Witness Name: Dr. Karthik Thangavelu

Statement No: WITN0206001

Dated: 28 December 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF

DR. KARTHIK THANGAVELU

I, Dr Karthik Thangavelu will say as follows: -

INTRODUCTION

1. I am a Consultant Psychiatrist, currently employed by the Nottingham Healthcare NHS Foundation Trust ('NHFT'), on employment break from NHFT commencing 22 October 2025.

2. This witness statement is made to assist the Nottingham Inquiry ('the Inquiry') with the matters set out in the Rule 9 Request dated 18 September 2025 ('the Request').

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

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

CAREER AND ROLE

5. I hold the following medical qualifications:

   a. Bachelor of Medicine and Bachelor of Surgery ('MBBS'), awarded by TN MGR Medical University, Chennai, India in 1999.

   b. Doctor of Medicine ('MD') (Psychiatry) awarded by the Institute of Mental Health, Chennai, India in 2004.

   c. Member of the Royal College of Psychiatrists ('MRCPsych'), awarded by the Royal College of Psychiatrists, UK, in 2006.

   d. Post Graduate Diploma in Clinical Psychiatry, awarded by the University of Nottingham in 2006.

   e. A Certificate of Completion of Training on the GMC Specialist Register, awarded in 2010.

   f. Master of Philosophy ('MPhil'), awarded by University of Nottingham, in 2015.

6. From 2004 – 2006, I was a Senior House Office in psychiatry, at the Trent Deanery. In this role I undertook training in General Psychiatry, Old-Age psychiatry, Child and Adolescent Psychiatry, and Addictions Psychiatry.

7. Between 2006 – 2009, I undertook Higher Specialist Training at Health Education England East Midland. This included training in General Psychiatry, Psychiatric Intensive Care Unit ('PICU'), Rehabilitation Psychiatry, academic training, research programme, and psychotherapy competencies. It also included a special interest training sessions in Forensic Psychiatry and Neuropsychiatry.

8. I obtained approval under Section 12 ('s.12') Mental Health Act 1983 ('MHA') in 2006 and Approved Clinician Status in 2010. I have maintained this approval, which remains valid until January 2027.

9. I have been a Consultant Psychiatrist since 2010, and am currently employed in this role by the NHFT.

10. Between 2016 – 2019, I was the Training Programme Director for Higher Trainees.

11. I was appointed an Honorary (Clinical) Assistant Professor, by the University of Nottingham between 2019 and 2021.

12. Between 2022 - 2025, I have acted as Clinical Director for Adult Mental Health, for the NHFT. I am no longer in this role.

13. Between 2024 - 2025, I was appointed as Interim Associate Medical Director, for Adult Mental Health at NHFT.

14. I have worked at NHFT from August 2004 as a trainee and since 2010 as a Consultant Psychiatrist and RC, in Redwood 1 Ward (the ward for men experiencing an acute mental health crisis), and in Community Local Mental Health Teams ('LMHT') providing secondary mental health support for patients in their home or clinics.

MENTAL HEALTH SERVICES

Inpatient mental health services

15. The broad clinical aim of providing treatment to in-patients – including those detained under the MHA – involves assessment of an individual's health and care needs, followed by care and treatment planning and delivery, and discharge to community, or transfer to another facility. This is done with multi-disciplinary team ('MDT') input with patient involvement and carer input where possible.[1]

16. There are guiding principles under of Code of Practice to the MHA ('the Code of Practice') that are designed to inform every decision taken under the MHA, these are:

    a. Purpose: decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, maximising wellbeing and safety and promoting their recovery, and protecting other people from harm.

[1] This approach is supported by Notts HC Service Guide [NHFT0000130] / IWI 2022, RCPsych Quality Standards QNWA 9th Ed 2025 [WITN0329020]

b. Respect: people taking decisions under the Act must recognise and respect the diverse needs, values and circumstance of each patient, including their race, religion, culture, gender, age, sexual orientation and disability. They must consider the patient's views, wishes and feelings whether expressed at the time or in advance, so far as they are reasonably ascertainable and follow them wherever practicable. There must be no unlawful discrimination.

c. Participation: patients must be given the opportunity to be involved in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other persons who have an interest in their welfare should be encouraged (unless there are reasons to the contrary).

d. Least restriction: people taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty.

e. Effectiveness, efficiency and equity: people taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way to meet the needs of the patients and achieve the purpose for which the decision was taken.

General procedure and scope of inpatient services provided by NHFT to individuals experiencing an acute mental health crisis.

17. Patients admitted to acute mental health in-patient wards, provided by NHFT, should expect high a quality of care, working towards their needs from admission before being discharged. The wards are staffed by a wide range of staff from different disciplines to ensure patients are provided with care from suitably skilled and experienced staff to provide therapeutic interventions.

18. During the admission, the ward MDT aims to carry out an extensive assessment of the individual's needs resulting in a robust community package of care or identification of long-term needs and a referral to facilitate these. The assessment and treatment must involve collaboration of the individual, wherever possible their carers or family along with any community services to support the service user. [2]

Detention under s.2 of the MHA

19. A patient can be admitted under s.2 of the MHA if they meet the criteria for detention, if they suffer from:

a. A disorder or disability of mind;

b. That is of a nature or degree which warrants detention in a hospital for assessment or assessment followed by medical treatment for at least a limited period; and

[2] As Per the Notts HC Service Guide /IWI Jul 2022 [NHFT0000130]

c. They ought to be so detained in the interests of their own health or safety or with a view to the protection of others.

20. The Code provides further guidance in respect to the language used:

a. "Nature" refers to the particular mental disorder from which the patient is suffering, its chronicity, its prognosis and the patient's previous response to receiving treatment for the disorder.

b. "Degree" refers to the current manifestation of the disorder.

21. Paragraph 14.7 of the Code says that before it is decided that admission to hospital is necessary, consideration must be given to whether there are alternative means of providing the care and treatment which the patient requires. This includes consideration of whether there might be other forms of care or treatment which the patient would be willing to accept.

22. Paragraph 14.4 of the Code notes that s.2 is used if the full extent of the nature and degree of a patient's condition is unclear, and there is a need to carry out an initial in-patient assessment in order to formulate a treatment plan or to reach a judgement about whether the patient will accept treatment on a voluntary basis.

Detention under s.3 of the MHA

23. Detention under s.3 should be used if the nature and current degree of the mental disorder, the essential elements of the treatment plan to be followed and the likelihood of the patient accepting treatment on a voluntary basis are already established (i.e. the patient will not accept

treatment on a voluntary basis) as per paragraph 14.5 of the Code of Practice.

24. A person can be detained for treatment under s.3 MHA only if all the following criteria apply;

a. The person is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital;

b. It is necessary for the health or safety of the person or for the protection of other persons that they should receive such treatment and it cannot be provided unless the patient is detained under this section; and

c. Appropriate medical treatment is available.

25. Paragraph 14.7 of the Code of Practice states:

> "Before it is decided that admission to hospital is necessary, consideration must be given to whether there are alternative means of providing the care and treatment which the patient requires. This includes consideration of whether there might be other effective forms of care or treatment which the patient would be willing to accept ..."

26. Additionally, s.117 of the MHA places a statutory duty upon the Local Authority and the Integrated Care Board ('ICB') to plan and provide mental health after-care for patients detained under s.3 of the MHA.

27. The Care Programme Approach ('CPA') is an overarching system for coordinating the care of people with mental disorders. The CPA requires identification of a named care coordinator, as per chapter 34 of the Code.

28. Central to the CPA, is the care plan which aims to ensure a transparent, accountable and coordinated approach to meeting wide ranging physical, psychological, emotional and social needs which are associated with a person's mental disorder.

29. Included with the CPA Care Plan are:

    a. A treatment plan which details medical, nursing, psychological and other therapeutic support for the purpose of meeting individual needs promoting recovery and/or preventing deterioration;

    b. Details regarding any prescribed medications;

    c. Details of any actions to address physical health problems or reduce the likelihood of health inequalities;

    d. Details of how the person will be supported to achieve their personal goals;

    e. Support provided in relation to social needs such as housing, occupation, finances, etc.;

    f. Support provided to carers;

    g. Actions to be taken in the event of a deterioration of a person's

presentation; and

h. Guidance on actions to be taken in the event of a crisis.

Relationship between the service provided by inpatient teams at Highbury Hospital and other agencies

30. A number of agencies are involved in care planning and treatment in relation to mental health, covering Nottingham City and Nottinghamshire County. The agencies involved depends on the services required. The list of agencies includes secondary mental health care teams, primary care, community care, two acute hospital trusts, Voluntary, Community, and Social Enterprises ('VCSE'), Local Authority, ICB, housing providers and student support from university.

31. My experience with these agencies has been variable and at different points in time. For example, there is significant social housing crisis. We do not have in-house social care workers attached to the Ward and we have to put in a Notification of Assessment by sending a referral form to Adult Social Care if we have identified any social care needs. We sometimes use occupational therapists to complete functional assessment of their independent living skills if there are indicators that the patient might lack those skills and this assessment will in turn be used to make a social care referral.

Treatment, care and management provided by inpatient mental health services, crisis resolution teams and community mental health teams

32. I have set out below, the different treatment, care and management that is provided by inpatient mental health services, crisis resolution teams and community mental health teams.

33. Acute in-patient treatment usually occurs when patients are admitted in crisis or relapse. This is often under the MHA but can also be voluntary. There is a time pressure in this situation to complete the assessment, and formulate a management plan, with a focus on risk assessment and risk management, to explore available treatment options and where and how this can be provided. Treatment initiation, continuation and monitoring responses to treatment are also part of the process. There is a high turnover in treatment of this type, with the length of stay being generally in the region of 20-30 days. In-patients will be the subject of weekly ward reviews and are under the care of the MDT.

34. Long stay in-patient treatment relates to those patients whose length of stay is typically in excess of six-months. The focus of this treatment is upon recovery, with an aim of a discharge pathway to community or step-down care. Patients will be under the care of the MDT.

35. Crisis Resolution Home Treatment ('CRHT') provides mental health support in patients' own homes or the community. Daily visits can be undertaken where necessary which allows the treatment to be responsive to acute needs. Care is provided by the MDT. The discharge pathway can be to another ward setting, to another team in community, or complete discharge back into the community.

36. Community mental health teams carry out the initial assessment for non-urgent referrals within the community. These referrals often come from primary care or another team or ward. There can be short- or long-term input depending upon the patient's needs. The discharge pathway is generally to community, another team or primary care.

Factors, indicators and presentations that distinguish a patient admitted for treatment from a patient admitted for assessment

37. A patient admitted for treatment either voluntarily or under s.3 would have an established diagnosis and treatment plan. The treatment plan is defined quite broadly and does not just consist of pharmacological interventions. It would be imperative that the treatment is available in the place of admission and that the treatment cannot be provided unless in hospital.

38. The following is to be considered in deciding between a s.2 or s.3 admission. If the full extent of the nature and degree of a patient's condition is unclear, there is a need to carry out an initial in-patient assessment to formulate or reformulate a treatment plan, or to reach a judgement about whether the patient will accept treatment on a voluntary basis following admission, then an admission for assessment, or assessment followed by treatment can be considered under s.2. If the patient has already had an assessment and the treatment plan is available, that requires in-patient admission and the likelihood of the patient accepting it are established, then a s.3 will be considered. The above principles apply if a patient is admitted on a voluntary basis as

well.

Assessment of "acutely unwell"

39. The term acutely unwell is quite broad and can refer to a range of scenarios.

40. In the context of psychotic illness, it could refer to a change from their baseline (i.e. their usual day-to-day presentation) which has come about acutely (often within a 2-week period, as per the International Classification of Diseases ('ICD 10') criteria for acute and transient psychotic disorders).

41. Being 'acutely unwell' could also refer to a sudden change in presentation with significant worsening of symptoms. This may result in overt changes such as disturbance in thought, mood, perception, cognition, anxiety, or behavioural changes such as agitation, violence, suicidality or self-harming behaviour, amongst other things.

42. In order to establish an acute change in presentation, it is important to know the history of the patient (ideally longitudinal history) so as to understand how different the behaviour is from the baseline presentation. We often rely on collateral history from family, carers or professionals who know the patient to help establish the picture, as well as mental state and physical examinations.

Diagnosis of psychosis

43. Clinical descriptions and diagnostic guidelines in psychiatry differ in comparison to most other branches of medicine as they carry no theoretical implications (as per ICD 10 Clinical Descriptions and Diagnostic Guidelines ('CDDG') p.3). In psychiatry, we take a syndrome approach grouping together certain symptoms. These diagnoses are not established with any objective testing in majority of conditions (such as blood tests or scans) but merely by the history, observation and mental state examination. ICD 10 goes on to say that "*they do not pretend to be comprehensive statements about the current state of knowledge of the disorder*". They are simply a set of symptoms and comments that have been agreed by a large number of advisors and consultants in many different countries to be a reasonable base for defining the 'limits' of categories in the classification of mental disorders. The ICD 10 acknowledges the long-standing difficult problems associated with the description and classification of certain psychotic disorders.

44. Psychosis broadly refers to groups of disorders characterised by distortions of thinking, perception and by inappropriate and blunted affect. This usually manifests in the form of delusions and hallucinations but also other symptoms relating to bodily experiences, emotions, volition and cognition. There are various forms of psychotic disorders, Schizophrenia being most common, but they also include delusional disorders, acute and transient psychotic disorders, schizotypal disorder or other disorders with psychotic symptoms.

<u>Diagnosis of paranoid schizophrenia</u>

45. There are key symptoms that are required to be present for a certain duration to meet the criteria for Schizophrenia. Paranoid Schizophrenia is the most common type.

46. The criteria for diagnosis vary slightly between the ICD 10/11 and Diagnostic and Statistical Manual of Mental Disorders ('DSMV'). They are two different diagnostic manuals which are used in different countries.

47. The presentation will include thought disorder either in form or content, often paranoid delusions, usually accompanied by hallucinations particularly of an auditory nature and possibly other perceptual disturbances. Disturbance of affect, volition, speech and catatonic symptoms are not prominent in Paranoid Schiophrenia.

48. The course of paranoid schizophrenia may be episodic - with partial or complete remissions - or chronic. In chronic cases, the florid symptoms persist over years, and it is difficult to distinguish discrete episodes.

Treatment, care and management of patients experiencing psychosis

49. A PICU bed is usually appropriate for the management of patients presenting with significantly challenging and disturbed behaviour that compromises their safety or that of others, and where such behaviour cannot be managed in a general psychiatric in-patient setting.

50. This presentation will be a direct result of an acute mental health condition and is likely to require or respond to treatment interventions

available in a PICU setting. This will usually fall into categories of externally directed aggression, internally directed aggression, absconsion or unpredictability.

51. When carrying out a clinical assessment, I would consider the following risks:

a. Risk to self. This includes significant self-harming, suicidal behaviour that is not responsive to the available treatment measures in the general psychiatry ward. It may require additional resources and interventions that can only be made available in a PICU setting such as seclusion with restrictions to means for self-harm and procedural security.

b. Risk to others. This includes situations where violence and aggression towards staff or patients that cannot be managed in a general ward, and/or which has not responded to interventions or increased observations.

c. Absconsion. I would consider whether the security of a general ward was safe for the patient to remain there, or if there was a risk of them absconding.

d. Unpredictability. It is sometimes necessary to consider a PICU for patients who are unpredictable and might need a response team to attend to incidents. The PICU has a higher staff to patient ratio that the general wards.

52. Where a patient has been assessed for admission as a result of - or in connection with - criminal behaviour, we make every attempt to seek information from police. The process, however, is not straightforward. We contact the police liaison officer for immediate access to obtain any significant information such as bail conditions or outstanding charges or details about court appearance. For Police National Computer ('PNC') checks, which lists out all criminal history, current and past, written requests from authorised staff are required, and it often takes days, or sometimes weeks, for information to be received.

53. I also believe that the PNC record even if obtained could not be directly uploaded to patient electronic records. The process of getting information from police has been easier in the past two years with the introduction of a liaison person which has sped up the process. Sometimes the information and details could be obtained from other sources, e.g. a copy of the bail conditions from the patient or probation officer, or the details could be obtained from other professionals who have been involved and aware of the criminal history.

54. Factors I might rely upon to determine whether a seclusion should be terminated include whether there has been an objective improvement in the presentation that warranted seclusion in the first place. Improvement in insight over the expressed concerns and ability to demonstrate safety. I would also consider any potential emergent risks that can be mitigated with a safety plan.

55. For example, when the seclusion is terminated and the patient returns to an open area, I would consider whether the patient be could be placed on higher observations with 1:1 or 2:1 staff so they could intervene immediately, should the patient engage in any risky behaviour towards themselves or others.

56. Sometimes the trigger for the risky behaviour might have been addressed through other means. For example, a leave plan for fresh air for someone who responded aggressively to being couped up in a highly restrictive environment. At other times it might be because they have simply responded to medications.

57. We would expect the patient to be able to demonstrate that they could engage with the proposed care plan and be able to demonstrate insight and capacity into the events that led to seclusion, or to respond appropriately to the concerns raised.

58. We monitor the response to the physical, pharmacological, and psychological interventions - such as post incident reviews - with the patient to gain an understanding of their ability to reflect and respond.

59. At times, seclusion needs to be terminated if it is deemed unsafe to continue care in seclusion. For example, if the patient is presenting as delirious or suffering from serious physical health concerns such as seizures.

<u>Observation levels for a patient who is detained under the MHA</u>

60. The appropriate observation levels for a patient detained under the MHA will be determined by the risk they pose to themselves, to others, to objects and property, and their vulnerability. Their risk of absconsion and physical health related will also be factored into this assessment, based upon all the evidence that we have available to us.

Information relevant to the initial period of observation following admission

61. During the initial period of observation, emphasis will be placed on information gathering in order to build a picture and narrative about the patient. This would include history,admission clerking, assessments of mental state, physical health, investigations and close monitoring. To begin with, this would include checking the patient every 10-15 minutes until it is deemed acceptable to reduce this frequency. Some patients are placed on high observations, such as constant supervision on a 1:1 or 2:1 basis if there are significant safety concerns.

62. In carrying out these observations, staff would be looking to assess their mental state in a semi-structured way to note any abnormality by observation of their general demeanour, their sleep patterns, or if they are presenting with overt signs of potential mental illness, such as extreme withdrawal, overactive behaviour, responding to unseen stimuli that may be suggestive of hallucinations, or expressing bizarre ideas that may indicate delusions.

63. The level of co-operation with their personalised care plan, diet intake, participation in ward therapeutic activities, risk and safety concerns in

terms of any self-harm or suicidal behaviour, or threats and harm to others, and physical health checks would also be monitored.

64. Depending on the initial presentation and feedback from MDT meetings and ward reviews, the frequency of observations and the focus of observations might change. For example, if a patient is presenting with self-harming behaviour their observation level may be stepped up and they would be helped with techniques to manage intense emotions.

