or irritability. I considered this risk primarily around his ability to adhere to conditions surrounding his leave, which is why I recommended his leave be restricted pending MDT review. While I was not the RC, and therefore not privy to the thought process

surrounding discharge, I have no doubt that this information was taken into account as it was known to the team.

64. VC's medical records dated 4 February 2022 at 10:41, which I made [NHFT0000168, at p.228], also records that I obtained further information from the University of Nottingham's Mental Health Services about VC's university work and that I spoke to VC's housemate. The information about VC entering a flatmate's bedroom and asking about seemingly hallucinatory screaming increased my suspicion that he had been experiencing psychotic symptoms prior to admission. The short screams heard from his room could have been viewed in this context but were less persuasive of psychotic symptoms. The argument leading to the incident in which VC held his flatmates "hostage" appeared to be a domestic argument about hygiene that escalated unnecessarily to physical confrontation. This in and of itself was something that might happen between any set of young men in shared accommodation and while it could have been in the context of psychotic symptoms, it did not persuade me of this. VC's response to this, however, appeared unusual and again increased suspicion he had been suffering from psychotic symptoms.

65. These incidents were suggestive that VC was experiencing psychotic symptoms prior to admission and increased the possibility that he was masking them on the ward. At the same time, there was no evidence of him displaying any psychotic symptoms on the ward, which would have been unusual, as patients' attempts to mask symptoms are usually not completely effective. These incidents were discussed at MDT and will have been factored into decision making about VC's care although I cannot say exactly how. I imagine continued attempts to persuade him to accept depot medication will

have been related though. As a focus of the admission was regarding VC's psychopathology and circumstances leading to admission, this will have been incorporated into risk assessments made by his clinicians, including myself. I cannot see reference to it in formal written risk assessments, however.

14 February 2022

66. VC's Summary and Care Plan was updated on 14 February 2022 [NHFT0000198] and under the heading "Summary/Formulation", the following information is recorded: "*[VC] has recently disengaged from EIP, thouh appears to be well and functioning*." The note also states, "*MENTAL HEALTH HISTORY: recent admission with similar presentation. In keeping with first episode psychosis, started on medication and discharged to community follow-up*."
67. I do not believe the Summary and Care Plan dated 14th February 2022 is an accurate reflection of the information known to clinicians at the time. It is unlikely that the lack of an accurate history surrounding the previous admissions in the Summary and Care Plan would have had an impact on decisions made during VC's treatment. In my experience, if there is a disparity between what is documented in a Summary and Care Plan and a clinician's own knowledge (particularly if the clinician's own knowledge implies there is an omission in the care plan) then the clinician will prioritise information from their own knowledge.
68. I cannot give a definite answer as to why there was a disparity between the Summary and Care Plan and the reported information from his housemates as I was not the author. I believe it is likely to be an omission.

69. VC's medical records note that there was an MDT on 7 February 2022 which you attended [NHFT0000168 at p.233]. I cannot recall the exact information that was discussed in the MDT on 7th February 2022. However, from reading the notes, it appears we discussed my contact with VC's housemates, my contact with the university and his likely non-adherence to his S17 leave conditions. This appears to be alongside discussions about his observed mental state and his own desires for leave. I cannot see any evidence there was any change in his mental state from the point of admission, although I did not personally assess his mental state or capacity prior to this MDT.
70. There was an MDT on 14 February 2022 [NHFT0000168 at p.246]. I did not assess VC's mental state prior to the MDT on 14th February 2022. I cannot recall my impression of VC's insight at the time of this MDT. From reading the notes, there is a mixed picture regarding his insight, as he is able to accept his initial admission was appropriate due to his mental state, but does not accept the subsequent admissions were warranted (which I would have disagreed with at the time).
71. Dr Thangavelu considered a potential transfer to Section 3 MHA due to the discussions around CTO. This is implicit, as a CTO can only be enacted for someone detained on Section 3. This will have been part of the calculus surrounding depot also. As VC was declining depot, there would have needed to be a legal framework to coerce him to take it in the community.
    This could only have been provided with the use of CTO.
72. I do not recall the specifics of the incident in which VC slammed a door in a nurse's face nor how it affected my assessment of his risk to others. Unfortunately, on psychiatric wards, such expressions of frustration about

admission and perceived intrusion by staff are not uncommon. Given the lack of threat or assault, it is unlikely this will have significantly changed the assessment of his risk when compared to his history (which contained much more significant incidents).

73. I believe the phrase "*both sides of the incident*" refers to the similar, but different accounts of the incident in VC's accommodation which led to him holding his flatmates "*hostage*". From VC's perspective, he wished for the police to resolve the matter, and therefore did not want anyone to leave prior to their attendance. He saw the lack of further action by the police as evidence that he had not done any wrong. From the flatmate's perspective, there had been an altercation over hygiene issues which had escalated to a physical fight via verbal provocations. The flatmate explained the police were called after VC had been acting bizarrely and not letting them leave the flat. I think more weight can be given to the flatmate's account.

74. I can see from various ward round entries that VC's CCO (Claudia Birtles) was present and gave feedback regarding his patterns of behaviour and engagement with community mental health teams. I believe the MDT entry on 14th February 2022 is simply a reflection of these discussions rather than a specific report at that time as his CCO was not present at that MDT.

75. Both I and members of the MDT will have assessed the risk and potential consequences of VC disengaging from mental health services. This will have taken into consideration his history, the opinion of other professionals, and his presentation on the ward. The outcome of the risk assessment was the management plan that was enacted. From my perspective, the most important aspect of this was use of depot medication. This was suggested on

multiple occasions, which shows that Dr Thangavelu, the community team, and I, believed this was the best course of action for him. This was declined at every instance, which pushed the risk assessment towards whether coercion was proportionate and justifiable, along with the likely long-term effects of said coercion on VC.

76. As previously noted, this would have required conversion to section 3 MHA and subsequent CTO. I believe a case could have been made at a Mental Health Act Assessment for conversion to section 3, although this would not have been a guaranteed outcome. The AMHP (Approved Mental Health Professional) and second doctor would have needed to be convinced that depot treatment was necessary, that appropriate treatment could not be given without detention and that it was the least restrictive option. This would have required argumentation based on the nature of his condition, rather than the degree, which was clearly mild, or even absent during admission.

REFLECTIONS ON FOURTH ADMISSION

77. VC was concordant with medication and did not display any psychotic symptoms during admission, which would have indicated that risks which led to admission had somewhat improved, although this was also in-keeping with his longstanding assertion that he had not relapsed into psychosis prior to admission and had remained concordant with medication.

78. VC agreed to continue oral medication and to be followed up by the community team, both of which had been concerns prior to admission. This could only be viewed as partial improvement though, as he had said such things in the past but concerns persisted around his concordance and

engagement. I do not recall my thoughts about the safety of VC's proposed discharge date of 24th February 2022. I do not see any notes that suggest an opinion in either direction.

79. Since there was no plan for a Mental Health Act assessment for Section 3 and subsequent CTO, I believe the conclusion to the discussion surrounding CTO would have been against this option, and instead to proceed with discharge.

80. It is unlikely that I would have reviewed the Core Assessment (NHFT0000187) prior to MDTs or Ward Reviews as I would have already reviewed it prior to my senior review as part of my background reading, and it would not have been updated following this.

81. While VC reported he had been concordant with his oral medication, I would have taken into account the previous incidents and admissions which appeared related to non-concordance and the views of the community team. I would have concluded that depot medication was the best way to ensure his concordance (should he have agreed) and manage his risks.

82. On 4 February 2022 [NHFT0000168 at p.229], VC's record indicates that the Covid vaccine was administered to him. I do not believe I was aware of VC having the Covid-19 vaccine on the ward. From reading the note dated 4th February 2022, I am unsure whether the vaccination was administered on the ward. This note was written by the patient secretary and suggests that he had already received the first and second doses of the Covid-19 schedule (not nearly enough time would have elapsed on the ward for him to have received both) and that a discussion should be had with him about receiving a booster in the community. On reviewing his patient medication chart [NHFT0014654] from the admission. I can see no evidence of a prescription for Covid-19

vaccination, which I would expect had he received one. There are also no notes from clinical staff about consenting him or administering the vaccine. This appears to have been an administrative entry due to the pressures around vaccinating psychiatric patients at this time

83. The notes from the first week of VC's admission [NHFT0000168 at p.216-227] do not specify the completion of a capacity assessment around consent to depot. I do not recall my own assessments but imagine they surrounded the uncertainty regarding his psychopathology and concordance in the community. If he had been concordant with medication and had not had psychotic symptoms prior to admission, he would very likely have had capacity to refuse. If he had not been concordant or had been psychotic prior to admission, it is likely that he would have lacked capacity to refuse. Either way, he could have been forced to have depot medication regardless of his capacity to consent, should the treating team have considered it necessary and justifiable.