Core Assessments

65. A Core Assessment is an information gathering template within NHFT's electronic patient record system ('RIO') that is used to assist clinicians in obtaining all relevant and comprehensive clinical information such as circumstances of admission, mental health history, background history, personal history, medical history. It is also used to record findings from physical health and mental state examination.

66. The aim is to capture all the key information in one place. However, it does not cover risk assessments which are captured in detail in another document called the Risk and Safety Assessment Form ('Risk Assessment').

67. Together the Core Assessment and Risk Assessment will feed into the Summary and Care Plan document. The Summary and Care Plan captures the diagnostic formulation and care plan details, including the risk management plan. The guidance document for the 'Summary and Care Plan' indicates that this not an exhaustive guide for all

circumstances and that it should therefore be used alongside clinical knowledge and training, to be read in conjunction with other relevant national and professional guidance.

68. Core Assessments are updated at the point of admission to a ward or initial assessment in the community. They are reviewed on a yearly basis.

Mental state examination

69. A Mental State Examination is the assessment of a patient's mental experiences and behaviour. It primarily examines a patient's thought, mood and perceptual experiences along with cognitive functions. It also assesses any risks associated as a result of their mental experiences. The purpose of this to establish evidence for and against a mental disorder. If evidence for a mental disorder is present, to then establish the nature or it, and its severity and likely consequences.

70. The approach I take towards conducting a mental state examination is to first familiarise myself with the relevant history (including past, present, personal, family, drug and alcohol, physical health, socio-occupational history, pre-morbid personality) from available resources such as records, other professionals involved, family and carers. This allows me to first understand the concerns and then weave in the mental state assessment to establish any abnormalities in their appearance, behaviour, speech, thoughts, mood, perception, insight and cognition.

71. In order to obtain a good mental state examination, I follow principles of establishing a therapeutic rapport with the patient first, to support them to feel at ease. I take a nonjudgmental approach to questioning and use a variety of questioning styles depending on the patient. I will make reasonable adjustments to meet their communication needs. I actively listen and use interview techniques in order to arrive at a diagnostic formulation and then a management plan.

Summary and Care Plan

72. A Summary and Care Plan is the document which captures the diagnostic formulation and care plan details including risk management plan.

73. The main factors that determine the formulation of this plan are a comprehensive history, mental state examination and then piecing together all the information.

74. The key question to answer when formulating a plan is "could I make sense of the individuals' presentation or experiences, and would I be able to help them make sense of it themselves?".

75. It is important to consider the following questions when formulating the plan:

a. Why the patient is presenting in the way they are presenting now;

b. What might have been the predisposing factors;

c. What might have precipitated the current presentation; and

d. What factors might be contributing to the continuation of the problem, approaching this from a biological, psychological and social perspective.

76. Summary formulation can be an iterative process that can evolve with new information coming in both in terms of history as well as in keeping with the progression of the condition.

77. Each episode and admission will provide new information which will be required to be considered, to determine whether a pattern of behaviour is established. The care plan may need to be altered accordingly with regular CPA meetings and relapse prevention plans. Patterns of behaviour would be noted through a review of the medical history.

Inpatient care planning and care planning undertaken by local community mental health teams

78. The broad principles of care planning are the same between in-patient and within the community team. However, care planning during the period of in-patient admission focuses on the short to medium term, when considering past history, current presentation and future planning. It would not be possible to account for all the potential changes to a patient's circumstances that could happen over a longer period of time post-discharge. The potential changes could include mental state, failure to comply with the agreed care plan, loss of accommodation, loss of employment, relationship breakdown, developing side effects of

medications or a change to the care plan based on the dynamic nature of risks.

79. With regular reviews, the community teams can have the care plan amended and updated as the circumstances change. There are also differences in focus of care planning between in-patients and community teams in terms of physical, relational and procedural security that could be put in place in in-patient settings which would not be available in community settings.

Mental Health Clustering Tool

80. The Mental Health Clustering Tool ('MHCT') is a tool that has been in use for nearly 15 years in my area of work. It was developed primarily as a tool to identify patients with similar characteristics and group them into clusters in order to understand the commissioning and provider needs.

81. It is also a useful tool to track the care pathways and outcomes as patients transition between services depending on their needs. It is underpinned by Health of the Nation Outcome Scales ('HoNOS') scores. HoNOS is a scale used to measure clinical severity and social functioning based on current and historical factors.

Risk Assessments in the formulation and development of an inpatient's Care Plan

82. Risk assessments are used in the formulation and development of an inpatient's Care Plan and can feed into the development of a risk management strategy as part of care planning. This is based on the health and social care needs of the patient during the period of admission and after discharge. For example, for patients with poor insight and non-concordance, the in-patient care plan would be able to assess the level of compliance and improvement in insight, or attitudes towards treatment. If there were risks identified, for example, in terms of low level aggression, violence or risk to self, the in-patient care plan can allow for positive risk taking in a controlled, and risk assessed manner through graded periods of leave to the community. Higher levels of risks would trigger a referral to secure in-patient settings.

83. If there are concerns about self-neglect, then an OT assessment of functional abilities could be carried out and included in the care plan. The risk assessment would also identify the key stakeholder need for inter-agency working and future risk management. This is often carried through a CPA approach in the community. The purpose of this is identifying the needs – both in relation to health and social care – and allocating the relevant services and resources, while monitoring the effectiveness of interventions. It is underpinned by the principle of MDT input and a patient-centred approach.

Discharge planning

84. Prior to commencing discharge planning, for a person experiencing psychosis, clinical assessment has to be completed to arrive at a

working diagnosis. This is to allow an understanding of the psychopathology, arrive at a formulation as to what might have caused the condition and its presentation, and then form a treatment plan based on a bio-psycho-social approach.

85. The treatment plan will inform the various aspects that are required to be considered. For example, medications, psychology input, OT input, risk management, social support and community team support. It will also consider whether the treatment needs to be given as an in-patient or if it can be provided in the community. If is required as an in-patient, it will be considered whether the acute treatment ward or a long stay ward would be required. The treatment plan would also consider whether any steps needed to be taken imminently, or in the future. For example, it would establish if the assessment of efficacy of medication might be required imminently, whereas psychological input could be required in the future. It would need to consider which teams are to be involved, including multi-professional input from secondary care, primary care or other agencies who can deliver the care plan.

86. The treatment plan encompasses a wide range of interventions depending on the patient needs. For some patients it could be initiation of medications, for others it might be optimisation of medication and in some instances, it could be even be de-prescribing a medication or making alterations to their medication.

87. A treatment plan in psychiatry is much more than just prescribing medications. It also involves addressing psychological, social,

educational or occupational needs. For example, for someone who might have lost a job or house, addressing those needs are also part of treatment. For others, merely the removal of psychological stressors that might have precipitated an episode could be an intervention in itself. The team would be looking for improvement in clinical severity of symptoms as well as functional improvement. The treatment objective is seldom complete symptom resolution or total functional recovery as invariably the nature of most severe mental disorder is such that they have a protracted course. The focus is adequate improvement to a level that no longer requires in-patient stay and that care can continue in the community. This will be addressed alongside any presenting risks the patient might be posing to themselves or others, such that the risks can be managed in the community. The dynamic nature of the risks are such that it may not be completely eliminated but measures put in place to mitigate the risks. Clinical judgement would be applied in every step of the process.

88. For a patient diagnosed with paranoid schizophrenia, either initiation or titration of medication dose would be required. This would be to establish compliance, efficacy of the treatment, to note clinical improvements, any risk reduction and improvements in safety concerns. Patient-centered psychological intervention (such as psychoeducation and counselling) or more structured psychological therapies, can also be undertaken. Other treatments depend on the needs identified, for example occupational therapy can also be employed to help prevent relapse.

89. Some of the key factors I would take into consideration when commencing safe discharge to the community are:

a. Improvement in a patient's mental state from time of admission;

b. Evidence of symptomatic improvement (such as reductions to delusions, hallucinations, behavioural disturbance);

c. An increase in insight and capacity;

d. Treatment compliance;

e. Improvement in safety concerns and risks to their self or others;

f. Functional improvement such as socio-occupational functions;

g. Engagement in future care planning; and

h. Ability to manage leave periods without major concerns.

90. The information on the above indicators will be obtained from several sources over a period and synthesized as the admission progresses. This would involve acting within the legal code of practice and meeting patient and service demands.

91. The indicators are not markedly different between patients experiencing psychosis or paranoid schizophrenia as paranoid schizophrenia is a form of psychosis. However, psychotic experiences can be part of a number of other conditions and the indicators may be different depending on what the associated condition is.

92. In terms of treatment objectives, a pragmatic aim is to attain an optimum balance between clinical recovery and functional recovery, addressing safety concerns in terms of risk to self and others, and supporting a discharge pathway back to the community.

93. After assessment and treatment plans are initiated, the service guide expects the clinical team to set an Intended Discharge Date ('IDD') and work towards the IDD unless there are deviations from the plan for any reason which requires IDD to be moved.

94. For a patient with a history of aggression in the community and in-patient settings, prior to commencing discharge planning, it is important to establish the nature and reasons for such presentation. This would include an assessment of whether the behaviour is directly related to the mental disorder(s). It would also be important to consider whether other factors are relevant such as personality, drug and alcohol, anti-social behaviour, and environmental or social factors.

95. Depending on the information gathered and the clinical evidence, an impression is formed of the reasons for and ways to address this behaviour. This is through a treatment plan which would start in the ward and be continued in the community following discharge. Once the information is gathered to suggest that the treatment plan is effective - including a response to medications, outcomes from s.17 leave to the community, and reassurance in the form of no ongoing risks - the discharge planning gathers momentum, and safeguards are put in place to mitigate the risk of the treatment plan failing in the community. These

safeguards could include a post-discharge plan which starts with a 3-day follow up, a CPA care plan, and review appointments.

96. Contingency plans would then be put in place to address any risk of the re-occurrence of such risks, such as treatment reviews, crisis team input, escalation through MHA assessment, and readmission.

97. For patients who are considered by clinicians to be at risk of becoming violent in the absence of treatment, ways to ensure that the treatment is not discontinued will be considered. This includes understanding why discontinuation happens and ways to improve adherence. Long-acting injections are considered and administered if indicated. Once these matters have been explored and understood, a plan can be put in place to address the issues, and discharge planning would commence. In arriving at the plan, the clinician takes a bio-psycho-social approach based on the risk formulation, in a patient-centred way, as well as working within the framework of the MHA and MCA.

98. For patients who have a history of non-concordance, it is important, before commencing discharge planning, to first establish the pattern of non-concordance. This includes the reason why it occurs, noting that concordance is often suspected as the reason for relapse when there may be other reasons for relapse too. These reasons may include illness related factors such as delusions about medications, command hallucinations, side effects of medications, stigma or a combination of a number of factors. It is important to establish a patient's acceptance of concordance, and work towards improving insight and their attitude

towards medications through psychoeducation. There should be consideration of alternative treatment options that are likely to improve adherence such as medication with less side effects, better acceptance, previous responses, long-acting depot injections and enforcing them if necessary.

99. For patients who have a history of violence it is important, before commencing discharge planning, to establish the possible reasons for violent behaviour, whether that be mental illness related, personality, or drug and alcohol related. An understanding must be gained of the antecedents of the behaviour and its consequences. A patient's insight into the behaviour, their capacity to understand the nature and consequences of their behaviour, any ongoing evidence of violence, or likelihood of violence, together with ways to manage them needs to be explored and considered. If violence is unrelated to mental illness, a criminal justice route needs to be considered and will not hinder discharge.

100. For patients with a history of social isolation, before commencing discharge planning it is important to gain an understanding of whether this behaviour is illness related or due to their personality or circumstances. It would be expected that such patients would be encouraged to engage with socially inclusive activities. A community care plan would be required to closely monitor any deterioration and related problems such as self-neglect or risks to self and others. A support worker in the community will be recommended.

101. For patients with a history of disengagement from treatment, before commencing discharge planning it is important to identify strategies to minimise disengagement such as a co-produced care plan. This will promote engagement that meets the need for monitoring as well as addressing psycho-social needs. It will be important to explore the patient's willingness to continue to engage and consider whether a Community Treatment Order ('CTO') might be required. Contingency plans must be in place, to minimise the risk of a patient disengaging. This should include regular appointments, home visits, and assertive engagement working on the 'assertive outreach model', with a multi-agency approach.

102. For patients with a history of masking psychotic symptoms before commencing discharge planning, it is important that an assessment is undertaken. The assessment is based on multiple sources, for example, ward reviews, nursing assessments, therapeutic observations from health care assistants and other professionals, collateral history from family or carers, and observations on how the patient is engaging in discussions about symptoms experienced. It will be important that clinicians are able to recognise when presented with conflicting evidence and strike a balance between not taking a judgmental view by disbelieving everything the patient says, whilst maintaining professional curiosity to explore matters further.

<u>Behaviour that contraindicates discharge planning.</u>

103. There are various behaviours that would lead me to consider that a patient who is detained under the MHA remains a risk to himself and/or a risk to others such that they should not be considered for discharge planning. Such behaviour would include:

a. Behaviours that are reflective of active symptoms that require further improvement. Active hallucinations or delusions related behaviour.

b. Non-concordance or expressing intent to not continue with treatment plan in the community;

c. A lack of insight or capacity to make informed treatment decisions;

d. A lack of insight into the nature of risks;

e. Behaviours on the ward or in the community (when on community leave) which demonstrated that they continued to present a risk to themselves or others (i.e. violence of threatening behaviour towards others, or self-harm);

f. Ongoing substance use which might be contributing to imminent relapse;

g. Unaddressed social care needs which would place them at high risk of relapse; and

h. Showing signs of vulnerability to exploitation, self-neglect or dangerous and reckless behaviour as a result of ongoing mental illness.

"Insight" in respect of patients detained under the MHA 1983

104. The concept of insight in mental health has been defined in various ways but one of the well-recognised definitions is by Anthony David, which conceptualises it in three dimensions, namely:

a. Awareness (i.e. the recognition of symptoms);

b. The ability to attribute unusual mental events such as delusions or hallucinations as a consequence of illness; and

c. The recognition of the need for treatment.

105. It is well recognised that 'insight' it is not an 'all or none' phenomena or a static state of mind. It is influenced by a number of factors such as illness, cognitive deficits, and psychological factors (such as stigma, distress or cultural acceptance).

106. From my experience, and as quoted widely in academic literature, insight can often exist in varying grades. At the lowest end, there can be a complete lack of insight in all aspects. Some patients will have partial awareness, where there is recognition that they are, or have been, unwell but where there is still attribution to a number of factors, or a reluctance to accept the diagnosis of mental disorder. In my experience, it is very rare that patients have truly full emotional and intellectual insights in all the three dimensions as described above, particularly in patients with psychosis.

107. Being detained under MHA does not in itself indicate a total lack of insight, as many patients will have partial insight. But they may still nevertheless meet the criteria for detention.

'Masking' in respect of patients who are experiencing psychosis

108. The term 'masking' does not have a technical definition in descriptive psychopathology but could be understood as a way that patients tend to conceal their mental health symptoms, needs and psychotic experiences from others. It is a complex subject as it is not easy to establish if the patient is deliberately 'masking' or if this this is occurring subconsciously.

109. There can be a number of reasons why such behaviour occurs, such as illness related factors which limit their ability to appreciate their experiences, or the fear of being judged as abnormal.

110. It can also be related to a patient not wanting to lose their social identity or feeling that the behaviour will allow them to fit in with socio-cultural norms. In mental health settings, when a patient fears that they will lose control over their way of life or treatment preferences, there is additional risk that they might try to conceal their symptoms.

111. As every individual is different and the way they understand their own difficulties is also different, mental health patients, particularly young patients with psychotic experiences, find it difficult to make sense of some of their experiences. Their model of understanding their experience could be at odds with the model that is presented to them.

Information relevant to the risks in the event that a patient deteriorates and experiences a "psychotic crisis" or becomes "acutely unwell".

112. There is significant information that can be drawn from a patient's history which is relevant to identifying the types of risks they might pose to themselves and/or others in the event that they deteriorate and experience a "psychotic crisis" or if they become "acutely unwell". This includes the nature of the risks the patient has presented with when acutely unwell such as self-neglect, dis-engagement, non-concordance, thoughts to harm themselves or others, acts of harming themselves or others, and if / how that could be attributed to their mental disorder or its manifestations such as delusions, hallucinations, affective symptoms or personality. Sometimes the risky behaviour may not be explainable by their mental health condition and could be un-related to the condition. For example, a patient with psychosis may still indulge in anti-social or criminal behaviour or self-harm / harm to others which could be related to their underlying anti-social personality structure, psychopathy or substance use. Establishing the causal link between the risky behaviour and illness related symptoms is key.

Discharge planning and follow-up

113. The discharge plan is formulated based on the patient and carer needs (where applicable) and support systems available to continue care after discharge. For any patient admitted to the ward, the initial process of assessment will inform what will be required to treat the person and facilitate a safe discharge process.

114. The broad framework of formulating a discharge plan involves addressing the bio-psycho-social needs of the patient. It would also take into consideration the predisposing, precipitating and perpetuating factors involved in the deterioration leading to admission and addressing them to aid recovery. One of the key challenges faced when the patient is admitted under the MHA is that the formulation of the plan should conform with the requirements of the Act. For example, as the patient will have been admitted against their wishes and deprived of their liberty, the clinical team and the Responsible Clinician ('RC') have to ensure that when they no longer meet the criteria for detention, they are not subject to any further restrictions under the Act.

115. Depending on the section the patient is admitted under, there are additional provisions to consider such as s.117 MHA after-care planning and a Care Programme Approach ('CPA'). The principle of the least restrictive approach should be adhered to. A prolonged stay under the Act should not be considered simply because it is 'desirable' but only if it is 'necessary'. Once a discharge plan is formulated based on the patient's needs, the ward team identifies key personnel and stakeholders who will be responsible for carrying out the plan in the community post discharge.

116. Appropriate referral to these agencies will be made and, where necessary, allocation of resources will be prioritised. Multi professional input is supported throughout in the lead up to discharge. For patients who are complex with multiple needs (medical follow up, psychological

interventions, social interventions including education, employment, financial needs or carer and family support), the framework of a Care Programme Approach will be applied and a care co-ordinator is identified to co-ordinate the care plan following discharge.

117. In principle, anyone who has, or will have, a role in supporting the patient to transit from the ward to the community, or a role in providing ongoing care in the community, will be invited to attend ward reviews and discharge planning. This includes the ward team, the community team, family or carers where appropriate, and other professionals who are identified as having a role in supporting post-discharge.

118. The community team with responsibility for the CPA responsibility hold the primary responsibility for ensuring that the discharge plan is followed and will work closely with other agencies supporting them. Patients on a CPA pathway will have a named care co-ordinator with responsibility for co-ordinating and co-producing the care plan.

NHFT's Service Guide for Adult Mental Health Inpatient Wards

119. NHFT's Service Guide for Adult Mental Health Inpatient Wards outlines that it is the responsibility of the named nurse and the ward MDT, "to carry out an extensive assessment of the individual [patient's] needs resulting in either a robust community package of care or the identification of longer-term needs and referral to facilitate these" [NHFT0000130 at p.7].