84. We considered a more assertive approach of enforcing depot under restraint, however, did not believe this to be necessary and justifiable. The main tension was between the history which showed florid psychosis and high risk to others when non-concordant, and his presentation on the ward which did not show this at all. We considered evidence from various sources, including the community team, university, his flatmates, his family, and VC himself. These were contradictory in some ways and did not show a clear picture. All of these factors will have been considered as part of his risk assessment and attempts to ensure concordance, but the team did not feel the threshold was met to enforce depot. I do not believe this thought process is specifically

recorded anywhere, although is implied by the repeated discussions around depot and CTO, followed by the ultimate decision not to enforce depot.

85. I was not present at the ward round on 10th February 2022. From reading the record [NHFT0000168 at p.238], I can see that further questions were asked about VC's symptoms and insight, but he did not give answers to this. As ward round entries such as this are summaries, they will often omit if similar questions are asked multiple times and similar answers are given.

86. At a ward round on 17th February, I did not seek further input from Crisis Resolution and Home Treatment (CRHT) clinicians. We had the CCO involved and notes available from CRHT. I doubt I would have considered it reasonable to ask for their input at this point.

87. I did not seek further input other than from VC's CCO. I am aware Dr Thangavelu had discussed with VC's community consultant surrounding the possibility of depot and CTO. These are the main people I would have considered consulting on such matters.

88. I and other members of the MDT will have undertaken risk assessments of VC's likely engagement with community services, although this is not specifically documented anywhere to my knowledge. This is the likely reason for the repeated discussions around importance of engaging with community teams and being open and honest about symptoms.

89. I do not recall my reaction to VC stating he did not have problems taking medications. In my normal practice though, I am unlikely to take any single piece of information as undoubtably true and instead weigh the likelihood of its truth. His community team certainly had concerns about his concordance with oral medications, and I repeatedly suggested depot administration to him,

which suggests I deemed it unlikely that he had no problems with taking medication.

90. The primary actions to ensure a safe discharge were not around his insight regarding his previous admissions (which was evidently lacking), but around the likelihood of him being concordant with oral medication and engaging with the community team on discharge. This was why these discussions were emphasised in the run up to discharge. While insight is beneficial and does impact on both concordance and risk, it is not required for discharge of a patient. What matters is that a patient can be safely managed in the community.

91. I believe the risk of VC's non-concordance was adequately considered during admission. However, in hindsight, the wrong conclusion was reached. Information was obtained and considered from all the appropriate sources. At the time I did not think the decision making was unreasonable. There was a clear attempt to reduce restrictive practice and enhance patient autonomy, both of which have been highly publicised goals of mental health care in response to societal objections to coercive treatment.

92. Other than the decision not to enforce depot using the MHA and ultimately CTO, I believe VC's risks were adequately addressed. Information was sought from all relevant sources, VC and relevant others were involved in management decisions, and a specific treatment plan was agreed. This was not formally recorded in a written risk assessment but clearly happened over the course of his admission. It could be argued that the weighting given to different factors was incorrect and as a result the wrong decision reached. However, the factors themselves were considered.

93. I had no concerns about challenging Dr Thangavelu's decisions, he was always receptive to my perspective and input. I do not recall having any concerns about the decision he made, but am sure I would have felt able to raise them should I have had any.

94. I agree with the finding of the Level 2 Comprehensive Report [NHFT0000452] that depot should have been enforced during the admission. I have come to this conclusion in the course of writing this statement and with a great deal of hindsight. At the time, I did not believe it appropriate for depot to be enforced.

95. I believe the history of attempting to gain entry to other people's flats (and the effects of this), violence, non-concordance, disengagement from community follow-up and lack of insight to be sufficient to justify enforcing depot (and the Section 3 followed by CTO that would have been required). This was balanced against VC's own history, that of his mother, his lack of symptoms on the ward, and his concordance with oral medication throughout admission. I do not believe the countervailing factors were sufficient to preclude the use of depot.

96. Despite all of this, I do not believe this was a clear-cut case and think either course of action could have been appropriately justified. Had VC not perpetrated the murders he did, I do not believe there would have been any scrutiny regarding the decision. Conversely, had he had depot medication enforced and been placed on CTO, he would have had a strong case to challenge the decision at tribunal and may well have succeeded in any appeal.

97. I broadly agree with the summary in the Level 2 Comprehensive Report that during inpatient admissions there was an undue focus on VC's "*snapshot*"

presentation rather than longer term pattern [NHFT0000451 – page 11]. This is more the case for his prior admissions as he was floridly psychotic prior to admission on each occasion but recovered quickly on starting oral antipsychotics. He did not present as clearly psychotic prior to or during his fourth admission, which was part of the uncertainty regarding the admission in the first place (under Section 2 for assessment rather than Section 3 for treatment). Despite this, there was evidence presented by the community team supporting the use of depot and CTO, alongside an understanding (and frequent attempts to persuade) by the inpatient team that depot would have been a better option for him. I think part of the reason why this was not enforced was due to an undue weighting to his presentation on the ward, his own wishes, his mother's collateral history, and emphasis on his autonomy and the least restrictive approach.

98. I think VC was often treated as if he had capacity to consent to his treatment and this had effects on his care. I also think that his insight was partial at best throughout his treatment, although appeared to fluctuate alongside his mental state. The Mental Capacity Act states that everyone should be assumed to have capacity to make a decision unless there is evidence to the contrary. In practice, this means that if someone makes a decision that is concordant with clinician's recommendations, they are generally assumed to have capacity to do so.

99. At least in his fourth admission, I do not believe considerations regarding VC's capacity to consent to treatment played a significant role. He was declining depot medication, despite recommendations from the inpatient and outpatient team. Depot medication could have been enforced using the Mental Health

Act regardless of his capacity to refuse. The fundamental question in the fourth admission was whether that threshold had been met. I would not like to comment on his other admissions, due to not being involved. I am not aware of previously being involved with a patient who has gone on to kill or seriously injured a member of the public.

MORE GENERAL REFLECTIONS

100. I remain profoundly sorry for the horrific murders perpetrated by VC and the missed opportunities in his care that contributed to them. While VC alone is responsible for his actions, I believe there is a chance they could have been prevented had different actions been taken at various points. For my own involvement in his fourth admission, I am of the opinion that depot antipsychotic should have been enforced. This is on balance and after a long period of reflection and consideration. I have detailed the nuances regarding this decision at various points earlier in the statement.

101. I believe this case also brings up various issues regarding mental healthcare in our current social, cultural, political, and economic climate. I will detail all I see as relevant.

102. The most important, I believe, is the tension between autonomy and safety in our society, particularly with regard to mental healthcare. There is a trade-off between these two principles. However, all too frequently I find people do not recognise this and instead believe both can be maximised. This veneration of autonomy is a product of our tacit ideology of liberalism, which breaks down particularly in the case of mentally unwell individuals. This

was appreciated more in previous generations and is the basis for the powers of coercion within the Mental Health Act. Unfortunately, there has always been (with particular recent resurgence) a countervailing narrative which states that all coercion of mentally unwell people is unjust and should be abolished. This becomes even stronger when there is disproportionate use of coercion with different demographic groups, with the larger proportion of young ethnic minority males being subject to coercion under the Mental Health Act drawing particular ire. In this sense it violates the principle of autonomy and the principle of equality, both of which are core tenets of liberalism. This is despite the fact that young ethnic minority males are more likely to both be diagnosed with schizophrenia and those diagnosed are more likely to disengage from treatment and commit serious violence than their respective white British counterparts.

103. This was the socio-cultural climate at the time of VC's care. I recall the discourse well and the accusations that psychiatrists were uncaring, overly coercive, or even outright racist, because of the data regarding coercion (this remains the case, albeit to a lesser extent). There was constant discussion about reform of the Mental Health Act to reduce coercion as a result. I acknowledge this climate will have been felt differently by different psychiatrists (particularly if they were from ethnic minority backgrounds themselves) but I recall feeling it viscerally and do not believe it had no bearing on VC's care.