120. An extensive assessment would involve regular assessment of a patient's mental state, risks and assessment of care needs. This would include using a bio-psycho-social framework, obtaining collateral history, establishing a treatment plan, testing treatment efficacy, trailing leave before discharge, and making a referral to the community mental health team and other agencies as required for follow up support.

121. The support would include a robust community package of care, with regular follow ups with the Community Psychiatric Nurse ('CPN') and community consultant, medication reviews, and other care plans as identified from the assessments.

Implementation of community care packages

122. The ward MDT team do not have responsibility to follow-up with the implementation of a community package following discharge from the ward. The care plan will be handed over to the community team at the discharge or CPA discharge meeting, sometimes this will be carried out by the CRHT until a community team takes over due to resource constraints.

Community Treatment Orders ('CTO')

123. A CTO can only be made in respect of patients who are detained in hospital for treatment under s3 MHA or are unrestricted Part 3 MHA patients.

124. Patients detained in hospital for assessment under s.2 of the MHA cannot be subject to a CTO, per the Code of Practice, Chapter 29, s.29.8. A patient must therefore meet the criteria for detention under s.3 or an unrestricted Part 3, though not subject to a Restriction Order.

125. Provided a patient with a diagnosis of paranoid schizophrenia meets the above criteria then I would consider the following circumstances;

a. The nature and degree of the illness and its relation to risks, both current and historical (to self and others);

b. Whether there is treatment available that is necessary for the health or safety of the patient or for the protection of others from serious harm (for patients who lack capacity); and

c. For patients with capacity where there is a substantial risk of serious harm to health or safety of the patient or to the safety of others if they remain untreated.

126. CTO is a treatment framework available under the MHA. It is considered when a patient is ready for discharge, but not complete discharge from liability under the Act, and where the power of recall might be required. CTOs require patients to accept clinical monitoring and allow rapid recall for assessment but do not authorise forcible treatment outside hospital.

127. A CTO may only be used if it would not be possible to achieve the desired goals without it and the principle of least restrictive approach should be considered always.

128. The patient's past history should be taken into consideration.

129. Though patients do not have to give formal consent to a CTO, patients should be involved in decisions about treatment to be provided in community and be prepared to co-operate with the treatment. Other factors include current mental state, capacity to make decisions about their care and treatment and attitude towards treatment and risk of relapse, and the circumstances into which they would be discharged.

130. Article 29.16 of the Code of Practice ('COP') states that 'A risk that the patient's condition will deteriorate is a significant consideration but does not necessarily mean that the patient should be discharged onto a CTO rather than be discharged'. A clear evidence between non concordance and relapse and a clear evidence that the CTO will promote recovery and recall may be necessary rather than informal admission or reassessment under the Act.

131. Paragraphs 29.10–29.18 of the Code of Practice set out the factors that are required to be considered when discharging a patient under a CTO.

132. It stipulates that the RC's ('RC') decision to place the patient on a CTO should only ever be made on clinical grounds where the patient meets the criteria in s.17A of the Act

133. The risks which I might consider would mean that CTO is appropriate include:

a. Total lack of insight into the nature of symptoms, disorder or need for treatment;

b. Refusal to accept any form of treatment or medication;

c. Lack of capacity to make informed treatment decisions about the choice of treatment that could be made available;

d. Disengaging from the care team due to reasons of worsening of mental illness or lack of capacity;

e. Non-concordance with the treatment plan without consultation or discussion with the care team; and

f. Not making themselves available for assessment despite reasonable adjustments from the care team.

134. There are no specific defined criteria in the Code for patients with a history of aggression in the community and inpatient settings, or who are considered by clinicians to be at risk of becoming violent in the absence of treatment, or with a history of violence, or with a history of non-concordance with medication, or with a history of social isolation, or with a history of disengagement from treatment, or with a history of masking psychotic symptoms.

135. It is largely a clinical decision where the RC has to take into account various factors related to patient and balance the decision. All the above factors under 135 would be relevant when considering whether to place

the patient on a CTO, provided that the patient meets the other statutory criteria such as a treatment section.

136. My approach to this decision would be to consider whether the aggression in the community and in-patient settings was a manifestation of the mental disorder, if so what are the driving factors and how best to address them. I would also take into account what the CTO would achieve that cannot be achieved through less restrictive means. I would also be mindful about other factors that could mitigate disengagement such as improving insight, psychoeducation, co-produced care plans, reducing social isolation and developing a trusting professional relationship.

137. Any associated factors that are likely to adversely affect the risk manifestation, such as significant forensic history, co-morbid substance or alcohol use, or a history of self-neglect would all support a case for a CTO.

138. It should be noted that it would be unlawful to detain someone under s.3 of the MHA (as opposed to s.2) purely for the purposes of placing them on a CTO. The Act requires the RC to exercise the duty to discharge a patient who was detained for assessment if they no longer meet the criteria for continued detention under s.2.

139. The Act does not define specific criteria to be used for discharge, but the essential consideration is whether the grounds for continued detention are satisfied.

140. The criteria to be applied by hospital managers considering discharge are covered under paragraph 38.16 of the Code of Practice, namely;

a. Is the patient still suffering from mental disorder?

b. If so, is the disorder of a nature or degree that warrants the continued detention of the patient in hospital?

c. Ought the detention to continue in the interests of the patient's health or safety or for the protection of other people?

141. If the answer to the above questions based on evidence is 'no', then discharge should be considered. Regard should be given to the principle of least restrictive option and maximising independence (as per para.38.23 of the Code of Practice).

Non-concordance and depot medication

142. There are a number of factors which might indicate that a patient poses a risk of non-concordance with medication. The primary factors are:

a. Lack of insight and capacity.

b. Refusal to accept medications.

c. Non-availability when medications are dropped.

d. Non-attendance to medication clinics to collect medication.

e. Regularly running out or having an oversupply of medications.

f. Unused medication supply in boxes, or the refusal to show the supply left.

g. Evidence from compliance aids, such as a flexipack or dosette box which can indicate if medication has not been taken appropriately.

h. Clinical testing, e.g. plasma levels from blood sampling which is available for certain medications.

i. Persistent symptoms which may be indicative of non-concordance with medication (noting that persistent symptoms could be due to other factors such as misdiagnosis, incorrect treatment or no available treatment, non-responsiveness to treatment, or treatment resistance).

143. I would consider that a patient might not be appropriately discharged from in-patient treatment unless they agree to accept their medication through depot where some of the following factors are present:

a. Clear evidence of non-concordance, i.e. the refusal to accept medication and/or the denial of current and future need for medication.

b. Circumstantial evidence to suggest non-concordance, i.e. unused medications being found.

c. Refusing to allow supervised medication intake where needed

d. Evidence of secreting or palming medications given under supervision.

e. Evidence that a patient requires prompting to attend medication clinic or else will fail to attend.

f. Ongoing symptoms that require depot to ensure adherence and establish effectiveness.

g. Memory difficulties which make it difficult to comply with other forms of medication route.

h. Certain social circumstances, e.g. homelessness, which might impact upon compliance, increase the risk of absconding, and failing to engage with further treatment.

i. The considerations are however not absolute, and in assessing an individual patient, it would always be important to balance any risks posed with the mitigating factors and support systems available upon discharge for monitoring and intervention.

144. I would consider the following risks would be relevant to a patient who posed a risk of non-concordance, and so could not be discharged unless they agreed to accept their medication through depot:

a. Evidence of non-concordance;

b. Evidence of symptoms emerging due to non-concordance and symptom resolution with concordance;

c. Not accepting of treatment in any form or at imminent risk stopping of medications;

d. Evidence of secreting medications, palming them or expressing the need to stop taking them against medical advice;

e. Lack of insight;

f. Lack of capacity to make informed decision on treatment;

g. Not accepting the need for monitoring in the community, supervised intake if required or review by care team; and

h. Risk of absconsion resulting in disengagement.

VC's TREATMENT

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

Background to Redwood 1

145. It is important at the outset to explain the background to the Redwood 1 Ward ('the Ward') in terms of the format, purpose and function of patient-related assessments and meetings.

146. When a patient is admitted to the Ward, upon arrival, they are welcomed and oriented to the ward and its relevant policies. They are clerked in whereby their history, and circumstances of admission are taken and a physical examination is completed. An initial medication plan is then established.

147. This is followed by a 72-hour review by a senior clinician (a consultant or higher trainee) which helps establish an initial care plan. Following this, the patient will have weekly 1:1 nurse sessions and weekly ward reviews (which at the time of VC's admission would have lasted around 30 min per patient). This has now increased to around 45 min per patient.

148. The ward reviews are for the purposes of assessment and treatment. In addition, we have a weekly MDT meeting, which acts as a review and planning meeting. Patients are not in attendance at this meeting. The available time for this meeting is about 10 minutes per patient. We spend more time for newly admitted patients as there will be more details to discuss as a review of their records will be required.

149. The MDT meeting allows a quick recap of how the patient has been presenting in the preceding days, in addition to any handovers, identifying jobs for the week ahead and planning for the weekly ward review. It is jointly led by the consultant and ward manager.[3]

150. The documentation of the ward MDT and ward reviews are primarily completed by resident doctors when they are present.

Initial observation and care plan

151. An MDT discussion took place in respect of VC's treatment during his Fourth Admission on 31 January 2022, at 14:15. The notes of which are

[3] As per NHFT Service Guide: AMH Inpatient wards, at p 19 [NHFT0000130]

recorded at [NHFT0000168, at p.220]. My recollection is that I led the MDT jointly with the staff nurse deputising for the ward manager.

152. The discussion involved feedback about the patient including a review of the history as obtained from the notes review and initial assessment, nursing and other professionals' feedback, collectively identifying key questions to explore, allocating the jobs, and resources planning for the ward review ahead.

153. The record of this MDT meeting states:

> "Valdo is currently doing 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."

154. Given the passage of time, I have limited independent memory of this meeting.

155. From what I do recall, this is a reasonable summary of the discussion held at the meeting, and I have no reasons to doubt the accuracy of the note taken. The minute taker will only be able to capture the gist of discussion

due to limited time and the speed of typing needed. The documentation is not a full transcript of all the details discussed, and was not made by me, but I believe that it reflects the key points discussed.

156. I have limited independent memory of which documents I would have reviewed prior to this specific MDT discussion. However, it is my normal practice to gather as much information as possible before the MDT, and also at the MDT. The various resources I would rely review before the MDT are: RIO records including progress notes, any MHA assessment related documentation, core assessments, risk assessments and summary care plan, and any alerts on RIO. For physical health related medical history, I review medical notes and GP records if available through the Notts Health and Social Care Portal. It would not be practically possible to review every single document with the time available , so it would be pooling of information from others present as well.

157. I have no reason to believe that I would have deviated from my usual practice on this occasion.

158. I also recall that I listened to the handover and summary presentation from Dr Gibson, as well as nursing staff feedback. The notes of this meeting mentions the three previous episodes, the incident leading to the current admission, medication history, and the police involvement, which indicates that all the relevant details were discussed.

159. I cannot recall precisely when I would have reviewed any records from VC's First, Second and Third Admissions at NHFT Highbury Hospital,

although I am confident that I would have reviewed these prior to this meeting, by scrolling though the RIO records or through verbal feedback from MDT meetings. My usual practice is to gather as much information as possible with the time available.

160. I cannot recall when I would have reviewed any records from VC's out of area admission at Cygnet Victoria and Priory Arnold. I do not have access to the full records from a private hospital as the electronic patient record systems are not accessible from outside the organisation. I believe there were discharge summaries and entry from a bed manager, but I cannot recall when these were reviewed. These are documents that I am confident that I would have reviewed, though I cannot recall at which point.

161. I would have quickly reviewed most of the records from VC's period in community care - as contained on RIO - as well as having regard to information obtained from resident doctors, nurses and the CPN. I did look at some entries from community outpatient clinics he had had with the EIP team, home visits and entries by other professionals.

162. I did not speak to any of VC's RCs in relation to this First, Second or Third admissions prior to this MDT meeting. This would not have been routine practice, and I would only have done so had I considered there was a specific reason to do so such as handover or gaps in information. I did not consider that there was a specific reason to do so at this time.

163. I did not have access to information from the Police at the time of this MDT meeting. Following the MDT meeting, I suggested that we obtained the

PNC records. I do not know if this request was actioned. This is recorded in [NHFT0000168, at p.220].

164. I do not believe that information was sought from the mental health team at VC's university prior to this MDT meeting. I can see from the RIO entries that there was contact with VC's university on both 3 and 4 February 2022.

165. I cannot recall specifically if I reviewed the MHA assessments undertaken by independent medical practitioners recommending VC's Fourth Admission, but it would be my normal practice to do so. I remember reading through the MHA assessment notes entry by Dr Ben Lomas, entered at 9:58pm, which gave a detailed description of VC's presentation at the assessment and his views compared to the previous admission.

Medication

166. At this time, VC was being treated with Aripiprazole (as noted at [NHFT0000168, at p.219]). He had previously been prescribed Haloperidol, Risperidone and Aripiprazole. They are anti-psychotics which work by blocking the effects of a certain neurochemical in the brain, dopamine. They are licenced and indicated in the treatment of Paranoid Schizophrenia. They differ mainly in tolerability and side effects though there are some pharmacological differences in their properties and effect on certain receptors. Aripiprazole has fewer side effects particularly parkinsonism-like side effects (stiffness, tremors, slowed movements) and also fewer metabolic (hormones related) side effects such as diabetes, lipid disorders or sexual side effects.

167. Compared to Risperidone, Aripiprazole has partial dopamine agonism (enhancing rather than blocking effect) in areas of the brain which, if blocked, leads to side effects. On the whole, the acceptance and tolerance rates are higher with Aripiprazole compared to Risperidone from clinical observations particularly in young patients.

Diagnosis

168. At the time of the MDT discussion on 31 January 2022, I was aware of a previous diagnosis of schizophrenia which was documented from in-patient records and some community clinics. However, I was also aware of a potential diagnosis of First-Episode Psychosis ('FEP').

169. Whilst the overall picture was in keeping with a diagnosis of Paranoid Schizophrenia, there were some features which I considered were suggestive of an acute and transient psychosis with schizophrenia-like symptoms (as per ICD 10). VC seemed to have an acute exacerbation of symptoms and then recover very quickly after every episode without any significant changes to treatment plan. The picture of psychosis in early stages (the first few years from onset or prodrome) is sometimes dynamic. The EIP teams do not always endorse a definitive diagnosis but many a times, maintain an umbrella term of 'psychosis'.

170. A categorical diagnosis of Paranoid Schizophrenia might have added to the weight of argument for certain treatment options however in psychiatry, diagnosis can still be an evolving picture in young patients. Whilst VC's working diagnosis remained as Paranoid Schizophrenia, a

differential diagnosis was Acute and transient psychotic disorder (ICD 10 F23) as this diagnosis encompasses Schizophrenia type symptoms (typical syndromes) but also involves acute onset (within 2 weeks) and the presence of associated stress. In VCs case the history suggested that his mental state can change acutely within days to weeks and is often associated with acute stress.

171. Regardless of whether the diagnosis is one of Paranoid Schizophrenia or broadly psychosis which fall under the F20-23 categories of ICD 10, the treatment approaches only differ very minimally, with anti-psychotic medications being the main treatment option from a psycho-pharmacology point of view.

172. I do not therefore consider that it would have made any difference to VC's care plan if the note of the MDT review had stated that VC had previously been diagnosed with Paranoid Schizophrenia. This was a matter of which I was already aware.

Concordance with current medication

173. The note of the MDT discussion on 31 January records:

> "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."

174. I would like to explain why this was recorded, in two parts. First in relation to concordance with medications during the period of admission and

second with regard to compliance with medications prior to Fourth Admission.

175. During the period of his Fourth Admission, VC was prescribed anti-psychotic medication in the form of Aripiprazole 20mg OD, which was within the recommended therapeutic dosing range. He was at this time (and during the entire period of this admission) fully compliant with the medications. Staff did not report back to say he declined medication or was suspected of not taking medications. He expressed his willingness to take medications during the period of stay in hospital and also after discharge. He did not require any additional prompting.

176. In terms of his compliance with medications prior to his Fourth Admission, the CPN had expressed concerns over his compliance prior to admission and since the last discharge in October 2021.

177. During his contact with CRHT on 21 January 2022, he was observed to be putting medications in his mouth but not drinking water. He was seen putting his hand in his mouth as he was walking away after accepting medication and throwing something in the bin on only one occasion. The CPN thought it 'appeared' to be medication as recorded in [NHFT0000168 at p.207] but no confirmatory evidence was recorded or sought at the time.

178. However, the plan continued with daily contact and VC was monitored to take medication. VC was noted to be taking his medication (see for example, the entry by the following day at 15:45, at 02:09 on 24 January, and at 11:40 on 26 January [NHFT0000168 at p.207]).

179. VC appeared to have been generally concordant with his medication plan despite his ambivalence about how helpful it was.

180. The note from the MDT recorded that VC had been concordant with his current medication, which was correct. We were however aware that there had been some level of non-concordance in the past, as was documented.

181. Given the history of non-concordance, depot medication was discussed at the MDT meeting.

182. At this time, I had no doubt that VC would require treatment in the form of anti-psychotics, long-term, for the management of his mental health condition alongside other psycho-social interventions, to allow him to achieve his goals of completing his university course and finding a job.

183. Given the concerns that this was the Fourth Admission in two years, it was suggested that the reason for relapse was a possible non-concordance (although this was subsequently disputed by VC).

184. I made every attempt to establish evidence for non-compliance in the months preceding this admission and could not definitely conclude that the relapses were only related to non-compliance. It is important to bear in mind that whilst medication non-concordance can lead to relapse, it is also possible that relapses can occur in patients with psychosis before non-concordance starts, i.e. patients stop medications after relapse of a symptom, meaning the non-concordance is not the reason for relapse.

185. Nevertheless, there is substantial body of evidence which supports the use of depot medication as a method to reduce relapse rates. It is a recognised method of tackling non-adherence, and so it is a matter that was considered at this stage.

186. I did not personally review VC prior to the MDT meeting on 31 January 2022 as patient reviews are part of ward reviews, not MDT meetings.

VC's risks at the time of the MDT discussion

187. I was aware of a number of risks both to VC and posed to others, at the time of this MDT assessment.

188. In terms of risk to himself, VC was living independently and doing a master's degree in engineering at the time. No concerns were expressed about his self-care or thoughts of self-harm or suicide. He was first diagnosed with a first episode of psychosis in 2020 and had in-patient admissions following the first episode. When unwell, he had experienced psychotic symptoms which had resulted in him acting in a significantly concerning manner. This put others at risk. Due to the nature of his presentation towards others, he was at risk of being harmed from self-defence, restraint, or retaliation.

189. If he were to remain unwell, he was at risk of not completing his university degree which was important to him. Equally, if he were to suffer with significant side effects from medications or a restrictive approach to his treatment, that was also going to have an impact on his studies, university

course and part-time job. He was not presenting with risks related to alcohol or substance use as far as I was aware at the time.

190. In terms of risk to others by this point, VC presented with significant risks to others on at least on three earlier occasions. This had included violent behaviour, to individuals and property. As such, he clearly posed a risk of physical harm to others when he was unwell.

Risk and Safety Assessment, 28 January 2022

191. On 28 January 2022, a nurse and member of VC's clinical team updated a Risk and Safety Assessment in respect of VC [NHFT0000191]. Under the heading Risk "To Others", the following information is recorded:

> "[VC] was reported to the Police and University staff alerted due to an incident in his flat. Two flatmates claim that Valdo physically assaulted them in the flat and refused to allow them to leave. They were only able to escape after one of them grabbed Valdo and held him back. According to the student report, the Police did not arrest Valdo as he hadn't inflicted any harm. Details of this assault are unclear at this point as Police have so far refused to share details [...]
>
> "During the MHA in September 2021 [...] [VC] refused entry to his flat and Police attended [...] [VC] became increasingly agitated and aggressive towards the Police officers, causing physical harm to 3 officers. He was tasered twice but to no avail, officers then had to use Pava Gas to subdue Valdo due to him punching an Officer with significant force 3 times in the face and attempting to assault other

Officers on numerous occasions. Valdo was not complying with any instructions or de-escalation techniques. Officers had to use leg restraints to remove Valdo from the address due to further attempted assaults."

"03/09/21: Valdo had gone to a neighbours' flat who was staying above him, knocked at his door to confront him as to why he was discussing him as he had heard voices to that effect and he was certain that it was this person living above his flat responsible. He barged into the persons flat [...] and other neighbours came to the rescue and called the police. [...] VC continued to experience auditory hallucinations and fixated on persecutory ideas relating to the government.

31.08.21 - Valdo appears to be relapsing. Appears quite suspicious / paranoid, little bit confrontational although no evidence of any aggression. Valdo has stopped treatment (Aripiprazole 20mg) abruptly [...].

14.07.20: Arrested for attempting to gain entry into random neighbours flat as he felt that someone is in trouble. Valdo did not gain entry or harm anyone but he was kicking the door. Prior to previous admission Valdo was involved in a similar incident whereby he entered into another resident's flat whilst experiencing distressing auditory hallucinations. The woman that resided in the flat jumped out of the window due to being frightened, she injured herself severely and needed surgery on her back.

192. The Service Guide for Adult Mental Health Acute Inpatient wards for NHFT, under section 7.0, Care and Treatment, [NHFT0000130] p.12, states that:

> "Comprehensive assessment and formulation of patient's needs inclusive of risk, is an ongoing process throughout inpatient stay and it is the named nurse along with the MDT's ongoing responsibility to review, complete assessments, interpret outcomes and plan care accordingly with patient/carer involvement in planning care wherever possible. Risk assessments are to be completed on admission and dynamically following this to ensure these assessments demonstrate current risks. A minimum expectation for review is monthly.
>
> HoNOS, clustering and risk assessments will be reviewed following incidents and/or changes in a patient's presentation and prior to transfer to other services or discharge from inpatient care. All incident reporting will follow Trust policy, procedures and guidelines."

193. In my experience, this guidance was followed. The accuracy of risk formulation was the responsibility of the MDT.

194. I would have had access to the risk and safety assessment quoted above. This was included on RIO. I cannot recall precisely when I would have read it, but I believe it would have been prior to the MDT meeting on 31 January 2022. I would have had regard to the comments in the risk assessment during the MDT discussions. The risk and safety assessment identified risks of physical harm to others, as well as damage to property.

VC also risked harm to himself, through the actions of other acting in self-defence, retaliation, or in attempts to restrain him.

195. Under the heading "Social Factors", the following information is recorded: "Valdo has always been very vague about his social circumstances. He appears to have given a false address to his care team following his last admission. University have since provided an accurate address. The risks associated with patients who have a history of disengagement from clinical services and provide false addresses, are that they may be more likely to disengage in the future, given the difficulty in respect of contacting them. It also potentially suggests a lack of insight into their underlying condition and desire for treatment, as it may present a potential obstacle to effective treatment. I have set out later in this statement my reasons for considering that VC had not in fact, given a false address".

196. If there is a suspicion that a patient might have given false address, the issue can be addressed by establishing the correct address which could done relatively easily by interagency working. The first step would be to check if the address in the records is the correct address and where that information was obtained from (whether it is the patient themselves, the carers, family or from documents such as the discharge summary). It would then be important to discuss this with the patient openly, make home visits, and if concerns over safety existed, then attend in pairs or obtain a S135 warrant. The information would need to be triangulated from GP records, student support or other sources. It might be necessary

to report the person as 'missing' to the police if the patient is not available at the given address, if there are serious concerns about their safety.

197. One could also request a safe and well check from police at the address. The aim is to establish contact with the patient so that an assessment could be carried out at the earliest opportunity to establish if the treatment plan can continue in the community or the patient need to be admitted to the ward.

198. The risks associated if the above process is not followed are that the patient can go for long periods without being assessed or treated and thereby posing risk of relapse and worsening of associated risks to self and others. It is imperative to establish contact with the patient regardless on whether they were on depot or CTO as the patient can still give false address and go AWOL if they are on a CTO.

199. I consider that the risk and safety assessment dated 28 January 2022 summarises the incidents that related to the relapse and previous admissions, but does not elaborate on the dynamic nature of risks. This would be how the presentation might change red flag signs that would indicate an escalation of risks, or how meeting some of the care needs might mitigate the risks from escalation. A strengths-based approach would also be useful. However, I do consider that the risk and safety assessment identifies the key risks posed by VC to himself, and others, when unwell.

Core Assessment, 28 January 2022

200. On 28 January 2022 a CT3 doctor completed a Core Assessment in respect of VC [NHFT0000186]. I saw this document, prior to the MDT meeting on 31 January 2022. This did not contain all the details of VC's previous treatment. I was aware that this document did not show the complete history prior to the MDT meeting, as it did not accord with VC's underlying medical records.

201. The Core Assessment did, however, provide a useful summary of why VC had been admitted at this time, which would have been taken into account in formulating his care plan during this admission. The information provided led to the further enquires being made from the university and the flatmate about what had occurred.

202. The subsequent discharge planning process was not reliant upon one document alone and certainly not fully reliant upon this document. VC's full medical history was well known (and elsewhere documented) at the time of discharge.

203. We arrived at discharge planning following several assessments, information fed into ward review meetings from MDT meetings and a suite of documents including progress notes. The Core Assessment, Risk and Safety Assessment and Summary & Care Plan are all under the 'Core Assessment forms' folder of RIO.

204. I note that that, within the Core Assessment [NHFT0000186], under the heading of History of Presenting Complaint it is recorded that: "VC is known with secondary mental health service with one previous admission

for a first episode psychosis. He is opened to the EIP and taking Aripiprazole."

205. More information about the VC's three previous admissions would have provided a more readily available summary of his presenting condition. However, I was aware of these previous admissions, and so the inclusion of more detail in this summary document would not have affected my approach to his care and discharge planning. Indeed, the other psychotic episodes were expressly discussed in the MDT on 31 January 2022. Previous admissions were discussed in the ward review on 3 February, as documented within the RIO notes. Further, on 10 February 2022, the ward review specifically records: "Dr Thangavelu explained that he had been in contact with his community consultant. They were concerned as its his 4th admission in 2 years" [NHFT 00000168, p.238]. Despite the inaccurate recording in the Core Assessment, I was fully aware of the correct position regarding previous admissions at the time of discharge planning.

206. It was also recorded within the Core Assessment [NHFT0000186] that the reviewing doctor's impression of VC' presentation was that:

> "Valdo declined to engage with any form of discussion, I met him sitting on the floor in the passage area of Cassidy suite in between the rooms. Wearing his hoodie which was put on and with his pair of eye glasses. He politely asked to be left alone. He also declined physical observations, physical examinations [...] He reports no physical health problems and declined any further questioning. He

was already appearing like someone who is becoming irritated by our presence and someone who could escalate any moment if we kept trying to engage him."

207. Under the heading "Mental State Examination" it was recorded;

> […] "He looked very unpredictable such that he may escalate at any time […] From the way he presented, he seemed like someone who is angry that he has been admitted into hospital and seemed not to fully appreciate his mental health difficulties and the associated risks. Based on this, I doubt if he has insight."

208. The fact that it was recorded that VC was becoming irritable, could, in my view, have been due to a number of factors. Often, patients are irritable at the point of admission and during the period of stay as it is an obviously restrictive environment, where they have been admitted against their wishes with no scope to leave the ward, sometimes for a prolonged period. This would have been a factor that would have considered by VC's MDT. Whilst irritability could be a sign of mental illness, this alone could not be interpreted as evidence for mental illness without understanding the context and holistic picture.

209. Throughout his admission, opinion regarding his insight was based on how he was presenting in his behaviour and mental state on the whole rather than based on any systematic assessment of one aspect such as thought, mood or perceptual disorders.

210. He was evidently upset about being admitted to hospital, despite his expressed intent to work with community team and agree a plan with the CRHT and the independent doctors who assessed him following the MHA assessment on 19 January 2022. However, when called to attend the MHA assessment on 28 January 2022, he willingly co-operated with transport to Highbury Hospital which resulted in detention under s.2 against his wishes.

211. The observation in respect of his irritability towards clinical staff at the time of his admission would have been given relatively little weight, given that his subsequent presentation on the ward did not include general irritability towards clinical staff. He was not causing any management concerns in the form of aggression, violence or hostility. There were no incidents reported to that effect during the entire period of admission. On one occasion a review nurse reported in the MDT on 14 February 2022 that he slammed the door when a nurse tried to do physical observations. No other details were mentioned or recorded about this. This behaviour was not repeated.

Insight

212. The assessment on insight, as documented by a CT3 doctor within the Core Assessment, was not drawn from a systematic assessment or mental state examination: it appears primarily based on the general observation that VC was irritable and declined to fully engage, due to being detained against his wishes, despite his agreement to work with care team in community. This was also acknowledged by the doctor who

commented "he seemed like someone who is angry that he has been admitted into hospital" and that based on his presentation he had "doubt if he has insight". [NHFT0000186 page 4]

213. It would be difficult to draw firm conclusions based on this. Over the following weeks, VC was able to express his views and engage in conversation about his mental health. He was able to discuss his abnormal experiences at the review on 3 February 2022 when he spoke about his past experience of hearing voices.

214. On 10 February 2022, at the ward review, he spoke about his experiences during his first episode and how anyone would have noticed how uncharacteristic his behaviour was. He also identified that a health professional would be able to say that this was a psychotic episode and that it was rational to admit him at the time. He did, however, consider that the later admissions were not rational.

215. At this time, I explained that we would want reassurance about his engagement and compliance, and that if he disengaged we would have to consider depot. We also sought reassurance that he would engage with CMHT upon discharge. VC stated that "it's a bit of an issues for me" but "it seems you to have to do, it so I'll play my part". [NHFT0000168, p.239]

216. On the same day, he informed staff that he was aware of his s.2 MHA rights, that he was not willing to appeal and was happy to continue with the current treatment. He also said he just wanted to get better and go back to his studies.

217. On each of the 3rd, 10th, 17th, 24th February, medications were discussed with VC as well as other treatment options. During this period, at no time did her refuse to take medications in the current format (Aripiprazole tablets) and explicitly expressed his wish to continue to take the tablets (as opposed to alternative medication). All of this demonstrated to me that he had reasonable levels of insight into the nature of his symptoms, disorder and treatment.

Specific Treatment

218. Non-concordance had been identified by both VC's community mental health team, and independent medical practitioner undertaking the MHA assessment on 28 January 2022. I carefully considered the treatment that would be appropriate to address both non-concordance, and the risks that VC might have posed to himself and others.

219. In light of this, to begin with, I explored with VC the details around the reported noncompliance, which he disputed. We explored any concerns over medications, side effects, choice of medications and alternatives. From the outset we considered the possibility of depot. Both Dr Gibson and I discussed the option of depot medication with VC on numerous occasions.

220. I psycho-educated him about the treatment options and advantages. He listened to the explanations, appeared to understand the information, and weighed up and communicated his preference, with capacity. He declined the offer of depot and gave the reason for not liking needles (which is a

common reason I hear from patients). Often there are other reasons too, such as patients finding it intrusive, humiliating, or they are worried about pain and side effects.

221. I weighted up the pros and cons of a forced depot injection against VC's wishes and forced blood and ECG monitoring, which I considered would be futile. I considered clinical evidence which highlights varying outcomes in this regard.

222. I also considered the possibility of a CTO but that was limited by the fact that he was detailed under s.2 MHA and did not meet the criteria for ongoing detention. As stated above, it would not be good practice to keep someone under detention to convert to a s.3 purely for the purposes of the imposition of a CTO.

223. I ensured that VC had a CPA care plan in place to mitigate the risks and to establish his willingness to engage with a care plan with close monitoring.

Forensic History

224. Under the section titled "Forensic History", this Core Assessment records that VC's forensic history is "*not known at this time but I do understand that police have been involved this time due to his mental health presentation*."

225. Following the MDT meeting on 31 January 2022, I suggested that we obtain the PNC checks. The process is completed by the ward nursing

team by putting a specific request form to the police. [NHFT0000168 at p.220].

226. It does not appear to show in records that this request was completed. However, I obtained the history surrounding the previous incidents from VC's records and discussions at reviews. This confirmed that VC did not have any convictions. I understood that the incident in 2020 was being dealt with as criminal damage. I also understood that the police were waiting for witness statements relating to the incident involving assault on the Police Officer in 2021. I did not understand there to be any other forensic history.

227. I did not have any direct correspondence from police related to any of the incidents from the past.

228. In the ward review on 3 February 2022, it was reported by his Care Co-Ordinator, ('CCO') that the Police would not share any information with her [NHFT0000168 at p.225].

229. A record in VC's notes from 18 January 2022 at 09:44 suggested that the police were unable to pass on information and that the matter was being escalated to the sergeant [NHFT0000168 at p.204].

230. As we wanted to get details about the incident, which was precipitant to the current admission, Dr Gibson called the flatmate for a firsthand collateral history. The details were made available on 4 February 2022 at 10:41, as recorded in RIO. [NHFT0000168 at p.228].

Summary and Care Plan, 28 January 2022

231. On 28 January 2022, a Summary and Care Plan in respect of VC was reviewed by a nurse [NHFT0000199]. It was further updated on 2 February 2022.

232. This document contains information regarding the events leading to the previous admission but does not give a narrative account, or a pen portrait to give full context of the presentation, risks and reason for current admission. As such, I do not think that this "Summary/Formulation" section of this document contains all the key information that should have been taken into account in formulating VC's care planning at the beginning of his Fourth Admission.

233. I do not know whether further information was sought from VC's CCO or the police. It is not documented that such information was sought.

234. I did not have any input to developing the care plan dated 28 January 2022. I believe this was completed when VC was at the Cassidy Suite. VC was admitted to Redwood 1 on 30 January 2022.

235. A subsequent care plan was completed on 14 February 2022, and it had input from my discussion in a Ward Review on 10 February and from other Ward Reviews and MDT meetings.

236. Under the heading "Diagnosis" it is recorded that VC's diagnosis was First Episode Psychosis. I believe that, at this time, VC's primary diagnosis

would have been Paranoid Schizophrenia, although a differential diagnosis of Acute and Transient Psychosis was also considered.

237. This entry was slightly misleading, however this was not taken into consideration in isolation. A holistic view of VC was formed, and I do not consider that this entry affected the overall treatment and care plan.

238. Under the question, "Are there any doubts about the patient's capacity to consent to any aspect of the care plan", the box marked "No" is checked. I do not know how VC's capacity was assessed at this stage, and I did not complete this assessment. It appears to have been completed by a Mental Health Nurse ('MHN'), Stephen Quatey.

239. It would appear that just prior to VC's Fourth Admission, VC was not exhibiting marked or persistent psychotic symptoms. During the MHA assessment on 28 January 2022, he does not appear to have displayed any symptoms of active psychosis. He had previously agreed to work with CRHT following the initial MHA assessment on 19 January 2022. He disagreed with the suggestion and need for admission but was agreeing to take medication as prescribed. There are no definitive indicators from the recorded information, prior to my assessment of VC, to suggest that he was not able to understand, retain, weigh-up and communicate the decision.

240. I first reviewed VC on 3 February 2022 during a Ward Review. At this time, I considered that he had capacity to participate in his care plan and plan for treatment. He indicated a willingness to continue with taking his

medication in the form of tablets; he felt it was easy to take tablets although he remarked that it was not making much difference to him. He was able to engage in discussions about using the gym, and that we would not immediately be able to attended for 1.5 hours (which was his preference) as he was on a section of the MHA. He agreed to accept the leave for 30 minutes initially.

Care Plan, 14 February 2022

241. On 14 February 2022, VC's Summary and Care Plan was updated [NHFT0000198]. I believe that this document took into account information from his past and current presentation in order to arrive at VC's care planning at that stage of his admission.

242. I consider that VC did have capacity to participate in his care plan and treatment during this later stage of his Fourth Admission. The question of capacity was considered throughout admission.

243. On 10 February during a Ward Review, (entered at 10:15), I explored with VC the issue of non-concordance in detail and, explained about medication options and depot. I had no reasons to suspect that he lacked capacity to make decisions on treatment choices at that time. He was not refusing treatment; he was only in disagreement with the route of administration. He explained that he was satisfied with the medications as it was (Aripiprazole tablets) and that when he changed it in the past, he experienced side effects. This was consistent with a previous account given to Dr Shelton on 19 January 2022. VC was still early on in his course

of illness and had tried Risperidone, Olanzapine and Haloperidol at different times. He had felt satisfied with the Aripiprazole.

244. At this time, I was aware of the comments that had been made by VC's community consultant, (as recorded at NHFT0000168, at p. 238) that there were concerns about this being VC's fourth admission. This information had come from an email dated, 3 February 2022, sent at 14:24, from Tuhina Lloyd Consultant Psychiatrist. The full text of this email reads [WITN0206011]:

> Hi Karthik, sorry to bombard you with emails today. I was just wondering how things were going with Valdo and his medication. As you know this will be his 4th admission and he is essentially becoming revolving door. Can we please consider a depot for him and possibly a CTO so that we don't end up back at square one with poor engagement and concordance at discharge. I appreciate that the situation isn't straight forward and he manages to conceal his symptoms well. However, his insight remains very poor according to Claudia and we really need a robust plan at the point of discharge. Many thanks, Tuhina

245. I responded to this on 8 February 2022, and stated "He was not keen on depot last time we spoke to him …but going to discuss Abilify in the next review" [WITN0206012]

246. I followed this up with a discussion about depot with VC on 10 February 2022, when I psycho-educated him about the advantages of depot,

expressed concerns from EIP team and explained that it would be the preferred option [NHFT0000168, p239]. VC remained persistent in his view that he would rather continue with the tablet form of Aripiprazole and did not want the injectable form.