104. The Mental Health Act Code of Practice itself promotes supporting patients' autonomy and using the least restrictive option for their care. These are worthy aims, although there will always need to be thresholds beyond

which autonomy is not respected, and restrictive practice is used. Otherwise, patients will use their autonomy to refuse treatment and risk will increase as a result. It is notable that throughout his care, VC's autonomy was maximised, and care was less restrictive than it could have been.

105. The increasing need for safety in our society is likely related to falling birthrates and an ageing population. These trends are unlikely to change in the near future and similarly, I find it impossible that society will accept lower levels of safety, particularly around the threat of violence from mentally disordered individuals. It is unfortunately the case that people with schizophrenia are significantly more likely to perpetrate violence and murder than the general population. Successive "destigmatisation" campaigns have unhelpfully obscured this fact, although high profile cases such as VC's, along with people's lived experience, are likely to reinforce it.

106. As such, I believe the trade-off between autonomy and safety is inevitably going to swing towards safety and therefore increasing coercive practice. This will need to be managed carefully, with appropriate legal safeguards (such as those in place currently). There is likely to be a reaction and an increase in coercion, with further calls to reduce said powers within the Mental Health Act. In my opinion, this should be resisted.

107. As I have detailed earlier in my statement, coercive practice is a serious matter and should never be taken lightly. In practice, it involves the use of state sanctioned violence in an essentially carceral setting to forcibly inject someone against their will. Patients are often highly distressed, frightened, agitated, or aggressive. They often have poor insight and understanding of the process, further exacerbating their distress. Some will

require full, face down restraint by 5-8 nurses in order to achieve this. The process is incredibly ugly, and would horrify significant proportions of the general population, but it remains necessary in certain circumstances. This process (or the threat of it) is implicit when we use euphemisms such as "*coercive practice"* or "*agree to accept depot*". No process is perfect and even with the best system and highest trained clinicians, there will be instances of error in both directions (coercion not used when it is appropriate or used when it is inappropriate). Any swing in the trade-off from autonomy towards safety will inevitably lead to an increase in people who are inappropriately subject to coercion.

108. If there is to be a swing in the trade-off towards safety, this will also inevitably increase the need for inpatient psychiatric beds. The number of inpatient beds has dropped precipitously over the last 50-60 years, despite a significant increase in the general population and fairly stable prevalence of schizophrenia. This is due to the policy of "Care in the Community" (and more recently relative austerity programmes) and has put significant pressure on an increasingly limited resource of inpatient beds. As a result, clinicians are instructed to consider discharge planning at the point of admission to hospital, and are pressured by "flow teams" to discharge patients quickly to free up precious beds. At the same time, there has been an increasing proportion of admissions of patients with other mental health conditions (such as personality disorders) and reduction in the availability of social placements for those that need it (leading to prolonged inpatient admissions), further reducing the stock of beds for people with psychosis who do not have significant social care needs.

109. There is a similar (but different) process in community settings, where provision is not nearly adequate to meet demand from the population. What little resource that is available has to be divided amongst patients. Some desperately want care and will demand as much as possible (particularly in light of recent public discourse on "destigmatisation" and the importance of discussing mental health problems), whereas others (often people with psychotic illnesses) want as little to do with mental health services as possible. Some patients (and conditions) therefore attract disproportionate attention, and others are relatively neglected (note that patients with psychosis who do not want involvement from mental health services will never make formal complaints that they are not receiving enough input). Clinicians are generally aware of this, and do their best in very difficult circumstances, but perverse incentives remain.

110. This case has been a formative event in my career. It occurred while I was still in training as a relatively junior registrar and has changed my consideration of coercion and risk. Earlier in my training, I weighted autonomy and least restrictive practice more highly. This was born out of the culture in which I grew up, but also a profound empathy for my patients. I could imagine myself in their place and wanted to behave towards them in as compassionate a manner as possible. I had read various dystopian novels (e.g. 1984 and Brave New World) and viewed coercive state power with scepticism. I still understood the need for it and have wrestled with the tension ever since.