247. His CPN was also present at this meeting. I was in agreement with the suggestion of depot although the question of a CTO could only be applied if he were to meet the criteria for continued detention under a s.3 MHA.

248. VC agreed to continue to take tablets as he was taking in the ward and agreed to engage with EIP team for close monitoring after discharge (even if it had to be weekly). I felt I could not justify giving depot under physical restraint taking into consideration his anxieties about the needles and his wishes. This would also mean that we would have to restrain him separately to take bloods and perform an ECG.

249. After deliberations we swayed towards giving him another chance on oral medications. I made it very clear that if he relapses again then a depot will have to be given as evidenced by the documentation under treatment plan.

250. It is documented in the ward review notes at [NHFT0000168, at p. 238]:

> "Dr Thangavelu explained that the other option was a depot which would be an injectable medication once a month. It was Explained that to him that he wouldn't have to think about taking tablets every day and that they were just as effective as they gets slowly released. It was explained that this may be a better options than the tablets and

would minimise confusion around remembering to take tablets and minimise likelihood of symptoms restarting. VC said 'no' to starting a depot. He said that he was satisfied with the mediations as it is, he has been on it for a while. He said that when he had changed medications in the past, he had experiences side effects. It was explained that the depot would be the same medication. VC expressed again wished to stay on the tablets rather than the depot.

It was explained that upon discharge, he will be followed up by the community mental health team.

It was explained that we want reassurance that he will engage with C and her team upon discharge. It was explained that we have a duty of care to give him right treatment and we have to consider the depot if he does not engage with the team. It was explained that this engagement initially may be weekly contact. When asked how he feels about this he said it's a 'bit of a issue for me' but 'it seems that you have to do it so I'll play my part'.

It was explained that there were certain thing that he will have to do as we have a duty of care towards him." (sic).

251. My view, from the detailed discussion I had with him, is that he had capacity to make an informed decision about the treatment options that were made available to him. He had an understanding and acceptance of the consequences of his decision. I felt reassured that he was able to take

in the various pieces of information provided, retain them long enough to weigh them up, and then communicate a decision.

252. At paragraph 2.10, the Code of Practice notes:

> 'Everybody has their own values, beliefs, preferences and attitudes. A person should not be assumed to lack the capacity to make a decision just because other people think their decision is unwise. This applies even if family, friends, healthcare or social care staff are unhappy with a decision'.

253. Later that day, within VC's RIO notes, it is recorded at 19:50 that VC was read his s.2 MHA rights and was aware of these. He did not want to appeal against his section, and happy to continue with the treatment plan (as discussed earlier in day). It was noted that he "demonstrated capacity throughout". [NHFT0000168, at p.241]

254. On 14 February 2022, the Summary Care Plan was completed. [NHFT0000198] This contains a Pen Portrait. A Pen Portrait is a well-known method for telling the narrative story of a patient, including their life history, their experiences, likes and dislikes, to aid a holistic understanding of the individual. It is written in collaboration with the patient. This document supports the assessment of the Redwood 1 in-patient team as there were no doubts about the patient's capacity to consent to any aspect of the care plan (as noted within this document).

<u>1 February 2022 email</u>

255. On 1 February 2022, an email was circulated to VCs MDT by one of NHFT's Mental Health Legislation Caseworkers [NHFT0000287]. The Caseworker asked a number of clinicians, including myself, to "*liaise with Valdo and ascertain if they are happy/has capacity for me to write to their nearest relative, Celeste Calocane about their detention under Section 2 of the MHA 1983?*"

256. A response was circulated by an ST5 Doctor Gibson which stated, "From my conversation with him yesterday, he didn't want his family involved at all and appeared to have capacity to make that decision. I'm not sure if anyone has gone over specific nearest relative things yet though?" [NHFT0000287]

257. My understanding was that the case worker in the MHA office team would write to the family member regarding their rights under the MHA. The staff member reading the rights to the patient would inform them of the rights that the patient and their nearest relative have under the Act. This included the right to appeal against the section and the right of the nearest relative to ask for discharge from the section which would trigger a decision-making process within 72 hours either to discharge or bar the request. The patient would be asked for their consent to inform the nearest relative of this and also get contact details of the nearest relative if that was not available.

258. When asking a patient whether family can be informed about their mental health treatment, their rights should be explained to them, they should be told what information can be shared with the nearest relative e.g.

admission, treatment plan, rights under the Act, and asked if they would be happy for the staff member to share some or all of that information with the nearest relative.

259. Capacity to make this decision is assessed in the usual way of checking if the patient understands the information provided, if they retain that and weigh up that information in order to arrive at a decision and communicate that decision. For example, a patient may refuse to give consent to share the information with the nearest relative for genuine reasons such as not wanting to cause any distress to them or for privacy as opposed to a refusal driven by persecutory delusions about the nearest relative or in response to a hallucination, in which case the capacity might have been compromised.

260. I was aware of previous contacts with VC's nearest relative as was documented within his medical notes. I considered that VC appeared to have capacity to withdraw consent to this. This accorded with the assessment of the ST5 doctor.

261. In light of the guidance contained within Chapter 10 of the Code of Conduct, "Confidentiality and information sharing", I considered that there was an overriding public interest in disclosing information about VC's admission to his nearest relative.

262. VC had historically felt that professionals contacting his mother caused her stress and had insisted that we rather not contact her.

263. He had declined to give consent to contact his family when he was assessed on 30 January 2022 and also when seen by Dr Gibson on 31 January 2022.

264. However, I decided to over-ride the confidentiality clause (based on public interest and risk history) and decided to make contact with the nearest relative. This risk history included VC's non-concordance, disengagement and aggression.

265. We contacted VC's mother on 2 February 2022 for collateral history and feedback. This was documented in his records from that day and discussed at the ward review meeting on 3 February 2022. [NHFT0000168, at p.253]

266. It was recorded by Dr Gibson on 2 February 2022 [NHFT0000168, at p.223] that "VC seemed normal to his parents until they heard about the incident [...] To them he doesn't seem unwell at the moment. [...] She also expressed some frustration about our lack of ability to share information based on confidentiality, but accepted explanations".

Clinical reviews

267. On 3 February 2022, notes in respect of a ward review were entered into VC's medical record [NHFT0000168 at pp.224-225]. This includes some information shared by VC's CCO that "police couldn't share any further information with Claudia."

268. My understanding of this at the time was that the information sought was related to incident relating to VC's flatmate as set out in the RIO entry on 18 January 2022, at 9:3t (sic). The only information I could find relating to the contact between the EIP team and police relating to this was a RIO entry on 18 January 2022 at 09:44. I had suggested that we obtain the PNC check but it does not appear that it was completed or returned. [NHFT0000168, at p.204]

269. The reason for seeking this information was simply that it was another source of information about VC's presentation and behaviour, shortly before his fourth admission.

270. On 3 February 2022, I reviewed VC. A note of this is at [NHFT0000168 at pp.224-225]. Under the heading "MSE" (Mental State Examination), it was recorded:

> "VC was wearing a black coat with his hood up. There was minimal eye contact and he had relatively closed body language. His speech was slightly monotone but normal rate and rhythm. He was not noticed to respond to any unknown stimuli and denied any hallucinations or delusions. There [is] some evidence of persecutory themes in terms of his thoughts and trust towards professional organisations."

271. The ward review on this date involved the usual format of multidisciplinary team providing feedback about history and presentation followed by assessment of mental state, risks, and treatment, plan including discussion about medications and leave plan.

272. In the initial feedback, we took into account the suggestion from the community team about the possibility of depot as an alternative to oral medication and discussed this further with VC.

273. I was able to gather from his records and feedback that he is generally a very reserved person, quiet and not particularly communicative or social, tending to keep himself to himself. In addition, he was aggrieved by the admission to hospital against his wishes. He had previously expressed a wish not to be admitted and for a less restrictive approach. I therefore understood his presentation on 3 February to be at least partly explained by his discontent with admission.

274. With regard to his mental state, there were no signs of positive symptoms of psychosis such as delusions, overvalued ideas or hallucinations, nor was there any feedback from nursing observations to suggest that. Though he had expressed persecutory ideas about professionals in the past he denied any such symptoms.

275. I noted that he preferred not to talk about what he saw as his personal matters relating to academic performance, finances and housing.

276. He expressed his grievance towards professionals deciding to bring him into hospital despite an agreement with them for home treatment which he said he followed but still ended up in hospital. My opinion was that there was a running theme whereby every time professionals escalated their concerns resulting in admission against his wishes, he was losing trust in them. He had made it clear in his personalised relapse prevention

care plan from January 2021 that he would prefer less restrictive approach and found admissions to be 'awful'. [NHFT0000168 at p. 198]

277. It appeared to me that was a vicious cycle, whereby with every relapse the threshold to take more coercive approaches, including admissions and police involvement, was becoming lower. This was starting to cause strain in professional therapeutic relationships.

278. The concern over paranoia was not present when we explored it at the ward review on this date.

279. His guarded presentation appeared to relate to his grievance about being admitted despite his willingness to engage with professionals in the community. Often patients associate agencies with power to curtail their liberty as colluding with each other which can develop into persecutory themes.

280. We discussed medications and shared concerns about compliance and choice of medication. My view was that he was ambivalent towards the medication he was currently taking, but nevertheless agreed to continue to take it. When we discussed the option of tablets versus depot, he expressed his preference for tablets over depot saying he disliked needles and that it was much easier to take tablets and gave his assent.

281. He was able to discuss his stress over his university course and his study plans. He discussed his accommodation and need for therapeutic leave to attend the gym.

282. Throughout my discussions with VC on this date, I did not have any reasons to believe that he lacked capacity to make decisions with regards to his care and treatment.

283. In respect of insight, my view at the time was that VC's insight was partial. He was able to acknowledge the symptoms he has experienced historically (hallucinations and persecutory ideas) and the need for treatment in the form of medications. He was not, however, convinced about the effectiveness of medication. He was accommodative of the ongoing need for input from mental health services and did not decline input from the EIP team. As it was the first Ward Review following admission, much time went towards active listening in respect of his grievance regarding how the police did not pursue the matter relating to the incident at the flat, that he had agreed to work with the community plan but yet was admitted to hospital against his wishes.

284. We considered that whilst he had not been forthcoming or engaged with the resident doctor who tried to clerk him in 28 January 2022, he was more communicative and engaged with us during this discussion, and was able to express his views.

Risks

285. My assessment of the key risks associated with VC at this stage, were the same as at the MDT discussion on 31 January 2022, which was three days earlier. Likewise, my understanding was that VC's presentation was in keeping with a diagnosis of Paranoid Schizophrenia, though there were

some features which were suggestive of an acute and transient psychosis with schizophrenia-like symptoms.

Treatment

286. At this stage, we agreed to continue with the current medication that VC had been taking.

287. My approach to treatment was at that time (and remains) underpinned by adopting a bio-psycho-social approach. The principle of risk management is not to look at risks in isolation but to understand them from a multidimensional perspective (diagnosis, psychological and social factors) and to address the treatment and risk management based on holistic assessment of care needs.

288. The key components of his treatment plan which I put in place were:

a. Treatment of mental illness with medications in keeping with principles of good clinical practice and guidelines. I explored the option of depot with VC but we arrived at a joint decision on choice of anti-psychotic medication, based on patient preference, tolerability, effectiveness and past experiences.

b. Continued psychoeducation regarding illness, treatment options and medications to improve insight and engagement.

c. Ensuring his care needs were addressed. VC lost the tenancy at the accommodation where he was staying prior to admission but found

alternative accommodation. We ensured that the details were shared for follow up visits.

d. Keeping the University Student support team informed.

e. Consideration of a collateral history from VC's mother.

f. Consideration of history about the incident with the flatmates by contacting them directly.

g. Involving home treatment / In-reach team in discharge planning and statutory 3-day follow-up review.

h. Testing therapeutic leave to community in incremental steps.

i. Supporting continuation of his care in community under a CPA pathway with the EIP team with input from CPN/ CCO and a Consultant Psychiatrist.

j. Working within the framework of Code of Practice.

289. As VC's primary diagnosis was considered to be Paranoid Schizophrenia, the mainstay pharmacological treatment is anti-psychotic medication. The nature of the condition of Paranoid Schizophrenia is one of relapses and remissions. There are a number of reasons for relapse. Medication non-adherence is one of the common cause for relapse, though not the sole cause.

290. In VCs case, he had identified psychological stress as a factor that may have contributed to having triggered his first episode of mental illness (as

per his Personal Relapse Prevention Plan from 18 January 2021). [NHFT0002533]

291. Throughout the admission period, as well as at his MHA assessments prior to admission on both 19 January 2022 and 28 January 2022, VC had maintained his stance that he was currently taking his medications. Historically he had admitted stopping medications when asked by professionals at the time.

292. VC was commenced on anti-psychotic medication Aripiprazole at 20mg dose which is an effective therapeutic dose for the treatment of psychosis. He was compliant with the medication throughout the period of admission and was not showing any signs of psychotic symptoms, including delusions of any form, first rank symptoms of psychosis or hallucinations both from subjective accounts and objective mental state examination. There was no clear record of him experiencing any psychotic symptoms during the period from November 2021.

293. I explained the importance of adherence to anti-psychotic medication in every Ward Review, and frequently offered the option of depot to him as well as providing psychoeducation about the importance of compliance with treatment plan.

294. We did not have formal psychology input for psychosis in our ward during the period and could not pursue this.

295. We engaged VC in OT activities. His preference was for attending the gym.

Medication choice

296. There are a number of matters to be taken into account in approaching treatment with anti-psychotic medications.

297. Anti-psychotic medications are effective in reducing the symptoms of psychosis in the acute phase and there is good evidence to show that anti-psychotic maintenance treatment reduces relapse risk in patients with Schizophrenia. However, the major caveat is that most of the studies were carried out only for up to two years of follow up, and the data on the long term is sparse. This has been highlighted in much academic literature. [WITN0206013]

298. The British Association of Psychopharmacology guidelines BAP, (Barnes et al 2019) [WITN0206010] states:

> "… despite the common use of continuing antipsychotic medication in clinical practice, relapse rates remain relatively high. Although the majority of people starting antipsychotic medication for the first time will experience remission of symptoms within 3 months or so, a third or more of these patients will suffer a relapse of their illness in the first year to 18 months, and around 80% within 5 years. Unfortunately, attempts to identify reliable clinical predictors of relapse or continuing remission among individuals who are prescribed continuing antipsychotic treatment have had only limited success"

299. In VCs case there was a clear parallel pattern that had emerged whereby he was experiencing relapse under psycho-social stress. This has been

documented throughout. His first episode was when he was 30 years old and the main precipitant was significant stressors in the form of pressure of exams, having to maintain employment and sleep disturbance, he was doing night shifts in a warehouse at times and was managing his studies and exams, he identified this as the main trigger for relapse. This has been well captured in an entry from 8 August 2020 by CPN Patrick Crolla, who explained the Stress Diathesis model to him [NHFT0000168, p126]. During the first MHA assessment on 24 May 2024 this has been documented, as it was in his relapse prevention plan from 18 January 2021.

Depot versus oral antipsychotics

300. There is substantial body of evidence to say that depot injections reduce relapse rates. It is one of the approaches to tacking non-adherence.

301. One of the challenges is that depot medications do not completely prevent non-compliance or relapse. The patient can still refuse to take the medication or the medication may not be effective.

302. Relapse rates in patients provided depot are also reported to be up to 40% during the 10-24 month period of follow up (Kane et al 1998) [WITN0206003]. In terms of clinical efficacy between depot and oral antipsychotics , meta-analysis of RCTS (highest possible level of evidence) did not find a difference (Kirson et al 2013) [WITN0206002].

303. The NICE Guideline for Psychosis and Schizophrenia CG178, 2025 at 1.5.6 states [NHSE0000539]:

When initiating depot/long-acting injectable antipsychotic medication:

- take into account the service user's preferences and attitudes towards the mode of administration (regular intramuscular injections) and organisational procedures (for example, home visits and location of clinics)

304. The NICE guidelines on improving adherence CG76 2024 [WITN0206009] states:

> Intentional non-adherence occurs when the patient decides not to follow the treatment recommendations. This is best understood in terms of the beliefs and preferences that influence the person's perceptions of the treatment and their motivation to start and continue with it. It follows that to understand adherence to treatment we need to consider the factors (for example, beliefs and preferences) that influence motivation to start and continue with treatment, as well as the practical factors that influence patients' ability to adhere to the agreed treatment.
>
> Applying this approach in practice requires:
>
> - a frank and open approach which recognises that non-adherence may be the norm and takes a no blame approach, encouraging patients to discuss non-adherence and any doubts or concerns they have about treatment
>
> - a patient-centred approach that encourages informed adherence

- identification of specific perceptual and practical barriers to adherence for each individual, both at the time of prescribing and during regular review, because perceptions, practical problems and adherence may change over time

305. The British Association of Psychopharmacology BAP guidelines for treatment Schizophrenia 2019 [WITN0206010] remarks:

> Overall, it seems very plausible that in early illness, depot/LAIs prevent relapse better than oral formulations but limitations in study design and heterogeneity in samples and outcomes (Kishi et al., 2016) preclude a confident assessment of their place in therapy. A meta-analysis by Kishimoto 2012 also draws the same conclusion. Similar discrepancies were raised in a meta-analysis particularly when RCTs comparing LAIs and oral antipsychotics as opposed to observational studies (Kirson et al 2013, [WITN0206002])

S17 leave

306. The Ward Review from 3 February 2025 records that VC told the MDT clinicians that he would like to make use of his s.17 leave so that he could go to the gym. The note records that VC was granted unescorted leave twice a day [NHFT0000168 at pp.224-225]. On the same day, at 18:50, a note states that a nurse had received a phone call from the University of Nottingham Student Services as VC had been seen by one of the students who he had held hostage in/around the shared accommodation [NHFT0000168 at p.227]. A doctor questioned VC about his attendance

at his old accommodation the next day, and VC denied that he had gone to his old accommodation [NHFT0000168 at p.228 on 4 February 2022 at 10:39]. The doctor considered that VC did not adhere to his leave requirement and VC's leave was restricted as a result

307. My impression of this was that when the subject was broached initially, VC was fearful to admit the truth. It was highly likely that he would have been worried about the consequences of further restrictions.

308. His leave was restricted until 7 February 2022 when his presentation was discussed in the MDT. [NHFT0000168 at p.233] As he had been open about his reasons for wanting to have further leave (to attend gym and wanting to hand over the keys, this information about wanting to hand over keys is documented from nursing feedback at the MDT on 7 Feb 2022) his leave was reinstated to "30 minutes of unescorted leave and escorted leaving to the gym", meaning that he could go into the community for up to 30 minutes without a member of staff accompanying, and could go the gym with a member of staff. [NHFT0000168 at p.233] He was complaint with the leave plan from that point onwards.

309. At the following ward review on 10 February 2022, VC was more open in discussing what he did with the leave. He went to hand in his keys and spent only 10 minutes there, and returned straight back in a taxi. He said that he did not see his flatmates during that time. He did not express any aggression or hostile thoughts towards anyone. It did not appear that he went to the accommodation seeking someone, he did not abscond and returned back on own accord.

Nottingham University information

310. On 4 February 2022, a junior doctor gathered further information about VC's history from staff at the University of Nottingham's Mental Health Services [NHFT0000168 at p.228]. The staff member highlighted that VC had been disengaged from his university work and she considered that "this pattern of behaviour had been typical during episodes of mental illness for him in the past."

311. Information was also obtained from one of VC's flatmates named "Chris". Chris stated that VC had assaulted him by "throwing a punch at him" on 18 January 2022. The note from this communication further records the following information:

> "Chris explained there had been some concerns about Valdo's presentation for about month. Short screams were heard intermittently from his room, which were thought to be him. He also reportedly entered another flatmate's bedroom in the middle of the night and asked "can you hear that screaming" (referring to a different scream, potentially hallucinatory)."

312. This information supported my view that VC's mental health was affected by his circumstances, and the underlying psychosis had the propensity to worsen under significant mental strain.

313. VC had identified the stress of university studies as a potential contributor towards the worsening of his mental state. He had also identified lack of

sleep as one of the stressors before his first admission. I understood this through the well-known 'Stress Diathesis' model of Schizophrenia

314. VC was a fourth year Masters student in engineering and was also managing a full-time job in a warehouse. Understandably this would have been a highly difficult set of circumstances. There are notes in his records that he had been spending long periods of time in the library, was time pressured with submissions and was also facing exams. During this period of stay on the Ward he expressed how important his studies were to him and that he wanted to get better and get back to studying so he could finish University and start employment. I considered that a prolonged in-patient stay might inadvertently impact on his mental wellbeing further as he had repeatedly identified his university course and studies as a major stressor for relapse.

315. At the Ward Review on 3 February 2022 [NHFT0000168 at p.226] VC denied any symptoms and, stated that "last time he had heard voices was a long time ago maybe over a year ago."

316. My impression from the above information was that under the set of stressful circumstances (pressure of course work, exams, employment, sleep deprivation) he might have experienced brief hallucinatory experiences. However, these, if they were present, did not appear to be persistent as they were not evidenced through any assessments. VC had been under regular observations during this fourth admission, and no hallucinatory symptoms had been noted. There were also no records of hallucinatory symptoms, following his discharge in October 2021 with no

ongoing symptoms. As such, the information from the flatmate was therefore somewhat inconclusive.

317. I could not come to a definitive conclusion at the time that there were ongoing hallucinatory experiences. VC consistently denied any current hallucinations and was not noted to be responding to any unseen stimuli by any of the staff members despite being on observations very regularly. His flatmate's feedback was not exactly clear on when exactly these incidents happened other than to say in the past month. My impression was that he might have had fleeting hallucinatory experience possibly weeks or months prior to admission but they seemed to have been remitted by the time he was admitted to Redwood 1.

318. The incident of aggression towards a flatmate was explored through a phone call with the flatmate. Chris explained there had been a running dispute about large amounts of hair being left in the shower (apparently VC's) along with other "hygiene issues" (which were recorded as being "vague"). Chris had repeatedly asked VC to clean the shower and VC had refused. Chris confronted VC about it and Valdo again refused, saying "what are you going to do about it?". Chris advised he (Chris) "started mouthing off" and said something along the lines of "I'll call you a dirty bastard". VC reportedly responded to this by throwing a punch and wrestling ensued for a short period. Police were called but VC refused to let the flatmate leave. [NHFT0000168 p.228] When we explored this with VC, he maintained that it was an altercation and the reason he refused to let Chris leave was because he wanted Chris to be present until the Police

came and that he did not know that it was illegal to refuse to let Chris leave.

319. My opinion at the time was that the incident with flatmate was not driven out of psychosis. There did not appear to be any paranoia nor persecutory ideas expressed towards the flatmate in that context. The altercation was not in response to hallucinations or other delusions or affective symptoms. The police had already decided not to pursue this and VC had handed in his keys and agreed to find alternative accommodation so the risks were mitigated.

320. It is of course possible that VC was not truthful, both with regard to his previous and current symptoms, and sought to conceal symptoms during every attempt by mental health professionals to elicit them throughout the period of admittance. However, the lack of any such objective evidence during the entire period of admission to hospital did not in my opinion, support such a conclusion.

7 February 2022 MDT Meeting

321. There was an MDT meeting on 7 February 2022 which I led jointly with the ward manager. [NHFT0000168 at p.223]. This meeting lasted approximately 10 minutes (as all such meeting do).

322. I did not review VC's mental state and capacity prior to this meeting. Patient assessment happens in ward reviews that were held on Thursdays. I had last reviewed VC on 3 February 2022.

323. From my recollection based on the records, I discussed the details about the incident with the flatmate prior to admission as we had obtained this collateral history. I also discussed the leave plan as I was aware that VC's leave had been stopped since the reported incident of him visiting the flat. The staff nurse present provided feedback about his general presentation and the discussion with VC about leave.

324. We discussed observation levels and it was decided to step down the observations to 30 minutes as there were no acute concerns to justify 10-minute observations any longer.

325. My observation was that VC was engaging with Staff Nurse Fanuel Shoko well, and had an open and honest discussion which was an improvement from the initial refusal to talk to the duty doctor on day of admission. The incident with the flatmate did not appear to be related to mental illness but rather occurred in the context of keeping the shared bathroom tidy in student accommodation.

1:1 review, 8 February 2022

326. On 8 February 2022 VC's medical records note a 1:1 review with a nurse [NHFT0000168 at p.234]. The note states that VC told the nurse that he did not want to engage with therapeutic activities or staff "as he did not agree with the admission and the reasons why he is here. He said that he did not believe that he had a mental health issue and that he was going to engage as minimally as he could."

327. On 14 February 2022 [NHFT0000168 at p.245] VC is noted to have "declined a copy of his care plan and refused to engage."

328. VC expressed his discontent throughout the fourth admission over the fact he had been admitted to a psychiatric hospital again despite his willingness to engage with community treatment.

329. He discussed this view in a number of meetings. Following the MHA assessment on 19 January 2022, VC had agreed to engage with CRHT. He only missed one of the appointments out of nine but despite his efforts he felt the mental health services reneged upon the agreement he had with them and decided to admit him under a section in psychiatric hospital. Following his first episode in 2020 he had expressed his wish to not be admitted but for the least restrictive approach to be taken.

330. His view was that ever since the first admission (which he considered to be rational) the mental health services had been too quick to decide on admitting him which he described as "unnecessary" and "awful".

331. My understanding from this 1:1 on 8 February was that he did not feel that there were reasons for the fourth admission on mental health grounds.

332. He remained ambivalent about accepting his mental illness fully, but was more accepting of the severity of his symptoms during his first admission.

333. At the time, I felt that ongoing work was required to improve his insight and engagement working collaboratively with the EIP team following discharge. This was very much within the ethos of the EIP model of

working. Young men with psychosis often find it difficult to come to terms with accepting a diagnosis such as Schizophrenia, and the need for coerced treatments. This is not uncommon in patients open to EIP teams but in psychiatry general. It will often take a sustained patient-centered effort to psychoeducate and improve insight which in turn can help with adherence to a treatment plan.

334. I felt that taking a further coercive approach in the form of forced depot medication or CTO when there were no grounds for continued detention would only make VC further lose trust in mental health services. In keeping with the principles of the least restrictive approach, particularly when VC was willing to engage with CCO and OPA and continue with the medications he was on. The actions taken in line with the least restrictive approach included not enforcing depot under restraint and not proceeding to section 3 and CTO.

VC's demeanour

335. During VC's Fourth Admission, observations recorded by nursing staff repeatedly noted that VC is "guarded on approach/interaction" and often declined engagement with staff which could make it difficult to assess his mental state. [NHFT0000168 at p.234]

336. VC's premorbid personality was frequently described as being quiet, introverted and reserved. He did not have many friends and generally kept himself to himself. This, combined with his grievance over his admission against his wishes, meant that he continued to remain upset during the

period of admission. He was losing trust with mental health services over his perception that an overly cautious approach had been taken in admitting him too soon. However, he did engage in more detailed discussions at the Ward Reviews including talking about his symptoms and experiences from the past.

337. His mental state examinations were primarily recorded in Ward Review entries and some nursing sessions.

14 February 2022 MDT meeting

338. An MDT meeting took place on 14 February 2022 [NHFT0000168 at p.246]. A note of that meeting records:

> "He has been quiet on the ward, not engaging. He slammed the door in one of the nurses face when trying to do physical observations. He doesn't want to appeal his section, he just wants to get better and return to his studies. Declined OT engagement this morning. CPN previously has said that he had been less hostile previously. He sees mental health services as intrusive and doesn't want to engage with services. Discussion around CTO to keep him engaged with services due to risk of deterioration. Provisional discharge date for the 24th [of] February.
>
> Both VC and his flatmates have given both sides of the incident that happened prior to admission. VC admitted that in the first episode he was unwell but he didn't see any reasons for his further admissions."

339. VC was on 30-minute observations at this time, which meant that a staff nurse would check on him every 30 minutes by opening his door hatch or the door.

340. We were aware that he was trying to also keep up with the university work during this period of his stay. He asked for permission to have a study desk in his room which we facilitated. Whilst I did not explore the reason for his behaviour directly with him, my hypothesis is that he might have found the frequent interruptions intrusive, so rudely shut the door.

341. This was not reported as a serious incident that required incident reporting for any harm caused or anyone being hurt. Sadly, such incidents are not uncommon in acute in-patient settings. This incident was not repeated and there were no other incidents of hostility, aggression or violence towards other patients or staff anytime during the fourth admission.

342. The reference to "both sides of the incident" relating to the incident with Chris, were VC's version as he described in the ward review on 3 February 2022 and Chris' version of incidents as recorded within the RIO notes. VC did not give any details about the reason for altercation, or answer the question directly about the reasons for altercations. My recollection was that he only spoke about the police not pursuing it and police saying it should have been dealt with by security. [NHFT0000168 at p.225]

343. VC's CPN had previously informed the MDT that VC did not want to engage with services, and found mental health services intrusive.

344. However, during the period of stay on the Ward, VC expressed a willingness to engage with the EIP team. We repeatedly emphasised in Ward Reviews the importance of this to prevent future relapses and prevent re-admission.

345. In the Ward Review entry from 10 February 2022, [NHFT0000168 at p.238] it is recorded that:

> It was explained that we want reassurance that he will engage with Claudia and her team upon discharge. It was explained that we have a duty of care to give him right treatment and we have to consider the depot if he does not engage with the team. It was explained that this engagement initially may be weekly contact. When asked how he feels about this he said it's a 'bit of a issue for me' but 'it seems that you have to do it so I'll play my part'. It was explained to VC the importance of being open and honest and proving the LMHT with the right address.

346. The Ward Review entry from 17 February 2022 [NHFT0000168 at p.250] records:

> The importance of engaging with the community team was emphasised in order to prevent further admissions to hospital. He is happy to engage with the community team.

347. At the discharge meeting on 24 February 2022, VC agreed to meet with the CCO for statutory follow up at the Stonebridge Centre on 25 February 2022.

348. I had explored the potential reasons for his disengagement and discussed with him at the Ward Review on 10 February 2022. The evidence given for disengagement was, the deteriorating relationship with his CCO, information regarding missing appointments with his consultant and giving a false address(which he disputed), and potential non-concordance.

Relationship with CCO

349. Since the previous admission, VC explained during our meetings that he felt aggrieved by the EIP team having a low threshold to admit him to hospital when he felt it was not necessary and despite his willingness to engage with a treatment plan and taking medications. During the fourth admission I tried my best to explain the duty of care professionals held towards providing him with the right treatment and care. I also tried to gain his trust and confidence by adopting the least restrictive approach and enabling treatment in the community which he was willing to co-operate with. I had hoped that this would improve his relationship and trust with professionals so the adherence with the treatment plan would also improve.

Addresses

350. With regard to the concerns that VC had missed appointments with his consultant and had given a false address, I explored this issue, in detail, with him during the Ward Review on 10 February 2022. I also did my own research to establish the veracity of his claims that he did not give false address.

351. When I looked through the records, there was evidence to suggest that VC's explanation was right in that hospital staff were informed of the correct address as early as 3 November 2021 (as per the entry by bed the management team) but the address in VC's records was not updated until 18 January 2022. [NHFT0000168 p.204] I therefore felt it was quite possible that there was some miscommunication and that the appointment letters were not being sent to the correct address. Further, I felt that the two home visits that were attempted with outcome as DNA may not have been due to VC's deliberate falsifying of information. I ensured that VC provided the correct current address which he did.

352. It is important to note that the ways in which clinicians communicate appointments to patients varies between out-patient and CPNs/CCOs teams. Where appointments are set by out-patient teams, letters are sent to the patient's address. They will also receive text reminders where they have opted-in to this service. Where appointments are organised by CPNs, they often call the patient or text them directly.

353. On 22 October 2021, a nurse, Abi Parsonage, rang Priory Arnold and was told that VC had been discharged that morning. Ms Parsonage was provided with the address of 278 Queens Road, Beeston NG92BD ("Beeston address"), recorded in [NHFT0000168, p.194].

354. There is an entry on 3 November 2021, 15:43, at [NHFT0000168, p.196], which states that the discharge address was the address at 15 Maddison Court, Nottingham, NG72EG ("Maddison Court address"). NHFT staff

were therefore informed of the correct address from this date, as this was in his discharge summary from The Priory Arnold.

355. However, in the period between 22 October 2021 and 18 January 2022, VC was offered a series of appointments which were marked as DNA (did not attend). This is possibly because the letters were sent to the wrong address. There is an entry on 6 January 2022, 15:30 which confirms that the team were attending the incorrect Beeston address. [NHFT0000168, p.202]. During this period, the following appointments were made (and presumably letters sent) to the Beeston address:

a. 8 November 2021 – Appointment with Dr TL at Stonebridge Centre. Result: DNA.

b. 15 November 2021 – Appointment with Dr TL at Stonebridge Centre. Result: DNA.

c. 29 November 2021 – Appointment with Dr TL at Stonebridge Centre. Result: DNA.

d. 6 December 2021 – Appointment with Dr TL via home visit. Result: DNA (Dr TL attended).

e. 6 January 2022 – Appointment with Dr TL via home visit. Result: DNA (Dr TL and CB attended).

f. 10 January 2022 - Appointment with Dr TL at Stonebridge Centre. Result: DNA.

g. 17 January 2022 - Appointment with Dr TL at Stonebridge Centre. Result: DNA.

356. Presumably the Beeston address was added to his records, and remained until 18 January 2022, 11:32, as entered by Abi Parsonage following an email from City South EIP, recorded at [NHFT0000168, p.204], when staff spotted this entry, and amended the Maddison Court address.

357. On 10 February 2022, I enquired with VC about him giving a false address to EIP team, at [NHFT0000168, p.239]. He refuted this and said that before his discharge from the Priory Ward in October 2021, he had identified accommodation in Beeston to which he was meant to be discharged. I later found out the exact address was the Beeston address. VC stated that the landlord changed his mind close to the discharge date, and hence he was discharged to a different address, the Maddison Court address.

358. He stated that he did not falsify the addresses. When I looked on RIO, the trail of events as set out above, supported his claim.

359. From my recollection, when VC disputed the allegation by the CPN of giving false address, he said that few days before the last discharge from The Priory hospital the landlord had changed their mind so he could not go to the address he was initially meant to go and hence there was a miscommunication from the ward rather than him giving a false address. I checked his notes as he was speaking and it appeared that there was a confusion between the address where the EIP team had been going to

see him (recorded entries said they went to address in Beeston) whereas the demographic sheet on the front page clearly said Maddison Court (which is not in Beeston). I knew this as I knew the area well. I saw a couple of entries that suggested that he was probably correct and was not lying.

360. This made me think that perhaps he was not deliberately giving a false address, but the team might have not paid attention to the change of address which was not communicated between them clearly. The notes said the CPN and community consultant went to an address in Beeston. [NHFT0000168 p.199 & 202] This address was recorded in his notes by a different CPN just before his discharge from the Priory based on what the ward told her. However, the ward discharged him to the Maddison Court address which was communicated through the discharge summary. The entry from bed management team also reflects this. The team only realised later after it was mentioned by University Student Support. I did not see any evidence of him foul playing from my quick glance through the records at the time.

Non-concordance

361. The third potential reason for disengagement was non-concordance. VC had disagreed with the allegation of non-concordance throughout his fourth admission. Again, when I tried to look for exact information on this by looking at the drug dispensing chart, it was evident that he was accepting his medication in the ward as well as collecting them on time. At this time, he was concordant with his medication.

362. The forensic risks were considered. VC had no convictions but the incident from 2020 was dealt with as criminal damage and the incident involving the police assault was still being investigated. There were no other pending charges as far as we were aware.

363. I fully acknowledged the risk of disengagement and the risk of relapse and associated risks. The risk mitigation plan was that VC was open to the EIP team and was on a CPA and entitled to s.117 MHA after care. He already had a CCO who was familiar with his history and risks. It was discussed in the Ward Review that should he disengage and relapse again a depot would be considered even if it had to be given coercively. This was documented under the plan from the Ward Review. [NHFT0000168, p.238],

364. In the community, as for any patient, the plan was that, if there were sufficient concerns about disengagement and relapse, VC should be referred to CRHT for intense support and monitoring. If the risks were such that the patient could not be managed in the community an admission would need to be considered (informal or under the MHA).

Improvement in risk

365. The Ward MDT team believed that the risks which had led to the fourth admission had improved prior to discharge.

366. VC was admitted under s.2 MHA despite not demonstrating any psychopathology, with a view to providing additional time for assessment and to establish his medication concordance. The pathway to the fourth

admission was the concern raised over the incident with the flatmate and missing appointments, which resulted in a referral to CRHT which further resulted in two MHA assessments, only one of which resulted in detention.

367. During the course of admission, the Ward team did its best to establish the clinical picture, risk history and treatment plan.

368. There were a number of factors which suggested that VC's condition had improved.

a. It was not considered that the incident with the flat mate Chris was related to VC's mental illness (it not being driven out of delusions, thought disorder or hallucinations).

b. Aside from the incident where he went to his old accommodation (and returned of his own accord) VC he managed unescorted leave without any concerns, willingly handed in the keys for his flat and found alternate accommodation.

c. The non-attendance at Out-Patients Appointment ("OPA") was considered to be possibly due to miscommunication about his address.

d. There were no incidents of aggression or violence during the period of admission.

e. Compliance with medications was established during the course of four weeks in hospital.

f. VC was not presenting with any active psychotic symptoms despite very regular assessment and observation throughout the period of admission.

g. He participated in ward reviews without fail on all occasions and expressed his views without hesitation or concealment.

h. VC agreed with the care plan of follow up with EIP team.