111. I recall my sense of curiosity about VC, trying to work out whether he had a relapse of psychosis or whether he was simply being a "difficult person" in the community. I remember that we recommended depot for him but also

feeling that enforcing this would be disproportionate. I think we had discussions around this (other than those that are documented) but cannot remember the specific details. My recollection of VC is somewhat limited, because his presentation was relatively unremarkable. This is a concerning aspect of his case as I (and I suspect every psychiatrist) know countless patients with schizophrenia who have similar histories and risk factors. As a result, I am now significantly more likely to initiate depot medications in my patients, including enforcing this when they are refusing. I am also more likely to discharge patients on CTO. I do this with full knowledge of the violence this necessitates and the potential harms it can cause. The trade-off between autonomy and safety has been moved towards safety in my practice.

112. I have not given any interviews or public statements about this case.

113. I agree with the findings of the NHS England Commissioned and Independent Investigation into the care and treatment provided to VC by NHS services prior to the tragic events of 13 June 2023 (NHFT0000053 at page xv] that *"[VC's] insight into his condition did not appear to increase", "he did not demonstrate retrospective insight"* and that *"VC's ability to fully understand the implications of his mental health condition were limited by his lack of insight. This may have meant he lacked full capacity to make decisions in relation to his care and treatment and engagement".* With respect to VC's fourth admission, I believe that this was taken into account and informed risk assessment. In hindsight, I believe the wrong conclusion was reached, but that does not mean the information was not considered. Many patients can take oral medication despite lacking insight into their condition, and patients' capacity is generally assumed to be present when they are making decisions

that are concordant with the recommendations of clinicians. I do not wish to comment on VC's first and second admissions as I was not involved.

RECOMMENDATIONS

114. I think calls to reform the Mental Health Act and weaken the powers of coercion should be resisted. The Mental Health Act contains provisions that could have prevented VC's murders. However, if these were removed, it would increase the likelihood of similar occurrences.

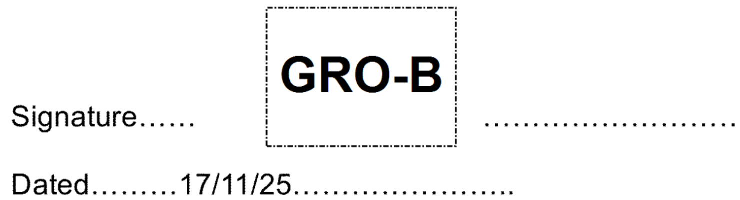
115. I think there needs to be an honest national debate about the trade-off between autonomy and safety within mental healthcare along with the role of publicly funded mental health services. If the outcome is an increased expectation for coercive practice in order to improve the safety of the general public, then consideration should be given to the resources that would be needed to achieve this. This may include consideration about how current scarce resources are allocated and the likely consequences of such a reallocation. There would also need to be an honest communication of what this would entail in practice, including likely unequal representation of different groups subject to coercion.

NOTE

116. 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.

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.

Signature…… 

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Dated………17/11/25…………………..

Index to First Witness Statement of Jonathan Gibson

No.	URN	Document description
1	NHFT0000168	RiO notes for VC
2	NHFT0000191	Medical Records of VC dated from 28/01/2022 to 02/02/2022, NHFT, Re: Risk and Safety Assessment.
3	NHFT0000199	Medical Records of VC from 02/02/2022, NHFT, re: Summary and Care Plan
4	NHFT0000198	Medical Records of VC dated 14/02/2022, Nottinghamshire Healthcare NHS Foundation Trust, Re: Summary and Care Plan
5	NHFT0014974	Medical records of VC from 03/02/2022 to 25/02/2022; Re: Section 17 Leave of Absence
6	NHFT0007527	Incident details for VC dated 03/02/2022
7	NHFT0000452	Level 2 Comprehensive Report
8	NHFT0000187	Core Assessment for VC dated 15/07/2020
9	NHFT0014654	Drug Prescription & Administration Record of VC
10	NHFT0000287	Email from Jonathan Gibson, re: VC nearest relative info
11	NHFT0000451	Report dated 15/06/2023, Re: Level 2 Comprehensive Investigation Report
12	NHFT0000053	Medical form of VC dated 03/09/2021 to 08/09/2021 re AMH Seclusion Discontinuation Record