369. By the time of discharge, VC did not meet the criteria for ongoing detention under the MHA; accordingly, his section was rescinded. He demonstrated reasonable insight and demonstrated capacity to make informed treatment decisions. All the above indicated that the risks that were considered in the lead up to admission had improved.

370. VC understood his right under the MHA but did not appeal his section and expressed his wish to get better and be discharged to continue with his studies.

371. We obtained corroborative history from his mother who felt he was not unwell, as well as history from his flatmate to clarify that incident. We also involved his university mental health team, EIP team and crisis in-reach team to facilitate the discharge plan.

372. We discussed alternative medication options such as depot and explained that should there be a further relapse this would have to be given.

373. VC demonstrated capacity to understand the care plan including the medication plan. He was open to the EIP team under the CPA pathway with input from CCO and consultant for follow up.

374. Based on all of these matters, it was considered that VC would be ready for discharge on 24 February 2022.

Likelihood of VC successfully engaging with the community mental health teams

375. I felt that there was a high-likelihood of VC successfully engaging with the community mental health team following discharge, at least in the short to medium term.

376. The basis for this was that he was no longer presenting with any persecutory ideas involving his care professionals which might have contributed to any previous engagement. He was open in expressing why there was a rift in his relationship with the care team owing that to the low threshold for admission to the ward, but I considered that he was coming to terms with the fact that professionals have a duty of care. He had agreed to co-operate as evidenced within the Ward Review discussions. He provided the new address to which he was being discharged to and expressed his intent to continue with the current medication and meet his CPN.

Transfer VC's admission to s.3 MHA

377. I did give consideration to whether it would be appropriate to transfer VC's admission to being under s.3 MHA but did not believe that he met the criteria requirements to make a recommendation / application.

378. The Code of Practice, at Chapter 14.5 says

a. A person can be detained for treatment under section 3 only if all the following criteria apply:

- the person is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital;

- it is necessary for the health or safety of the person or for the protection of other persons that they should receive such treatment and it cannot be provided unless the patient is detained under this section; and

- appropriate medical treatment is available.

(Emphasis my own)

379. As VC was willing to continue the prescribed treatment (Aripiprazole) in the community, as he did on the Ward, I did not feel that I could justify the clause that the treatment "cannot be provided unless the patient is detained". The compliance in the community could be monitored by indirect methods in the first instance, such as pill counting and reviewing dispensing history, and, if required through direct observations.

380. The criteria require consideration of both the nature and degree of a patient's mental disorder.

381. VC was still in early stages in terms of illness chronicity at the time of his fourth admission (less than two years since the first onset of mental illness). He had a number of positive prognostic factors such as short duration of acute episodes, good previous response to treatment (as evidenced by short periods of admission), good pre-morbid functioning (Masters student at university and employed), and no known co-morbidity such as drug and alcohol use or personality disorder.

382. The factors which did make me consider s.3 was if it would be necessary to enforce treatment in form of depot coercively, with physical restraint which would require a longer period of stay, and that this could not be provided unless in hospital. However, on balance I decided to apply the least restrictive principle under the Code of Practice.

383. VC was highly aggrieved by decisions to admit against his wishes despite his willingness to engage with a care plan in community. In his personalised relapse prevention care plan completed in January 2021, he had clearly indicated a desire for professionals to be non-judgmental and to consider the least restrictive approach should he relapse. I felt the need to take that into consideration to some extent, and to be accommodative of his choice of treatment in taking a patient centred approach.

384. At the heart of patient centred care is taking a patient's wishes into account wherever possible. That is the essence of a co-produced care

plan which is an important part of the rehabilitation and recovery based model of treatment approach in psychiatry. There will, of course, be instances when the plans would be overridden, particularly if a patient changed their mind and not willing to work as per the plan or lacks capacity and insight to engage with the plan.

385. During the course of his fourth admission, as well as in the period immediately prior, there was no indication that the psychotic symptoms were of severe degree.

386. I also had regard to the matters listed under paragraphs 14.7 and 14.8 of the Code of Practice, which I did not consider supported transfer to admission under s.3 MHA.

CTO

387. As VC did not meet the criteria for continued detention under the MHA, I could not justify progressing to a s.3 dentition. A CTO cannot be applied for patients under s.2 MHA. Continued detention under s.2 or placing someone on s.3 purely for the purpose of a CTO beyond the point they meet the criteria for continued detention is not supported by the Code of Practice.

Pattern of non-concordance with medication – Fourth Admission

388. VC's medical records from his fourth admission include multiple references to discussions with VC around depot medication and MDT discussions considering a CTO.

389. At the Ward Review on 3 February 2022 [NHFT0000168 at p.224], VC's CPA CCO stated that she "wasn't completely sure" about whether VC concordant with his medication while he was under the care of the community mental health teams, highlighting that VC hadn't been collecting his medication on time and that that "they" considered that VC "would be better off on a depot." The note records that depot medication was discussed with VC however VC refused and "said that he didn't like needles and would prefer to continue with tablets."

390. There was a dispute around non concordance between VC and his CCO. I explored VC's account of this in detail during the Ward Reviews on 10, 17 and 24 February 2022. I explored the evidence for his non-compliance from his CPN on 10 February 2022 in a ward review. [NHFT0000168 at p.238] His CPN informed me that he was late in collecting medications and that he was coming to collect every five weeks rather than every four weeks.

391. When I challenged VC on this, he said there was a period when he was taking one tablet a day as usual and only realised that they were 10mg tablets, and he was meant to take two a day to make it up to 20mg. After it was pointed out, he started taking 20mg and hence he had more supply that he should have.

392. I checked his RIO notes and one of the community cards to see if he had been missing much. It appeared that he had been receiving his medication at the correct frequency. To illustrate this further I have given

a breakdown of dates he collected his medications from the community team prior to fourth admission:

a. VC was discharged from Priory Arnold on 22 October 2021 with TTOs (reported to be 2-week supply). [NHFT0000168 at p.194]

b. On 1 November 2021 the CCO spoke with VC's mother, who reported that VC had told he had been taking his medications. [NHFT0000168 at p.195]

c. On 5 November 2021, VC was seen by his CCO, where it was reported that due to "an oversight" VC had only been taking one 10mg instead of two. He was advised to take 20mg which he said he would do from then onwards. [NHFT0000168 at p.198]

d. On 19 November 2021, VC collected 28 days of medication. [NHFT0000168 at p.199]

e. On 17 December 2021, VC collected 28 days of medication. [NHFT0000168 at p.202]

f. From 19 January 2022 the CRHT team took over the medication monitoring. [NHFT0000168 at p.205]

g. During his contact with CRHT he was observed to be putting medications in his mouth but not drinking water. On one occasion he was noted to be putting his hand in his mouth as he was walking away after accepting medication and then throwing something in the bin. The CPN thought this appeared to be medication, however the plan

continued with daily contact and VC was monitored to take medication. [NHFT0000168 at p.205]

h. Subsequent concordance was noted. [NHFT0000168 at p.205]

393. VC only failed to attend one of the nine CRHT visits, so overall seemed to have been generally concordant with his medication plan during this period, despite his ambivalence about how helpful it was.

394. In order to improve the mediation concordance, I proactively engaged VC in first understanding the possible reason for non-adherence, and then in discussion about strategies to improve adherence. This included psychoeducation on the advantages of taking a depot, explaining the benefits and reducing negative attitudes towards this.

395. VC was adamant that his preferred choice of medication was oral Aripiprazole and gave reasons of this suiting him better than other medications and tolerating this without side effect, as well as his dislike for needles. I did not opt for coercive treatment by administering depot with physical restraint and force. This would have also required taking blood tests and undertaking an ECG under restraint which would be a futile experience as ECG would not be a reliable trace in those circumstances. Sedating a patient to obtain an ECG would be an extreme measure.

396. I continued to discuss the necessity of continued treatment and gave due consideration for VCs wishes, feelings and choice hoping that this would

in turn improve concordance. There is good evidence from research[4] to suggest that: a positive relationship between a patient and therapist; assessing the possible reasons for non-adherence and making attempts to modify that behaviour; performing routine evaluation to check for adherence; adapting to a patient's needs and allowing the patient to participate in decision making; and accepting that patient has a right to share their views about medication, all enhance patient concordance.

COVID Vaccine

397. VC's records indicated that on 4 February 2022 a Covid vaccine was administered to him [NHFT0000168 at p.229].

398. I do not recall if I was aware of this, and do not recall having taken this information into account at the time, nor questioning whether VC was honest about his reasons for refusing depot medication.

399. In hindsight, it may have been that VC was dishonest regarding his view about needles. Equally, VC's decision making regarding the COVID vaccine may have been quite different to that related to depot medication. COVID was perceived as a condition with a high mortality rate and there was no option to choose between injection or oral medication. The need for depot injection was met with a choice. VC may not have perceived the

[4] NICE 2009 Medicines Adherence: Involving patients in decisions about prescribed medicines and supporting adherence); [WITN0206009] Julius RJ, Medication adherence: A review of the literature and implications for clinical practice. Psychiatry Practice 2009; 15: 34-44 [WITN0206004]

benefits in same way between the two. Also, the COVID vaccine was one-off, whereas the depot is recurrent for a long period.

400. These are however just my reflections in hindsight as I did not challenge him on this at the time.

10 February 2022 Ward Review

401. At a Ward Review on 10 February 2022 [NHFT0000168 at p.238] VC's CPA Care Co-ordinator stated that she considered that VC would benefit from depot medication. The note also records that CTO was considered. During the clinical team's discussion with VC at this Ward Review, VC is recorded as denying that he was ever non-concordant with his medication, and saying "that he had one recognised episode which was the first admission […] [h]owever he said that the following ones were not rational […] [and] that his experiences never reappeared" after his first admission.

402. At the review on 10 February 2022, the records state that the four admissions were discussed and the reasons behind his previous admissions were explained to VC. It was only in this context that he gave a detailed description of the first episode. I do not recall exactly how much he remembered about the other incidents but my recollection is that that he had memory about those incidents .

403. I recall that during the course of his first or second admission he has informed the staff member in that ward that he wanted to apologise to the victim for his behaviour. It is likely that the aggression towards police was

mentioned as the documentation says reasons for previous admissions were explained.

404. The incident that led to the crisis referral and fourth admission was discussed at the Ward Review on 3 February 2022. [NHFT0000168 at p.225] At that time, VC recalled the incident and gave a response to say that it was an altercation, and that police decided not to take matters further, but gave little further information, hence we obtained the version of events from his flat mate.

405. The incident of aggression towards the police prior to the third admission was discussed on 21 February 2022 by Dr Lomas who was going to provide a witness statement. [NHFT0000168 at p.225] That entry does not suggest that VC lacked memory of the incident. My recollection of what I understood about the incident was that he was not aggressive towards staff and was polite until the police arrived when he showed aggression towards them and assaulted them.

406. His insight into his mental illness was partial in my opinion as I have explained above.

407. In most instances, patients admitted to mental health wards present with partial insight into some aspects of the disorder. They may recognise that they experience symptoms, and that the symptoms are a feature of mental illness, but may not agree with the clinical explanation from a medical or treatment perspective. They may have only a patchy recollection of every acute episode. Sometimes this can be because of the severity of illness.

Sometimes it can be due to impact on cognitive functions affecting memory for that period. On occasion, it will be a psychological defence mechanism to safeguard the recovered mind from painful memory.

408. Continued detention under a MHA section or treatment with medication do not necessarily bring back those memories or improve insight into them. Sometimes it can be traumatic to probe these memories persistently, which can become a source of confrontation to the patient who become more and more defensive. VC discussed his experiences such as hallucinations, thought interference and persecutory ideas that he has experienced in the past. He admitted that it was uncharacteristic and equated to this to a psychotic episode. My impression was that, subjectively, he may not have experienced psychotic symptoms during the second admission in the same way as he experienced them during the first episode, perhaps in terms of its intensity or his response. Any psychotic experience he might have experienced shortly prior to the fourth admission certainly appeared less intense than those which had preceded this.

Masking psychotic symptoms

409. As explained above, the term masking does not have a technical definition in descriptive psychopathology but could be understood as a way a patient tends to conceal their mental health needs and psychotic experiences from others. It is a complex subject.

410. During the four-week period of admission, which involved regular assessment in Ward Reviews and nursing observations, there was no substantial evidence to suggest that VC was experiencing psychotic symptoms.

411. The mental state examination was carried out by a number of different experienced professionals including clinicians who have assessed him in the past. It is, in my experience, extremely unlikely that someone is able to conceal their symptoms and experiences over that period. The incident of aggression towards a flat mate prior to admission was not felt to be related to psychosis. VC was able to discuss his psychotic experiences from the past during Ward reviews but yet maintained that he did not experience them for some time, at least for a minimum of four weeks if not longer.

412. Collateral history from his mother also suggested that from her perspective he was not presenting as unwell prior to admission. Based on direct and circumstantial evidence I did not think he was masking symptoms. There is, of course, always a chance that he might have been masking his symptoms, and defied every attempt by clinicians to elicit psychopathology (though I consider this relatively unlikely).

17 February 2022 Ward Review

413. A Ward Review took place on 17 February 2022 [NHFT0000168 at p.249-250]. The note from this states that it was led by an ST5 doctor. VC was recorded as having "denied any problems with medications and when

asked whether he would be happy to continue the medication in the community he replied that this was the argument they always have." VC was asked if he would accept depot medication and he refused. VC told his treating team that he was "happy to engage with the community team."

414. VC's treating team considered the risk that VC might disengage from treatment. It was noted, however that there had not been long periods of disengagement from the EIP teams in the time prior to previous admissions. VC had not spent long periods without contact, whilst unmedicated. When he has stopped medication, it was reported as 'for days' only.

415. The treating team's view was that given that we had agreed a joint care plan taking into account his wishes and choice of medication, his acceptance to continue the medication in the community and willingness to meet the CPN at the stipulated frequency, the likelihood of remaining engaged was high.

416. VC was relieved with the plan to not prolong admission as he was keen to complete his university studies. He was under care of the EIP team under a CPA pathway. The EIP team tend to care for patients following the first episode of psychosis for at least 3 years. Any disengagement could be flagged as a concern and a MHA assessment could be arranged to consider admission back to hospital if required.

NFHT Level 2 Comprehensive Report

417. NFHT produced a Level 2 Comprehensive Report, dated 15 March 2024 [NHFT0000451].

418. On page 18, at paragraph 54, the report states the following:

> "In our view, [the inpatient's] decision not to enforce to depot took too little account of VC's significant risk history when psychotic and placed too much emphasis on his personal assurances to them on the ward. The clinical record evidences the team's conclusions but does not indicate what their thinking was in relation to the two-year history of risk and non-concordance [...] it is our view that there was sufficient evidence from VC's behaviour over the preceding two years to lend weight to the importance of instigating depot medication – and therefore placing VC on Section 3 of the MHA, and a CTO in order to enforce it longer term for the benefit of longer-term community management. However, we recognise that this is an area of clinical judgement where different professionals may reach different conclusions."

419. VC was a 30-year-old man with a diagnosis of Paranoid Schizophrenia. He was open to the EIP team at the time of admission. It was clear that VC felt aggrieved by the fourth admission under a section of MHA against his wishes despite his willingness to work with the community mental health teams.

420. VC did not present with any psychotic symptoms during the admission, nor during the two mental health assessments carried out on 19 January

2022 and 28 January 2022. The obtained collateral information obtained from his mother on 2 Feb 2022, stated that VC did not seem unwell prior to the last admission. [NHFT0000168 at p.223]

421. VC was not showing signs of aggression or violence during the entire period of admission and his risk was classed as low in the 14 February 2022 assessment.

422. VC was compliant with medications during admission and adherent to the treatment plan that was agreed with him. On 10 February 2022, he reported that he "wanted to get better and continue with studies". It was noted that that time he "demonstrated capacity throughout". [NHFT0000168 at p.238]

423. I took into consideration the concerns expressed by the EIP team around non-adherence to treatment plans and discussed this subject with VC throughout his admission. As he disputed the complaint of noncompliance and not making himself available for reviews, I explored this in detail.

424. There was sufficient evidence (as documented within his notes) to support that misunderstandings had arisen on the part of the EIP team over VC's address and that he had not misled them. VC gave his current address for discharge.

425. Following his discharge from his third hospital admission on 22 October 2021, although there were times where he had not responded to text messages and phone calls, he was collecting medications on a monthly basis prior to his fourth admission. There was a brief period where he was

taking Aripiprazole 10mg tablets instead of 20mg tablets. He gave what I consider was a plausible explanation for this. He collected 4 weeks supply of medications on 19 November 2021 and 17 December 2021 and was supervised for medication compliance from 19 January 2022.

426. VC was about to be discharged to EIP team under the CPA. VC was willing to engage with the EIP team post discharge and adhere to treatment plan. In the event of disengagement and nonadherence resulting in relapse of illness a MHA assessment could be arranged following discharge.

427. I advocated for depot medication for VC from the outset. During the Ward Reviews on 3, 10 and 17 February 2022, I engaged in conversations about depot but VC clearly expressed his preference for staying on the oral medications. He also refused to have ECG which is a requirement for initiation of long-acting injectables ('LAIs'). [[NHFT0000168 at p.225 - 251]

428. It is always a balancing act with regards to deciding on the most appropriate treatment choice for a patient, and I took into consideration the clinical picture, risks, evidence base and treatment guidelines, the views of multi-professional team, the views of patient and carer, as well as acting within the legal framework of the MHA and its guiding principles including the least restrictive approach.

429. Depot medication can be an effective choice for managing non-adherence, however prescribing LAIs should take into consideration a

number of factors particularly when this is not the patient's preferred choice.

Principle of 'least restrictive approach'

430. The concept of using the least restrictive approach has been the guiding principle in the Mental Health Act legislation since 1983. This has been further endorsed by the CQC in their report, The State of Care in Mental Health Services 2014 to 2017. The Care Quality Commission found that some patients are still receiving 'overly restrictive' care and called for this to be reviewed. These practices can cause harm because of the very nature of using force to restrict an individual's movements, leading patients to feel powerless and potentially retraumatised, especially if they have previously experienced trauma (Care Quality Commission, 2020). [WITN0206014]

431. During the fourth admission if we were to give a depot injection, it would have been against VC's preferences and choice. There was no doubt that this would have required physical restraint to administer as he made it clear during the discussions that he did not want this.

432. VCs personal relapse prevention care plan dated 18 Jan 2021 had expressed clearly his wish to be assessed in a non-judgmental manner and that admission was to be the last resort. [NHFT0002533]

433. In the circumstances, for the above reasons, I consider that the MDT were justified in not instigating depot medication at this time. None of the ward

team were raising concerns over VC's compliance, or proposed that he should be on depot to ensure compliance.

434. On page 11, at para.29, the report states the following:

> "In summary, VC appeared to recover quickly from each episode/relapse of psychosis when an inpatient, resuming work or attendance at university on discharge. In our view, discharge planning reflected an inpatient focus on VC s presentation in the present as a snapshot view of someone with a recent relapse and relatively quick short-term recovery, rather than taking a longer-term view of VC's pattern of behaviour, risks and needs with consideration of what might be required for successful community management."

435. The investigators made no clear reference an establish the pattern of noncompliance by cross-checking drug cards or by looking for direct evidence of this. Instead, their conclusions appear to be based on reports by the CPN and indirect evidence which is subject to errors

436. I did take into consideration the longitudinal view, and explored the issues of non-compliance, and did my best to look for direct evidence for noncompliance as well as discussing depot options and actively promoted it.

437. There is an inherent tension RCs face in making decision between administering coercive treatment such as depot under restraint, when the patient is concordant and no longer meets the sectioning criteria, in

accommodating the principles of patient centred care, patient choice, coproduced care plans, and least restrictive approaches to treatment.

438. The report attributed relapse to non-concordance with medications, with no reference to possible psycho-social causes of relapse which the VC gave importance to in his personalised relapse prevention plan.

439. I do not believe that too much focus was placed on inpatient compliance. I believe that the longer-term pattern of VC's behaviour was appropriately considered based on information we had at the time by the MDT during the discharge process.

440. In arriving at a clinical decision around engagement and compliance, I did take into consideration the various practice guidelines, academic and clinical evidence and nuances in making a clinical decision about where a more or less coercive route should be taken to manage his condition.

441. I felt that enforcing the depot against his wishes and taking a coercive and restrictive route was likely to break the therapeutic relationship with the professionals thereby alienating him even further. He was already very aggrieved by the compulsory admission despite his willingness to work with professionals in the community and expressed wish and intent to engage with his care team in community post discharge. The essence of treatment plan for VC was ongoing treatment with medications, monitoring of his mental health and support his recovery. Depot and CTO are not the only means to achieve this. He needed medications and was taking oral medications and was willing to continue with this. He needed monitoring

and was open to a care team with a good level of resources to monitor him closely. In the event of his mental health deteriorating relating to poor concordance or disengagement there were significant safeguards and tools which were always available such as a MHA assessment.

442. He could have still decided to refuse to take the depot or refuse to meet with the community team even if he were on a depot and CTO (notwithstanding the fact that he was on s.2 and did not meet the criteria for continued detention or conversion to a s.3 and hence CTO was not possible). The only additional power that would have been available under CTO would have been the power of recall and from a practical perspective, the same outcome of admission to hospital could be achieved through a MHA assessment without necessarily subjecting him to a CTO.

443. It was never suggested in the ward review or discharge meeting that the EIP team were not going to see him at his home address post discharge or would discharge him completely from services should he disengage as he was on a CPA pathway and subject to S117 aftercare.

NHS England Commissioned independent investigation

444. NHS England Commissioned an independent investigation into the care and treatment provided to VC by NHS services prior to the events of 13 June 2023 [NHFT0000530]. On page xv, two of the key findings are summarised. Firstly, the Report finds that VC's insight into his condition "did not appear to increase" and he did not demonstrate

retrospective insight." Secondly, the Report found 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 [...] the question of capacity does not appear to inform all assessments of risk across the different care settings."

445. I have set out earlier in this statement my views on VC's capacity and how it was assessed. I consider that VC's capacity was appropriately kept under review, and that during the period of his fourth admission, when I assessed him, he had capacity to make decisions relating to his care and treatment.

Royal College of Psychiatrists' Good Practice Guide for the Assessment and Management of risk to others

446. With reference to the Royal College of Psychiatrists' Good Practice Guide for the Assessment and Management of risk to others [NHFT0015099], I consider that, whilst the general principles were followed, there were aspects where improvement could have been made.

447. With regard to risk assessments, as a team we tried to gather as much information as possible with the available resources. Though a PNC check was requested from MDT it was not followed through.

448. Interaction between clinician and patient is crucial, when assessing the risk of aggression, violence, the possibility of masking psychotic symptoms, and a lack of insight. I engaged with VC throughout the

period of admission in assessment and treatment plans and psycho-educated him.

449. We established a comprehensive history, and sought out information about previous incidents and their relationship to VC's mental state as well as exploring the history and evidence for non-concordance and disengagement.

450. We considered the possible triggers for relapses (namely stress of university course and exams, loss of sleep and possible non-concordance) and included them in the discussion around treatment planning.

451. Historical factors, environmental factors (i.e. ensuing accommodation issues were addressed before discharge) and the least restrictive principles were considered to promote engagement.

452. VC was deemed to have capacity to make informed decisions. He was deemed to have partial insight, which is a common occurrence in patients with mental illness particularly psychosis. I consider that the entries regarding the findings in relation to insight should, however, have been more explicit.

453. The four-week period of admission with regular assessments in Ward Reviews, mental state examinations, regular observations by multi-disciplinary teams, trial periods of leave, and establishing concordance with medications provided reassurance that VC was not masking symptoms. The lack of any incidents of aggression or violence during the

period of admission, and the reasons established for the aggression prior to fourth admission provided adequate reassurance to instigate a risk management plan as part of treatment plan and discharge back to community.

454. The recording of risk management plan could have been better. The management plan was discussed with the EIP team, ensuring that communication was not compromised. Positive risk taking and recovery principles were considered and leave tested through trial community leave. The treatment plan was established with the intention of providing opportunity for social recovery and therapeutic optimism. Patient's capacity was assessed and recorded. Community support through CPA pathway was ensured prior to discharge.

455. The Good Practice Guide of RCPych sets out some general principles in the assessment and management of risk to others. It acknowledges the key challenges faced in management of risk in that risk cannot be eliminated but managed and mitigated. [NHFT0015099] It emphasises the need for formulation and management with regular monitoring and review of the dynamic nature of the risk which can change in the briefest of times. Under the management of risks it has some guiding principles which were considered in the plan for VC:

a. Capacity. The patient's capacity was considered and deemed to have capacity to make informed treatment decisions.

b. Engagement. This was considered and he was willing to engage with the care team post discharge, including agreeing a safety plan for e.g. when asked if he would co-operate with regular monitoring such as weekly basis, he was willing to do so. The issue was previous disengagement, which was explored. There were reasons to support his position with regard to a miscommunicated address as at least partly contributing to the perceived disengagement.

c. Admission. It was deemed that he could be treated in the community and admission under a section was no longer necessary

d. Community Support. VC was already open to the EIP team and was under a CPA pathway with a care co-ordinator and consultant psychiatrist to monitor his mental state, for dynamic assessment of risks and implement any risk management plan

e. Family input. The views of family were considered

f. Psychological interventions. VC declined any formal psychological input but supportive psychological interventions were considered. Some of the aspects around respecting patients' wishes, psychoeducation on treatment options, and co-produced care plans are essential aspects of psychological interventions which were provided during the period of admission.

g. Use of MHA. The necessity of continued detention under s.3 MHA and a CTO were considered and his rights under the Act were explained to him. As he no longer met the criteria for continued detention under the Act, I had to exercise the power of discharge from the section in keeping with the good practice guidelines. Hence a CTO could not be implemented.

h. Medications. Depot injections were considered to enhance adherence but this was at odds with the patient's choice. The principles of least restrictive approach were followed, with a mitigation plan for the short and long term, that should non-compliance emerge resulting in relapse, the provision of a MHA assessment was available for reassessment and readmission with a view to more restrictive approaches.

i. Compliance was established and monitored, evidence for non-compliance as a risk factor were explored and discussed.

j. It was considered that with regular monitoring of his mental state, any future episodes of aggression and violence could be mitigated with escalated interventions such as medication review in community or a readmission to ward.

k. CPA - He was already under Care Programme Approach to identify and manage treatment needs.

l. Assertive outreach teams did not exist, however the EIP's remit includes CPA case management.

m. Carers and other professionals were consulted throughout the period of admission and discharge planning.

n. Long term plan of managing disengagement of prospective discharge plan from EIP in the event of disengagement were not discussed.

456. One of the fundamental principles of risk assessment and management is that although risks cannot be eliminated they can be managed and mitigated. During the course of his fourth admission and discharge planning, various mitigation factors were taken into account, as described above.

457. It was decided that a less restrictive approach should be taken, to promote patient trust and engagement with the psychiatric services in general and EIP team in particular. VC was on a therapeutic dose of anti-psychotic medication which appeared to be objectively effective in reducing symptoms and was tolerated by him without side effects which he was willing to continue and be monitored. He had no outstanding social risk factors such as homelessness, or drug use, had good pre-morbid functioning and family contact, was known to his university mental health support system. He was asymptomatic. He demonstrated partial but adequate insight to make a capacitous decision on choice of medications, he had not presented with risk to self or others due to mental disorder during the period of fourth admission. The incident involving risk to others (namely the altercation with flatmates) prior to admission was not considered to be related to

his psychosis. He was managed under CPA pathway by the EIP team. The framework of MHA was always available to call out for a MHA assessment should things deteriorate due to disengagement and non-compliance so any emergent risks could be adequately managed in the most appropriate setting with the most appropriate treatment plan.

REFLECTIONS

458. I would like to express my deepest and most sincere condolences to the victims' families. I do not know how to begin to describe their grief.

459. The incident was a huge shock that changed me as person forever. It has left me with several questions for which I am still searching for answers.

460. I saw VC as a young man with a lot of potential. He was an independent, intelligent man who had his dreams. He was focused on his studies and getting through his university course meant a lot to him. He was managing this alongside employment, working long hours in a warehouse.

461. His presentation was unusual in many ways. He was thirty years old by the time of his fist psychotic first episode, and when I saw him, still early in his journey with a mental health condition that would have caused more anxieties and uncertainties about his life. His admissions were short-lived and his presentation seemed to have improved after every admission within a matter of days to weeks.

462. He had had three periods of admission prior to my involvement. Adjusting to his 'normal' life after a relapse and admission would have been

challenging. It appeared he had good level of pre-morbid functioning, no forensic history until the first episode, no convictions, no drug and alcohol issue, no dissocial personality (i.e.many positive prognostic factors).

463. He had endured difficulties growing up mainly related to having to adjust to a new country, language and culture and faced bullying when young. Though he came across as a quiet, reserved person, the more trust he gained the more the open he was. Equally there was a sense of grievance and helplessness or powerlessness over his repeated admissions to the ward environment. Despite that, he was able to acknowledge his symptoms and their impact upon himself and others, and I felt he was getting to accept that he needed help, and despite the differences in opinion over his mental illness, he was willing to "do his part" as he put it. At the time, I thought the more powerless he felt over his lack of choice in respect of his own care and treatment, the more entrenched his delusions were becoming. At one point he began involving people who were trying to help him within his delusional belief systems, and he was distancing himself and becoming less open and transparent. This was in keeping with what he had stated in his personalised relapse prevention plan that he had made in 2021. I attempted to regain his trust by taking a less restrictive approach but whilst ensuing that he was still treated with medications at a therapeutic dose, something that he tolerated well, responded to and was willing to continue.

464. I tried to undertake a bio-psycho-social approach to understanding and treating his mental illness rather than imposing a purely bio medical

framework. I have had more success in helping patients by adopting this approach. I felt a collaborative approach by fostering a trusting and compassionate professional relationships would be more helpful in supporting him with his treatment plan by working with his wishes and choices and at the same time ensuring my duty of care to him and the duty of public safety.

465. I was in no doubt that he needed ongoing long-term help, which would involve a combination of medical and non-medical approaches in the form of medication, monitoring of outcomes and progress, psychological input to promote engagement, and social support to achieve meaningful recovery. However, we faced many challenges. Firstly, VC's presentation was atypical. The symptoms were very acute in their onset and recovery. It did not appear that he was presenting with active symptoms or evidence of psychosis immediately before or during the fourth admission. He persistently disputed that he had been non-concordant, and I felt that it was sometimes difficult to refute his claims in this regard without clear evidence.

466. There was also a dispute with regard to the accusation about giving a false address, and lack of evidence to substantiate those accusations.

467. His presentation during the admission did not suggest he was suffering with active symptoms. He was demonstrating concordance and capacity, not presenting with obvious risks of causing immediate harm to himself or others. He had managed independent leave safely, and expressed a willingness to co-operate with the community team post discharge.

Making a collaborative plan incorporating his choices and wishes, knowing that he has no other care needs from a social perspective and that he would be supported by a community team supporting him under the framework of the CPA gave me the confidence in initiating a discharge plan. At the time I did not have strong reasons to doubt his commitment to engage with the plan, in order to get better and get on with his life.

468. As the in-patient RC, I always face some inherent challenges. Whist I am to work with a patient's best interest at heart, there are conflicting demands which are at constant tension with each other. Balancing between coercive approaches to treatment, such as physical restraint to treat someone who is expressing intent to accept alternative forms of treatment, which can be equally effective, as opposed to adopting a least restrictive approach.

469. Statistically, homicide by a service user living with a psychotic illness is very rare, at a rate of less 0.01%. It is a statistically unpredictable occurrence – although lesser degrees of violence and aggression are not uncommon.[5] The relationship between violence and psychosis is highly complex. Whist there are some static risk factors, there are a number of dynamic risks as well which can change within a short period of time. Regardless, a robust plan to mitigate the risks in the community is essential.

[5] (Walsh et al, 2002) [NHSE0002438]

470. Mental health services have long operated with resource constraints. In hindsight, I realised that the total time I had, for planning, assessment and treatment of VC during the four-week period was about three hours. I attended three 30 minutes for Ward Reviews, four MDT meeting of around 15 minutes plus time to read notes and discuss with professionals

471. My timetable only had 3.5 sessions per week (14 hours in total per week) for all 8 patients under my care together. This included activities such as 72 hr review of newly admitted patients (which takes approximately 1 hour per patient, MDT time of around 15 minutes per patient, Ward Review time of approximately 30-45 minutes per patient, reviewing records which takes significant time in mental health, direct clinical support and supervision of trainees, family meetings, liaison time with other agencies / families, time required to address 'consent to treat', refer to Second Opinion Appointed Doctor ("SOAD") and liaise with SOAD, physical health reviews, medico legal time such as preparing and presenting at tribunals , carrying out MHA assessments for patients on the Redwood 1 Ward, and cross-covering the college consultant on their non-working days. This is highly insufficient. Therefore, I had to rely heavily on other team members providing feedback and delegating tasks.

472. I do not know if VC was concealing his symptoms and was untruthful about his intentions throughout the period of treatment (which was missed by all who treated him). Whilst I was cognisant of the potential for relapse and aggression of lesser degree, I never thought he was capable of carrying out such extreme and heinous acts of violence.

Changes to my practice

473. As a consequence of these events, I have been taking more time to look for discrepancies and variations in evidence in patient records and where there are variations, I continue to put due diligence in understanding the reasons and explanations.

474. The time allocated per patient in ward review has increased slightly and the template for recording the minutes of ward review has also been modified to be more inclusive, however it is still highly insufficient. The incident has changed my clinical practice. I would now err towards a more coercive treatment approach and be less trusting of reassurances from patients. My overall approach to the principle of least restrictive approach has also changed particularly when there is debatable evidence and potential for the risk of harm. I sincerely hope that this does not turn into a defensive restrictive practice to the detriment of patient's rights and choices.

475. There has been an improvement in inter-agency working with the appointment of police liaison officers who are more readily accessible. The threshold to override confidentiality in cases where there are concerns over safety and risk has been lowered even further. I have been more explicit in discussing the aftercare contingency plans with community teams and not leaving this entirely to their discretion.

Public comments

476. I have not given any interviews or otherwise made any public comments about the actions of VC or the matters under investigation by the Inquiry, save for commented made in the context of the NHFT investigations and the NHS England Theemis report.

RECOMMENDATIONS

477. I would be grateful if the chair of the inquiry could take into consideration the inherent challenges faced in the management of patients with serious mental illness that I have explained in my reflections above.

478. Recommendations to improve inter-agency working would be extremely helpful. A number of invisible barriers exist between agencies working towards a common objective. It is not possible to access records from one NHS Trust to another, or between private contracted services and NHS Trusts. Primary care records can only be accessed with limitations. Social care records are not linked to health records. Accessing essential information from public sector agencies such as police in a more readily available manner would be useful. Information sharing is key and should not be a barrier, and improvements in this regard will likely enhance the level of care that can be provided to patients, and reduce the risk that they might pose in the community.

479. There is always pressure to discharge patients from ward to community due to lack of beds, community services lack resources too, the number of beds available does not keep pace with the increasing demands on

health services. Mental health services have been underfunded for a long time.

Statement of Truth

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

Signed: GRO-B

Dated: 28 December 2025

Index to First Witness Statement of Dr Thangavelu

Reference	Description
NHFT0000191	Risk and Safety Assessment dated 28 January 2022
NHFT0000186	Core Assessment completed on 28 January 2022 by a CT3 doctor
NHFT0000168	RIO notes including ward review documentation
NHFT0000451	NFHT Level 2 Comprehensive Report dated 15 March 2024
NHFT0000530	NHS England Commissioned independent investigation into the care and treatment provided to VC by NHS services prior to the events of 13 June 2023
NHFT0000130	NHFT Service Guide: Adult Mental Health Acute Inpatient wards
WITN0329020	RCPsych Quality Standards QNWA 9th Ed 2025
WITN0206009	NICE clinical guidelines titled "Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence" published January 2009.
WITN0206010	British Association for Psychopharmacology Guidance titled "Evidence-based guidelines for the pharmacological treatment of schizophrenia: Updated recommendations from the British Association for Psychopharmacology" published in the Journal of Psychopharmacology 2019.
WITN0206011	Email from Tuhina Lloyd, Consultant Psychiatrist, dated 3 February 2022 at 14:24
WITN0206012	Email to Tuhina Lloyd from Dr Karthik Thangavelu, dated 8 February 2022
WITN0206004	Paper titled "Medication Adherence: A Review of the Literature and Implications for Clinical Practice" published 2009.

WITN0206003	Paper titled “Guidelines for depot antipsychotic treatment in schizophrenia” published in European Neuropsychopharmacology 1998.
WITN0206002	Paper titled “Efficacy and Effectiveness of Depot Versus Oral Antipsychotics in Schizophrenia: Synthesizing Results Across Different Research Designs” published June 2013.
NHSE0000539	NICE Guideline for Psychosis and Schizophrenia CG178, 2014
NHSE0002438	Paper titled “Violence and schizophrenia: examining the evidence” published in the British Journal of Psychiatry 2002.
NHFT0002533	Personal Relapse Prevention Plan from 18 January 2021
WITN0206013	R. Murray (2016), Should psychiatrists be more cautious about the long-term prophylactic use of antipsychotics
NHFT0015099	RCPsych, Good Practice Guide, Assessment and management of risk to others (2016)
WITN0206014	CQC, The state of care in mental health services, 2014-2017

NHFT0000199	**Medical Records of VC from 02/02/2022, NHFT, re: Summary and Care Plan**
NHFT0000198	**Medical Records of VC dated 14/02/2022, Nottinghamshire Healthcare NHS Foundation Trust, Re: Summary and care plan**
NHFT0000287	**Email from Jonathan Gibson to Haley Stocks; Becky Ash; Rachel Buczkiewicz and others, re: RE: VC nearest relative info**